

WONDER Foundation

FEMALE GENITAL MUTILATION

Report

Estimating FGM Risk in Westminster

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INTRODUCTION

Female genital mutilation is a human rights violation that is estimated to affect over 100-140 million women and girls around the world¹. In recent years, the United Nations General Assembly and European Parliament have recognised the urgent need to address this issue, and thus passed resolutions to intensify efforts to end the practice.

Here in the UK, efforts have been made by government and local authorities to safeguard girls who may be at risk and provide services for those already affected. In 2007, a groundbreaking study funded by the Department of Health revealed that 16,000 girls under the age of 16 were at risk of the practice in England and Wales alone². However, this report failed to break down the estimates of FGM prevalence into regions and is based on 2001 census figures, making these estimates out of date. More recent studies that take into account a rise in immigration from FGM practising countries, argue that the number of young girls at risk of FGM today may be as high as 65,000³. Yet, despite new research and government efforts, there is still growing concern that not enough is being done. The Intercollegiate⁴ report on FGM, published in November 2012 states that 'At the local level, FGM is still not fully integrated into the child protection system and girls at risk of FGM are not receiving adequate protection from harm.'⁵

WONDER understands the essential role that local research plays in the fight against FGM. It is a practice that is best tackled from the grassroots up and through initiatives co-produced by affected communities. Teachers, health workers and other professionals responsible for safeguarding children need to be able to adequately identify girls who may be at risk. We have produced this report to help frontline professionals and policy-makers in the

City of Westminster to better identify and safeguard those at risk of FGM through a better understanding of the extent of risk. We hope that this report will instigate the change necessary to end FGM and encourage other local authorities and councils to conduct research into the prevalence of FGM in their local area. To this end, we invite critique of the methodology used so that it can be refined and used as a tool by other areas wishing to assess local FGM risk.

Note on language: Female Genital Mutilation, FGM, Female circumcision and cutting are all words used to describe FGM. Different communities tend towards using different words. Female Genital Mutilation, or its abbreviation, FGM, is our preference, reflecting most accurately the reality of the practice. However, we have not used it exclusively and recognise that some communities where FGM takes place find it uncomfortable to use and prefer the term 'cutting'.

WONDER's mission is to improve the all-round wellbeing of vulnerable communities worldwide, through increased access to education, healthcare and economic and personal development tools. We work with partners in the UK and internationally to create change in afflicted communities and help lift them out of poverty. We have a particular focus on projects that help women and their families and sharing knowledge on the issues that affect them.

Acknowledgements

We would like to thank the following, amongst others, for their contributions to this report: Westminster City Council, Dr Richard Adams, Manuela Balliet, Councillor Iain Bott, Andrea Burgui, Sophie Fleming, Dr Raheal Gabrasadig, Carmen Gonzalez, Olivia Rathbone, Peter Smith, Seday Yegebriel.

¹ FORWARD, (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*. London: Summary Report, (London: FORWARD)

² FORWARD, (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*. London: Summary Report, (London: FORWARD)

³ Bindle, J.,(2014) *An Unpunished Crime: The lack of prosecutions for female genital mutilation in the UK*, (London: The New Culture Forum)

⁴ A coalition of The Royal College of Midwives, The Royal College of Nursing, The Royal College of Obstetricians and Gynaecologists, Equality Now and other trade unions.

⁵ RCM, RCN, RCOG, Equality Now, UNITE (2013) *Tackling FGM in the UK: Intercollegiate Recommendations for identifying, recording, and reporting*. (London: Royal College of Midwives)

BACKGROUND

1.1 Definition

Female genital mutilation (FGM) also referred to as female genital cutting, is defined by the World Health Organisation as:

'All procedures that involve partial or total removal of the external genitalia, or the injury to the female genital organs for non – medical reasons'.⁶

FGM has been recognised by the United Nations as a human rights violation that causes serious physical and psychological harm to women and girls.

The procedure can also potentially deny women of sexual enjoyment and reproductive health.

1.2 Types of FGM

TYPE	TYPE	DESCRIPTION
Type 1	Clitoridectomy	The partial or total removal of the clitoris or the prepuce (the fold of skin surrounding the clitoris).
Type 2	Excision	The partial or total removal of the clitoris and the labia minora (lips surrounding the vagina), with or without the excision of the labia majora.
Type 3	Infibulation	The narrowing of the vaginal opening by creating a covering seal. This is formed by cutting and repositioning the inner, or outer, labia with or without removal of the clitoris.
Type 4	Other	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

⁶ UNICEF(2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, (New York: UNICEF)

1.3 Health Implications

FGM comes with a long list of serious, harmful, physical and psychological consequences listed below:

PHYSICAL	PSYCHOLOGICAL
Extensive bleeding when a girl is first cut	Low libido
Severe pain	Depression
Wound and urine infections	Post traumatic stress
Chronic vaginal pains	Flashbacks
Difficulty urinating and menstruating	Substance misuse and self harm
Pregnancy complications	Anxiety
Childbirth death	Sexual dysfunction
Infertility	

1.4 Reasons Given For the Practice of FGM

Justifications for FGM differ across communities, cultures and countries. However, the most common reason is a shared desire to maintain longstanding traditional practices. In Cote d’Ivoire, Eritrea and Sudan, close to 70% of women claim that ‘tradition and custom’ are the most compelling justifications for the continuation of the practice.⁷

Other cultures believe that FGM reduces a woman’s libido making her less promiscuous thereby limiting

the chances of her committing adultery. This belief is particularly harmful in communities where it has become a societal norm, making it extremely difficult for women who have not been cut to get married.

In some African countries, FGM is more of a rite of passage for girls who are coming of age, and in many countries where FGM prevalence is above 70%, women believe it to be required by religion.⁸

1.5 Role of Religion

FGM is practiced by Christian and Muslim groups and also by those practising traditional beliefs. UNICEF’S Global FGM Statistical Report found that religion can help explain FGM distribution in many countries, but this relationship is not consistent.

For example, in Benin, Cote d’Ivoire, Ethiopia, Ghana, Kenya and Senegal Muslim groups were more likely

to practice FGM than Christian groups; however, in Niger, Nigeria and Tanzania the prevalence of FGM was greater among Christian groups.

In other countries where religion data was available, UNICEF found that there was no significant relationship between FGM and Christian or Muslim belief.⁹

⁷ UNICEF(2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, (New York: UNICEF)

⁸ UNICEF(2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, (New York: UNICEF)

⁹ UNICEF(2005) *Female Genital Mutilation/Cutting: A Statistical Exploration* (New York: UNICEF)

1.6 Prevalence of FGM Worldwide

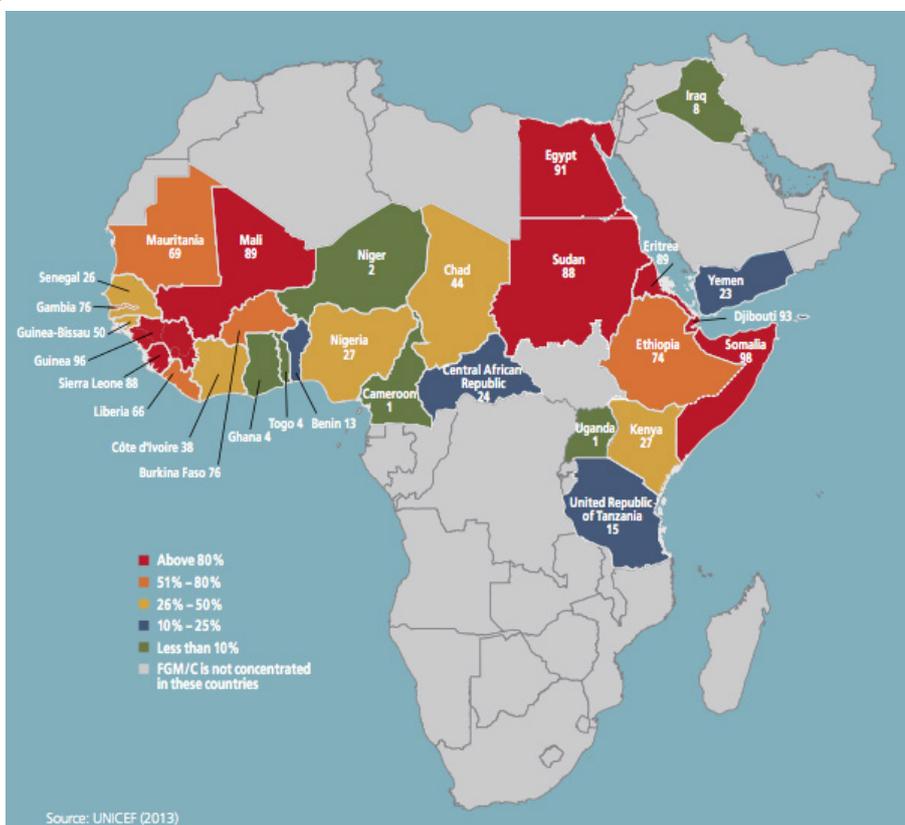
FGM takes place throughout the world. It is estimated that between 100 -140 million women and girls alive today have experienced the practice in one form or another.

The majority of FGM takes place in 28 African countries, but is more concentrated in the horn of Africa where nearly all women have undergone the procedure. This includes countries such as Sudan, Ethiopia, Eritrea and Egypt. FGM is also known to be

practiced among some Muslim populations in parts of Malaysia, Pakistan, Indonesia, the Philippines and Iraq.

In more recent years, there has been an increase in immigration from communities where FGM is practised and as a result Western Europe, North America, Australia and New Zealand have been added to the list of regions where women are now at risk of FGM.

Figure 1: Estimated rates of FGM across Africa and the Middle East



1.7 FGM in the UK

In 2007, the Foundation for Women’s Health, Research and Development (FORWARD) published a seminal report which estimated that 66,000 women resident in England and Wales in 2001 had undergone FGM and 20,000 girls under the age of 15 were at risk of FGM.

It also suggested that 16,000 girls under the age of 8

are at high risk of the most severe type.¹⁰ British born girls are at risk of being cut both in the UK and abroad in their country of origin. Girls whose parents originate from an FGM practicing country are most vulnerable during the summer holidays when they can be taken abroad to be cut, leaving enough time to heal before returning to school.¹¹

¹⁰ FORWARD, (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. London: Summary Report*, (London: FORWARD)

¹¹ HM Government(2011) *Multi- Agency Practice Guidelines: Female Genital Mutilation* (London: HM Government)

1.8 Girls at Risk

- Tend to be between the ages of 5 and 9
- Tend to have mothers who have undergone FGM
- Tend to live in areas with large populations of FGM practising communities¹²

1.9 British Law on FGM

The practice of FGM has been illegal in the UK since the introduction of the Female Circumcision Act in 1985. In 2003, the Female Genital Mutilation Act was introduced to solve the issue of extraterritoriality, making the act of taking girls from the UK to be circumcised abroad illegal.¹³

It also increased the penalty of aiding, abetting or counselling to procure FGM to 14 years imprisonment¹⁴. In addition, a specialist anti -FGM unit was established by the Metropolitan Police Service's Child Abuse Investigation Command (SCD5)

1.10 Current National Initiatives

In 2011, the government published the Multi-Agency Practice Guidelines on FGM, which provides support to all front-line professionals that have a responsibility to safeguard children and adults from FGM-related abuses. This guideline is part of a larger scheme to eradicate all violence against women and girls across the country.¹⁷

In 2012, the Home Office piloted a pocket sized booklet explaining the law on FGM and potential criminal penalties which was reviewed in 2013.¹⁸ In June 2013, the NSPCC launched a national FGM

to help implement the FGM Act (2003) and raise FGM awareness. It consists of one officer who works three days a week and one detective sergeant.¹⁵

In 2008-9 there were 46 FGM investigations undertaken by the police.

This increased to 58 in 2009-10. To date, there have been no successful prosecutions in the United Kingdom for FGM although three doctors have been found guilty of serious professional misconduct before the General Medical Council and were subsequently struck off.¹⁶

helpline to help children at risk as well as offer advice to concerned professionals or members of the public. In just over three months, the helpline received 102 FGM enquiries which have led to 38 police referrals so far.¹⁹

In March 2013, the Department for International Development (DFID) launched a programme to tackle FGM in Africa. With a budget of £35 million, DFID will work with communities in over 15 countries with the goal of reducing FGM by 30% over a 5 year period.²⁰

¹² HM Government(2011) *Multi- Agency Practice Guidelines: Female Genital Mutilation* (London: HM Government)

¹³ Metropolitan Police Authority (2010) Female Genital Mutilation – MPS Project Azure, available from: <http://www.policeauthority.org/Metropolitan/committees/cep/2010/101104/08/index.html> accessed(6/1/14)

¹⁴ Crown Prosecution Service (2012) Action Plan on FGM, available from: http://www.cps.gov.uk/news/latest_news/cps_decision_on_female_genital_mutilation_case/ accessed (6/1/14)

¹⁵ Metropolitan Police(2011) Freedom of Information Request Disclosure, available from http://www.met.police.uk/foi/pdfs/disclosure_2011/may/2011050001449.pdf accessed (6/1/14)

¹⁶ Metropolitan Police Authority (2010) Female Genital Mutilation – MPS Project Azure, available from: <http://www.policeauthority.org/Metropolitan/committees/cep/2010/101104/08/index.html> accessed(6/1/14)

¹⁷ HM Government(2011) *Multi- Agency Practice Guidelines: Female Genital Mutilation* (London: Home Office)

¹⁸ HM Government (2012) Statement Opposing Female Genital Mutilation, available from: www.gov.uk/government/publications/statement-opposing-female-genital-mutilation accessed (18/2/14)

¹⁹ NSPCC (2013) *FGM Helpline Launched*, Press Release. NSPCC.

²⁰ DFID(2013) UK To Help End Female Genital Mutilation available from www.gov.uk/government/collections/female-genital-mutilation accessed (18/2/14)

Estimating FGM Prevalence in Westminster Among Girls Under 18

INTRODUCTION

FGM is a heavily under-reported issue, which makes obtaining data on both the national and local level difficult. Although FORWARD's report estimated that over 20,000 girls are at risk of FGM in England and Wales, these figures were not broken down by region²¹. However it is safe to assume that the prevalence of FGM is likely to be higher in areas with large populations of FGM practising communities.

The City of Westminster is one of such areas and like many other London boroughs, has an incredibly

diverse and large population of people. With an estimated 66,000 women and girls affected by FGM across the country, services need to be provided to not only care for those who have already undergone FGM, but also protect those 'at risk' of the procedure²².

In order for local services to be planned and delivered, a more local, reliable and detailed estimation of need must be provided. For this reason, this section of the report will estimate the number of girls under the age of 18 at risk of FGM in the City of Westminster.

²¹ FORWARD, (2007) A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. London: Summary Report, (London: FORWARD)

²² FORWARD, (2007) A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. London: Summary Report, (London: FORWARD)

METHODOLOGY

2.1 Chosen Methodology

FORWARD's statistical study was the first systematic attempt to estimate FGM prevalence in England and Wales²³. To estimate the number of females younger than 15 with or at risk of FGM, the report used the 2001 census to determine the number of girls under 15 born in a FGM practising country.

This was then tabulated with additional birth registration data on the birth of females born to mothers from FGM practising countries between 1993 and 2004 which gave a basic number of girls at risk in England and Wales. The magnitude of this risk was then assessed by placing the FGM practising countries from where these girls originate, into categories according their FGM prevalence rates. These categories ranged from universal risk (FGM prevalence rate over 85%) to low risk (FGM prevalence rate below 25%).²⁴

This method used by FORWARD is however subject to several limitations:

1. The estimates base the probability of having FGM on country of origin data alone, as opposed to country of origin AND ethnicity data. Ethnicity is a more accurate proxy for determining FGM risk. (See section 2.2)
2. The estimates do not include girls who are born in

the UK, but have a background that suggests they are still at risk of FGM.

3. The estimates also do not consider the effects of migration on the practice of FGM.

To circumvent limitations 1 and 2, this report will employ the method used by Islington Council in their recent study of FGM prevalence among Islington schoolgirls.²⁵ This study will use data on the ethnicity of girls in Westminster as opposed to data on nationality/country of birth alone.²⁶

This method produces a more accurate estimate, as leading research confirms that FGM is more deeply entwined with ethnic identity, than nationality.

The UK records at best, data on nationality of birth or parent's birth, but rarely records more specific and detailed data on ethnicity that would be pertinent to this discussion. Fortunately, school censuses record detailed information on languages spoken by pupils, which is an excellent indicator of ethnicity.

Language can effectively tell us what ethnic tribe or group a person is from. For this reason, this report will use language as a proxy to determine the ethnic group a child belongs to in order to more accurately calculate FGM prevalence and risk.

²³ Equality Now, (2012) *Report of a research methodological workshop on estimation the prevalence of FGM in England and Wales* (London: Equality Now)

²⁴ FORWARD, (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales Summary Report*, (London: FORWARD)

²⁵ Islington Council (2013) *Female Genital Mutilation (FGM) in Islington: A Statistical Study* (London: Islington Council)

²⁶ Islington Council (2013) *Female Genital Mutilation (FGM) in Islington: A Statistical Study* (London: Islington Council)

2.2 Comments on the Methodology

1. Using language as an indicator of ethnic group allows for a more accurate estimation of those at risk. Country of origin data can sometimes be misleading and fail to show the variation in FGM practice within a country.

Nigeria's overall FGM prevalence rate is 26.9%. Within the country however, prevalence rates vary from 0.4%- 56.9 % across ethnic groups and tribes.

2. In comparison to the method used by FORWARD, using language data produces an estimate that

includes at least some girls (those who speak their mother tongue at home) who have been born in the UK but come from an FGM practicing community. This assumption naturally relies upon the fact that use of a second language at home is unlikely for those not from this background.

3. Our data have been obtained from Westminster City Council and sourced from the January 2013 schools census making it more up to date and reliable than other studies based on data from the 2001 national census.

2.3 Limitations

1. Our methodology makes the assumption that national or ethnic prevalence rates can be translated into a UK context. However the proportion of Somali women in the UK is not the same as in Somalia, meaning that this statistic cannot simply be applied to the number of Somali women in the UK.

2. The fact that there is insufficient research on the effects of migration on FGM is still a significant limitation. This report uses ethnicity and country FGM prevalence rates to reach its estimates, but these could be different among immigrant communities who may be more educated, wealthier and therefore, less likely to continue the practice of FGM. There are studies to suggest the prevalence of

FGM may be lower among communities who have immigrated to the West.²⁷

3. As the data presented in this report is based on self-reporting of language and ethnicity, girls who have chosen not to report the language that they speak at home are not included in this estimate. Furthermore, girls who are privately or home educated, along with girls who are educated outside of Westminster are also not included.

4. The number of girls included in the report decreases with age, meaning that girls from older age groups 16-18 may be underrepresented in the final estimate.

²⁷ Morison L, Dirir A, Elmi S, Warsame J and Dirir S (2004) 'How experiences and attitudes relating to female circumcision vary according to age on arrival in Britain: a study among young Somalis in London', *Ethnicity and Health*, Vol. 9, No. 1, pp.75-100

2.4 Steps

1. Using data obtained from the World Health Organisation, a table was produced listing every country around the world known/believed to practice FGM and the FGM prevalence rate of that country.

Table 3: List of FGM practising countries and their prevalence rates

COUNTRY	YEAR	ESTIMATED PREVALENCE (%)
Benin	2006	12.9
Burkina Faso	2006	72.5
Cameroon	2004	1.4
Central African Republic	2008	25.7
Chad	2004	44.9
Cote d'Ivoire	2006	36.4
Djibouti	2006	93.1
Egypt	2008	91.1
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005/6	78.3
Ghana	2006	3.8
Guinea	2005	95.6
Guinea-Bissau	2006	44.5
Kenya	2008/9	27.1
Liberia	2007	58.2
Mali	2006	85.2
Mauritania	2007	72.2
Niger	2006	2.2
Nigeria	2008	29.6
Senegal	2005	28.2
Sierra Leone	2006	94
Somalia	2006	94
Sudan, northern (approximately 80% of total in population survey)	2000	90
Togo	2006	5.8
Uganda	2006	0.8
United Republic of Tanzania	2004	14.6
Yemen	2003	38.2

Highlighted are the countries where we have established that girls at schools in Westminster have cultural backgrounds, based on the provenance of their stated mother tongue.

2. To determine the number of girls at risk in Westminster, we obtained a list of all the languages spoken by girls at Westminster schools from Westminster City Council. The list was combined with the prevalence rates for FGM practising ethnic groups (where available/ necessary) and used to form the table below.

Table 4: A list of the number of Westminster schoolgirls speaking a particular language, the country/ region where the language is spoken and the FGM prevalence rates for associated ethnicities

LANGUAGE	COUNTRY / REGION	NO OF PUPILS	%	PREVALENCE RATE (BY ETHNIC GROUP %)
Somali	Somalia	225	2.1	97.9
Arabic (Iraq)	Iraq	133	1.2	N
Urdu	Pakistan	80	0.7	N
Yoruba	South West Nigeria	67	0.6	56.9
Pashto / Pakhto	Afghanistan / Pakistan	49	0.4	N
Tigrinya	Eritrea	48	0.4	88.7
Amharic	Ethopia	47	0.4	74.3
Arabic (Sudan)	Sudan	41	0.4	90
Akan / Twi-Fante	Ghana	16	0.1	3.8
Arabic (Yemen)	Yemen	15	0.1	38.2
Krio	Sierra Leone	11	0.1	94
Swahili (any other)	Congo*	11	0.1	5
Kurdish (any other)	Turkey / Iran /Iraq	7	0.1	72.7
Akan (Twi / Asante)	Ghana	5	0.0	3.8
Akan (Fante)	Ghana	3	0.0	3.8
Hausa	Northern Nigeria	3	0.0	0.4
Edo / Bini	Edo State, Nigeria	2	0.0	34.7
Wolof	Senegal	2	0.0	28.2
Oromo	Ethiopia	2	0.0	74.3
Afar - Saho	Djibouti	1	0.0	93.1
Ebira	Kwara state, Nigeria	1	0.0	9.6
Efik - Ibibio	Akwa Ibom State and Cross River State, Nigeria	1	0.0	34.7

N= Not Know (these are countries where FGM has been documented but there is no data available)
*Ethnicity data obtained from Westminster City Council shows that all Swahili speaking girls are from the Democratic Republic of Congo

3. The data was then put into categories according to level of prevalence, with the highest category containing languages with an associated FGM prevalence rate of over 85% and the lowest category, a rate below 25%.

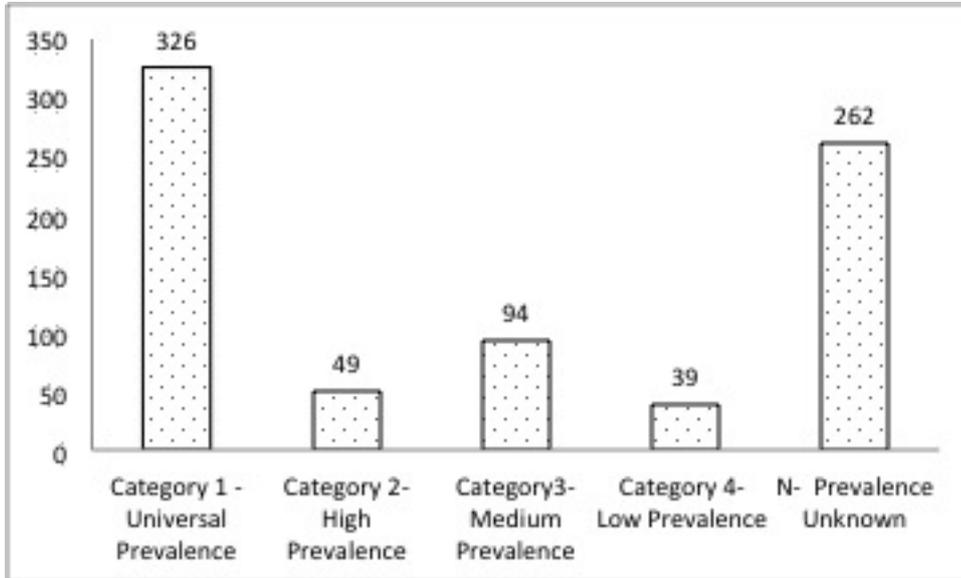
CATEGORY	LANGUAGE
1 Universal Prevalence (85-100%)	Somali
	Tigrinya
	Arabic (Sudan)
	Krio
2 High Prevalence (75-84%)	Afar - Saho
	Amharic
3 Medium Prevalence (25-74%)	Oromo
	Arabic (Yemen)
	Kurdish
	Edo / Bini
	Wolof
4 Low Prevalence (Under 25%)	Yoruba
	Efik - Ibibio
	Akan Twi - Fante
	Akan Twi Asante
	Akan Fante
	Swahili
	Hausa
Ebira	
N Prevalence Unknown	Arabic (Iraq)
	Urdu
	Pashto / Pahkto

*All data used in the study is anonymous.

4. Table 4 and 5 were then combined to produce the graphs below which display the number of girls at risk of FGM in each prevalence category.

RESULTS

Chart A - Number of girls in each FGM prevalence category



As the chart above illustrates, the majority of girls are in the highest risk category. This suggests that they come from a country that has a FGM prevalence rate of over 85%. The second largest category is category N where FGM prevalence is unknown.

Charts B – F show a breakdown of the languages in each FGM prevalence category.

Chart B - Category 1: Universal Prevalence (85-100%)

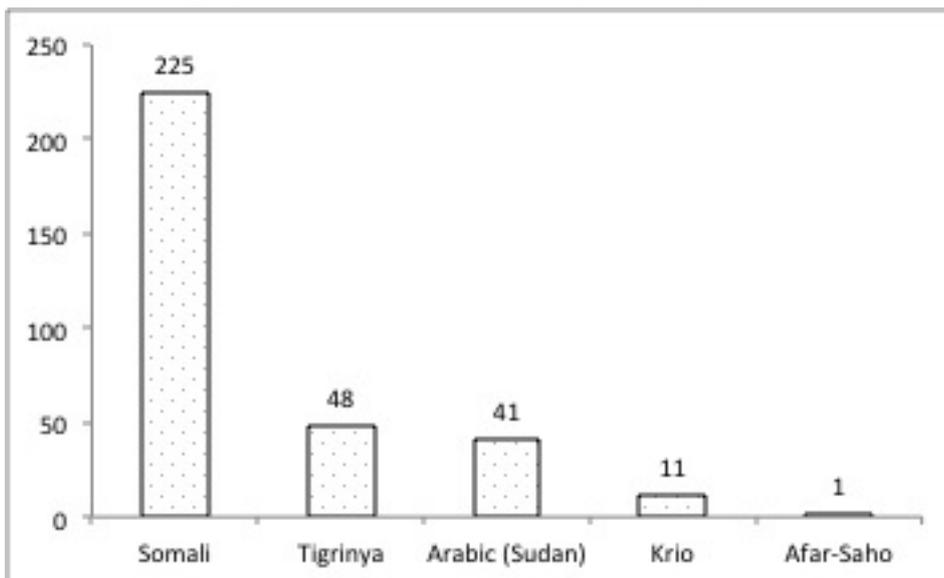
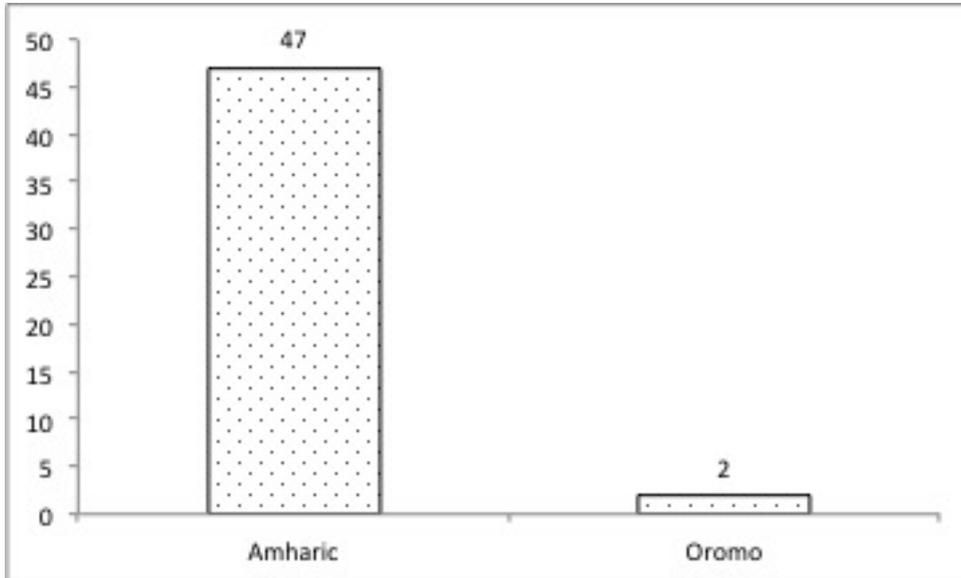
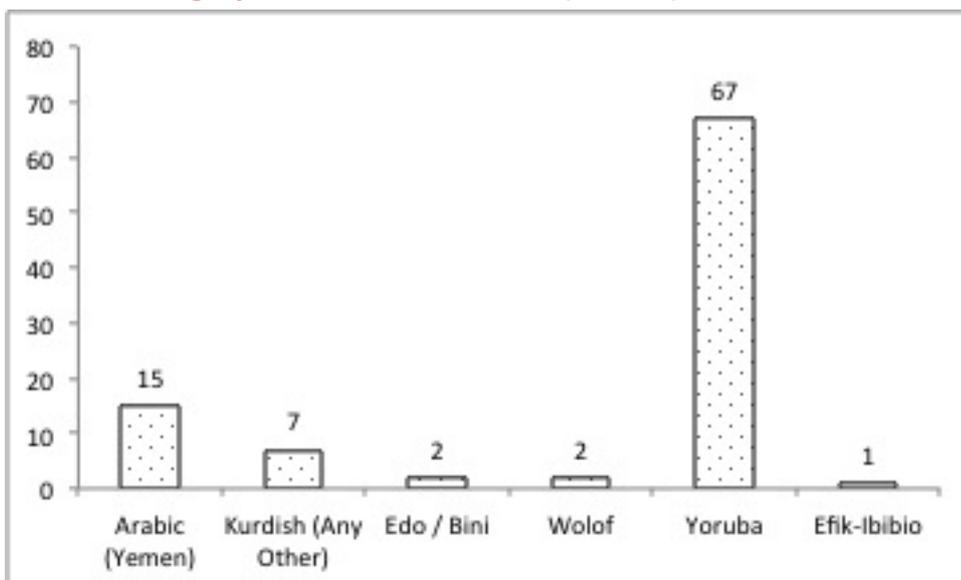


Chart B shows that Somali speakers make up a very large majority of those in the highest risk category, where the FGM prevalence rate in country of origin is classed as universal. Also at high risk are Tigrinya-speaking girls from Eritrea, Sudanese girls, as well as Krio and Afar- Saho-speaking girls from Sierra Leone and Djibouti respectively.

Chart C - Category 2: High Prevalence (75-84%)

Only two of the languages spoken by Westminster schoolgirls fall into category 2 (High Prevalence 75-84%), both of which are spoken in Ethiopia which has a FGM prevalence rate of 74.3%.

Chart D - Category 3: Medium Prevalence (25-74%)

In chart D we see that Yoruba is the most spoken language in category 3 and it is also the fourth most spoken language among Westminster schoolgirls. It is also worth noting that the second and third most spoken languages in this group are non-African languages Arabic and Kurdish.

Chart E - Category 4: Low Prevalence (<25%)

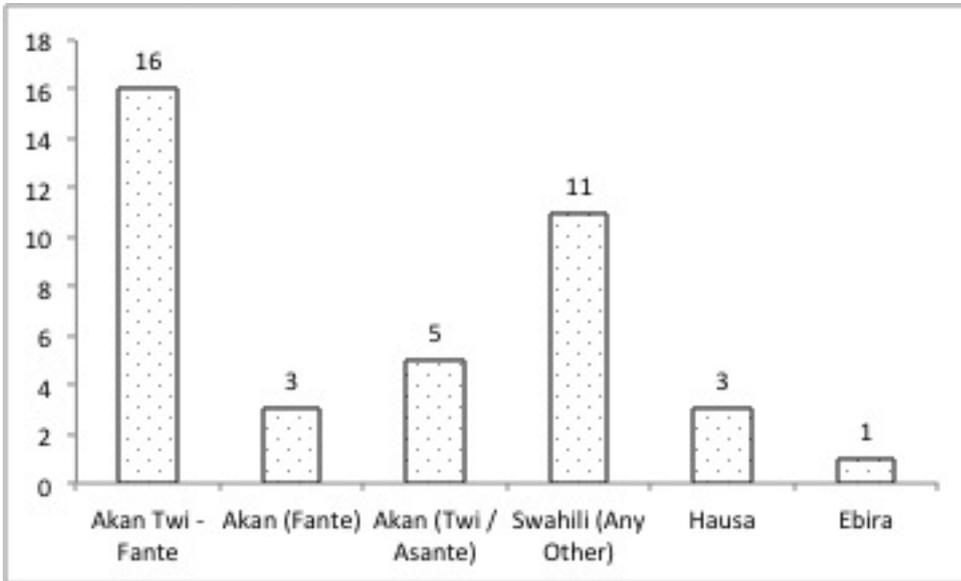


Chart E is mainly comprised of languages either spoken in Ghana or Nigeria, with the exception of Swahili. Girls who speak these languages are at a lower risk of FGM.

Chart F- Category N: Prevalence Not Known.

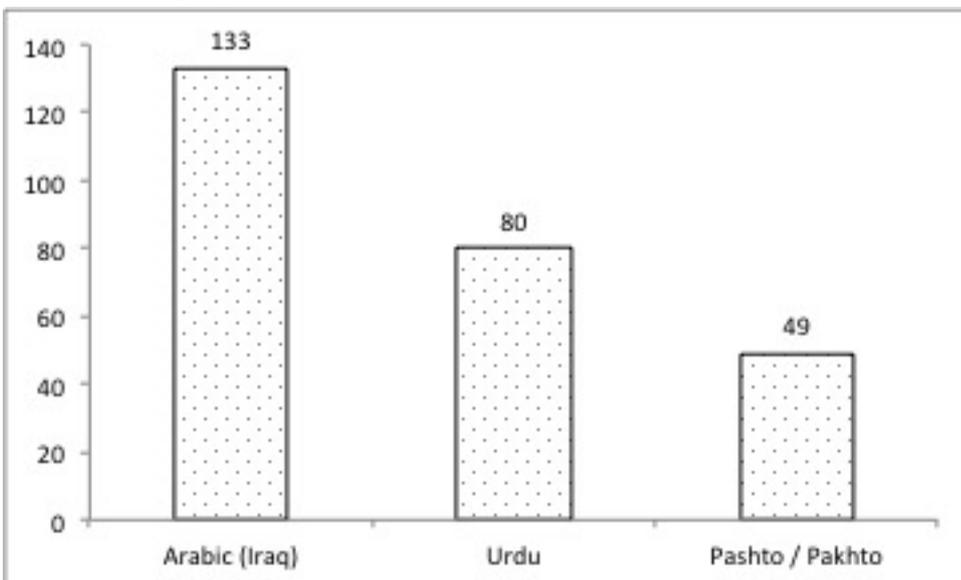


Chart F, the second largest category, displays the language breakdown of languages associated with countries where FGM has been reported, but no prevalence rate has been produced. The most spoken language in this category is Iraqi Arabic, which is the second most spoken language among Westminster schoolgirls.

CONCLUSIONS

- The results of this study indicate that 770 girls aged 3-18 studying in Westminster schools are at risk of becoming, or are already, victims of FGM. As previously mentioned, this number is likely to be an underestimate as the data is reliant on self-reporting of language spoken at home. It does not include girls who study outside of the borough or those who are privately educated.

- The total number of girls in Westminster schools is 10,942. The 770 girls identified as being at risk make up 7% of this number. 326 of these girls are in category 1 and are at the highest risk of FGM; they make up 3% of all girls who study in a Westminster state school.

- The results also find that Somali speaking girls with a total of 225 speakers constitute the highest number of those at risk. Somalia has the world's highest FGM prevalence rate of 97.9%, so these girls are the most likely to have undergone/undergo FGM.

- The largest group of girls with the highest risk are those who speak Somali. Other ethnicities that are also at risk include girls from Eritrea, Ethiopia, Djibouti, Sudan, Nigeria, Ghana and Sierra Leone.

- The second largest group of girls at risk of FGM, equating to 17% of those at risk, are girls who speak Iraqi Arabic e.g. Iraqis of Arab background as opposed to Iraqi Kurds. FGM has been documented in Iraq but reports note that there is no reliable estimate of prevalence.

- There are also no reliable estimations of prevalence for Pashto and Urdu speakers in Afghanistan and Pakistan. Consequently, when combined with Iraqi Arabs (i.e. category N) it can be seen that 34% of those at risk in Westminster come from countries where prevalence is unknown, making policy decisions to address this difficult.

- It must be noted further that it is important that other organisations and governmental bodies working on FGM do not overlook these non-African groups, especially with regards to identifying those at risk or FGM awareness raising campaigns/ activities.

As previously noted, the data presented in this report is based on self-reporting of language and ethnicity and therefore is likely to be an underestimate. Not included in this estimate are girls who have chosen not to report the language that they speak at home and girls who are privately educated, homeschooled, or resident in Westminster but studying in state schools elsewhere.

RECOMMENDATIONS and FINAL COMMENTS

The WONDER Foundation strongly believes that, whilst it is evident that Westminster City Council has made a commitment to providing services to FGM victims, there is still plenty more to be done to protect and support women. As we have established 7% of girls at Westminster state schools are at some risk of FGM with 3% in the highest risk category. Even if we only look at the highest risk category, this 3% totals over 230 girls. Whilst this number is lower than in other London boroughs, no girl in London should be subjected to FGM.

This risk level, whilst lower than some other London boroughs, suggests that there is a significant population of women living with the consequences of FGM in the City of Westminster.

As we have discussed, the data that we have been able to access only allows us to make an informed estimate. However we believe that these figures provide us with a clear enough understanding to make recommendations for future work to end FGM in Westminster and to suggest areas for much-needed further research.

We invite constructive criticism of our methodology as we hope that it can be used as a tool to estimate FGM risk within other areas of the UK.

Recommendations

1. Anyone seeking to develop initiatives to prevent FGM and support those living with its consequences in the City of Westminster needs to gain a clear understanding of FGM from affected communities. These groups need to be enabled to come up with solutions to FGM. This will be most effective when consultation engages broadly with affected people and not simply with the loudest voices.

a. More work needs to be done to find ways where women and girls at risk of FGM or who have been cut, can be identified and offered support. However, we are very conscious that if this is done in an insensitive way, women with FGM may feel targeted and stigmatised, as could children in the classroom from affected communities. A balance needs to be struck between awareness of FGM that leads to the eradication of the practice and the type of awareness that can lead young people to feel stigmatised and could reinforce current prejudices against communities where FGM is practised.

b. Efforts need to be made to better understand the levels of FGM practice in Middle-Eastern communities.

c. More needs to be done to train frontline healthcare professionals and teachers who regularly come into contact with at-risk young women and girls or their families on how to support these women and girls in a sensitive way. Co-producing training and practice with affected communities, so that it is effective, is essential.

d. Campaigns against FGM should be made in conjunction with local communities. This is both an effective use of funds, as it ensures that materials reach their desired audience, but is also an effective exercise in community awareness in and of itself.

2. WONDER recommends that the limited funds dedicated to FGM prevention and support would be better spent in working with communities to address FGM from within. Promoting prosecutions could push the practice of FGM further underground in communities where people already feel marginalised by the establishment.

Areas for future research

1. There is limited research showing how the practice of FGM differs when a community migrates to the UK, or in different generations of immigrants from affected communities, either regarding prevalence or type. This makes estimating prevalence and consequences of FGM difficult.

2. We have made estimation for school-aged girls affected by FGM in one London borough. FGM risk and prevalence is still unknown in many other boroughs in the capital and across the UK. We hope that similar research will be undertaken elsewhere to help policy makers support women and girls at risk of FGM in their local areas.

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