Public Document Pack

Executive – appendices: Tackling Violence against Women Task Group

Monday 24 March 2014 at 7.00 pm
Boardroom - Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Lead Member Councillors:	Portfolio
Butt (Chair)	Leader/Lead Member for Corporate Strategy & Policy Co-ordination
R Moher (Vice-Chair)	Deputy Leader/Lead Member for Finance and Corporate Resources
A Choudry	Lead Member for Crime Prevention and Public Safety
Crane	Lead Member for Regeneration and Major Projects
Denselow	Lead Member for Customers and Citizens
Hirani	Lead Member for Adults and Health
Mashari	Lead Member for Environment and Neighbourhoods
McLennan	Lead Member for Housing
J Moher	Lead Member for Highways and Transportation
Pavey	Lead Member for Children and Families

For further information contact: Anne Reid, Principal Democratic Services Officer
020 8937 1359, anne.reid@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:
democracy.brent.gov.uk

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

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14 APPENDICES: Report from Task Group Tackling Violence against Women and Girls 1 - 116

Members of the Health Partnership Overview and Scrutiny Committee (HPOVS) on a number of occasions, expressed an interest in forming a task group to tackle violence against women and girls in Brent; focusing on Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM). The task group was agreed by HPOVS in March 2013 and has used this time to conduct an in-depth review into harmful practices. The task group report is attached as appendix A. The findings of the task group's review is wide reaching, effects many pubic services and has a direct impact on the lives of women, children and young people.

Ward Affected:
All Wards

Lead Member: Councillor
Contact Officer: Kisi Smith-Charlamagne, Scrutiny
Tel: 0202 8937 2129 kisi.smith-charlamagne@brent.gov.uk

Date of the next meeting: Tuesday 22 April 2014

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public on a first come, first served basis.

Tackling Violence Against Women And Girls in Brent Task Group
Professional Discussion Group

Meeting 1 – Female Genital Mutilation (FGM)

Meeting:

Tackling VAWAG in Brent Task Group – Professional Discussion Group
Friday 8th November 2013,
Brent Civic Centre Room – 5M 003
10.00am – 12.00pm

Questions:

1. In your professional opinion and in your area of work, what methods:
   A) Have been successful?
   B) Have been unsuccessful?
   C) Would you recommend for good practice?

2. What has made the biggest impact on improving the work you do, tackling FGM?

3. Other than funding, what could we recommend to the Council and its partners that would help your work?

4. How has funding cuts impacted on your work? And how have you managed to maintain your services?

5. What do you feel we should say about the issues that affect you?

6. Where do you think best practice is taking place e.g. other boroughs, cities, countries?

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Tackling Violence Against Women And Girls in Brent Task Group
Professional Discussion Group

Meeting 2 – Forced Marriage & Honour Based Violence

Meeting:

Tackling VAWAG in Brent Task Group – Professional Discussion Group
Friday 6th December 2013,
Brent Civic Centre Room – 7M 003
10.00am – 13.00pm

Questions:

Discussion 1, Forced Marriage - FM

What is your opinion on the criminalisation of Forced Marriage?
(Continue with Q. 1-6)

Discussion 2, Honour Based Violence - HBV

Where is the notion of honour coming from and how do we begin to change mind set?
What are the sign leading up to HBV being inflected on an individual?
(Continue with Q. 1-6)

1. In your professional opinion and in your area of work, what methods:
   A) Have been successful?
   B) Have been unsuccessful?
   C) Would you recommend for good practice?

2. What has made the biggest impact on improving the work you do?

3. Other than funding, what could we recommend to the Council and its partners that would help your work?

4. How has funding cuts impacted on your work? And how have you managed to maintain your services?

5. What do you feel we should say about the issues that affect you?

6. Where do you think best practice is taking place e.g. other boroughs, cities, countries?

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Members Training, 21st November 2013

Tackling Violence against Women & Girls in Brent

Questionnaire

This Council Members Task Group was set up to review Violence against Women and Girls in Brent and will focus on:

Female Genital Mutilation (FGM)
Forced Marriages
Honour Based Violence

With the aim of bringing these highly illegal and violent crimes against women to the forefront of public awareness, the task group will be collecting and reviewing evidence from victims, partners and other professionals, in order to improve services and protect Women and Girls in Brent. The task group would like to you know your thoughts and ask if you could please complete this short questionnaire; part 1 before the start of the training, and part two once the sessions has finished.

Thank you in advance for your cooperation

Name of your Ward ……

Part 1

(To be completed before training session)

Please circle your answers

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are you aware of the law regarding these offences?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

3. Are you aware of the council's responsibility in protecting women and girls in Brent?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

4. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
   (Please list outside bodies)……
   ……
   ……
   …

Part 2

(To be completed after training session)

Please circle your answers

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are you aware of the law regarding these offences?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

3. Are you aware of the council's responsibility in protecting women and girls in Brent?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

4. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
   (Please list outside bodies)……
   ……
   ……

5. How do you ensure that vulnerable women and girls in your wards receive information about such sensitive subjects, particularly with regard to the dangers and existence of the offences previously mentioned?

   (Please Write in) ……

6. What kind of training and materials would you need in order to cover these topics in your wards?

   (Please write in)……

7. To your knowledge, is there any work currently being done in your wards to tackle the above offences? **Yes/No**

8. In your opinion, what would you like to see members do to protect women and girls against the above offences?

   (Please write in)……

9. What one thing have you learnt here today that you will take away and discuss with others?
   ……
   ……
   ……...

Annual Brent Governors Conference 2013

Tackling Violence against Women & Girls in Brent

Questionnaire

This Council Members Task Group was set up to review Violence against Women and Girls in Brent and will focus on:

Female Genital Mutilation (FGM)
Forced Marriages
Honour Based Violence

With the aim of bringing these highly illegal and violent crimes against women to the forefront of public awareness, the task group will be collecting and reviewing evidence from victims, partners and other professionals, in order to improve services and protect Women and Girls in Brent. The task group would like you know your thoughts and ask if you could complete this short questionnaire and return it to the Tackling Violence against Women & Girls in Brent display stall today.

Thank you in advance for your cooperation

Name of your school (Optional)…… …..... **Please circle your answers**

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are any of the above listed offences covered in your safeguarding training? **Yes/No**

3. Are Personal Health Sex Education (PSHE) lessons on your school's curriculum? **Yes/No**

4. If you answered yes to Q3, would you like to see these topics included in the PSHE lessons? **Yes/No**

5. How do you ensure that pupils in your school receive information about such sensitive subjects, particularly with regard to the dangers and existence of the offences previously mentioned?

   (Please Write in) ……

6. What kind of training and materials would your school need in order to cover these topics?

   (Please write in)……

7. To your knowledge, is there any work currently being done in your school to tackle the above offences? **Yes/No**

8. Does your school currently employ a school nurse? **Yes/No**

9. In your opinion, what would you like to see schools do to protect females against the above offences?

   (Please write in)……

10. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
    (Please list outside bodies)……

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FORWARD

Safeguarding rights & dignity

A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales

Summary Report

Principal Investigators
Efua Dorkenoo BSc MSc RGN RSCN OBE
Linda Morison BSc MA CStat
Alison Macfarlane BA Dip Stat CStat FFPH

Foundation for Women's Health, Research and Development (FORWARD)
In collaboration with
The London School of Hygiene and Tropical Medicine and
The Department of Midwifery, City University

Funded by
Department of Health, England

Acknowledgements

The authors would like to thank Chris Grundy of London School of Hygiene and Tropical Medicine for producing the maps in Figures 1 and 2 and Baljit Gill and Denis Till of the Office for National Statistics for advice and help in accessing the birth registration data, Rhian Tyler for producing estimates of migration and the Census Customer Services staff for help in accessing tables from the 2001 Census. Acknowledgements also go to the Council of Management and staff of FORWARD in particular Adwoa Kwateng Kluvitse (former Director of FORWARD) for securing the funding for this research. We are also grateful to all who gave comments on the report.

Funding

The project was funded by the Department of Health, England. The views expressed are those of the authors and of FORWARD and are not necessarily those of the Department of Health. The authors and FORWARD would like to thank the Department for funding this work.

PRINCIPAL INVESTIGATORS

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Linda Morison BSc MA CStat

Alison Macfarlane BA Dip Stat CStat FFPH

MAPS

Chris Grundy

FOREWORD

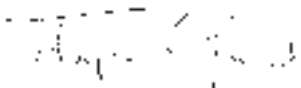
Female genital mutilation (FGM) is a grave human rights violation which is perpetuated by families in the name of culture, tradition and religion. The World Health Organisation estimates that globally from 100 to 140 million girls and women have undergone some type of FGM. It has been estimated that currently, about three million girls, most of them under 15 years of age, undergo the procedure every year. The majority of FGM takes place in 28 African countries but many immigrant communities continue the practice in Europe, North America, Australia and New Zealand.

The practice of FGM is an international problem. Numerous international human rights laws and conferences have highlighted the need to eliminate this practice. FGM violates the human rights of women and girls, causing them physical and psychological harm. It also denies them the enjoyment of the highest attainable level of sexual and reproductive health. Steps have been taken by the UK parliament to discourage FGM, for example, the government introduced a new Law on FGM in 2003 to demonstrate its commitment to preventing the occurrence of FGM in the UK, but to date there have been no convictions under this law.

More needs to be done to tackle FGM. The lack of data on FGM makes it difficult for policy makers and professionals to respond effectively to the needs of affected women and to protect girls from undergoing FGM. Within the UK, data used to support policy decisions have been at best estimates.

FORWARD's new collaborative work with the London School of Hygiene and Tropical Medicine and the City University is a welcome attempt to address this gap. "A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report", provides reliable data to inform and plan better maternity and gynaecological care and related support services for girls and women affected by FGM. This study suggests that over 20,000 girls under the age of 15 are potentially at risk of FGM in England and Wales. It also suggests that the practice is on the increase. It is hoped that the results of the study will support the planning and implementation of a comprehensive national strategy in the UK that will help to expedite efforts to end FGM within one generation.

Many sectors need to work collaboratively, including health, social, education, community and the police to integrate a better understanding of FGM into its policies and services to meet the needs of those affected and to eliminate this human rights violation. It is hoped that this study and its recommendations will provide the impetus to change.



Baroness Joyce Gould - FORWARD Patron

A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report

Foundation for Women's Health, Research and Development (FORWARD)
In collaboration with
London School of Hygiene and Tropical Medicine
Department of Midwifery, City University

FORWARD is an African Diaspora led non-profit organisation dedicated to improving the health and human rights of African girls and women in the UK and Africa. We focus on tackling harmful gender based discriminatory practices such as female genital mutilation and child and forced marriage through enabling our partners and key stakeholders including women and young people to help shape the health and rights of African girls and women. Through advocacy, training and advice, research and resource development we seek to influence government and other statutory bodies in the area of policy development and implementation. FORWARD is one of the leading advocates in the UK fighting to eliminate female genital mutilation.

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Contents

1. Introduction

The United Nations has recognised female genital mutilation (FGM) as a human rights violation. In the UK the practice is included in the UK Children Act and other legislation. There is recognition that it is practised in some minority communities in the UK. It has also been the focus of two and half decades of educational campaigns by voluntary groups in the communities concerned.

Despite this, there are no reliable data on the extent of FGM in the United Kingdom. Lack of data on FGM marginalises the issue. An urgent need for these data has been expressed at all levels, from grassroots organisations to parliament.

Data are needed for the planning and implementation of a comprehensive national strategy for the prevention and the elimination of FGM in the United Kingdom, to act as a baseline against which to measure the success of programmes to combat FGM and for targeted advocacy. Reliable data on FGM are also needed to inform maternity and gynaecological care as well as other support services that are needed for girls and women with complications of FGM.

These are the first systematic estimates for England and Wales. Although, as the report describes, there are some limitations in the methods used, they give some insight into the scale and the spread of FGM in England and Wales and support the view that action is needed to prevent FGM being passed on to the younger generation.

2. Background

Female genital mutilation (FGM) constitutes partial or total removal of the external female genitalia or injury to the external female genitals for non therapeutic reasons.[1] It is estimated that 100-140 million girls and women in Africa and Yemen have undergone FGM and that 3 million young girls undergo FGM every year.[2] FGM also occurs in some parts of the Middle and the Far East. Mainly due to migration, women with FGM are increasingly found in Europe, the United States, Canada, New Zealand and Australia.

Table 1: WHO 1995 classification of FGM types

Type	Description
I	Excision of the prepuce, with or without excision of part of the clitoris
II	Excision of the clitoris with partial or total removal of the labia minora
III	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
IV	Practices including piercing, pricking and incising of the clitoris and/or labia, cauterisation by burning of the clitoris and surrounding vaginal orifice (angurya cuts) or cutting of the vagina to cause bleeding or for the purposes of tightening or narrowing it.

Source: WHO, 1995[1]

The World Health Organisation has classified FGM into the four types shown in Table 1. FGM Type III accounts for approximately 15 per cent of all women with FGM in Africa, whilst FGM Type I and II account for approximately 80 per cent. Little is known about Type IV FGM, including types of FGM practised outside Africa.

2.1. Reasons given for practising FGM

The practice of FGM is embedded in ancient beliefs surrounding women's fertility and control of their sexual and reproductive capacity. The reasons given by communities who practise FGM vary widely but a common reason given for the practice is that it reduces the sexual desire of girls and women, promotes virginity and chastity, maintains fidelity in married women and is done for aesthetic reasons. FGM is practiced to enhance girls' marriage ability and to please their husbands. In some groups, FGM is central to girls' rite of passage into adulthood and is an integral part of society's definition of womanhood.

2.2. FGM as a human rights issue

FGM is a human rights violation in the absence of any perceived medical necessity. Among those rights that are violated are the right to the integrity of the person and the highest attainable level of physical and mental health.[3] FGM is recognised by the United Nations to be part of discrimination as well as a form of violence against girls and women.

Article 1 of the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) defines discrimination as "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social cultural, civil or any other field, CEDAW art. 1, United Nations General Assembly Resolution 34/180 of 18 December, 1979.

Article 24 of the Convention on the Rights of the Child (1989) states:" States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health … " (Para 1) and "States Parties shall take all effective and appropriate measures with a view to abolishing traditional with a view to abolishing traditional practices prejudicial to the health of children … "(Para 3), UN General Assembly resolution 34/180 of 18 December 1979

The Declaration on the Elimination of Violence against Women expressly states in its article 2: "Violence against women shall be understood to encompass, but not limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including … dowry related violence … female genital mutilation and other traditional practices harmful to women …" .UN General Assembly,A/RES/48/ 104, 85th plenary meeting, 20 December 1993.

The 2002 UN Special Session on Children, endorsed by 69 heads of states and governments, which include the United Kingdom, set a goal to end female genital mutilation by the year 2010.[4]

2.3. Health risks

The health risks associated with FGM are wide and some are severely disabling.[5] Despite this, there are few large series of case reports or quantitative community-based reports of the frequency and patterns of the consequences of FGM. Girls and women undergoing FGM Type III are particularly likely to suffer serious and long-term complications as the stitching of the labia majora to create a flap of skin covering the vaginal opening causes a direct mechanical barrier to urination, menstruation, sexual intercourse and to delivery.

A recent large scale WHO collaborative study in six African countries showed that women with FGM were at higher risk of caesarean section, post-partum haemorrhage, prolonged maternal hospitalisation, infant resuscitation and perinatal death among women with FGM than those without FGM; and that the risk increased with the severity of FGM.[6] Another study in the Gambia, where Type II FGM is commonly practised, found that women with FGM were more likely to have Bacterial Vaginosis and to have been infected with Herpes Simplex Virus-2. Both of these could have implications for increasing risk of HIV infection.[7]

There is little documentation on the psychosexual and the mental health consequences of FGM. One controlled study which was undertaken in Senegal, found that women who had been subjected to FGM were significantly more likely to suffer from post-traumatic stress disorder (PTSD) and other psychiatric syndromes when compared to women who had not been subjected to FGM.[8]

2.4. FGM practitioners

FGM is largely performed by traditional practitioners without anaesthetics but in urban centres and amongst the elite it may be performed by western trained health professionals with anaesthetics.

2.5. Age when FGM is performed

Amongst ethnic groups for whom FGM is a traditional practice, it is generally performed on young girls who are below the legal age of majority. The age at which the procedure is performed varies from one community to another. It can be carried out during infancy, on girls under ten years old or on adolescent girls and occasionally on adult women including pregnant women. Most experts agree that the age at which genital mutilation is performed is decreasing.

2.6. Evidence that FGM is a concern in the UK

The United Kingdom has had a long history of migration from its former colonies. FGM is known to be commonplace in some of these countries. More recently, increasing numbers of refugees from the Horn of Africa fleeing from civil unrest and war have sought asylum in the UK. A study involving case studies of 50 women attending an African well-woman clinic in London described 14 primigravid women with FGM Type III who required episiotomy for sustained perineal tears at the time of delivery.[9] Small scale academic studies and local authority casework interventions on girls deemed at risk of undergoing FGM, also show that FGM is a continued traditional practice in specific African communities in the UK.[10-13]

Because of the concern about FGM, the UK Prohibition of "Female Circumcision" Act came into force in 1985. The Act made it an offence to carry out or to aid, abet or procure the performance by another person, of any form of female genital mutilation, except for specific medical purposes. FGM was further recognised as a denial of the girl child's fundamental human rights to her physical integrity and natural sexuality and has been incorporated as a case for concern into 'Working Together to Safeguard Children', a guide to arrangements for inter-agency co-operation in the UK to protect children from abuse.[14]

Further legislation, the 'Female Genital Mutilation Act 2003', came into force in March 2004. It introduces the issue of extraterritoriality, which makes it an offence for FGM to be performed anywhere on UK nationals or UK permanent residents. This closes the loophole in the 1985 Act, which gave room for parents to get around the law by taking their girls abroad for FGM and then returning them to the UK. The 2003 legislation also increases the penalty for aiding, abetting or counselling to procure FGM to 14 years imprisonment or a fine or both. FGM is a hidden practice which is difficult to detect. To date, no prosecutions on FGM have been made under the UK legislation although two doctors have been found guilty of serious professional misconduct before the General Medical Council.[15] Although FGM is incorporated into child protection, at present no data are collected on the number or type of social work cases involving FGM in the UK.

In 2005, Scotland amended its legislation on female genital mutilation in line with the 'Female Genital Mutilation Act 2003' that applies to England, Wales and Northern Ireland. Although female genital mutilation is already illegal in Scotland, the amended Bill extends the provisions of the current legislation by giving them extra-territorial effect and increases the maximum penalty from 5 to 14 years imprisonment.

There are at least ten specialist clinics in the NHS which treat women and girls who have been mutilated. These clinics all have trained and culturally sensitive staff who offer a range of healthcare services for women and girls including reversal surgery. Services are confidential and in many instances interpreters are available. These clinics are open to women to attend without referral from their own doctor.

The Department of Health has also recently funded a well-received DVD for health professionals, which provides factual and clinical information on this subject. Female genital mutilation is also recognised as a form of domestic abuse highlighted in Responding to domestic abuse: A handbook for health professionals, published by the Department in January 2006.

3. Statement of the problem

3.1. Previous estimates of the prevalence of FGM in the UK

It has been estimated that there are from 3,000 to 4,000 new cases each year in the United Kingdom but no indication was given of the methods used to derive these figures.15 Other estimates suggest that 22,000 girls under the age of 16 years are at

risk of FGM and 279,500 women already resident in the UK have undergone FGM.[16] These estimates were derived by applying the WHO estimates of the prevalence of FGM figures in practising countries17 to estimates of numbers of women reporting six of these countries of origin in the 1999 Labour Force Survey.

In the United States, the Centers for Disease Control and Prevention derived estimates using 1990 census data and estimates of the prevalence of FGM in women's countries of origin.[18] The Population Reference Bureau updated these analyses using 2000 census data and more recent prevalence survey data. It concluded that the numbers of women with or at risk of FGM had risen by 35 per cent over the decade.[19] Similar methods have been used to derive estimates for Belgium and Spain.[20]

3.2. Limitations of previous estimates for the UK

Although the methods used so far to derive estimates of the number of women and girls affected by FGM in the UK have led to the best estimates available to date, there are obvious limitations with the reliability of these figures.

- The UK Labour Force Survey sample used to derive the estimates of females affected by FGM was not large enough to produce estimates about the size of the country of birth groups which were estimated to be fewer than 6,000 in number and the estimates were subject to sampling variability.
- It omitted the second generation of women, who were born in the UK but who may have undergone FGM.
- It assumed that the prevalence of FGM in practising migrant or refugee populations in the UK was the same as in their countries of origin. This assumption may not be valid but there are very few data on the effect of migration on the practice. One study suggested a lower prevalence of FGM among young Somalis in London than the population average in Somalia.11

In this report, we present estimates which overcome the first of these limitations by deriving numbers of women born in practising countries from the 2001 Census of Population. We have extended the number of countries of origin practising FGM from six to twenty nine. The improved estimates are still subject to limitations 2 and 3 so a survey will be needed to produce estimates which include second generation women and to allow for possible differences between the prevalence of FGM in women living in the UK and in their countries of origin. The process of producing the estimates presented here will provide the groundwork for designing such a survey as well as furthering future community based research.

4. Study objectives

To estimate for women and girls resident in England and Wales:

- The prevalence of FGM among women aged 15 and over.
- The number of registered maternities, that is, pregnancies ending in a registrable live or stillbirth, to women who have undergone FGM.
- The estimated numbers of girls aged below 15 at risk of FGM and the type of FGM.

The study was restricted to England and Wales. Although the proportions of births in Scotland and Northern Ireland to women born outside the UK in general and women from FGM practising countries has increased over the years since 2001 as a consequence of inward migration, the numbers of births to women from FGM practising countries were still relatively low.

5. Methods

The overall approach was to identify countries in which FGM is practised and from which there is significant migration to England and Wales, identify published data about the prevalence of FGM in those countries and apply them to Census and birth registration data for England and Wales obtained from the Office for National Statistics.

5.1. Identifying published data about the prevalence of FGM

Demographic and Health Surveys (DHS) implemented by Macro International for USAID (http://www.measuredhs.com) or the Multiple Cluster Indicator Surveys (MICS) implemented by national governments with technical assistance from UNICEF or other UN agencies. For countries where such estimates were not available published, bibliographic databases and reports from national and international bodies were searched.

5.2. Estimation of the number of women born in FGM practising countries and the number likely to have undergone FGM.

The method used for the calculation of prevalence was adapted and refined from FGM prevalence studies in the USA, Belgium and Spain.18,20 These also used census data.

The data items of relevance are women's ages, countries of birth, ethnicity and local authority of residence on census night. In discussion with the Office for National Statistics (ONS) Census Customer Services staff, tabulations using these variables already undertaken either as part of ONS own programme of publications or commissioned by others were reviewed. We obtained a table for England and Wales as a whole, M1000, which tabulated the numbers of women born in each of the countries in which FGM is practised, by age-group.

The number of women with FGM was estimated by multiplying the number of women in each age-group from each FGM practising country by the age-specific FGM prevalence for that country and then summing these numbers over all the FGM practising countries. The age-specific FGM prevalence in each country of origin was assumed to represent the probability that a woman from that country in that age group would have FGM.

It was planned to do further work that will repeat the above tabulation by ethnicity so that women with Asian and white ethnicity can be excluded from the figures and also to include tabulations by region in order to examine geographical spread, but this was not possible within the time and resources available.

5.3. Updating the 2001 estimates

Since the estimates calculated using methods described in 5.2 are now five years out of date, migration data were requested from ONS with the aim of updating estimates of numbers of women from practising countries. Because of disclosure control these were requested for groups of countries, according to the categorisation described in Table 2, rather than for all individual countries.

5.4. Estimating the number of maternities to women born in FGM practising countries by local authority.

Because of the emphasis on affected women, the analysis of birth registration data was conducted in terms of maternities, defined as pregnancies leading to one or more registrable live or stillbirths. In order to satisfy disclosure control procedures, tabulations of numbers of maternities by age and mother's country of birth for mothers born in the FGM practising countries for each year from 2001 to 2004 were held within ONS and not released to us. The study team provided age-specific FGM prevalences for each of the countries. Estimates of numbers of maternities to women with FGM in each local authority were calculated by ONS by multiplying the number of women delivering in each local authority area in each age-group and in each country where FGM is practised by the age-specific FGM prevalence estimate for that country. These numbers were then summed over all the countries where FGM is practised to estimate the total number of women with FGM overall in England and Wales and for each region.

5.5. Estimates of numbers of females younger than 15 years with FGM or at risk of FGM

Numbers of girls aged below 15 who had been born in FGM practising countries, were derived from the 2001 census. An additional tabulation of the birth registration data provided us with births of females to mothers from countries which practice FGM between 1993 and 2004. This gave a minimum estimate of numbers of girls under 15 residents in England and Wales at risk or having undergone FGM. To assess the magnitude of these risks, the FGM practising countries were categorised by level of risk of FGM.

5.6. Mapping

Two maps were created by Chris Grundy of the Public and Environmental Health Research Unit at the London School of Hygiene and Tropical Medicine.

5.7. Ethics

This study involved secondary analysis using FGM rates derived from publicly available survey data DHS and MICS as well as other published research data not requiring prior permission before use. Following an application to ONS' Microdata Release Panel, the birth registration statistics for England and Wales were made available as aggregated counts, not as individual records, to comply with ONS' disclosure control rules. According to the ONS, secondary analyses of census material which we will be working with can be used for research without prior permission. All analyses of ONS data in this report were checked by ONS to ensure that disclosure did not occur.

FORWARD was the institutional base for the study with collaboration from the London School of Hygiene and Tropical Medicine and City University.

6. Results

6.1 Prevalence of FGM in countries of birth

Countries in which FGM is reported to be a traditional practice were identified as:

North Africa and Yemen	Sub-Saharan Africa
Djibouti	Benin
Egypt	Burkina Faso
Eritrea	Cameroon
Ethiopia	Central African Republic
Somalia	Chad
Sudan	Cote D'Ivoire
Yemen	Democratic Republic of the Congo
	Gambia
	Ghana
	Guinea
	Guinea Bissau
	Kenya
	Liberia
	Mali
	Mauritania
	Niger
	Nigeria
	Senegal
	Sierra Leone
	Togo
	Uganda
	Tanzania

FGM has been reported in other countries or groups but little is known of the extent or type of practice. A form of FGM, probably Type I or IV, has been described in Muslim women in Malaysia[21] and Indonesia.[22] FGM has also been reported among some Kurdish groups, the Dowdi Bohra in India21 and Ethiopian Jews now resettled in Israel, although little information is available.

For 20 of the 29 countries in the above list, estimates of FGM prevalence by country among 15-49 year olds overall and for five year age-groups were obtained from rigorous national surveys notably the Demographic and Health Surveys (DHS) implemented by Macro International for USAID (http://www.measuredhs.com) or the Multiple Cluster Indicator Surveys (MICS) implemented by national governments with technical assistance from UNICEF or other UN agencies. For the nine countries where such estimates were not available published, bibliographic databases and reports from national and international bodies were searched for data on FGM prevalence.

International and national organisations with a possible interest in FGM known to work in these countries were also approached by the principal investigator for any information they could provide on FGM prevalence. Best estimates were then derived by pooling any published data found with local information. The results of this are shown in Table 2.

Countries were then classified according to the prevalence of FGM and the types of FGM found there, using the WHO 1995 classification of types of FGM. This method of grouping countries, shown in Table 2 is modified by us from that of UNICEF which was based only on prevalence.[2] The results of this are shown in Table 3, which shows the prevalences. These categories were then used in plotting Figure 1. FGM practices usually vary by ethnic group so the overall prevalence for a particular country tends to reflect the number and size of practising ethnic groups within it.

Table 2 Grouping of countries according to prevalence and type of FGM

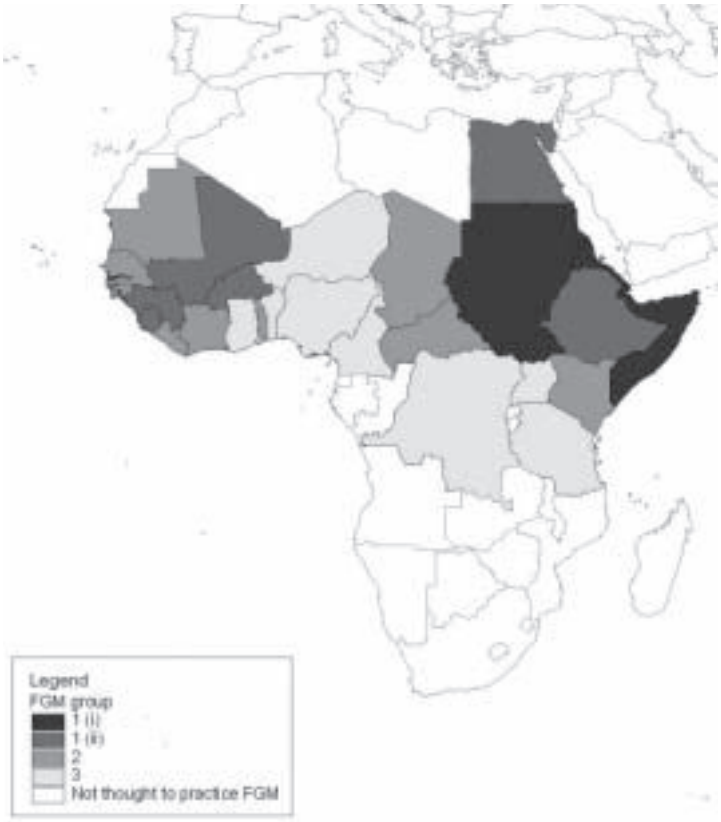
FGM category	Descriptive title of category	Definition
1(i)	Almost universal FGM and substantial WHO FGM Type III	Prevalence 85 per cent or higher and over 30 per cent of operations are type III
1(ii)	High prevalence WHO FGM Types I and II	Over 75 per cent prevalence and predominantly Types I and II
2	Moderate prevalence WHO FGM Types I and II	25 -74 per cent prevalence and predominantly Types I and II
3	Low prevalence WHO FGM Types I and II	Under 25 per cent prevalence and predominantly Types I and II

Adapted from UNICEF[2]

Table 3 shows FGM prevalence estimates overall and by age-group for the 29 practising countries identified. Because prevalence rates differed by age, being lower in younger age groups for some countries such as Kenya and Nigeria, we decided to use age-specific prevalences in the calculations for England and Wales, where available. The overall and age-specific prevalences were assumed to be probabilities that a woman from that country would have FGM. Table 3 also shows which countries were in each of the four risk groups specified in Table 2. These groupings were used where disclosure control did not allow categories as small as country to be used or where we had no information on probability of FGM, as was the case for females under 15 years old.

6.2. Estimates of the number of women likely to have FGM in England or Wales

Table 4 shows that 174,528 women resident in England or Wales in 2001 had been born in an FGM practising country. This figure seems likely to be an underestimate. Firstly, they did not include the 9,030 women who said they were born in Africa but did not state which country. Of these, 3,626 said they were born in East Africa, 276 in North Africa and 896 in West Africa. The second problem was low response to the census in inner city areas, particularly in Inner London. ONS took steps to compensate for this by imputing missing data, but this may not have fully compensated for any non-response by women born in the 29 countries considered here.



Countries in each FGM group shown in Table 2

1(i)	Almost universal FGM, over 30% FGM Type III	Sudan (north), Somalia, Eritrea, Djibouti.
1(ii)	High national prevalence FGM WHO Type I and II	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
2	*Moderate national prevalence of FGM WHO Type I and II	Central African Republic, Chad, Cote D'Ivoire, Guinea Bissau, Kenya, Liberia, Mauritania, , Senegal, Togo
3	*Low national prevalence of FGM WHO Type FGM I and II	Benin, Cameroon, Ghana ,Niger, Nigeria, Democratic Republic of Congo, United Republic of Tanzania, Uganda

*FGM prevalence is tied to ethnicity in these countries. Although national FGM prevalence's in these countries are moderate to low, FGM prevalence could be high amongst the specific ethnic groups who practice it.

Table 3 FGM prevalence by age group and grouping of country according to FGM risk

Country	Source of data	Year of survey	Overall	Age group							Group1
				15–19	20–24	25–29	30–34	35–39	40–44	45–49	
Benin	DHS	2001	16.8	12.1	13.4	16.9	18.4	18.3	25.1	23.7	3
Burkina Faso	DHS	2003	76.6	65.0	76.2	79.2	79.4	81.6	83.1	83.6	1(ii)
Cameroon	DHS	2004	1.4	0.4	2.5	1.6	1.1	1.2	1.8	2.4	3
Central African Republic	MICS	2000	35.9	27.2	33.8	35.6	39.9	43.3	41.5	41.9	2
Chad	MICS	2000	44.9	41.6	43.9	44.4	46.5	45.0	45.2	51.5	2
Côte d'Ivoire	DHS	1998–99	44.5	41.2	42.7	42.4	49.0	44.5	51.4	51.0	2
Democratic Republic of the Congo	WHO	1998	5.0								3
Djibouti	Union National des Femmes de Djibouti3	1991	98.0								1(i)
Egypt	DHS	2003	97.0	96.8	97.4	97.3	96.5	96.4	96.5	98.0	1(ii)
Eritrea	DHS	2001–02	88.7	78.3	87.9	90.8	93.4	92.6	94.1	95.0	1(i)
Ethiopia	DHS	2000	79.9	70.7	78.3	81.4	86.1	83.6	85.8	86.8	1(ii)
Gambia	Singhateh SK4	1985	79.0								1(ii)
Ghana	DHS	2003	5.4	3.3	3.8	6.4	6.3	6.7	5.5	7.9	3
Guinea	DHS	1999	98.6	96.6	98.5	99.1	99.1	99.1	99.3	99.5	1(ii)
Guinea Bissau	WHO	1998	50.0								2
Kenya	DHS	2003	32.2	20.3	24.8	33.0	38.1	39.7	47.5	47.7	2
Liberia	Marshall R5	1984	60.0								2
Mali	DHS	2001	91.6	91.2	91.3	91.9	92.1	92.3	91.2	91.0	1(ii)
Mauritania	DHS	2000–01	71.3	65.9	71.1	73.4	74.2	71.7	76.5	68.5	2
Niger	DHS	1998	4.5	5.0	4.8	4.3	5.3	3.8	3.3	3.3	3
Nigeria	DHS	2003	19.0	12.9	17.0	20.8	19.4	22.2	22.2	28.4	3
Senegal	DHS2	2005	28.2	24.8	28.0	28.4	30.1	30.5	30.3	30.6	2
Sierra Leone	Koso Thomas O6	1987	90.0								1(ii)
Somalia			97.0								1(i)
Sudan (north)	MICS	2000	90.0	85.5	88.6	89.3	89.8	91.5	91.6	92.9	1(I)
Togo	National Committee on Harmful Practices7	1993	50.0								2
Uganda	WHO8	1998	5.0								3
United Republic of Tanzania	DHS	1996	17.7	13.2	15.7	19.3	20.6	18.3	21.3	21.9	3
Yemen	DHS	1997	22.6	19.3	22.2	21.3	22.9	23.6	25.1	25.0	3

Footnotes

1. See Table 2 for definitions of groups
2. Data for Senegal (2005) are from preliminary report.
3. Anecdotal report from Union National des Femmes de Djibouti. Unpublished report.
   In Warzazi A. Report of the Working Group on Traditional Practices Affecting the Health of Women and Children. New York,NY United Nations,ECOSOC, Commision on Human Rights,1991
4. Singhateh SK. Female Circumcision, the Gambian experien ce: a study on the social,economic and health complications.Banjul, The Gambia Women's Bureau,1985.Unpublished report
5. Marshall R et al.Traditional Practices Affecting the Health of Women and Children in Liberia, Seminar on Teaditional Practices, Dakar, IAC, 1984
6. Koso Thomas O. The circumcision of women: a strategy for eradication.London,Zed Press,1982
7. The National Committee on Harmful Traditional Practices,Togo, Unpublished Report
8. IAC. Female Genital Mutilation in Uganda. Geneva,Inter-African Committee on Traditional Practices Affecting the Health of Women and Children,1993(IAC)
9. Other reports on FGM not reflected in the table above

a. Israel: Asali A et al. Ritual female genital surgery among the Bedouin in Israel.Archives of sexual behaviour,1995,24:573-577.
b. Israel: Grisaru N, Lezer S,Belmaker RH. Ritual female genital mutilation among Ethiopian Jews. Archives of sexual behaviour,1997,26(2):211-215
c. India: Ghadially R. All for Izat: the practice of female circumcision among Bohra Muslims'Manushi,No.66,New Delhi,India,1991,Unpublished paper
d Iraqi Kurdistan: A study by WADI showed that 60 per cent of women (out of 1,544 women and girls interviwed) in the rural area of Germain had undergone FGM,
   United Nations Office of Humanitarian Affairs, Jan 2005 Unpublished study.
e. Indonesia: Pratiknya AW. Female circumcision in Indonesia:a synthesis profile for cultural,religious and health values. In: Female circumcision:strategies to bring about change
   Proceedings of the International Seminar on Female Circumcision,Mogadishu,Somali,13-16 June 1988.Rome,Somali Women's Democratic Organization/Italian Association for Women in Development,1989.Unpublished paper.

The largest population groups from practising countries were from Ghana, Kenya, Nigeria, Somalia and Uganda. Table 4 also shows estimated numbers with FGM. The estimated number of women resident in England and Wales in 2001 who had been subjected to FGM was 65,790. The highest estimated numbers of women with FGM were from Kenya and Somalia.

Table 4 Number of women born in FGM practising countries and estimated number of women with FGM, residents in England and Wales enumerated in 2001 census

Country of birth	Enumerated number of women aged 15-49	Estimated number aged 15-49 with FGM
Benin	99	18
Burkina Faso	33	26
Cameroon	1,353	21
Central African Republic	163	64
Chad	44	20
Côte d'Ivoire	1,082	489
Democratic Republic of the Congo	1,199	60
Djibouti	93	91
Egypt	3,698	3,592
Eritrea	2,804	2,545
Ethiopia	3,421	2,807
Gambia	1,387	1,096
Ghana	22,116	1,340
Guinea	101	100
Guinea Bissau	155	78
Kenya	45,396	18,516
Liberia	555	333
Mali	41	38
Mauritania	13	9
Niger	39	2
Nigeria	33,485	6,925
Senegal	264	77
Sierra Leone	6,625	5,963
Somalia	15,744	15,272
Sudan	3,200	2,879
Togo	174	87
Uganda	19,640	982
United Republic of Tanzania	10,512	2,102
Yemen	1,092	262
Africa - East (not otherwise stated)	3,626	
Africa - North (not otherwise stated)	276	
Africa - West (not otherwise stated)	896	
Africa (not otherwise stated)	4,232	
Total ignoring not stated	**174,528**	**65,790**

ONS' Migration Statistics Unit provided data about inward and outward migration to update these estimates over the years 2001 to 2005. It was unable to subdivide estimated numbers of migrants by age as these estimates are based first on the International Passenger Survey, which has a relatively small sample and does not record informants' ages. In addition, asylum seeking statistics are not disaggregated by sex. The data provided do imply a net inflow of women migrants from countries practising FGM, however. Although the largest numbers came from the countries with low prevalence, it was estimated that there was a net inflow of about 3,000 women from the high prevalence countries.

6.3. Estimated number of maternities in England and Wales in women with FGM

Table 5 shows the number of maternities in England and Wales to women born in FGM practising countries, the estimated number of maternities to women with FGM and the total number of maternities for each of the four years 2001 to 2004. Over the four years, the estimated number of maternities to women with FGM increased by 44 per cent from 6,256 in 2001 to 9,032 in 2004. Figure 2 and Table 6 show the geographical spread of the maternities to women likely to have undergone FGM in 2001 and 2004. As expected, the geographical distribution was extremely uneven with the highest estimated percentages in London, but with prevalences of over two per cent in the cities of Cardiff in Wales and Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough, Milton Keynes and many London boroughs. In 2004, the prevalence was 6.3 per cent in Inner London and 4.6 per cent in Outer London.

Table 5 Maternities to women from FGM practising countries and estimated number and percentage of maternities to women with FGM, England and Wales, 2001 to 2004

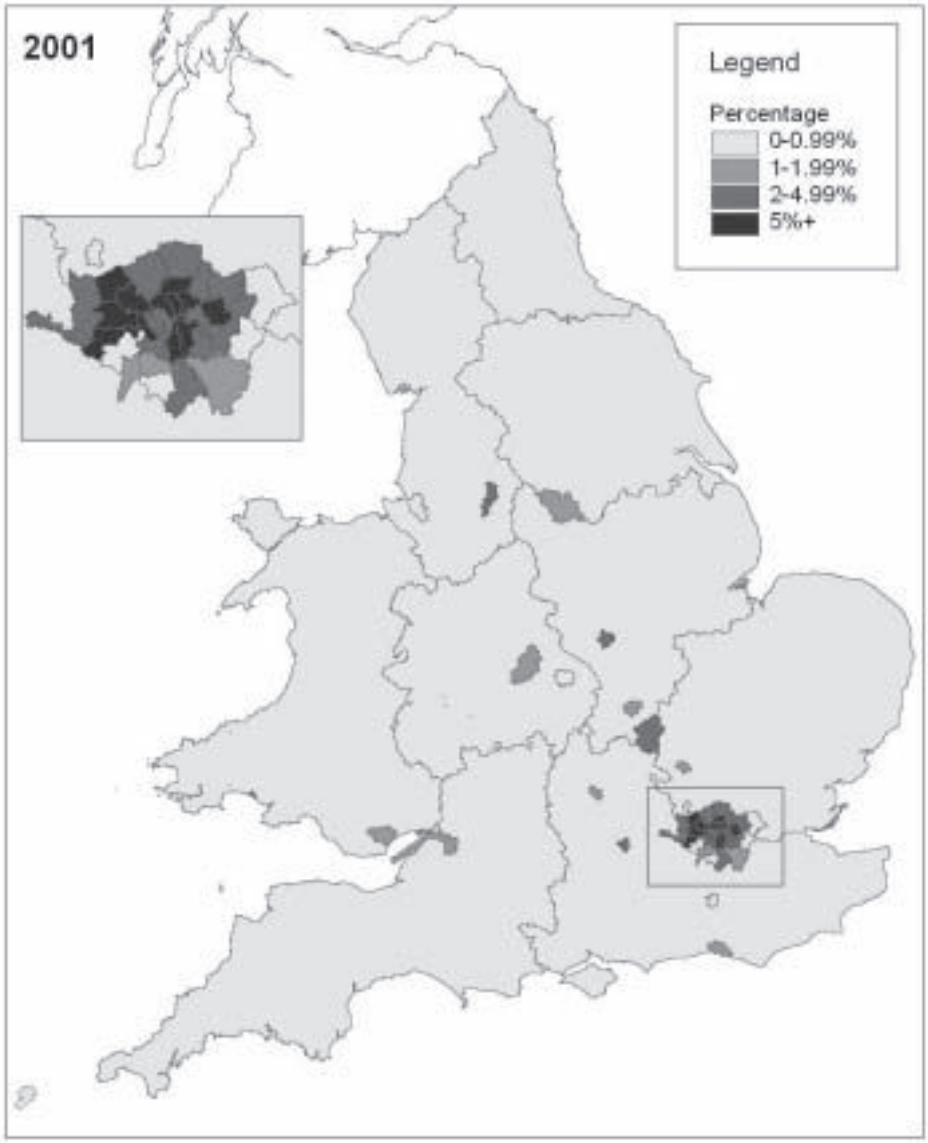
Year of birth	Number of maternities to			Percentage of maternities to women with FGM
	Women born in FGM practising countries	Women with FGM	All women	
2001	13,328	6,256	588,868	1.06
2002	14,666	7,109	590,453	1.20
2003	16,890	8,090	615,787	1.31
2004	19,356	9,032	633,651	1.43

Table 6 Estimated number of maternities to women with FGM and percentage of all maternities to women with FGM by region for local authorities where percentage exceeds one per cent, England and Wales, 2001-2004

Local authority	2001		2002		2003		2004		Total
or region of residence	Number	%	Number	%	Number	%	Number	%	Number
Non-residents	5	1.84	6	2.93	5	2.25	6	2.73	22
Cardiff / Caerdydd	70	1.97	96	2.72	90	2.45	103	2.81	360
Rest of Wales	18	0.07	18	0.07	29	0.11	28	0.10	95
Wales	88	0.29	114	0.38	119	0.38	131	0.41	455
NORTH EAST	31	0.12	40	0.15	36	0.13	39	0.14	152
Manchester	150	2.74	176	3.13	216	3.66	252	3.84	794
Liverpool	44	0.90	65	1.33	61	1.20	67	1.34	237
Rest of North West	62	0.10	63	0.10	87	0.13	120	0.17	338
NORTH WEST	256	0.34	304	0.41	364	0.47	439	0.55	1,369
Sheffield	69	1.22	105	1.92	126	2.15	130	2.14	430
Rest of Yorkshire and the Humber	55	0.11	86	0.17	97	0.19	158	0.29	396
YORKSHIRE AND THE HUMBER	124	0.22	191	0.35	223	0.39	288	0.48	826
Northampton	44	1.79	57	2.37	62	2.37	81	3.18	243
Leicester UA	116	2.92	181	4.41	212	4.85	226	4.98	735
Rest of East Midlands	61	0.16	69	0.18	81	0.20	93	0.23	307
EAST MIDLANDS	221	0.50	307	0.69	355	0.76	400	0.84	1,285
Birmingham	185	1.29	236	1.63	365	2.39	500	3.20	1,286
Coventry	23	0.64	27	0.76	50	1.33	63	1.60	164
Rest of West Midlands	61	0.14	80	0.19	86	0.19	135	0.30	366
WEST MIDLANDS	269	0.45	343	0.57	501	0.79	698	1.07	1,816
Watford	11	0.99	11	1.05	16	1.46	22	1.92	60
Luton UA	32	1.13	36	1.16	43	1.40	34	1.07	143
Rest of East	138	0.25	124	0.22	156	0.27	170	0.29	591
EAST	181	0.30	171	0.29	215	0.35	226	0.36	794
City of London	3	5.77	2	3.57	1	1.64	2	3.45	8
Camden	175	6.34	234	8.35	240	8.20	235	7.81	883
Hackney	209	5.15	233	5.77	249	5.87	231	5.32	921
Hammersmith and Fulham	144	6.19	181	7.10	192	7.60	194	7.48	711
Haringey	253	6.66	216	5.82	238	6.18	241	6.06	948
Islington	130	5.23	175	7.01	188	7.12	183	6.90	676
Kensington and Chelsea	92	4.39	104	4.90	103	4.69	101	4.64	400
Lambeth	289	6.64	308	7.09	373	7.87	394	8.35	1,364
Lewisham	152	4.12	172	4.52	188	4.80	213	5.28	726
Newham	331	6.90	339	6.87	367	7.19	345	6.70	1,381
Southwark	347	8.74	374	9.15	439	10.18	431	9.76	1,590
Tower Hamlets	105	2.90	119	3.12	139	3.52	166	4.08	528

Local authority or region of residence	2001 Number	%	2002 Number	%	2003 Number	%	2004 Number	%	Total Number
Wandsworth	131	3.19	138	3.43	157	3.65	174	4.05	600
Westminster	109	4.30	124	4.93	141	5.17	125	4.63	499
Inner London	2,470	5.53	2,719	6.00	3,015	6.35	3,035	6.30	11,235
Barking and Dagenham	82	3.42	100	4.15	122	4.74	167	6.08	471
Barnet	151	3.76	174	4.22	200	4.70	208	4.70	733
Bexley	25	0.96	29	1.16	36	1.38	53	1.99	143
Brent	356	9.13	382	9.27	403	9.28	422	9.83	1,563
Bromley	41	1.22	31	0.92	46	1.28	43	1.22	162
Croydon	106	2.43	121	2.79	132	2.91	148	3.08	506
Ealing	348	7.99	342	7.77	333	7.50	371	7.85	1,393
Enfield	122	3.28	165	4.18	196	4.85	247	5.91	730
Greenwich	158	4.96	195	5.85	202	5.88	230	6.22	785
Harrow	138	5.38	150	5.90	169	5.99	183	6.45	639
Havering	6	0.26	8	0.36	15	0.64	17	0.67	47
Hillingdon	126	3.94	121	3.70	145	4.37	177	5.12	569
Hounslow	161	5.18	184	5.73	184	5.61	222	6.17	752
Kingston upon Thames	19	1.08	15	0.84	21	1.14	19	0.95	74
Merton	40	1.52	39	1.55	41	1.51	58	2.07	179
Redbridge	103	3.33	114	3.56	125	3.73	156	4.51	498
Richmond upon Thames	16	0.68	8	0.33	16	0.64	18	0.71	58
Sutton	13	0.63	16	0.76	17	0.77	17	0.77	63
Waltham Forest	128	3.68	143	4.03	174	4.66	189	4.82	635
Outer London	2,139	3.66	2,337	3.94	2,577	4.16	2,945	4.57	10,000
LONDON	4,609	4.47	5,056	4.83	5,592	5.11	5,980	5.31	21,235
Oxford	23	1.53	24	1.54	18	1.10	38	2.24	103
Crawley	10	0.81	13	1.03	13	0.99	28	2.06	64
Reading UA	40	2.04	34	1.75	42	2.11	42	2.00	158
Slough UA	51	2.76	54	2.92	58	2.92	71	3.51	234
Milton Keynes UA	59	2.11	81	2.83	101	3.25	96	3.03	336
Brighton and Hove UA	29	1.04	29	1.07	28	0.93	26	0.91	112
Rest of South East	132	0.18	169	0.23	163	0.21	215	0.27	688
SOUTH EAST	344	0.39	404	0.46	423	0.47	516	0.56	1,695
Bristol, City of UA	78	1.68	115	2.47	180	3.62	239	4.58	612
Rest of South West	38	0.09	44	0.10	67	0.15	72	0.15	227
SOUTH WEST	116	0.24	159	0.33	247	0.48	311	0.60	839
England and Wales	6,256	1.06	7,109	1.20	8,090	1.31	9,032	1.43	30,487

Figure 2 Map showing estimated percentage of maternities to women with FGM in England and Wales, 2001 and 2004




2004

6.4 Estimates of the number of girls/women under 15 years of age who are at risk or have undergone FGM

Table 7 shows that at least 24,012 girls and women are at high risk or may have already undergone FGM, Type III and that 8,913 are at high risk or may have undergone FGM, Type II. In the countries where the prevalence of FGM is high the most common age for the FGM procedure is between 6 and 8 years. Adding the numbers aged four or under in 2001 to those born from 2002 to 2004 suggests that an estimated 15,710 girls were at high risk of Type III FGM and 5,573 were at high risk of Type II in 2005.

Table 7 Estimated numbers of girls at risk of or subject to FGM in England and Wales

	FGM Group of Country				
	1(i) High risk of FGM Type III	1(ii) High risk FGM Type I or II	2 Med risk FGM Type I or II	3 Low risk FGM Type I or II	Total
Born in FGM practising country and enumerated in 2001 census					
Aged **under 1 year** in 2001	191	71	35	171	468
Aged **1-4 years** in 2001	1201	359	348	1,082	2,990
Aged **5-9 years** in 2001	2177	610	811	2,279	5,877
Aged **10-14 years** in 2001	3231	932	1152	4,090	9,405
Total	6,800	1,972	2,346	7,622	18,740
Born in England or Wales 1993-2004 to mother who was born in an FGM practising country, derived from birth registration data					
Aged **under1 year** in 2001	1,861	643	964	3229	6,697
Aged **1-4 years** in 2001	5,084	2,049	4,243	12,710	24,086
Aged **5-8 years** in 2001	2,894	1,798	5,255	13,571	23,518
Born **2002-2004**	7,373	2,451	3,026	12,485	25,335
Total	**17,212**	**6,941**	**13,488**	**41,995**	**79,636**
Grand total	**24,012**	**8,913**	**15,834**	**49,617**	**98,376**

7. Discussion

The estimates presented in this report are subject to several limitations. For some countries where FGM, is practised, data on the prevalence of FGM are very sparse and this uncertainty in the prevalence will affect our estimates. Using Census data for England and Wales to estimate numbers of women born in countries where FGM is practised overcomes the problems due to the lack of estimates for small groups from the previous study based on the Labour Force Survey. The Census also produces more reliable estimates than a sample survey. Even so, Census data are still likely to underestimate numbers in some groups who may be reluctant to participate in the census because of concerns about residence status or who may not be living in a conventional or legal dwelling.

In addition our method underestimates numbers as the Census does not identify second generation women who may be subject to this traditional practice. Basing the probability of having FGM purely on the country of birth does not take account of the ways in which the practice might change with migration. There is some evidence that it declines with migration to the West.11 For these estimates, this is likely to affect only women who left their country of birth before the usual age of undergoing FGM.

An additional problem of basing the probability of having FGM on country of origin is that in many countries it is particular regions or specific ethnic groups who practise FGM. These groups may be more or less likely than others to migrate to the West. Data on changes in practice with migration are very sparse. Two studies of Somalis, one in London11 and one in Sweden,[23] suggest changes in attitudes against FGM although newspaper reports on two recent prosecutions on FGM in the Somali community in Sweden[24] suggest that the practice is hidden.

Although imprecise, the migration data suggested that there were was a net inflow from countries practising FGM. In particular, there is a net inflow from Somalia where FGM is nearly universal. Increasing numbers of maternities to women born in Somalia made a substantial increase to the rise in estimated proportions of maternities to women with FGM.

The results presented here are the most rigorous estimates to date. To obtain a clearer picture of actual prevalence among both migrant and second generation women, a survey of women giving birth in the UK would be needed, however. As well as being useful in their own right, the data presented here also provide a useful framework for designing such a survey.

8. Conclusions

The estimates derived through these analyses suggest that nearly 66,000 women with FGM were living in England and Wales in 2001 and their numbers are likely to have increased since then.

This is reflected in the increase in the estimated percentages of all maternities which were to women with FGM from 1.06 per cent in 2001 to 1.43 per cent in 2004.

There were nearly 16,000 girls aged 8 or younger at high risk of WHO Type III FGM and over 5,000 at high risk of WHO Type I or Type II. In addition over 8,000 girls aged 9 or more had a high probability of already having type III FGM and over 3,000 a high probability of having types I or II.

The estimates of FGM provided in this study highlight the need not only to enhance health care for girls and adult women who have already undergone FGM but calls for systematic actions to prevent FGM being passed on to the younger generation. Despite the limitations of these estimates, they suggest that the numbers of women living in England and Wales with FGM are substantial and increasing. Action is therefore needed to provide appropriate care to girls and women concerned and to prevent FGM being passed on to the younger generation.

Women with FGM are largely but not exclusively concentrated in particular areas, but there are many other areas of the country where there are smaller numbers of affected women. It is therefore important to ensure that services in all areas respond to their needs and the potential risks to their daughters.

9. Recommendations

Given that the estimates of FGM provided in this study suggest that the numbers of women living in England and Wales with FGM are substantial and are increasing.

Given that there are girls living with FGM; and given that over 20,000 under 15 year old girls are potentially at risk of FGM, the following are recommended for intensified action on FGM elimination and care for women and girls with complications due to FGM:

1. A survey should be undertaken to provide more reliable estimates of the prevalence of FGM in England and Wales. The data presented in this study provide a useful framework for designing such a survey
2. Further research on FGM is needed to increase knowledge in the following areas:

(a) Attitudes, perceptions and motivations of women and families from FGM practising countries, including those who have stopped practising it and are opposed to it, reasons for continuing the practice and factors precipitating change.

(b) Barriers to FGM prevention and care by health and social workers who frequently have to deal with attempted FGM and other groups who work to prevent FGM.

(c) The health complications particularly the psychological and the sexual aspects of FGM.

(d) How women with FGM perceive health services.

(e) Evaluation of approaches and programmes against FGM.

3. Data on FGM should be collected routinely by health and social services in order to inform the provision of better care and service provision for women and girls who have undergone FGM and for girls at risk of undergoing FGM. The Department of Health and the Department for Children, Schools and Families should provide the policy framework and guidance for documentation and the collection of data on FGM within clinical practice and within child protection.
4. Women with FGM are largely but not exclusively concentrated in particular areas, but there are many other areas of the country where there are smaller numbers of affected women. It is important to ensure that services in all areas respond to their needs and the potential risks to their daughters. All strategic health authorities, primary care trusts, acute trusts and foundation hospitals should ensure that services including commissioning of services in all areas respond to the health needs of women and girls with FGM.

5. As well as girls at risk of FGM there are substantial numbers of girls under15 likely to have undergone FGM. Girls with FGM Type III may have restricted mobility, in case the scar splits, difficulties in participating in sports, difficulties with urination and menstruation and they may need psychological support. In order to improve access to health care and support for affected young people, it is important that professionals in the health and education professionals are alert and respond to their needs.
6. FGM care and prevention should be mainstreamed into existing strategies that respond to the needs of women and girls with FGM and the potential risks to their daughters, for example through Child Health, Sexual Health and Maternity Improvement strategies working through Local Area Agreements and Local Strategic Partnerships.
7. There is a need for an understanding of FGM not just as a health issue but primarily as an issue of violence against women and an abuse of girl children. Thus FGM should be given equal status with other forms of child abuse and all Social Services, Health, Education and the Police Child Protection Units should update their child protection policy and procedures to include FGM.
8. All education and training programmes on child abuse, reproductive and sexual health care should incorporate FGM, but most importantly, because of the large turnover of staff in social services and health, FGM education should be incorporated into the core curricula of professionals in social, health, education and the police.
9. FGM prevention and care should be fully mainstreamed into the government child care provisions through the implementation of 'Every Child Matters' and into the National Service Framework for Children, Young People and Maternity Services.
10. FGM prevention should be integrated into the work of the joint Home Office and Foreign and Commonwealth Office Unit on Forced Marriages as FGM occurs in similar context. Messages to schools regarding forced marriage could easily and usefully incorporate information about FGM. New refugees, particularly from countries with high prevalence of FGM should be targeted with information on the illegality of FGM.
11. The voluntary sector and community groups' involvement is crucial to address issues of prevention as well as delivery of services that take FGM issues into account. Thus community action on FGM should be strengthened and promoted for all the FGM practising communities.

References

1. World Health Organization (1995) Female Genital Mutilation Report of a WHO Technical Working Group. Geneva, 17–19 July 1995, WHO/FRH/WHD/96.10.
2. UNICEF (2005) Female Genital Mutilation/cutting: A statistical exploration. UNICEF, New York
3. World Health Organization (1997) Female Genital Mutilation: A joint WHO/UNICEF/UNFPA Statement, pp.1–2, WHO.
4. UNICEF (2005) Female Genital Mutilation Must End, UNICEF, New York
5. World Health Organization (2000) A systematic Review of the Health Complications of Female Genital Mutilation including Sequelae, WHO, Geneva
6. WHO Study Group on Female Genital Mutilation and Obstetric Outcome (2006) 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries' The Lancet 367: 1835–41
7. Morison L, Scherf C, Ekpo G, Paine K, West B, Coleman R and Walraven G (2001) 'The long-term reproductive health consequences of female genital cutting in rural Gambia: A community-based survey' Trop Med Int Health (2001) 6(8): 643–53.
8. Behrendt, A and Moritz, S (2005) 'Post-traumatic Stress Disorder and Memory Problems After Female Genital Mutilation', American Journal of Psychiatry, 1000-02
9. McCaffery M, Jankowska S HO and Gordon H (1995) 'Management of female genital mutilation: the Northwick Park Hospital experience' British Journal of Obstetrics and Gynaecology, 102: 787–90.
10. Hedley R and Dorkenoo E (1992) 'Child Protection and Female Genital Mutilation' FORWARD, London
11. 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 9(1): 75–100
12. Mwangi-Powell, F(2000) 'Somali Women in the Community Health (SWITCH) Project', FORWARD, London.
13. Reed D (1998) 'Out of Sight, Out of Mind?' FORWARD, London, UK.
14. HM Government (2006) 'Working Together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children'.

15. Sleator.A (2003) The Female Genital Mutilation Bill: House of Commons Library.
16. Kwateng-Kluvitse A (2004) 'Legislation in Europe regarding female genital mutilation and the implementation of the law in Belgium, France, Spain, Sweden and the UK' p.25 International Centre for Reproductive Health, Ghent University, De Pintelaan 185 P3,9000 Ghent, Belgium.
17. World Health Organization (2001) Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Teacher's Guide, WHO, Geneva.
18. Jones W K, Smith J, Kieke B, Wilcox L (1997) 'Female genital mutilation/female circumcision. Who is at risk in the US?' Public Health Reports 112: 369–77
19. Nour NM (2005) 'Number of women, girls with or at risk for female genital cutting on the rise in the United States'. Press Release. Boston: African Women's Health Centre, Brigham and Women's Hospital, 28/1/2005. See: www.brighamandwomens.org/africanwomenscenter/research.asp. [Accessed October 12 2005]
20. Leye E and Anon J G (2004) 'Legislation in Europe regarding female genital mutilation and the implementation of the law in Belgium, France, Spain, Sweden and the UK' pp.26-8 International Centre for Reproductive Health, Ghent University, De Pintelaan 185 P3,9000 Ghent, Belgium
21. Toubia, N. (1993) Female Genital Mutilation: A Call for Action. Population Council, New York.
22. Pratiknya A. W. (1994) 'Modern Womens' Attitude toward FGM - The Indonesian Experience'. LBWHAP: Change Without Denigration Conference, June 30 - 1 July, 1994. LBWHAP, London.
23. Johnsdotter S (2003). FGM in Sweden. Swedish legislation regarding 'female genital mutilation' and implementation of the law. Research report in Sociology 2004:1. Department of Sociology,Lund University.
24. M&C News(2006). Somali-born woman sentenced for violating female circumcision ban.

FORWARD

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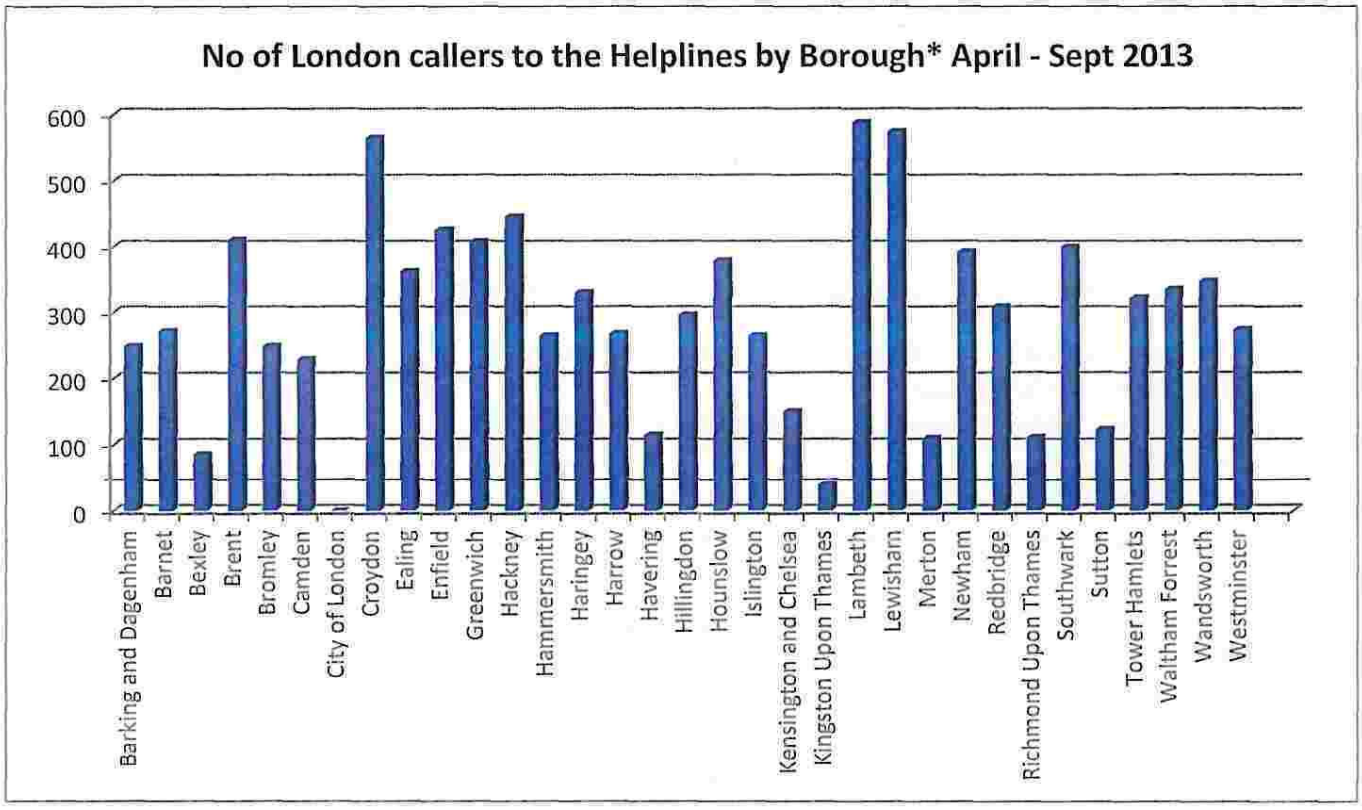
Update on impact: October 2013

In the 6 months from 1st April to 31st September 2013 the Domestic and Sexual Violence Helplines:

- Responded to **11,886** callers from London
- Referred 1,499 women in London to a refuge space
- Provided information on welfare benefits, immigration, medical, housing and/or legal rights to 4,291 callers in London
- Carried out online crisis and safety planning for 4,928 callers in London



*A further 2,187 calls were received from London where the Borough was unknown.

The ASCENT Project

The partners delivering London domestic and sexual violence helpline services are doing so as part of the ASCENT project. ASCENT is a project of the London Violence against Women and Girls (VAWG) Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils.

For more information about this project, please do not hesitate to contact Nicki Norman, Director of Operations, Women's Aid - n.norman@womensaid.org.uk

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Counting the Somali Community In Brent

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September 2013

Counting the Somali community

Previous estimates of the Somali community have been based on Immigration, asylum claims, National Insurance, Languages spoken, country of birth and apportionment of national survey proportions to the local area.

These are all likely to underestimate the size of the community. The estimates are often based on old data and/or have wide margins of error.

The method we have used is based on matching two sources: The GP register and the School Census.

The GP register was from February 2013. The way the register is being compiled is changing. It used to be all people living in Brent wherever they are registered with a GP. It is changing to be a register of people who have a Brent GP, wherever they live. The list we used is a hybrid of the two. The register includes children with a Date of Birth up to the 26th February 2013. There are, of course some people who are not registered with a GP. However our experience of analysing many administrative datasets and census returns is that people are more likely to be registered with a GP than to appear in any other dataset.

The School Census is updated three times a year. We used the January 2013 Census. Potentially it gives us three ways to identify children as Somali: their national origins (Often described as 'Ethnicity'), the languages they speak and their names. We did not match the language field at the individual level in this case but at the aggregate level we identified that that only 50 Somali speaking children did not identify themselves as Somali. We also looked at an earlier Brent school Census database and identified that of 60 children who simply identified themselves as Black African only six said they spoke Somali and 37 said they spoke English. It is possible that some of these English speaking 'Black African' children are Somali but it is a very small number. Finally because we have done this exercise before (see over) we have a large database of distinctively Somali names. We can therefore identify as Somali people who may have lived in countries other than the UK or Somalia and children of Somali origin who do not speak Somali. A possible source of underestimation is that the school census does not include children at private schools. From what is known about the socio economic profile of the Somali community it is likely that the vast majority of Somali children are at state schools. Data from Free schools are not included.

GP Register

Based on 322k probable population of Brent our estimate of the Somali population is 10,375.

Compared to other boroughs:

Borough	Somali population	Year of data
Brent	10,375	2013
Newham	6,512	2011
Haringey	5,012	2012
Tower Hamlets	4,645	2010
Waltham Forest	3,804	2011
Greenwich	2, 877	2011
Hackney	2,013	2011
Waltham Forest	3,804	2011
Barking and Dagenham	592	2011

Outside London

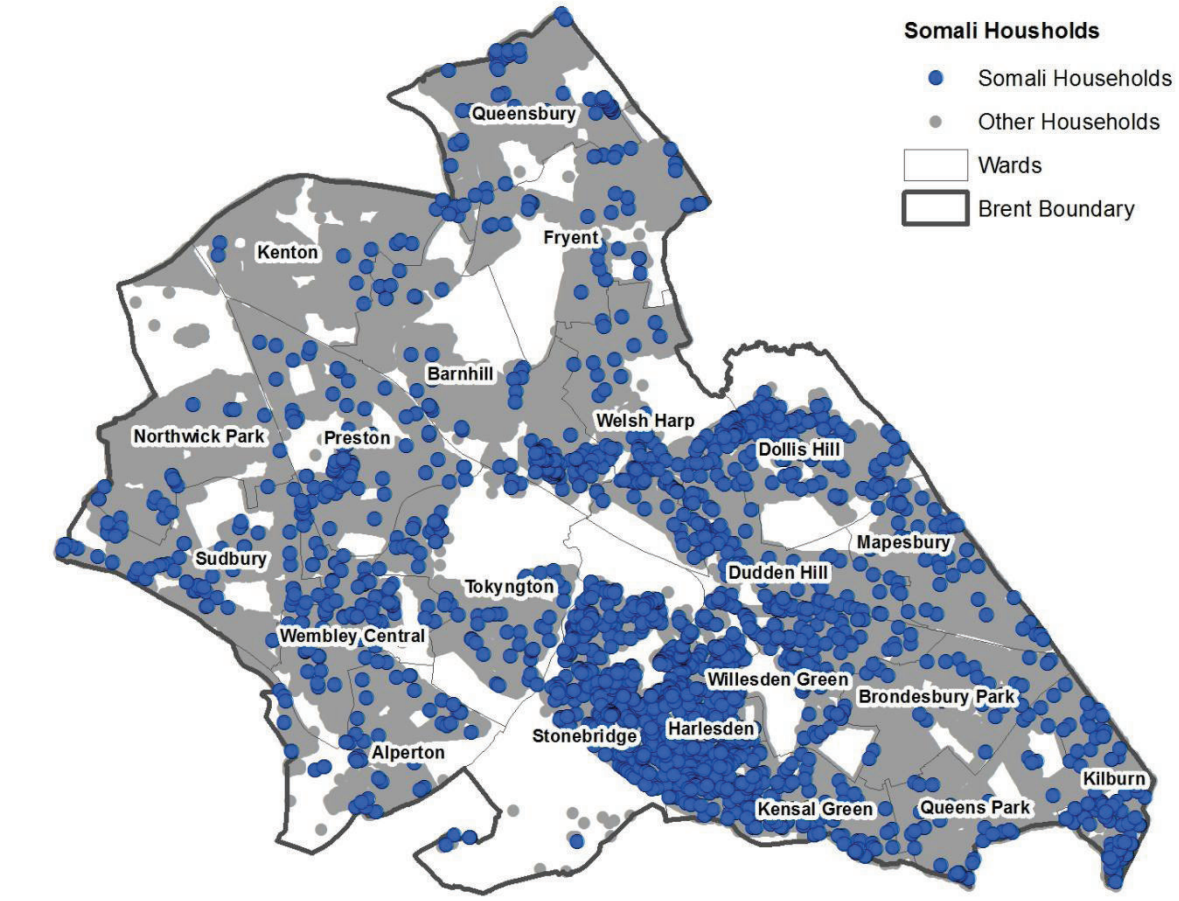
- Luton 1,360 (2010)

When we did the analysis of the 2008 school census Ealing had the largest Somali pupil population followed by Brent. We have no reason to think this has changed.

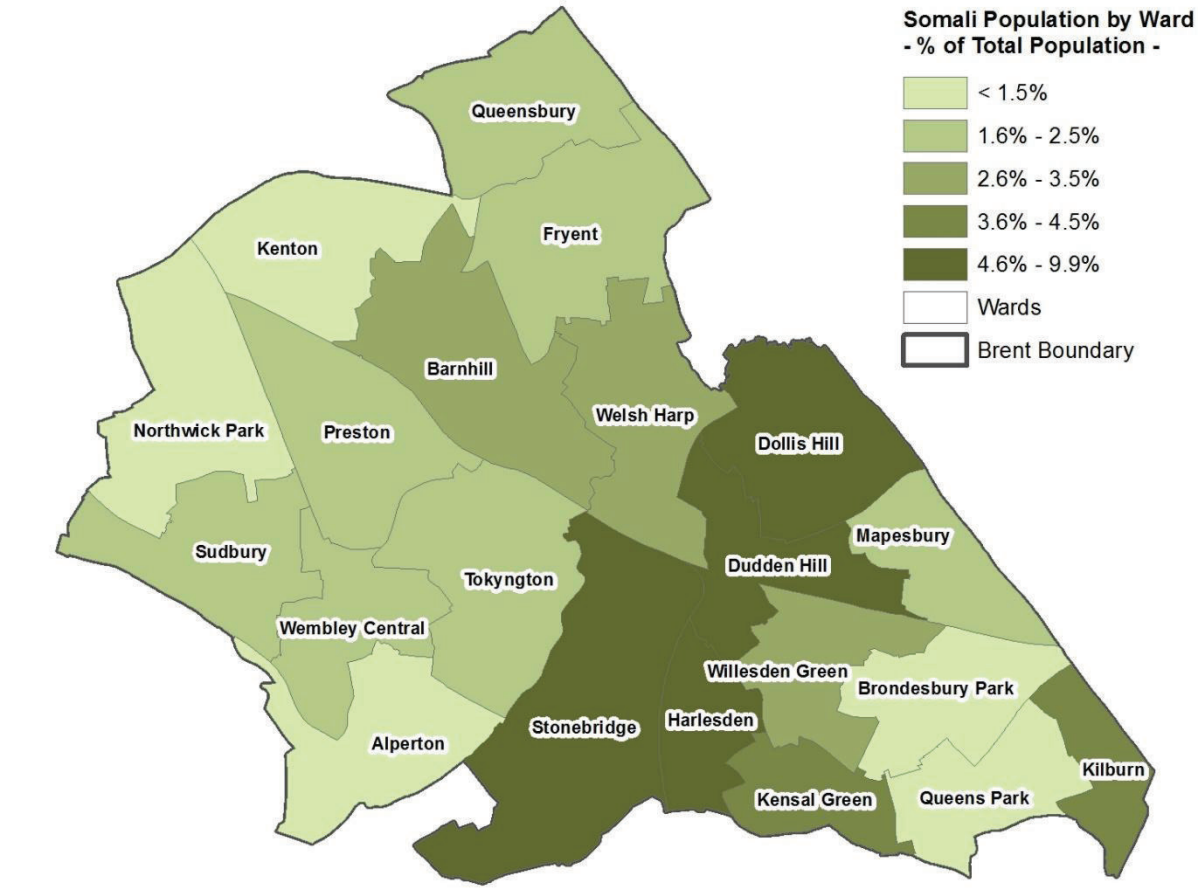
Age and Gender Population Distribution

Age	Somali Population				Total Brent Population	% Somali
	Female	Male	Unknown	Total		
<5	679	664	1	1344	22976	5.8
5-9	818	825	0	1644	19913	8.3
10-14	742	756	1	1500	17778	8.4
15-19	618	652	3	1273	17802	7.1
20-24	383	362	0	745	23050	3.2
25-29	350	306	1	657	34312	1.9
30-34	298	258	1	557	33631	1.7
35-39	284	274	0	558	26223	2.1
40-44	323	334	1	658	23478	2.8
45-49	222	272	0	494	21820	2.3
50-54	138	174	2	313	19617	1.6
55-59	71	114	2	186	15494	1.2
60-64	61	59	1	121	12313	1.0
65-69	60	39	1	99	9851	1.0
70-74	53	40	0	93	8283	1.1
75-79	46	24	0	70	6854	1.0
80-84	25	19	0	43	4683	0.9
85-89	10	3	0	13	2343	0.6
90+	5	2	0	7	1180	0.6
Total	*5185*	*5178*	*13*	***10375***	*321601*	*3.2*

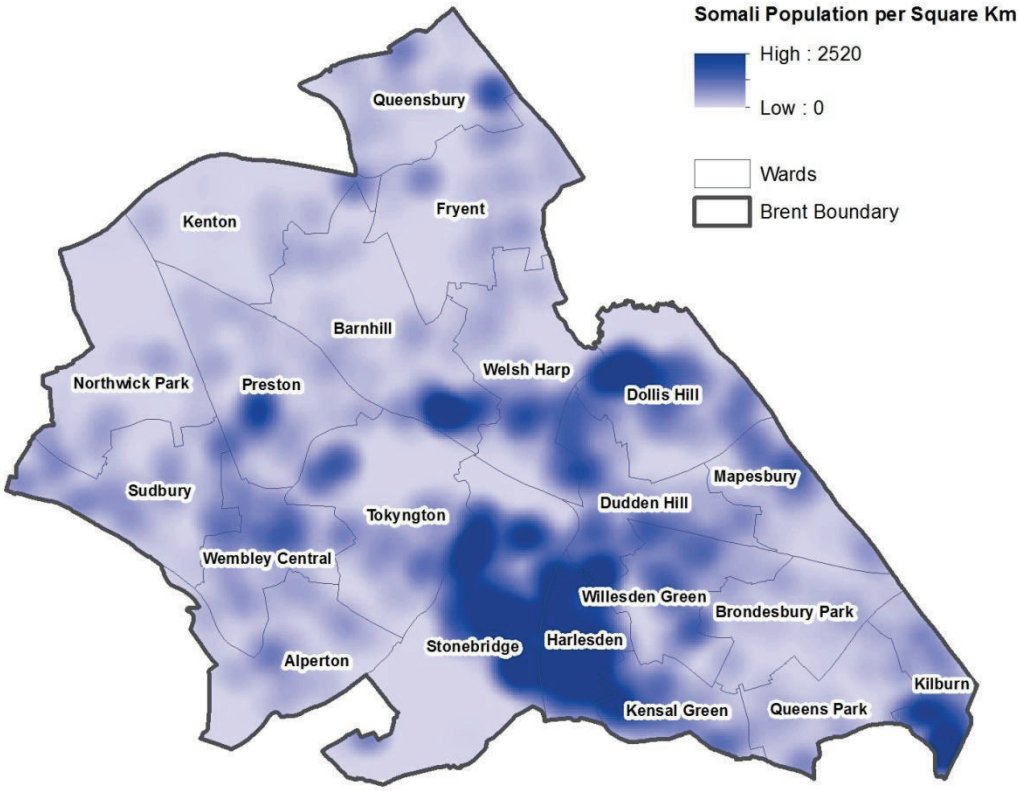
Location of Somali Households (A Somali Household in this instance is defined as a Household where at least half of the residents are Somali)

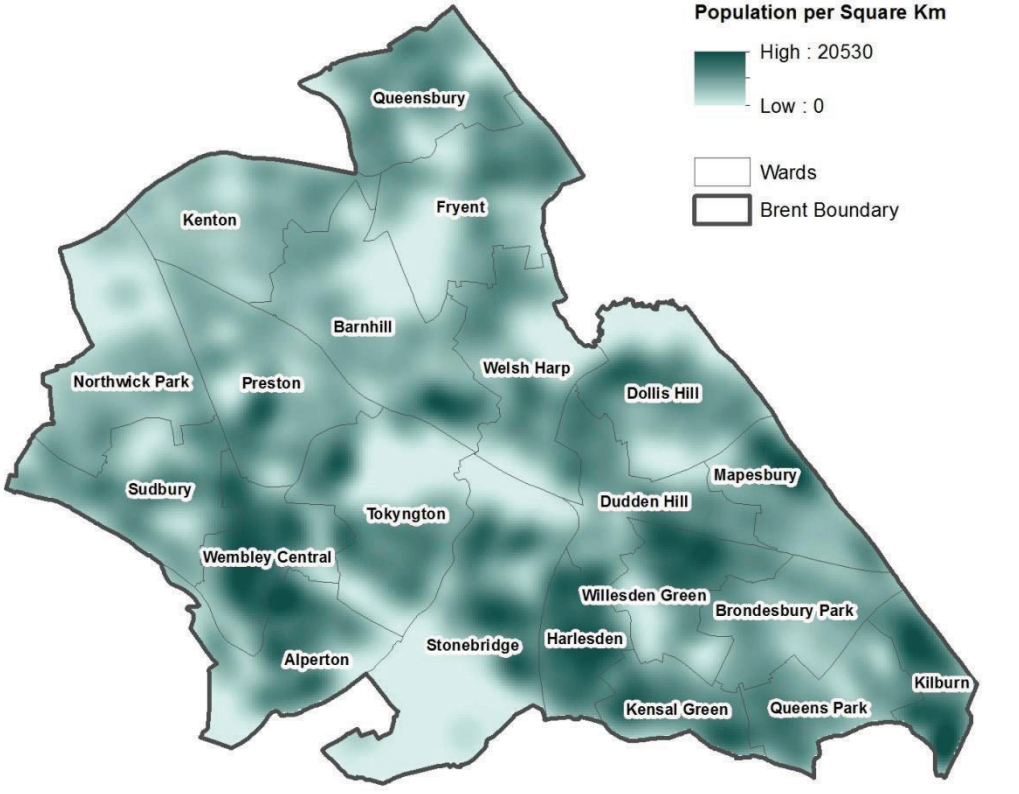


Somali Population by Ward



Somali Population Density (compared to general population density distribution below)





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STRICTLY EMBARGOED UNTIL: THURSDAY 00:01 6 FEBRUARY 2014

Postcode lottery: police recording of reported 'honour' based violence

Report on research undertaken by the Iranian and Kurdish Women's Rights Organisation (IKWRO) on police records of 'honour' based violence

January 2014

IKWRO
IRANIAN AND KURDISH WOMEN'S RIGHTS ORGANISATION

FOREWORD

In undertaking the research for this report we, the Iranian and Kurdish women's rights Organisation (IKWRO), set out to ascertain the scale of reported 'honour' based violence (HBV) in the UK and to check that police forces are properly recording HBV cases.

Flagging (labelling) of HBV cases is essential to enable the safeguarding of victims and those at risk. It allows the scale of the reported problem to be understood, both locally and nationally, and helps prevent under-resourcing. Once an HBV case is properly flagged, it reduces the risk of other police officers failing to identify it as HBV, not acting appropriately and endangering the victim, for example by negotiating with their family or community. It is also crucial for risk profiling and risk management.

We submitted Freedom of Information Requests to every police force across England, Wales, Northern Ireland and Scotland. We were encouraged by the fact that we received a response from every police force. I would like to take this opportunity to thank each police force for their co-operation.

What became apparent from the responses, is that it is not possible to establish the full scale of reported HBV. This is because a significant proportion, 20% of police forces, failed to flag all HBV cases reported to them. This failure puts lives at risk.

In this report we have set out recommendations to help 'honour' based violence be tackled effectively. We hope that the government, the Association of Chief Police Officers, all police forces and Her Majesty's Inspectorate of Constabulary will commit to implementing these recommendations, to ensure the protection of those at risk of HBV.

I would like to thank Sara Browne, our Campaigns Officer for writing this report and to all staff at IKWRO who supported this project.

Diana Nammi
Executive Director, IKWRO

CONTENTS

1 BACKGROUND

1.1 THE IRANIAN & KURDISH WOMEN'S RIGHTS ORGANISATION

The Iranian and Kurdish Women's Rights Organisation (IKWRO) is a registered charity which was founded in 2002 in response to extremely poor understanding of and inadequate responses to 'honour' based violence by the police and other front-line agencies.

IKWRO provides advice, advocacy, support, referral and counselling services to Kurdish, Farsi, Arabic, Turkish, Pashtu, Dari and English speaking women and girls living in the UK who are facing 'honour' based violence, forced marriage, child marriage, female genital mutilation and domestic abuse. We provide support and advice to frontline professionals. We deliver training to professionals and women and give presentations in schools and colleges as well as campaigning for better laws, policies and implementation.

1.2 DEFINITION OF 'HONOUR' BASED VIOLENCE

The Association of Chief Police Officers' (ACPO) definition of 'honour' based violence (HBV) is as follows;

> ***'Honour based violence' is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community'.***

In their national 'Honour Based Violence Strategy' (herein referred to as HBV Strategy) which was implemented on 30 September 2008 and remains current, ACPO stated that the term 'honour' based violence is used *'to include Forced Marriage (FM) (so often the driver for or context in which HBV is committed) and Female Genital Mutilation (FGM).'*

In this research, we requested figures for reported 'honour' based violence, however we were concerned to find that there is inconsistency in what the UK's police forces include under this category. For example, some police forces, such as the Metropolitan Police, flag forced marriage cases separately from, rather than under the term 'honour' based violence. We also understand that some police forces do not include female genital mutilation under the category 'honour' based violence.

IKWRO believes that some of this inconsistency may flow from the definition (above) which is too vague to underpin concerted action. We therefore propose this fuller and more explanatory definition which will help people understand and identify 'honour' based violence more easily.

> ***'Honour' based violence is normally a collective and planned crime or incident, mainly perpetrated against women and girls, by their family or their community, who act to defend their perceived honour, because they believe that the victim(s) have done something to bring shame to the family or the community.***
>
> ***It can take many forms including: 'honour' killing, forced marriage, rape, forced suicide, acid attacks, mutilation, imprisonment, beatings, death threats, blackmail, emotional abuse, surveillance, harassment, forced abortion and abduction.***

In addition to our concerns about inconsistency in how HBV cases are recorded, we are also concerned, that some police officers still do not have a proper understanding of HBV. This prevents them from properly investigating incidents and crimes, recording all pertinent information and acting appropriately

to protect victims. We believe that this fuller, more explanatory definition will help police understanding of HBV as will better, regular training and effective risk assessment and management tools.

1.3 THE ASSOCIATION OF CHIEF POLICE OFFICERS' POSITION ON THE FLAGGING (LABELLING) OF HONOUR BASED VIOLENCE CASES & WHY FLAGGING IS CRUCIAL

1.3.1 Identifying the scale of HBV & ensuring resources meet needs

The first of the ***'stated priorities for the police service'*** in the HBV Strategy (2008) is;

> ***'to identify the scale of HBV in all police services across the UK.'***

ACPO therefore made it clear in the HBV Strategy 2008 that there is a need for every police force to flag (label) HBV cases and to understand the prevalence of HBV reporting.

Provided every police force accurately flags every reported HBV case, each police force can easily identify the scale of reported HBV. This would also mean that ACPO would be in a position to obtain national figures for reported HBV and analyse the issue.

So what happens when a police force fails to flag HBV cases? To ascertain how many HBV cases have been reported to them, they have to manually check each file. Unfortunately, it appears that this is unlikely to happen, since it is prohibitively resource and time intensive. This prevents not only the local police force, but also ACPO from having the data that they need to be able to assess the prevalence of reported HBV.

ACPO states in their HBV Strategy 2008 that;

> ***'identifying the scale of the problem is essential if services are to be underpinned by an evidence base; are to be tailored to the needs of the communities being served; are to be sensitive and appropriate and are to be developed in line with identified and/or emerging trends and patterns. By identifying the scale of honour based violence, police services will be able to allocate resources appropriately, target interventions, deploy more effectively'.***

ACPO also state in their HBV Strategy 2008 that;

> ***'regular reports (every six months) will be required by the ACPO and Home Office Working Groups so that a more complete view of the scale of HBV is available.'***

It follows that without this data, these objectives cannot be achieved.

With the introduction of local commissioning, through Police Crime Commissioners (PCC's), it is now even more essential for every UK police force to accurately flag all reported HBV cases as this will help avoid under-resourcing where there is need. When assessing these figures PCC's must factor in underreporting;

a problem in all domestic abuse cases and in particular with HBV. Furthermore PCC's should appreciate that the figures may not reflect the true scale of reported HBV, as some police officers could fail to identify HBV, particularly if not all police officers are fully trained on the issue. All police officers, at every level, need effective, regular training to ensure that they understand, can identify and appropriately handle HBV cases.

1.3.2 Reducing risk of police officers failing to identify HBV cases & responding inappropriately

It is essential that all police officers handling an HBV case, including 999 and 101 telephone responders, understand from the outset that it is an HBV case. To ensure that anyone at risk is protected, and not further endangered, knowledge about HBV needs to be applied. There are important 'dos and don'ts' which must be followed.

Some examples of what the police must do:

> Recognise that any family member or community member of the person/ people at risk may be a perpetrator.
>
> Recognise that there may be many perpetrators, including people not known to the victim (such as bounty hunters and contract killers). This means the victim may be at risk even if far away from their family.

*Some examples of what the police must **not** do:*

> They must never inform the family or community about their involvement, or interview a victim in front of any family or community member, or attempt to mediate as doing so would put the person/ people who are at risk in greater danger.

If a police officer flags an HBV case, this reduces the risk of all other police officers, who may be involved at that stage, or a later time, failing to identify it as HBV. Therefore the risk of the police acting inappropriately and failing to protect the victim or endangering them further is reduced.

Sadly, there have been a number of cases which the police have failed to identify as HBV, where they have not acted appropriately to protect the victim, and have put the victim in greater danger.

> One example is the case of Banaz Mahmod. She was murdered in an 'Honour' Killing in 2006. Before her murder she reported HBV to the police five times. On the last of these occasions, on New Years Eve 2005, her father made her drink alcohol and then attempted to murder her. She managed to escape and the policewoman handling her case that night failed to understand the context, disbelieved Banaz and took the view that she was just a girl who had drunk too much. The police informed Banaz's father that she had raised a complaint and the police went to Banaz's family home to interview her in front of them. A few weeks later, in London

on 24 January 2006, Banaz was raped and murdered in by her family and her body was later found buried in a suitcase in Birmingham.

Flagging is essential to prevent multiple police failure to identify HBV and trigger the appropriate approach.

With HBV cases, there is a real likelihood that the case could be encountered by a number of different police officers, at different times and in different places.

It is probable that police officers could encounter an HBV case over a long time span. This is because the risk to those in danger never disappears, until the perpetrators are satisfied that they have regained their 'honour', by erasing the person/ people that they believe have brought shame to the family and community.

It is likely that police officers in different areas may encounter an HBV case because people at risk often move to try find safety, however there are likely to be a high number of potential perpetrators, who could be spread across the UK and abroad.

In a case that IKWRO was involved with, our client and her children had to be moved to 8 different refuges because she and her children were being pursued by her family and members of the community. Perpetrators went to refuges and shops in different areas with pictures of her to try to find her.

The greater the numbers of officers that are involved in a case, the more likely it is that one or more of them will fail to identify it as HBV, and as a result will not act appropriately to protect the victim, which could put them in greater danger.

Therefore every single police force must identify and flag all HBV cases and information about cases must be able to easily be safely shared between all police forces.

1.3.3 Risk profiling

Flagging HBV cases is important for effective risk profiling. In HBV cases there is a significant likelihood that other family members could already have experienced HBV. This is key intelligence which can help the police to safeguard all family members at risk. If all cases of HBV are flagged, this assists the police with their risk assessment and risk management.

In the case of Banaz Mahmod, her sister Bekhal was already under police protection, because their brother had tried to kill her in what a clear 'honour' based violence case. If the police had flagged Bekhal's case as being HBV, they would have

had a record of the Mahmod's being a family that took 'honour' very seriously, and when Banaz reported, it would have been noted that the Mahmod's were perpetrators of 'honour' based violence and her reporting is likely to have been taken more seriously.

1.3.4 Importance of flagging all HBV cases; incidents as well as crimes

Significantly, ACPO's definition of 'Honour' based violence, which is set out at 1.2 of this report above, includes not only crimes but also incidents. Importantly ACPO recommends;

> ***'that each force puts in place the mechanism to record the number of HBV incidents reported.'***

It is vital that as well as recording and flagging every HBV crime, that every reported HBV incident is also recorded and flagged.

HBV cases can escalate very quickly, from what someone without a proper understanding of HBV might interpret as a trivial incident, to extreme violence and 'honour' killing. To protect people at risk of HBV, all reported incidents must be taken seriously, investigated thoroughly and acted upon appropriately and sensitively. Furthermore the case must be fully recorded and flagged as HBV, so that all police officers involved from the start, and at any later stage, know to apply the appropriate approach.

We know from our work with women and girls at risk that eight years on from the murder of Banaz Mahmod, there are still cases where the police are failing to identify risk and are not taking steps to protect the person/ people reporting to them.

Recently a woman came to IKWRO who had just been turned away from a police station. The police had asked her if she had any bruises and she told them that she did not. They asked her if there was a history of violence against her and she told them there was not. They asked her if she was being forced into a marriage and she told them that no she was not. She explained to them that her family believed that she had brought them dishonor because she had fallen in love with a man who they had not chosen and she was scared that they would harm her. The police did not take a statement from her. They told her that no crime was committed and told her to go home. IKWRO undertook a risk assessment the same day and we found her to be at high risk of HBV. We accompanied her to the same police station and they then accepted that she was at high risk.

To ensure this does not happen, every police officer needs to be properly trained to understand and identify HBV and every HBV case must be flagged, to reduce the risk of their colleagues failing to identify the case and acting inappropriately.

Recording incidents, as well as crimes, gives a more accurate picture of reported HBV prevalence. Reported incidents must be flagged by every police force, so that they can easily understand the true scale of reported HBV locally. This is imperative if they are to respond to the issue effectively. It is also essential so that Police Crime Commissioners have accurate data to help ensure that the issue is not under-resourced.

Furthermore, unless each police force flags all reported HBV incidents, as well reported crimes, which would enable ACPO to easily identify the national scale of reported HBV, ACPO cannot effectively address the issue.

1.3.5 Need to flag HBV cases throughout the criminal justice process

But flagging HBV cases when they are reported and investigated is not enough. It is vital that every HBV case is flagged and remains flagged at every stage, including when a charge is pressed, and if it results in a conviction. This is essential, so that the case can be properly understood and dealt with appropriately by all who handle it.

Flagging at every stage is also crucial so that all police forces and ACPO can gather data on the scale of HBV at the different stages of the criminal justice system. This information is vital to enable effective planning to address HBV.

1.3.6 Importance of consistency

In their HBV Strategy, ACPO state that;

> ***'the ambition is to achieve consistency in terms of identifying an honour based violence incident, recording such incidents and the collation and analysis of this data.'***

This is vital so that HBV cases are not missed and so that accurate information can be obtained both locally by individual police forces and nationally by ACPO about the scale of HBV.

2. METHODOLOGY

In August 2013, IKWRO submitted requests under the Freedom of Information Act 2000 to every police force in; England, Wales and Northern Ireland (in total 44 forces). Each police force was asked the following:

For the full year of 2012, please can you confirm;

1. How many incidents of 'honour' based violence your police force recorded?

2. How many of these incidents led to criminal charges being pressed?

3. How many of the charges referred to in question 2 resulted in convictions?

For the full year of 2012 there were eight regional police forces in Scotland, which on 1 April 2013 were amalgamated into one force; Police Scotland.

In August 2013, under the Freedom of Information (Scotland) Act 2002, the following request was submitted to Police Scotland;

Separately, for each of the former regional police forces in Scotland, please can you confirm;

1. How many incidents of 'honour' based violence your police force recorded?

2. How many of these incidents led to criminal charges being pressed?

3. How many of the charges referred to in question 2 resulted in convictions?

3 FINDINGS

3.1 SUMMARY OF FINDINGS

More than one in five police forces in England, Wales, Northern Ireland and Scotland failed to flag and provide data for both HBV incidents and crimes reported in 2012. It was therefore not possible to establish the scale of HBV reported in 2012.

Please refer to the infographic at Appendix 1.

It should be noted that police figures must always be treated with caution; the police may fail to identify and/ or record a case as 'honour' based violence. It must also be remembered that reported HBV does not represent the prevelence of HBV within the UK as many HBV cases are never reported to the police.

3.2 SOME POLICE FORCES FAILED ENTIRELY TO FLAG HBV CASES

These forces (see 3.2.1 below) failed to flag all HBV cases including; incidents, crimes, cases where a charge had been pressed and convictions.

They were unable to provide any of the information that was requested. They stated that in order to gather the requested data they would need to manually search through each case. They claimed exemption under the relevant Act; the Freedom of Information Act 2000 and the Freedom of Information (Scotland) Act 2002.

3.2.1 England, Wales & Northern Ireland

Derbyshire Constabulary stated;

> ***'the Constabulary utilises a computerised crime recording system to log all reported crimes. Whilst the system has some search facilities it cannot search for 'honour' based violence crimes per se. Given that there is no central register for these crimes the only way to extract the data would be to open each crime and read notes to see whether or not it is relevant to this application.'***

Gloucestershire Constabulary stated;

> ***'unfortunately, there is no central register for the information you have requested. Due to there being no Home Office Crime Category for 'honour' based crimes, the reports would only be recorded on the Constabulary's system as an incident. Our incident recording system does not have a flag or marker for 'honour' based crime and therefore we would have to manually review all incidents for the year requested to see if they would fall under your request remit.'***

Staffordshire Police stated;

> ***'there is no specific system to easily retrieve the required data. There are thousands of incidents which would require a manual search of each crime to investigate whether it is 'honour' based violence'.***

3.2.2 Scotland

The response from Police Scotland regarding four of the former eight police forces, which existed prior to it's formation on 1 April 2013; Dumphries and Galloway, Northern, Fife and Strathclyde, was that;

> ***'there was no way of extracting this information from the incident and crime recording systems without examining each individual record, which would be a considerably time consuming task given the number of crimes reported in each legacy force every year.'***

IKWRO is however encouraged by the following statement from Police Scotland;

> ***'the Lead officer for the ACPOS HBV working group identified that there was both under-reporting and a lack of identifying and recording of HBV incidents throughout the eight different forces. She identified this gap and as a result a national recording mechanism was agreed and put in place from 6 December 2012.'***

IKWRO intends to carry out further research to investigate whether, since the formation of Police Scotland on 1 April 2013, lessons learned from the earlier failures are being addressed in practice.

3.3 SOME POLICE FORCES FLAGGED ONLY CRIMES & NOT INCIDENTS

These forces stated that the data they provided was specifically for crimes, not incidents;

Avon and Somerset Constabulary, Hampshire Constabulary, Police Service Northern Ireland, West Mercia Police and **Surrey Police.** The later stated;

> ***'Results are extracted from a live Crime Information System (CIS) which is subject to change over time…only notifiable crimes are included (those which police are required to notify formally to the Home Office)'.***

3.4 SOME POLICE FORCES FAILED TO FLAG HBV CASES IN WHICH A CHARGE WAS PRESSED

These forces are **Bedfordshire Police**, **Cleveland Police** and **Lancashire Constabulary.**

3.5 OTHER FINDINGS

3.5.1 There is significant variation in how 'honour' based violence is interpreted; some forces include Forced Marriage and others do not. For example, the Metropolitan Police record Forced Marriage under a separate category.

3.5.2 Some forces claimed exemption to providing data on the basis that disclosure could impede investigations.

4. SUMMARY

It is IKWRO's view that following some significant progress culminating in the publishing of ACPO's HBV strategy in 2008, that subsequently ACPO has neglected the issue of HBV. This is demonstrated by the fact that no HBV review or action plan has been published since the 2008 HBV Strategy, despite it clearly being stated in the strategy that it was due to be reviewed on 30 September 2010.

This neglect is further illustrated by the finding from this research that more than one in five UK police forces failed to flag all HBV incidents and crimes, despite it being clear in the ACPO HBV Strategy 2008 that this is essential.

5. RECOMMENDATIONS

The following recommendations are made on the basis of IKWRO's findings from this research, as well as IKWRO's expertise on HBV. Our expertise comes from over 11 years of campaigning on this issue and providing front-line services to women and girls at risk of HBV.

1. **Adopt fuller more explanatory definition:** The government, police and all statutory and voluntary organisations should adopt this fuller more explanatory definition;

   'Honour' based violence is normally a collective and planned crime or incident, mainly perpetrated against women and girls by their family or their community, who act to defend their perceived honour, because they believe that the victim(s) have done something to bring shame to the family or the community.

   It can take many forms including: 'honour' killing, forced marriage, rape, forced suicide, acid attacks, mutilation, imprisonment, beatings, death threats, blackmail, emotional

abuse, surveillance, harassment, forced abortion and abduction.

2. **An inspection of current police handling of HBV:** Her Majesty's Inspectorate of Constabulary (HMIC) should carry out an inspection into the handling of HBV by UK police forces and ACPO. This should include an examination of training provided on HBV for all levels of police officer, including telephone responders (101 and 999) and the response to, recording, analysis and monitoring of HBV.

3. **Greater Transparency:** ACPO and Police Scotland should operate with much greater transparency with regards to HBV strategy.

4. **Greater partnership working to keep women and girls safe:** ACPO should work much more closely with, and meet regularly with HBV stakeholders, including charity organisations with expertise in HBV, such as IKWRO, to ensure shared learning and progress in tackling HBV.

5. Police recording and flagging of HBV should be made a statutory requirement.

6. **Every police force should flag HBV at every stage:** ACPO must ensure that every police force in England, Wales and Northern Ireland has a system in place to flag all cases of reported 'honour' based violence, including both incidents and crimes, as well as cases in which a charge is pressed. ACPO should set and publicise a date by which all police forces must demonstrate that this system is operational. If any police force fails to comply, ACPO should publicise their failure and take all steps in their power to ensure timely compliance.

7. **Scotland:** Police Scotland must ensure that it learns from the mistakes of the former Scottish police forces, highlighted by the former Association of Chief Police Officer's Scotland and that it flags all cases of reported 'honour' based violence, including both incidents and crimes, as well as cases in which a charge is pressed.

8. **Regular reporting essential:** In line with ACPO's HBV Strategy 2008; ACPO should collect ***'regular reports (every six months)'*** on HBV from each police force. ACPO should carefully analyse this data and produce reports on their findings, which they should publish. ACPO should learn from their findings and demonstrate this in subsequent reports. Police Scotland should so the same.

9. **Training for police officers:** ACPO and Police Scotland must ensure that every police officer, including telephone responders (101 and 999), is sufficiently and regularly trained to ensure that they properly understand and can identify HBV cases. ACPO and Police Scotland should publicise details about training on HBV for all levels of police officers.

10. **Home Office Crime Category for HBV** should be set up and implemented by all police forces.

11. **National recording system of all non-crimed incidents:** should be put in place and implemented by all police forces.

12. **ACPO HBV network needed:** ACPO should set up a network of named HBV leads for each police force. For the larger police forces such, as the Metropolitan Police, each borough/ area should also have a named HBV lead. Police Scotland should do the same. The contact details of these named leads should be made publically available so that they are easily accessible to all police, agencies, charities and individuals who may need to contact them. Should the individual leave their post, they should immediately be replaced and the contact list should be updated.

13. **Clearer responsibilities:** Each named HBV lead, referred to at Recommendation 12, should keep an updated list of, and be familiar with, every HBV case reported within their area. They should be in a position to easily be able to safely share information about each HBV case, as appropriate.

14. **Ensure effective implementation in each police force:** The HBV leads network, referred to at Recommendation 12, should have responsibility for ensuring that regular, effective HBV training is implemented at all levels within their area and that all reported HBV incidents, crimes and cases in which charges are pressed, are flagged and reported to ACPO in accordance with Recommendations 6 and 8.

15. **Access to help on the ground:** We understand from discussions with police that currently when a police officer is called out to a domestic abuse incident, they should take a booklet with them which includes a D.A.S.H. risk assessment which they must apply. We recommend that the standard risk assessment must include questions to ascertain whether the person or people at the scene are at risk of HBV. The risk assessment must always be carried out in full and there should be penalties for police officers who fail to do this. The booklet should include the referral details of support organisations with specialist knowledge of HBV, such as IKWRO, as well as the definition at recommendation 1 and the key do's and don'ts for HBV cases.

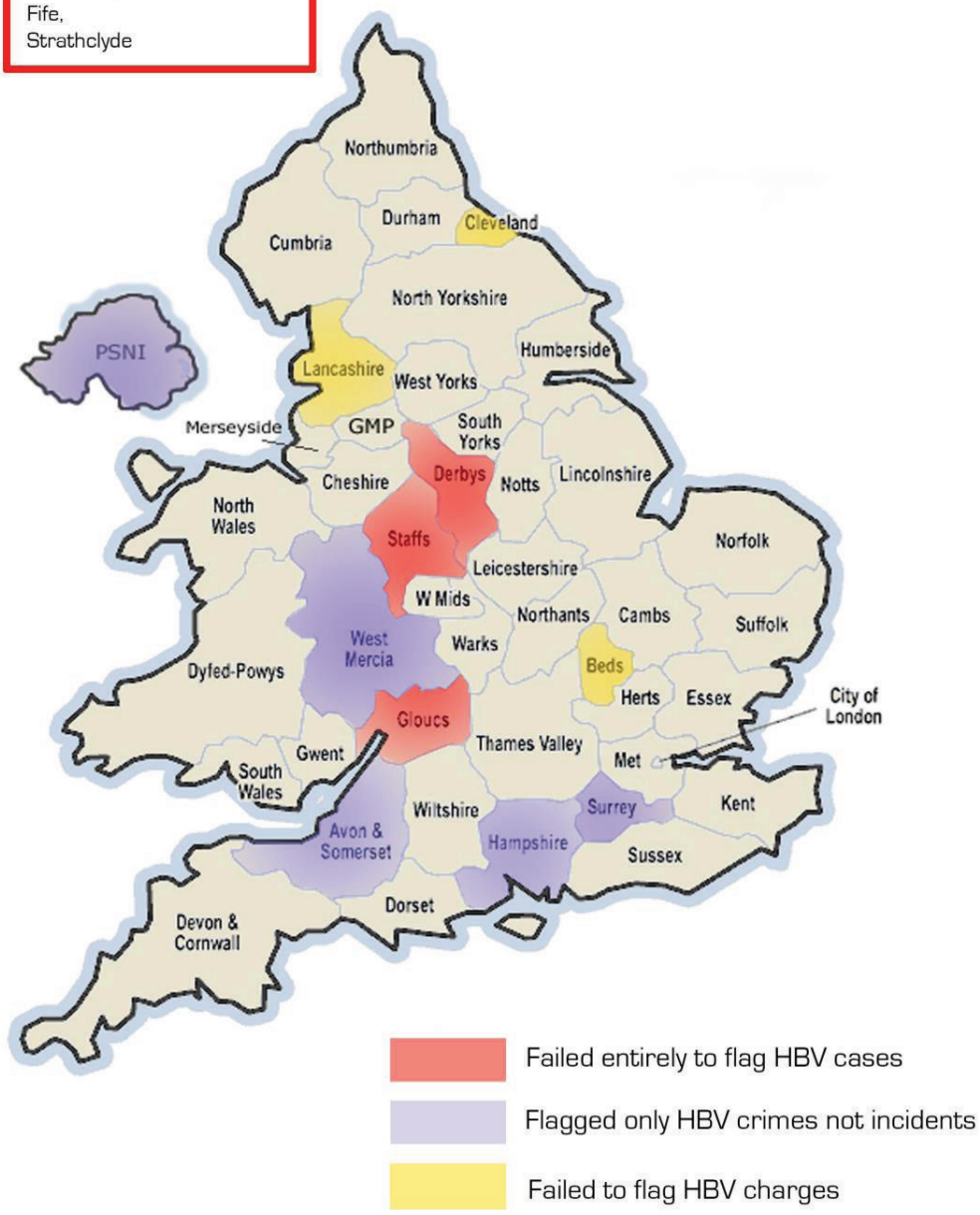
16. Child protection policy for all front-line agencies must ensure that HBV is thoroughly addressed including requiring regular, effective training of all staff.

IKWRO
IRANIAN AND KURDISH WOMEN'S RIGHTS ORGANISATION

Appendix 1

Police recording of 'Honour' Based Violence (HBV) 2012

4 out of 8 former Scottish police forces failed entirely to flag HBV cases;
Dumphries & Galloway,
Northern,
Fife,
Strathclyde



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Brent Harmful Practice Case Studies

Case Study 1 - Female Genital Mutilation

FORWARD was contacted by social services from the London Borough of Brent regarding a case involving several children believed to be at risk of FGM. FORWARD provided support, advice and guidance for the family and local social services. One-to-one support sessions and emotional support were delivered to the mother who was also provided with information about FGM in a culturally sensitive way, information about the law. As a woman who had undergone FGM, she was also signposted to FGM specialist services for medical care and counselling.

FORWARD delivered group sessions with for the young girls, providing them with FGM information in an age appropriate format. The girls were also provided with emotional support and advice to guide them through the challenging situation. The young girls were provided with information about services and options for where to go if they or their peers felt at risk.

- FORWARD also worked with other family members including the father to ensure that children were supported and safeguarded.
- FORWARD provided social services with a report as well advice on best practice and cultural sensitivity.
- FORWARD believes that the HP Strand will be able to ensure that more women and young women are supported and protected

Case Study 2 - Forced Marriage Case Study

A young Asian young woman was referred to the AWRC by her teacher at college. The young woman was being forced to marry one of her cousins in Pakistan, by her parents. They had found out that she had a boyfriend from a different cultural background, which they did not approve of. As a result they beat her and attempted to strangle her. The parents had further threatened to break her legs, arms and kill her if she did not do what they said. The parents had accused her for becoming too “westernised” by developing relationships before marriage, deviating from her culture and for bringing shame on the family. The young women feared for her safety and did not want to return home.

The AWRC provided the following support:

- Risk assessment /Safety planning advice.
- MARAC referral
- IDVA referral
- Reported the threat of honour based violence to the police (worker accompanied her).
- Reported violence to the GP – (worker accompanied her).
- Provided emotional support
- Made referral to a refuge, provided her with taxi fare to travel.
- Provided follow up support

Case Study 3 – Honour Based Violence Case Study

A young Asian Women started dating a young Asian man who seemed like a nice man at first. After a while it became clear that the relationship was not working and she decided she wanted to end it. The young man was aware all along that our relationship was a secret, and due to his controlling behaviour, began to use this against her. He threatened to tell her family about their relationship, which was absolutely, terrified her. The thought of what her parents would do if they found out petrified her. Honour was embedded in her family

"I've never known any different. Having a relationship with a man would bring dishonour to the family. It's not just my mother and father that I had to worry about."

The young women continued to see the young man for fear of her finding out – this was effectively against her will, again she tried to end the relationship and the threats continued.

"I thought about them all the time. The anxiety was always there, it's not a nice feeling to have. I kept on blaming myself for getting into the position I found myself in. Eventually I decided enough was enough, I could not go on living my life in this way."

The young women lived with the threats for a year before she contacted the AWRC,

The AWRC provided the following support:

- Risk assessment /Safety planning advice
- Reported the threat of honour based violence to the police (worker accompanied her).
- Provided emotional support
- Provided follow up support

ISLINGTON

Female Genital Mutilation (FGM) in Islington: A Statistical Study

Contents

Executive Summary

The purpose of this study is to establish a more detailed picture of Female Genital Mutilation (FGM) in Islington. The study adapted the method used by the Foundation for Women's Health, Research and Development (FORWARD; 2007) which used UK census data and national and regional FGM prevalence data to estimate the number of women and girls in the UK who were likely to have undergone FGM. This study combined FGM prevalence data with language and ethnicity data for Islington to produce a similar estimate. There are several key findings:

There are 1,812 girls aged 0 – 18 in Islington who are at risk of (or who may have already undergone) FGM, and this is undoubtedly an underestimate.

This number represents 10.2% of the 0-18 female population in Islington.

There are 1289 girls in the highest risk category for FGM; they are from backgrounds where FGM is effectively universal in their country of origin.

This number represents 7.3% of the 0-18 female population.

A significant proportion of girls in the two highest risk categories are aged 0-7 (47% in category 1 and 63% in category 2)

The data presented here is based on self reporting of language and ethnicity therefore this is very likely to be an underestimate. Whilst the conclusion of this study is not that every one of these girls will undergo, or will have already undergone FGM, cultural background is the most important risk factor and there are a number of countries in the world where FGM is practiced on a universal scale. Therefore, it is vital that we are fully aware of the level of risk to girls and young women in Islington from all backgrounds and that we do not assume that living in the UK where FGM is illegal, is enough to eradicate the practice.

This study is a starting point, designed to help us estimate the likely level of risk around this practice, and to help us ensure we are protecting all Islington residents. FGM is one of the serious violent crime types within the Violence Against Women and Girls (VAWG) agenda, and Islington Council's VAWG Strategy 2011-15 outlines the Council's aims and objectives around VAWG over the next four years. Conducting this study was part of the work plan that underpins Islington's *Violence Against Women and Girls Strategy 2011-15 and t*he recommendations at the end of this report will feed into the Council's work plan around FGM and VAWG.

1. Introduction

1.1. The purpose of this study is two-fold. Firstly, it will provide some background to the practice of female genital mutilation (FGM); the procedure itself, its causes and impacts, and the profile of those most at risk. Secondly, this report will draw together information we have locally to establish an estimation of the level of risk to girls and young women in Islington.

1.2. This study uses a methodology similar to that used in the 2007 report by the Foundation for Women's Health, Research and Development (FORWARD; 2007); combining country and regional statistics on FGM prevalence with local data to estimate the numbers of girls and young women likely to be at risk of FGM. Islington is the first local authority in the UK to use this method to assess the risk of FGM in the local area.

2. Background and context

Definition

2.1. The World Health Organisation (WHO) defines FGM as comprising all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons, and has categorised FGM into four major types:

i) **Clitoridectomy**: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

ii) **Excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

iii) **Infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

iv) **Other**: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Reasons Given for the Practice

2.2. There are a number of different reasons given for FGM by different communities, most of which stem from traditional beliefs about the importance of controlling a woman's sexuality, preserving virginity and promoting fidelity. FGM is sometimes also practised for aesthetic reasons.

2.3. In many communities FGM is seen as an important rite of passage for girls entering adulthood, it is continued both to maintain a traditional custom but also because it is widely believed to be beneficial to women; many believe it is more hygienic, that it makes women cleaner, and some even mistakenly believe it may make childbirth safer.

Health Implications

2.4. FGM has no health benefits and is associated with a range of long and short term harmful health and welfare consequences. The following are just some of the potential physical consequences of FGM, but the list is by no means exhaustive:

- Severe pain
- Wound infections
- Chronic vaginal, pelvic and urine infections
- Difficulties with menstruation and passing urine
- Renal impairment and possible failure
- Complications in pregnancy
- pain during sex and lack of pleasurable sensation
- Damage to the reproductive system, including infertility
- Increased risk of HIV and other STIs
- Death in childbirth

2.5. It is widely acknowledged that there are also a number of psychological and psychosexual consequences associated with FGM, including:

- low libido
- depression
- anxiety and sexual dysfunction
- flashbacks during pregnancy and childbirth
- substance misuse and/or self-harm

2.6. There is also an increasing body of research demonstrating the link between FGM and a number of psychological syndromes and anxiety disorders. A study undertaken in Senegal in 2003 found that women who had suffered FGM in childhood showed a significantly higher prevalence of Post Traumatic Stress Disorder (PTSD).

Prevalence Worldwide

2.7. Internationally FGM is recognised as a human rights violation. Yet the World Health Organisation (WHO) estimates that between 100 and 140 million women and girls worldwide have undergone the procedure and that in Africa alone around 3 million girls undergo the procedure every year.

2.8. There are 28 African countries where FGM is known to be practiced, and although less statistical information is accessible the practice has also been

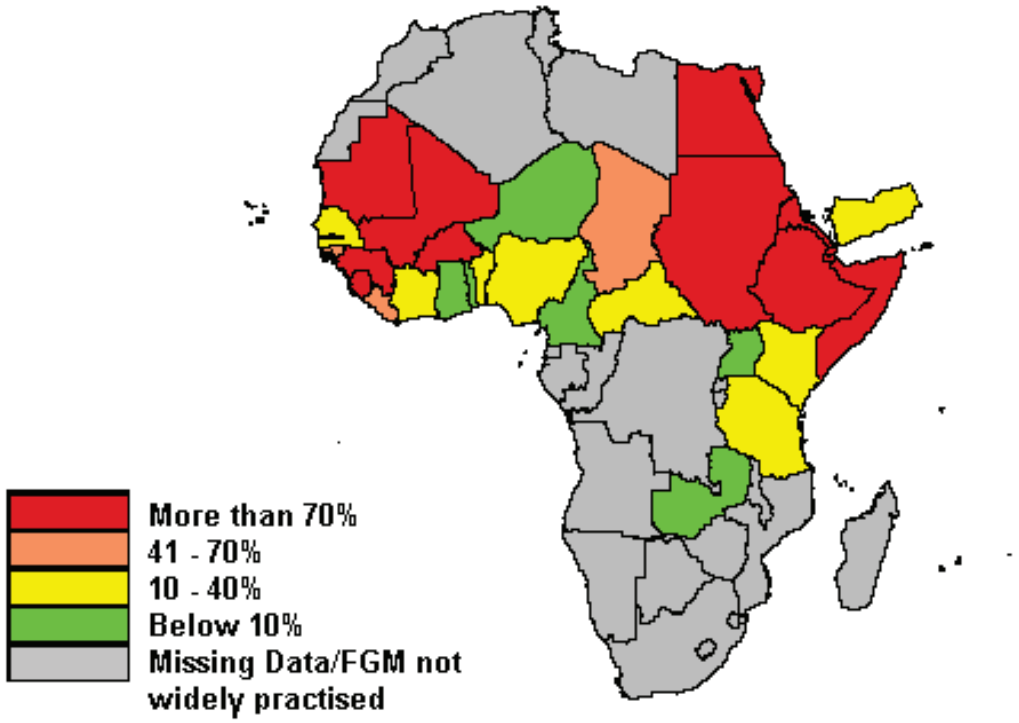
documented in Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

2.9. A 2010 study by WADI, Association for Crisis Assistance and Development Co-operation used a mixture of questionnaires and interviews to establish an estimate of the prevalence of FGM in the Kurdish Autonomous Region of northern Iraq. The result of the study was that the overall FGM prevalence rate in this region was 72.7%.

2.10. In addition to this, a WADI press release from 9th April 2012 announced that a new study conducted by WADI and a local women's rights organisation investigated the prevalence of FGM in Kirkuk (outside of the Iraqi Kurdistan region) and found a prevalence rate of 65.4% among Kurdish women living in Kirkuk and 25.7% among Arab women in Kirkuk.

2.11. The map below shows estimated rates of FGM across Africa.

Source: HM Government (Feb 2011), *Multi-Agency Practice Guidelines: Female Genital Mutilation*, p. 5



Risk Factors

2.12. The highest risk of FGM is obviously among girls and young women from FGM practising communities and within this there are further characteristics that obviously increase the risk level:

- Level of integration of a family into society
- Girls born to mothers who have undergone FGM

- Girls whose sisters have already undergone FGM

2.13. The age at which girls are likely to undergo FGM varies across different communities. The highest risk period is believed to be between the ages of 5 and 9, although it is important to note that there have been reports of FGM being performed on newborns, in childhood, adolescence or before marriage.

FGM in the UK

2.14. In the UK FGM is illegal under the Female Genital Mutilation Act 2003. Despite this, a study into UK prevalence by FORWARD based on 2001 census data estimated that over 20,000 girls under the age of 15 could be at high risk of FGM in England and Wales each year; and nearly 66,000 women are living with the consequences of FGM.

2.15. In February 2011 the Government published the Multi-Agency Practice Guidelines on FGM, which aimed to provide support to all front line professionals who have responsibility for safeguarding children and adults from the abuses associated with FGM.

2.16. The UK Government estimates that the prevalence of FGM in the UK is not evenly distributed and that higher prevalence is likely to be found in areas with larger populations from practicing countries, and London is listed as an area where rates of FGM are likely to be high.

2.17. It is believed that FGM is carried out on British girls both in the UK and overseas, often in the family's country of origin. As a result girls are at particular risk during school holidays, especially the long summer holiday, when they can be taken overseas and have a significant period of time to recover before returning to school.

2.18. Islington has a very diverse community with populations from all over the world. There are a number of community groups and projects in the borough that do work with communities to raise awareness about the harmful health and welfare consequences of FGM, and support women and girls who have undergone the procedure.

2.19. Female Genital Mutilation is one of the serious violent crime types within the Violence Against Women and Girls (VAWG) agenda. Islington Council has a VAWG strategy that outlines the Council's aims and objectives over the next four years. The VAWG Strategy is delivered through a number of working sub-groups with responsibility for different areas and FGM comes under the Harmful Traditional Practices (HTP) sub-group.

2.20. Part of the work plan of the HTP VAWG sub-group was to use local data and information to provide an estimate of the risk profile of girls and young women in Islington.

3. Methodology

3.1. Following a similar method to that used by FORWARD in their 2007 report on the UK prevalence of FGM, the purpose of the study was to establish an estimate of the level of risk to girls in Islington using country prevalence data from international sources, and local data on language and ethnicity from our own databases (where FORWARD used census data for a national estimate).

3.2. The first stage was to identify the country and regional prevalence rates of FGM in countries around the world. This was done using estimates available through the World Health Organisation (WHO), and a number of regional or country based Demographic and Health Surveys (DHS). For prevalence rates among Kurdish women this was done using the study by WADI as the WHO doesn't have prevalence data specifically for the Kurdistan region.

3.3. After a list of countries had been established, a full list of all ethnicities and languages associated with those countries was produced. These ethnicities and languages were used to run a search through the database of Islington children. This Data Warehouse is a central collection of records that draws together a number of databases and reporting systems used in the borough including council tax, housing, schools and others.

3.4. Due to the variety of ages at which FGM can be performed it was decided to focus on girls aged 0 -18, so the Data Warehouse was used to establish the numbers of female 0-18 year olds in Islington whose ethnicity or language indicated they were from an FGM practising community.

3.5. The information that came back from the Data Warehouse was carefully cleaned and checked to make the count as accurate as possible.

3.6. Language and ethnicity were looked at for each individual and it was decided that language would be used as the basic measure for this study as the language records were more detailed and could be most easily associated with particular countries. Ethnicity was still considered where language information alone was not sufficient to establish whether the individual belonged to a practising community. Age was also included in the profiles and the results are published below.

3.7. All the data analysed was anonymous, the records viewed showed only certain characteristics, with all information that would have allowed personal identification removed.

Advantages

3.8. The fact that the Data Warehouse is a central collection of a number of different databases meant that we were able to access as wide a range of

information as possible, and that we could identify siblings and children living in the same household to further increase the accuracy of results.

3.9. The use of language as well as ethnicity allowed a more accurate estimate to be drawn from the data since there were a number of individuals for whom only one was listed, and often for children we have information on language and not on ethnicity, so it enabled us to identify more of those potentially at risk.

3.10. The use of language also allowed greater accuracy as it meant the estimates did not have to rely on national prevalence estimates only. For example, in a country such as Nigeria, the overall country prevalence rate is comparatively low (29.6%), but there are significant regional variations in the prevalence rate revealed through the 2003 DHS. The survey revealed that in Nigeria prevalence was found to be as low as 0.4% in some areas and as high as 56.9% in others. The use of language data in this study allowed a more accurate appraisal of the risk level as it was possible to identify the prevalence rate associated with individual languages.

3.11. Previous estimates on FGM prevalence, including the 2007 estimate by FORWARD, have used country of birth and ethnicity as the proxies from which to estimate FGM prevalence or risk. This method has the limitation that it does not include those of a second generation who may have been born in the UK but whose background would still indicate that they are at high risk of FGM. Including language data in this estimate enables us to identify those from FGM practising communities regardless of their country of birth.

3.12. These estimates are based on live data, which means that they are likely to be more up to date than those that were, for example, based on a particular population survey such as the 2001 census, which is now over ten years out of date.

Limitations

3.13. The limitation identified by FORWARD, that there is insufficient research on the impact of migration on FGM practice, also applies to this study. The dearth of research in this area means that this study uses country of origin prevalence to reach estimates, and we cannot know how different prevalence in migrant communities is likely to be from those in country of origin.

3.14. The study by Morison et al (2004) conducted a survey with a sample of young Somali men and women living in London. The sample consisted of 80 Somali men and 94 Somali women all aged 16 – 22. In this study 70% of the women reported having undergone FGM, and two thirds of those had undergone type iii. The study also found that there was a significant difference in the prevalence of FGM between girls who had arrived in the UK before age 6 (42%) and those who had arrived when aged 11 or older

(91%). Whilst this study provides some insight, there is a need for more research to fully understand the impact of migration to the UK in terms of FGM practice.

3.15. The evidence is limited by the fact that we only have information on those 0 -18 year olds or their siblings about whom we have at one point collected ethnicity or language data. The fact that this relies on self reporting means that it is this is very likely to be an underestimate.

3.16. Where an individual's language is one that is extremely widely spoken, such as Arabic, they will have not been counted in this study unless additional information was available on their ethnicity or nationality. This is because there are some Arabic speaking countries associated with a high prevalence of FGM and others with a very low, or no evidence of FGM at all. Since it cannot be assumed that all speakers of the language are from countries where FGM is practiced, they have been excluded. This inevitably means there has been some under-counting.

4. Results

4.1. The full list of languages which existed within the Data Warehouse and were counted in this study are shown in Table 1 below.

Table 1 – List of Identified Languages	
Afar-Saho	Krio
Akan/Twi-Fante	Kurdish
Amharic	Lingala
Arabic (Egypt)	Nigerian (Language not known)*
Arabic (Iraq)	Nzema
Arabic (Sudan)	Oromo
Arabic (Yemen)	Pashto/Pakhto
Bambara	Somali
Berber (Tamashek)	Swahili/Kiswahili
Ebira	Temne
Edo/Bini	Tigre
Efik-Ibibio	Tigrinya
Esan/Ishan	Urdu
Ewe	Urhobo-Isoko
Hausa	Wolof
Igbo	Yoruba
*This category was used to describe those whose ethnicity was listed as Nigerian but for whom there was no language data available.	

4.2. Each of these languages is associated with a country or region where FGM is known to be practiced. Where languages are associated with more than one country, the ethnicity was examined and this often indicated the country of origin. Where there was no clear country of origin the country selected was the one most associated with the language.

4.3. The list of languages with countries (or regions) and associated prevalence rates (where available) is shown in Table 2 below.

Table 2 – List of Languages and Associated Prevalence Rates

Language	Country/Region	Prevalence Rate (%)
Afar-Saho	Djibouti	93.1
Akan/Twi-Fante	Ghana	3.8
Amharic	Ethiopia	74.3
Arabic (Egypt)	Egypt	91.1
Arabic (Iraq)	Iraq	N
Arabic (Sudan)	Sudan	90
Arabic (Yemen)	Yemen	38.2
Bambara	Mali	85.2
Berber (Tamashek)	Sierra Leone	94
Ebira	Kwara state, Nigeria	9.6
Edo/Bini	Edo state, Nigeria	34.7
Efik-Ibibio	Akwa Ibom State and Cross River State, Nigeria	34.7
Esan/Ishan	Edo state, Nigeria	34.7
Ewe	Ghana	3.8
Hausa	Northern Nigeria	0.4
Igbo	SE Nigeria	40.8
Krio	Sierra Leone	94
Kurdish	Turkey/Iran/Iraq	72.7
Lingala	CAR	25.7
Nigerian (Language not known)	Nigeria	29.6
Nzema	Ghana	3.8
Oromo	Ethiopia	74.3
Pashto/Pakhto	Afghanistan/Pakistan	N
Somali	Somalia	97.9
Swahili/Kiswahili	Congo*	5
Temne	Sierra Leone	94
Tigre	Northern Sudan	90
Tigrinya	Eritrea	88.7
Urdu	Pakistan	N

Urhobo-Isoko	Delta State, Nigeria	34.7
Wolof	Senegal	28.2
Yoruba	SW Nigeria	56.9
N = Not Known (countries where FGM has been documented but where there is little or no data available) *From listed ethnicity		

4.4. The total count for girls aged 0-17 whose language or ethnicity or both indicated that they could be at risk of FGM was 1,812. The numbers of girls listed as speaking the 32 languages above is shown in Table 3 below:

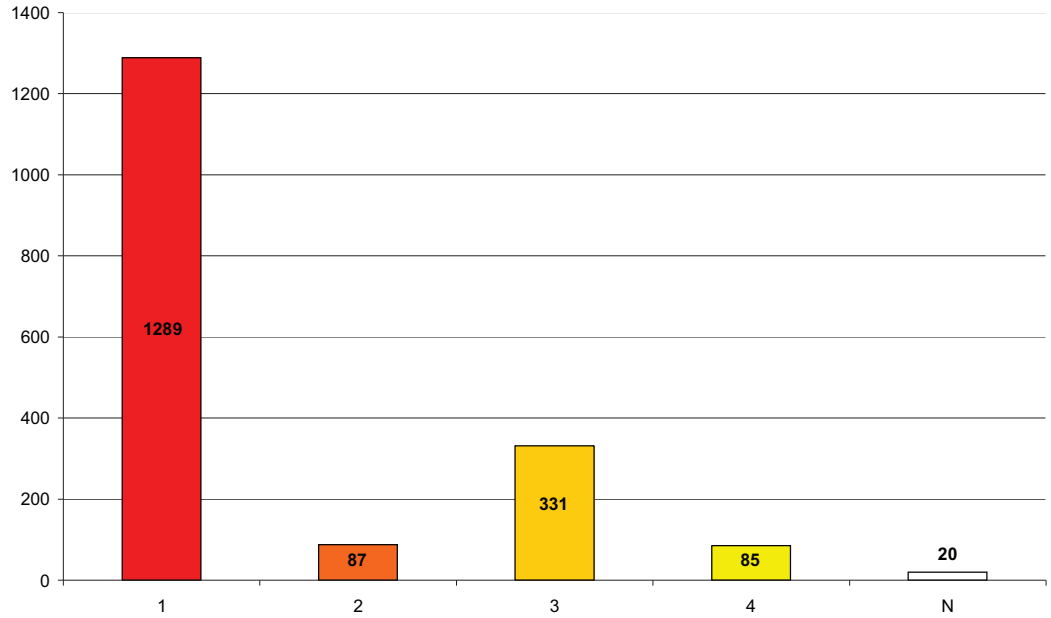
Table 3 – Numbers of Girls Speaking Each Language			
Language	**No. of Girls**	**Language**	**No. of Girls**
Afar-Saho	3	Krio	6
Akan/Twi-Fante	69	Kurdish	104
Amharic	85	Lingala	3
Arabic (Egypt)	19	Nigerian (lang not known)	30
Arabic (Iraq)	16	Nzema	1
Arabic (Sudan)	40	Oromo	2
Arabic (Yemen)	6	Pashto/Pakhto	2
Bambara	2	Somali	1092
Berber (Tamashek)	3	Swahili/Kiswahili	3
Ebira	5	Temne	1
Edo/Bini	8	Tigre	11
Efik-Ibibio	1	Tigrinya	112
Esan/Ishan	5	Urdu	2
Ewe	4	Urhobo-Isoko	4
Hausa	3	Wolof	1
Igbo	28	Yoruba	141
Grand Total			**1812**

4.5. By adapting the categories used in UNICEF's 2005 report, and FORWARD's 2007 report, this study designated 4 categories of FGM prevalence.

Table 4 – Categories of FGM Prevalence	
Category	**Description**
1 (Universal Prevalence)	85 – 100%
2 (High Prevalence)	75 – 84%
3 (Medium Prevalence)	25 – 74%
4 (Low Prevalence)	Under 25%

Table 4 shows the four categories and Chart A below shows the number of girls in Islington by Category, established using their language:

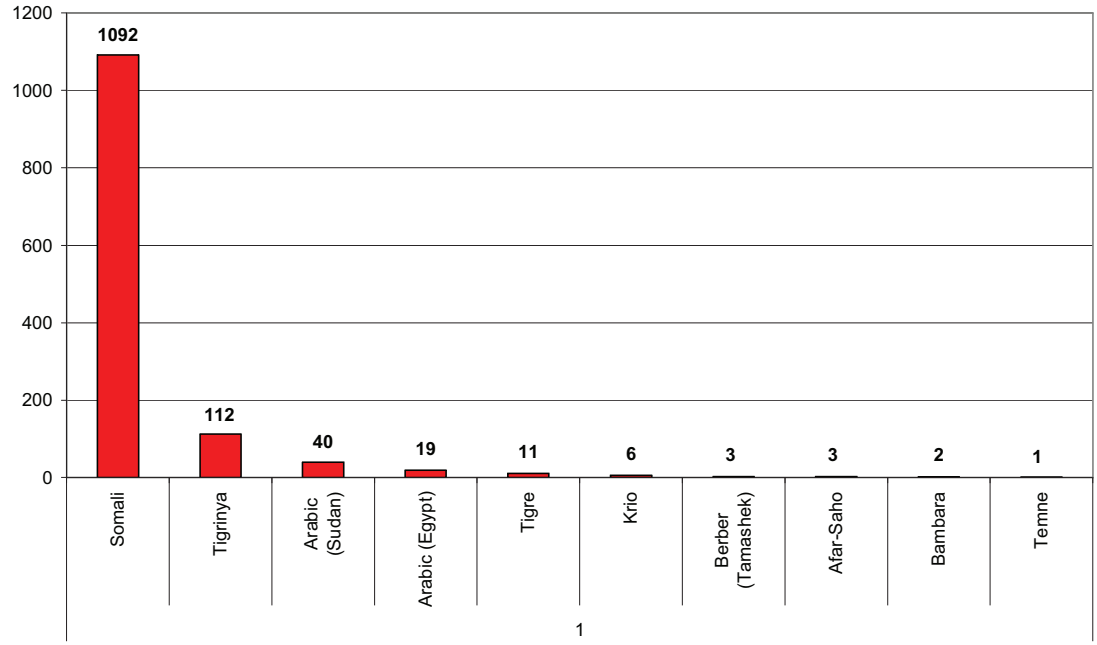
Chart A – Number of Girls by FGM Prevalence Category



4.6. As Chart A illustrates, the highest number of girls are in the highest risk categories; they are from FGM practising communities where there is a universal prevalence rate in countries of origin. 'N' represents the number of girls whose language indicates they are from a practising community but where prevalence is not known.

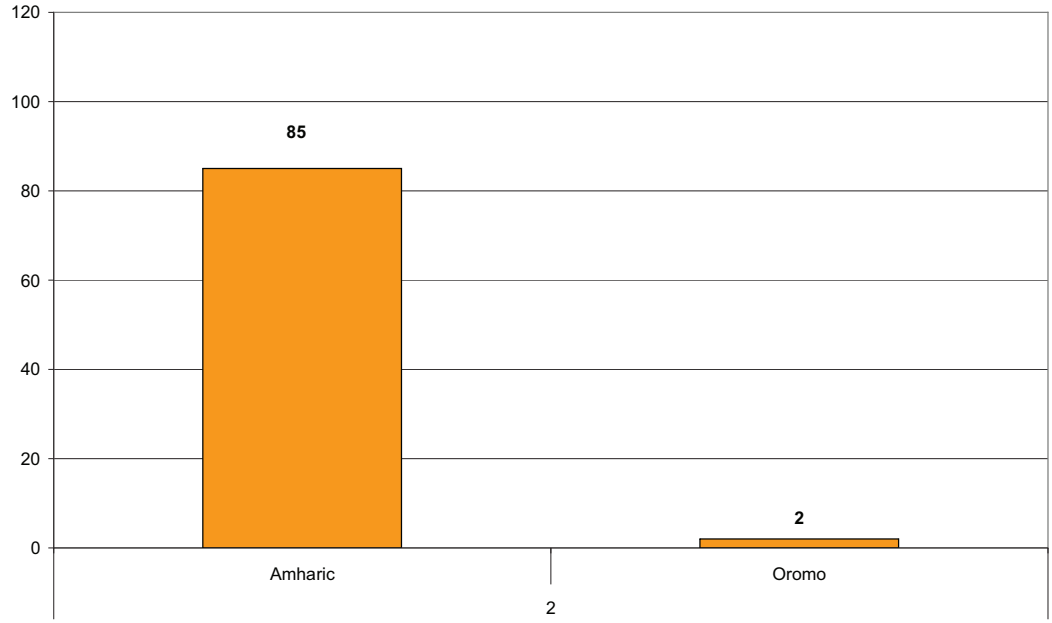
4.7. Charts B – F show a breakdown of the languages in each FGM prevalence category.

Chart B – Language Breakdown in Category 1



4.8. Chart B illustrates 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.

Chart C – Language Breakdown in Category 2



4.9. Chart C shows just two languages; Amharic and Oromo, both primarily spoken in Ethiopia, a country with an FGM prevalence rate of just over 74%.

Chart D – Language Breakdown in Category 3

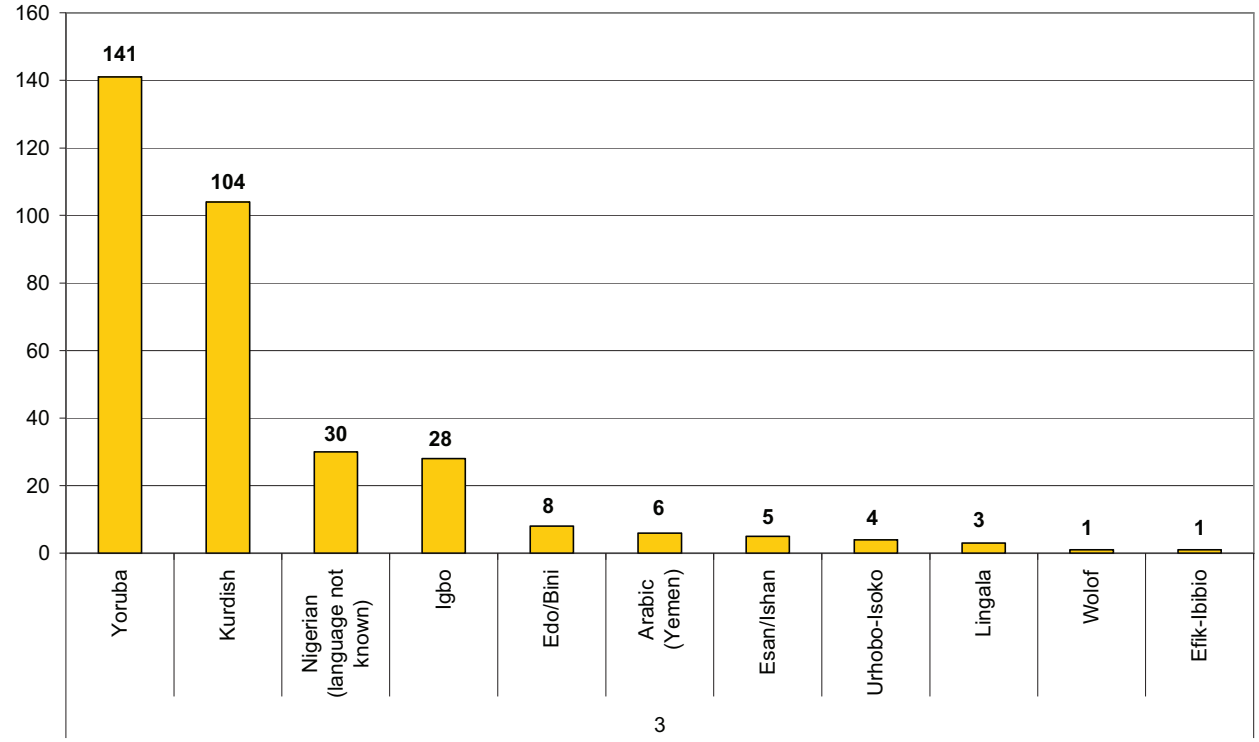
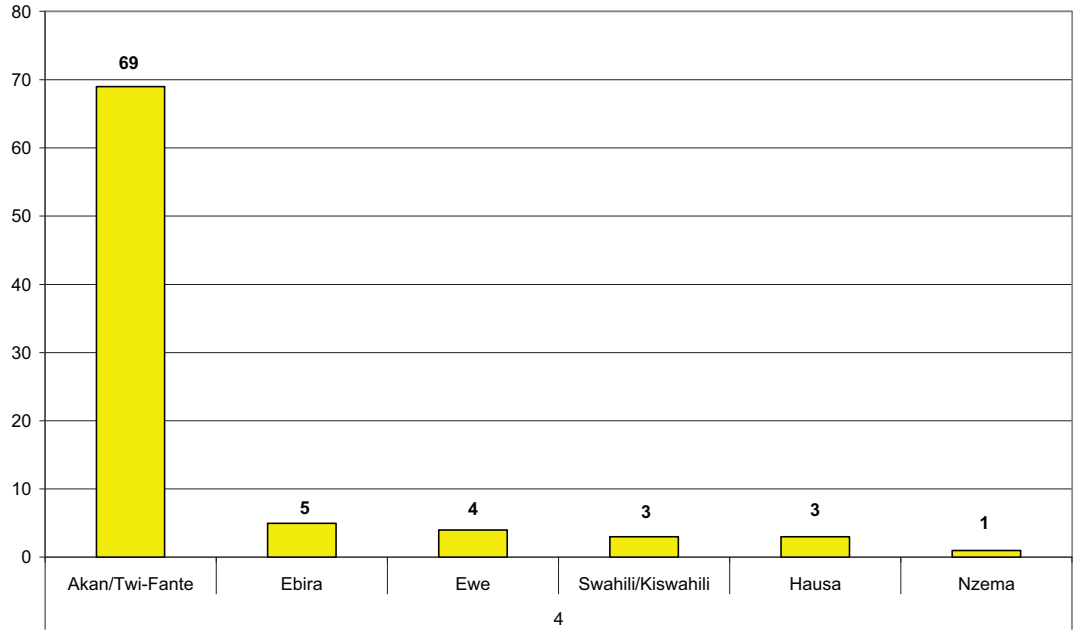


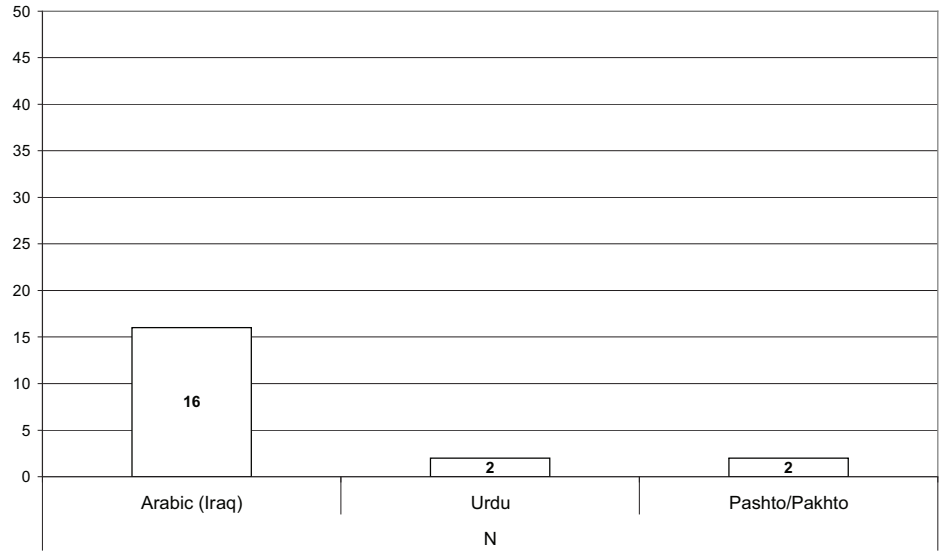
Chart E – Language Breakdown in Category 4



4.10. Charts D and E show the spread of languages across the medium and low prevalence categories. The most common being West African languages spoken in Nigeria (in Chart D) and Ghana (in Chart E), as well as Kurdish (Chart D).

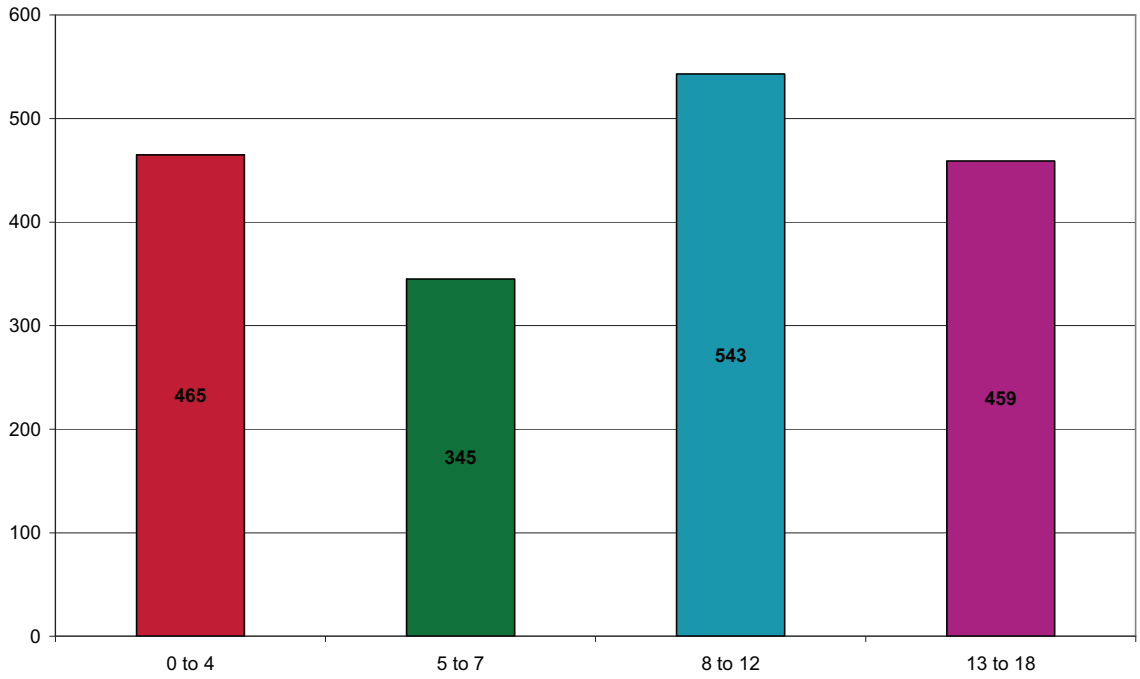
4.11. Chart F shows the number of girls speaking languages from communities where there is not enough information available to estimate prevalence rates. The numbers in this category are very low overall. Arabic speakers from Iraq are the majority, and although there has been one study looking at prevalence rates among Arab women in Kirkuk in Iraq, there is not enough evidence to estimate a prevalence rate for Arab speakers across Iraq.

Chart F – Language Breakdown where Prevalence is Not Known (N)



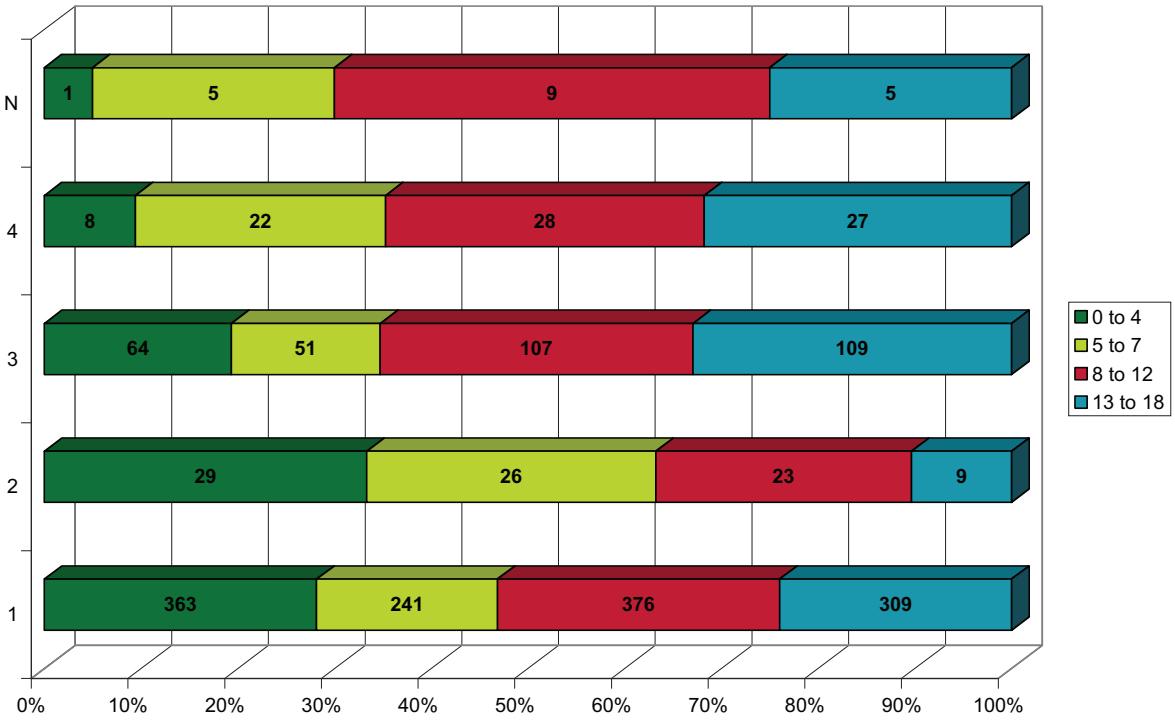
4.12. The ages of the girls identified are shown below in Chart G in four categories: 0-4, 5-7, 8-12 and 13-18. As the chart shows, there is reasonably even distribution across all the age groups.

Chart G – Age of Girls Identified



4.13. Chart H shows the percentage age breakdown for each FGM prevalence category.

Chart H – Age Breakdown by FGM Prevalence Category



4.14. The chart illustrates that the higher risk categories, 1 and 2 see a relatively even distribution across the age groups. Category 3 has a relatively high number of 13 – 18 year olds and Category 4 has a relatively low number of 0 – 4 year olds.

4.15. Categories 1 and 2 both have a significantly higher proportion of girls in the 0-7 group than categories 3 and 4 (47% and 63% as against 34% and 35%).

5. Discussion

5.1. The overall count indicates that we have 1,812 girls aged 0 – 18 in Islington who are potentially at risk of, or who will already have undergone, FGM. As discussed above, this is likely to be an underestimate as the data is reliant upon self reporting of language and ethnicity.

5.2. The Office for National Statistics mid year population estimates for 2010 estimate the 0 – 18 female population in Islington to be 17, 696. Therefore the numbers of girls identified in this study represent 10.2% of the 0-18 female population in Islington.

5.3. The study identified 1289 girls in the highest risk category for FGM; that is they come from backgrounds where the prevalence rate is effectively universal in their country of origin. This constitutes 7.3% of the 0-18 female population.

5.4. Even bearing in mind that there has been insufficient research into the impact of migration on the continuation of FGM, the extremely high prevalence rates in countries of origin should still be cause for concern.

5.5. Somali speakers constituted the highest number in the study, with 1092 girls identified. The most recent estimate of FGM prevalence in Somalia is 97.9%, the highest in the world. These girls are at the highest risk.

5.6. The finding in the study by Morison et al (2004) that 91% of young Somali women surveyed who had come to the UK older than age 11 had undergone FGM, perhaps suggests that age at time of migration could be considered as another risk factor in future research.

5.7. There were 20 girls identified as belonging to communities where FGM has been documented but where there is insufficient evidence to estimate prevalence. It is important that these communities are not overlooked when considering risks around FGM locally.

5.8. The age breakdown revealed that a significant proportion of the girls in the two highest risk categories were 7 and under. This has implications for what support or interventions are most appropriate when we consider that the most likely age when FGM will be performed is 5 – 9.

6. Conclusions and Recommendations

6.1. The conclusion of this research is that there is a risk to girls in Islington around FGM. 1 in 10 girls aged 0-18 in Islington come from a background where FGM is practiced, and over 70% of these are girls from backgrounds where levels of FGM practice are near universal.

6.2. There are pockets of good practice in Islington, including a number of community groups that provide support and advocacy in relation to FGM, and a specialist midwife at the Whittington hospital who has expertise in FGM and in conducting the necessary operation to reverse type iii.

6.3. This work forms a crucial part of the response to FGM locally, but there is currently no co-ordinated response to FGM across the borough. The nature of the issue requires that there be a joined up response from health (including mental health), education, social care (because FGM is a safeguarding issue), the police, the local authority and the voluntary and community sector.

6.4. The basis for this multi-agency response can be found in the Government's *Multi-Agency Practice Guidelines: Female Genital Mutilation* (2011) published last year. Below are some recommendations for action we can take around FGM locally. More detail on the implementation of these recommendations can be found in the agency-specific chapters of the Guidelines.

6.5. Further research could focus on identifying whether there are particular locations in the borough where there are concentrations of populations with high FGM prevalence to allow targeting of resources.

6.6. This study has focused on 0 – 18 year old girls but further statistical analysis could try and identify numbers of adult women from FGM practising communities who may require support around FGM. The publication of data from the 2011 Census may assist with this.

References

HM Government, (2011) *Multi-Agency Practice Guidelines: Female Genital Mutilation*, (http://www.homeoffice.gov.uk/publications/crime/FGM?view=Binary)

Behrendt, A and Moritz, S (2005) 'Post-traumatic Stress Disorder and Memory Problems After Female Genital Mutilation', *American Journal of Psychiatry*, pp. 1000-02

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

London Borough of Islington (2011), *Violence Against Women and Girls Strategy 2011-15*

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

National Population Commission, Federal Republic of Nigeria (2003), Nigeria Demographic and Health Survey 2003, (http://www.measuredhs.com/pubs/pdf/FR148/00FrontMatter.pdf)

Office for National Statistics (2010), Mid Year Population Estimates, (http://data.london.gov.uk/visualisations/ons-mye-custom-age-tool.xls)

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

Wadi Association for Crisis Assistance and Development Co-operation, (2012) *Female Genital Mutilation in Iraqi-Kurdistan: An Empirical Study by Wadi*, (Frankfurt, Germany: Wadi).

WHO, Female genital mutilation and other harmful practices, Prevalence of FGM, (http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html)

July 2012

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STONEBRIDGE SCHOOL

SAFE GUARDING POLICY

January 2014

SAFEGUARDING POLICY

STONEBRIDGE SCHOOL 2014

Agreed by Governors: January 2014
Agreed by Staff: January 2014

The policy is to be reviewed: SPRING 2017

INTRODUCTION

The governors and staff of Stonebridge School fully recognise the contribution they make to the safeguarding of children. We recognise that all staff, teaching and non-teaching, including volunteers, have a full and active part to play in protecting our pupils from harm[1].

All staff and Governors believe that our school should provide a caring, positive, safe and stimulating environment which promotes the social, physical, emotional and moral development of the individual child.

The aims of this policy are:

- To support the child's development in ways that will foster security, confidence and independence
- To raise the awareness of both teaching and non-teaching staff of the need to safeguard children and of their responsibilities in identifying and reporting possible cases of abuse.
- To provide a systematic means of monitoring children known or thought to be at risk of harm.
- To emphasise the need for good levels of communication between all members of staff.
- To develop a structured procedure within the school to be followed by all members of the school community in cases of suspected abuse.
- To develop and promote effective working relationships with other agencies, especially Social Services and the police.
- To ensure that all adults who work within the school environment have carried out a full and current DBS check in order that their suitability is checked.
- To ensure all members of the school community are treated with dignity and respect.

[1] HARM should be read with reference to any kind of physical, sexual, emotional abuse or any kind of neglect.

PROCEDURES

Our school procedures for safeguarding children will be in line with LA and LSCB procedures (Local Safeguarding Children's Board). We will ensure that:

- The HT and Assistant Head Teacher with responsibility for Inclusion, will act as the Designated Teachers for Child Protection at Stonebridge School. They will both undertake regular training.

- There is a senior member of staff who will act in the designated teachers' absence, the Deputy Head, who will also receive appropriate training.

- The Designated Teachers for Child Protection will be the first person to be approached in the light of any concerns, allegations or disclosures.

- Both DTCP will update the Child Protection record and share information. Cases will be allocated for one DTCP to take a lead on but regular meetings will take place to review progress and to offer supervision to each other.

- The DTCP will meet each term to monitor the update of the Child Protection record for the school to ensure it is an accurate and up to date record. Cases at this point may also be reallocated.

- All members of staff are familiar with the categories and definitions used when referring to Child Protection. (See Appendix 1 - 4)

- All members of staff develop their understanding of the signs and indicators of abuse. (See Appendix 1 - 4)

- All members of staff know how to respond to a pupil who discloses abuse. They will ensure that time is given to the child in order that they can fully concentrate on the child's disclosure and that this time is found as a matter of urgency. This information will then be passed on via the Child Protection Report form (see Appendix 5) and / or by speaking to a Designated Teacher for Child Protection – forms will be given to the Head Teacher PA.

- The Designated Teachers for Child Protection will ensure that the correct Child Protection forms for monitoring, recording and reporting to formal settings are made available to staff. Staff will ensure that these forms are kept confidentially, kept up to date and completed in line with deadlines. (See Appendix 5 -9 for copies of these forms)

- Safeguarding and Child Protection will be included in all staff handbooks and group training and professional meetings throughout the academic year.

- All parents/carers are made aware of the responsibilities of staff members with regard to child protection procedures. A Child Protection statement will be included in all school parent hand books.

- Our procedures will be regularly reviewed and up-dated following a three year cycle outlined at the end of this policy.

- All new members of staff will be given a copy of our Safeguarding Policy as part of their induction into the school.

- Training undertaken by the designated teachers for child protection and staff will be documented and filed.

CHILD PROTECTION & SUPPORTING CHILDREN

We recognise that the school has a role to play in supporting children who are experiencing great challenges in their lives. We also recognise that these challenges may be of a child protection nature. We acknowledge that the school may provide the only stability in the lives of children who have been abused or who are at risk of harm. We recognise that the school should fully understand how being a victim of abuse can manifest itself in numerous ways. We recognise that the school must endeavour to put in place systems and training in order that all members of staff can act appropriately. Children will always be given time and privacy to talk to a member of staff in order to discuss issues that are affecting them or worrying them.

We appreciate that a child who is abused or witnesses violence may find it difficult to develop and maintain a sense of self worth. We understand that a child in these circumstances may feel helpless, humiliated and may feel self blame.

We accept that research shows that the behaviour of a child in these circumstances may range from that which is perceived to be normal to aggressive or withdrawn.

Our school will therefore support all pupils by:

- Encouraging self-esteem and self-assertiveness whilst not condoning aggression or bullying – PSHE , Circle Time, Comments Box, Article 12, Inclusion officer support, Lunchtime Clubs, Art Therapists and Place 2 Be (where appropriate)
- Promoting a caring, safe and positive environment within the school – Class Rights and Responsibilities, School Core Values, Year Group assemblies, and School Collective Worship, PSHE, Circle Time
- Offering the support of Place 2 Be counsellors at the school and by working closely with the School Project Manager.
- Holding regular Inclusion meetings with key school based professionals – every half a term.
- Liaising and working together with all other support services and those agencies involved in the safeguarding of children.
- Notifying Social Services as soon as there is a significant concern.
- Providing continuing support to a pupil about whom there have been concerns when moving from one class teacher to another or who leaves the school by ensuring that appropriate information is forwarded under confidential cover.
- Ensuring that children who are at risk are closely monitored.
- Ensuring that monitoring procedures are up to date and regularly reviewed.
- Children will be given time & privacy should they wish to talk to an adult.

RESPONSIBILITIES

The designated teacher for child protection is responsible for:

- Adhering to the LSCB (Local Safeguarding Children Board), LA and school procedures with regard to referring a child if there are concerns about possible abuse.

- Keeping written records of concerns about a child even if there is no need to make an immediate referral.

- Ensuring that ongoing monitoring of children is kept up to date.

- Ensuring that action points agreed at Child Protection Conferences, Child Protection Reviews and Core Group Meetings are carried out. (see record sheet Appendix 10)

- Ensuring that accurate and up to date information about individual children is presented at Child Protection Conferences.

- Ensuring that all such records are kept confidentially and securely and are separate from pupil records.

- Ensuring that an indication of further record-keeping is marked on the pupil's general records and that all records are passed on to their next school.

- Ensuring that any pupil currently with a Child Protection plan who is absent without explanation for two days is referred to their key worker at Social Services and that the attendance of children with a Child in Need Plan (CIN) is monitored closely and any concerns referred to their key social worker.

TYPES OF ABUSE (See appendix 1 – 6) for definitions and signs.

There are four main types of abuse and these are:

- Physical abuse including FGM (Female Genital Mutilation)
- Emotional abuse including domestic violence
- Sexual abuse
- Neglect

Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Uncaused syndrome by proxy and cutting (including female genitalia).

Physical Abuse Continued - Female Genital Mutilation (FGM)

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health

consequences, both at the time when the mutilation is carried out and in later life. It is acknowledged that some FGM practising families do not see it as an act of abuse, however it is illegal in the UK and suspicions of FGM having already taken place or knowledge of girls at risk must be reported. It is also against the law to groom or prepare a girl to have any type of FGM. FGM is known by a number of names, including 'female genital cutting', 'the cut', 'circumcision' or 'initiation'. The age at which girls undergo FGM varies enormously according to the community. **The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy.** However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 years old and therefore girls within that age bracket are at a higher risk. FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. FGM has also been documented in communities in **Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan**.

Emotional abuse

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Emotional abuse also happens when a child is subjected to witnessing domestic abuse between both or one of his/her parents.

Domestic Abuse - Emotional abuse continued

Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A child who is subjected to domestic abuse either through directly observing it or is exposed to its effects is emotionally scarred and is under a lot of stress. Domestic Abuse chips away at feelings of self-worth and independence. Domestic abuse can also include *verbal abuse* such as yelling, name-calling, blaming, and shaming. It can also include controlling behaviours like financial control, Isolation and intimidation, these are all aspects of emotional abuse. The physical, psychological and emotional effects of domestic abuse on children can be severe and long-lasting. Some children become withdrawn and find it difficult to communicate, others may act out the violence or aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under a great deal of stress and need support.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

CONFIDENTIALITY

- We recognise that all matters relating to Child Protection are of a Confidential nature and should be treated as such.

- The Designated Teachers will disclose information about a pupil to the key member of staff on a Need to know basis only. This information will only be passed on to relevant members of staff by the Key member if and when it is required.

- All staff must be aware that they have a professional responsibility to share information with other agencies in order to safeguard children.

- All staff must be aware that they cannot and must not promise a child to keep a secret.

SUPPORTING STAFF

We recognise that staff working in the school who have become involved with a child who has suffered harm, or appears to be likely to suffer harm may find the situation stressful and upsetting. We will support such staff by providing an opportunity to talk through their anxieties with a designated teacher and to seek further support as appropriate. The Designated Teachers for CP act as each other's supervision support. All members of staff can approach Place to Be for this support if required.

ALLEGATIONS AGAINST STAFF

We understand that a pupil may make an allegation against a member of staff.
If such an allegation is made the following action will be taken:

- The member of staff receiving the allegation will immediately inform the Head Teacher / Deputy Head Teacher and not enter into a dialogue.
- The head teacher on all such occasions will discuss the content of the allegation with the LA Lead Officer for Child Protection (LADO).
- If the allegation made to a member of staff concerns the Head teacher, the designated teacher / deputy will immediately inform the Chair of Governors who will consult with the LAs Lead Officer for Child Protection (LADO).
- The school will follow the LEA procedures for managing allegations against staff, a copy of which will be readily available in the school.

WHISTLE BLOWING

We recognise that children cannot be expected to raise concerns in an environment where the staff fail to do so. All staff should be aware of their duty to raise concerns, where they exist, about the attitude or actions of colleagues. These concerns should be brought to the attention of the Head Teacher or Deputy Head Teacher.

PHYSICAL INTERVENTION

We acknowledge that staff must only ever use physical intervention as a last resort and at all times be the minimal force necessary to prevent injury to another person. We understand that physical intervention of a nature which causes injury or distress to a child may very well be considered under child protection or disciplinary procedures. The school follows the LSCB guidelines on the use of restraint and is covered in the school Restraint Policy.

SAFEGUARDING CHILDREN

BULLYING

Our policy on bullying is set out in our school Anti – Bullying Policy and Behaviour Policy. We acknowledge that to allow or condone bullying may lead to consideration under child protection procedures.

RACIST INCIDENTS

Our policy on racist incidents is set out in a separate policy. It acknowledges that a single serious incident, repeated racist incidents or to allow or condone racism may lead to consideration under child protection procedures.

PREVENTION

We recognise that the school plays a significant part in the prevention of harm to our pupils by providing pupils with good lines of communication with trusted adults, supportive friends and an ethos of protection.

The school community will therefore:

- Establish and maintain an ethos where children feel secure, are encouraged to talk and are always listened to – Article 12 Group, Circle Time, Lunchtime Clubs, Art Therapy Support and Place to Be.
- Ensure that all children know there is an adult in the school whom they can approach if they are worried or in difficulty.
- Include in the curriculum opportunities for PSHE which equip children with the skills they need to stay safe from harm and to know to whom they should turn for help – Curriculum Map for PSHE across the school.
- The school also has an E-safety policy which emphasises how children can be safe when using the Internet. Staff are trained and themes of e-safety are looked at through the curriculum and assemblies throughout the year.
- The school monitors attendance and punctuality rigorously and any concerns are followed up with an initial letter from the head teacher and

persistent absences are referred to the Educational Welfare Officer (EWO).

Outside agencies – working in partnership

- The school works very closely with outside agencies to support children and families. This includes health services, speech and language therapist, social care and the Educational Welfare Officer (EWO).

Safer Recruitment

- The school is committed to safer recruitment and ensures that members of staff have DBS and this is updated every 4 years as agreed by governors.
- The school holds a single Central Record with relevant data for all members of staff.

HEALTH AND SAFETY

Our Health & Safety policy and our Educational Visits Policy is set out in separate documents. They reflect the consideration we give to the protection of our children both within the school environment and when undertaking school trips and visits away from the school environment.

Accidents and Welfare

- If an accident occurs, the child/ren are sent to the medical room. The Welfare officer then judges whether any medical attention is required. In cases when children are medically attended to, a letter is sent home to the parents and a copy of a HSL is kept on file. There is also a list of children who visit the medical room. The welfare officer is first aid trained as well as a number of other adults in various classes in the school. Where a child requires medication regularly, a meeting is held with the welfare officer and parent/carer and a plan is set out, outlining the frequency of the medication and dosage. The parent also signs a letter to consent that the welfare officer can administer the medication.

Intimate Care

- Intimate care is any care which involves carrying out an invasive procedure (such as cleaning up a pupil after they have soiled themselves) to intimate personal areas. The school is committed to ensuring that all staff responsible for intimate care of children will undertake their duties in a professional manner at all times. Please see Intimate Care Policy for more details.

Site Safeguarding

- The school safe guards the site in a variety of ways. All entrances to the school building are secure. Access to the school site is via the main office and all visitors are expected to sign in and wear a visitor's badge. All members of the school have a fob and an identification badge which has their name and role. A weekly survey is carried out by the site manager and the fire alarm is tested on a weekly basis as well. On-going issues are raised by staff and these are put on the school's intranet for the site staff to deal with. These are monitored regularly and actions and outcomes are written in response to issues.

Fire Drills

- Fire drills are carried out half termly and the findings are reported to the governors and actions are written and followed up by site staff.

Inappropriate Behaviour

- The school expects all the school community to adhere to the schools core values of Consideration, Positive Attitude and Respect. Where any visitor is causing harassment, anxiety and distress, (HAD) the school will record such incidents and further action such as a ban from the school premises may be enforced.

APPENDICES

- **APPENDIX 1 – Definition & Signs – Physical Abuse (including FGM)**
- **APPENDIX 2 – Definition & Signs – Emotional Abuse (including Domestic abuse)**
- **APPENDIX 3 – Definition & Signs – Sexual Abuse**
- **APPENDIX 4 – Definition & Signs – Neglect**
- **APPENDIX 5 – Child Protection Report Form**
- **APPENDIX 6 – Every Child Matters (ECM) Summary of Needs**
- **APPENDIX 7 – Individual Child Protection Record Sheet**
- **APPENDIX 8 – Stonebridge Welfare Check/Core Group Record Sheet**
- **APPENDIX 9 – Confidential Incident Record Sheet**
- **APPENDIX 10 – Confidential Meeting Record Sheet**
- **APPENDIX 11 – Record of CP Meeting & Action Form**

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

PHYSICAL ABUSE

DEFINITION:

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Uncaused syndrome by proxy.

SIGNS:

- Marks and Bruises
- Suspicious stories about how marks made
- Frequent bumps etc
- Broken Bones
- Frightened / nervous at simple movements / jumpy
- Jumping when adult raises voice
- Introverted, shy or withdrawn
- Tearful
- Poor behaviour / Bullying others
- Repeating inappropriate behaviour/ bullying
- Violent outbursts
- Hair missing
- Scratches / burns
- Stories include violent descriptions / pictures depict regularly violent scenarios
- Hitting or aggressive to other children
- Sleeping in class
- Self conscious when changing for PE
- Restless and fidgety
- Wetting / soiling them self
- Mood swings
- Little contact with other children
- Poor attendance
- Use of bad language
- Physically threatening behaviour
- Shouting

(STONEBRIDGE CPD 16/12/13)

Additional signs:

CONSTANT INJURIES THAT CAN ALWAYS BE EXPLAINED / CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / SELF COMFORT / VERBAL ABUSE / NON-COOPERATION / POOR HEALTH / UNKEPT / FEAR OF ADULTS / ABSENCES / STRANGE BEHAVIOUR AFTER WEEKENDS OR HOLIDAYS / FORGOTTEN PE KIT / FLINCHING IN RESPONSE TO SUDDEN MOVEMENTS / FREQUENT MEDICAL APPOINTMENTS / DO NOT WANT TO GO HOME AT THE END OF THE DAY / UNABLE TO FORM RELATIONSHIPS WITH ADULTS / SELF PROTECTION / GUARDING / LACK OF EYE CONTACT / CONSTANTLY ILL WITH NO REAL SYMPTOMS / FEARFUL OF ADULTS

FEMALE GENITAL MUTILATION (FGM) IS PHYSICAL ABUSE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF FGM?

DEFINITION:

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. FGM is against the law except when performed by a registered medical profession on medical or mental health grounds. It is also illegal for someone to arrange for a child to go abroad with the intention of having her circumcised.

SIGNS

- Difficulty walking, sitting or standing
- Spending longer than normal in the bathroom or toilet due to difficulties urinating.
- Fracture or dislocation of legs/arms as a result of restraint
- Spend long periods of time away from a classroom during the day with bladder or menstrual problems
- Severe pain in groin area
- Haemorrhage
- Being withdrawn - emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends);
- Urinary infections
- Detached / isolated
- Change in physical appearance/dress & body language
- Withdrawn aggressive
- Unable to form relationships with adults
- Changes in attitude, personality or behaviour
- Changes in interaction with others
- Feelings shown through writing or art work
- Peer group problems
- Extremes of emotion
- Underachieving

(STONEBRIDGE CPD 16/12/13)

Any suspicions of a child at risk of having or having had FGM must be reported immediately to the Head teacher or Designated teacher for Safe guarding. Girls aged 5 to 8 years are most risk.

APPENDIX 2

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

EMOTIONAL ABUSE

DEFINITION:

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Children witnessing domestic abuse between the parents or carers is also emotional abuse.

SIGNS:

- Low self esteem
- Withdrawn / frightened / shy
- Secretive
- Makes little eye contact
- Emotionally finds it difficult to maintain relationships with peers and adults
- Jumpy or stuttering during conversations with adults
- Cries a lot / very sensitive
- A Loner
- Pictures use mainly dark colours
- Stealing
- Mood swings
- Lack of concentration
- Very quiet, speaks little
- Poor social skills
- Bullies others
- Very unsettled
- Anti-social behaviour
- Lack of confidence

(STONEBRIDGE CPD 16/12/13)

Additional signs:

WETTING / SOILING / SELF HARM / SELF COMFORT / ROCKING / CHANGE IN APPETITIE / UNDEACHIEVEMENT / TIMID / TEARFUL / ANOREXIC / BULIMIC / DO NOT WANT TO GO HOME AT THE END OF THE DAY / ATTENTION SEEKING / CHANGES IN STANDARD OF WORK / DEPRESSION / INTROVERTED / WITHDRAWN / CHANGES IN RELATIONSHIPS / NO FRIENDS / HARD TO MAKE FRIENDS / NEEDY / CLINGY / CHANGE IN PHYSICAL APPEARANCE/DRESS & BODY LANGUAGE / WITHDRAWN AGGRESSIVE / CHANGES IN ATTITUDE, PERSONALITY OR BEHAVIOUR / CHANGES IN INTERACTION WITH OTHERS / PEER GROUP PROBLEMS / EXTREEMS OF EMOTION / ALIEN TO PRAISE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF DOMESTIC ABUSE?

DOMESTIC ABUSE IS EMOTIONAL ABUSE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF DOMESTIC ABUSE?

DEFINITION: Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A child who is subjected to domestic abuse either through directly observing it or is exposed to its effects is affected emotionally and is under a lot of stress.

SIGNS

- Disproportionate reactions (overly apprehensive, tearful, angry or fearful)
- Withdrawn or quiet
- Negative relationships with opposite sex (children and peers)
- Aggression or bullying
- Tantrums
- Vandalism
- Problems in school, truancy,
- Difficulty with speech problems that were not there before
- Difficulties with learning
- Attention needing
- Struggle to make or keep friendships
- Reluctance to come to school
- Reluctance to go home with parents
- Aggressive comments or language (sometimes not expected for that age)
- Self-harming
- Nightmares or insomnia
- Bed-wetting
- Anxiety, depression, fear of abandonment
- Feelings of inferiority
- Constant colds, headaches, mouth ulcers, asthma, eczema
- Seem afraid or anxious to please
- Need for constant acceptance
- Be possessive over friends or belongings

(STONEBRIDGE CPD 16/12/13)

Additional signs:

CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / SELF COMFORT / VERBAL ABUSE / NON-COOPERATION / / UNKEPT / FEAR OF ADULTS / ABSENCES / STRANGE BEHAVIOUR AFTER WEEKENDS OR HOLIDAYS /EXTREME RESONSES TO CORRECTION/ FLINCHING IN RESPONSE TO SUDDEN MOVEMENTS / FREQUENT MEDICAL APPOINTMENTS / DO NOT WANT TO GO HOME AT THE END OF THE DAY / UNABLE TO FORM RELATIONSHIPS WITH ADULTS / SELF PROTECTION / GUARDING / LACK OF EYE CONTACT / CONSTANTLY ILL WITH NO REAL SYMPTOMS / FEARFUL OF ADULTS

APPENDIX 3

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

SEXUAL ABUSE

DEFINITION:

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

SIGNS:

- Hides under clothes / baggy clothes
- Inappropriate physical contact with other chn
- Withdrawn / shy
- Aggressive to chn of the opposite sex
- Scared of others
- Don't like being touched
- Touch themselves or others
- Won't change for PE
- Very quiet or loud
- Use of sexual language
- Stories or drawings include sexual connotations
- Exposing self
- Hesitate when wanting to talk to teacher
- Soiling/ wetting / stains on underwear
- Repeated Urine problems
- Re-enacting sexualised behaviour as part of play
- Bruising
- Sexually specific behaviour or / and language
- Abusive to other chn
- Little physical contact, finds hugs touches difficult will move away.

(STONEBRIDGE CPD 16/12/13)

Additional signs:

SEXUAL PLAY – HOME CORNER / PLAYGROUND / INAPPROPRIATE / PROVOCATIVE SEXUAL LANGAUGE / MEDICAL DIFFICULTIES / CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / MASTERBATION / ANOREXIC / BULIMIC / SELF HARMING / DO NOT WANT TO GO HOME AT THE END OF THE DAY / SECRETIVE / WITHDRAWN / CHANGE IN PHYSICAL APPEARANCE/DRESS & BODY LANGUAGE / UNABLE TO FORM RELATIONSHIPS WITH ADULTS

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF NEGLECT?

NEGLECT

DEFINITION:

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

SIGNS:

- Child smells, clothes are dirty, hair un brushed
- Appears unhealthy but is always in school when unwell
- Low attendance – EWO involvement
- No Breakfast
- Is unfamiliar with basic routines of feeding self and toileting etc
- Always hungry
- Late before and after school
- Attention seeking / needs praise to feel confident
- Poor hygiene, does not know how to use toilet properly
- Angry
- Parents have little contact with school. Do not attend parents evening
- Homework not completed / PE kit repeatedly forgotten
- Correct clothes not worn to school i.e. not warm enough in winter, not cool enough in summer
- Steal things
- Come to school on their own when they are too young
- Lying
- Older siblings care for younger chn and take on the parent role.
- Cries a lot
- Makes slow progress
- Packed lunch does not provide child with a balanced diet
- Over eats at lunchtime
- Untidy / unkempt
- Parents do not follow up medical requests form school i.e. need for eyes to be tested.
- Instability in family, different carers/ boyfriends
- Sleeps in class / Goes to sleep late little routine at home

(STONEBRIDGE CPD 16/12/13)

Additional signs:

INADEQUATE PACKED LUNCH / UNKEMPT / CRUFFY / SLEEPING DURING LESSONS / OVERLY TIRED / REPEATED HEALTH PROBLEMS THAT GO UNCHEACKED OR ARE NOT DEALT WITH / HEADLICS / RINGWORM NOT DEALT WITH AND CONSTANTLY REOCCUR /DISORGANISED / ATTENDANCE / PUNCTUALITY (END & BEGINNING OF DAY) / DO NOT WANT TO GO HOME AT THE END OF THE DAY / OVERWEIGHT / UNABLE TO FORM RELATIONSHIPS WITH ADULT / CONTENT OF WRITING OR DRAWING / UNDERACHIEVING

APPENDIX 5

CHILD PROTECTION REPORT FORM

NAME OF CHILD					
CLASS					
NAME OF PERSON PROVIDING INFORMATION					
DATE		LOCATION			
TIME		THOSE PRESENT			
NOTES OF CONCERNS					
TICK APPROPRIATE LEVEL OF URGENCY BELOW					
INFORMATION		QUITE URGENT		URGENT	

CHILD PROTECTION REPORT FORM

NAME OF CHILD					
CLASS					
NAME OF PERSON PROVIDING INFORMATION					
DATE		LOCATION			
TIME		THOSE PRESENT			
NOTES OF CONCERNS					
TICK APPROPRIATE LEVEL OF URGENCY BELOW					
INFORMATION		QUITE URGENT		URGENT	

APPENDIX 6

EVERY CHILD MATTERS SUMMARY OF NEEDS	
Name of Child:	
Year Group:	Date:
Purpose of Summary:	
BE HEALTHY	
STAY SAFE	
ENJOY & ACHIEVE	
MAKE A POSITIVE CONTRIBUTION	
ECONOMIC WELLBEING	
Signature and Role of Person filling in form:	

APPENDIX 7

CHILD PROTECTION RECORD – CLASS TEACHER NAME OF CHILD : START DATE :	
DATE	**COMMENT / OBSERVATION**

APPENDIX 8

STONEBRIDGE SCHOOL
Shakespeare Avenue
Harlesden
London NW10 8NG
Tel: 020 8965 6965

Fax: 020 8838 0784

STONEBRIDGE SCHOOL WELFARE CHECK / CORE GROUP			
NAME OF CHILD			
DATE OF BIRTH		YEAR GROUP	
ADDRESS			
INFORMATION REQUESTED BY			
DATE			
ACADEMIC PROGRESS AND ACHIEVEMENT			
BEHAVIOUR AND SOCIAL RELATIONSHIPS			
ATTENDANCE & PUNCTUALITY			
CONTACT WITH PARENTS / CARERS			
ANY SPECIFIC INCIDENTS OR MATTERS OF CONCERN			
ADDITIONAL INFORMATION REQUIRED			
CLASS TEACHER SIGNATURE		DATE	
DTCP SIGNATURE		DATE	

APPENDIX 9

CONFIDENTIAL

Incident Sheet

Name of Child _____ Date of Birth _____

Chronology of incidents and concerns

Date	Time	Location	Those Present

Notes of incidents / allegations or observation giving rise to concern.

Name _____

Designation _____

Signature _____

Date _____

Date received by designated teacher for inclusion in the Child Protection File _____

APPENDIX 10

CONFIDENTIAL

Meeting Record Sheet

Present: _____ Date _____

Name of Child _____ Date of Birth _____

General outline of Concerns

Issues discussed and action agreed:

Name _____

Designation _____

Signature _____

Date _____

Date received by designated teacher for inclusion in the Child Protection File _____

APPENDIX 11

RECORD OF CHILD PROTECTION MEETING & ACTION
Name of Child:
Year Group: Date:
Purpose of Meeting:
Those present:
NOTES

ACTION & BY WHOM	WHEN COMPLETED
Signature and Role of Person filling in form:	