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

Summary Report

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

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FOREWORD

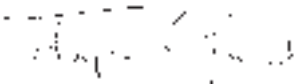
Female genital mutilation (FGM) is a grave human rights violation which is perpetuated by families in the name of culture, tradition and religion. The World Health Organisation estimates that globally from 100 to 140 million girls and women have undergone some type of FGM. It has been estimated that 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.



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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)
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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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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

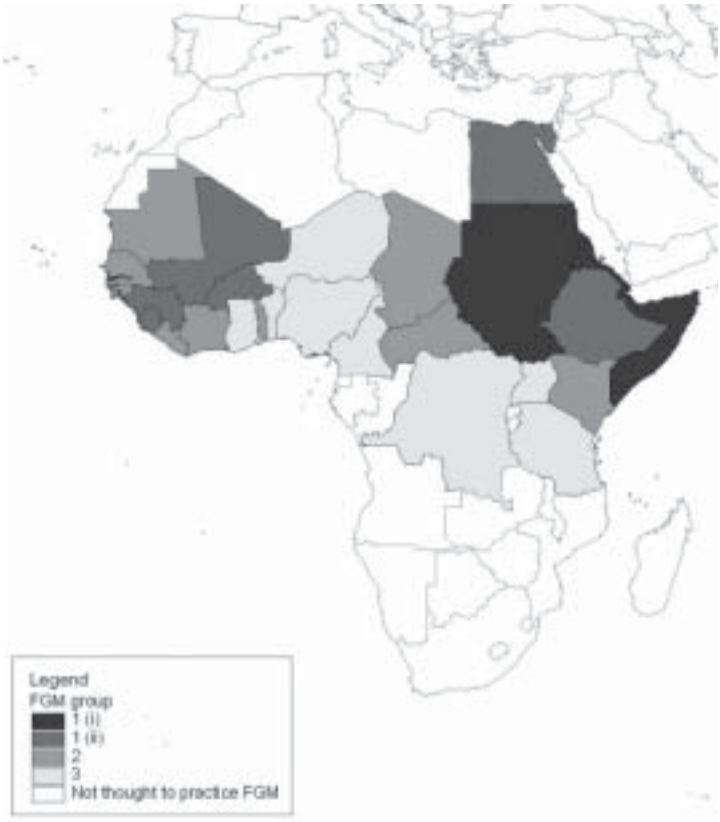
FGM category	Descriptive title of category	Definition
1(i)	Almost universal FGM and substantial WHO FGM Type III	Prevalence 85 per cent or higher and over 30 per cent of operations are type III
1(ii)	High prevalence WHO FGM Types I and II	Over 75 per cent prevalence and predominantly Types I and II
2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

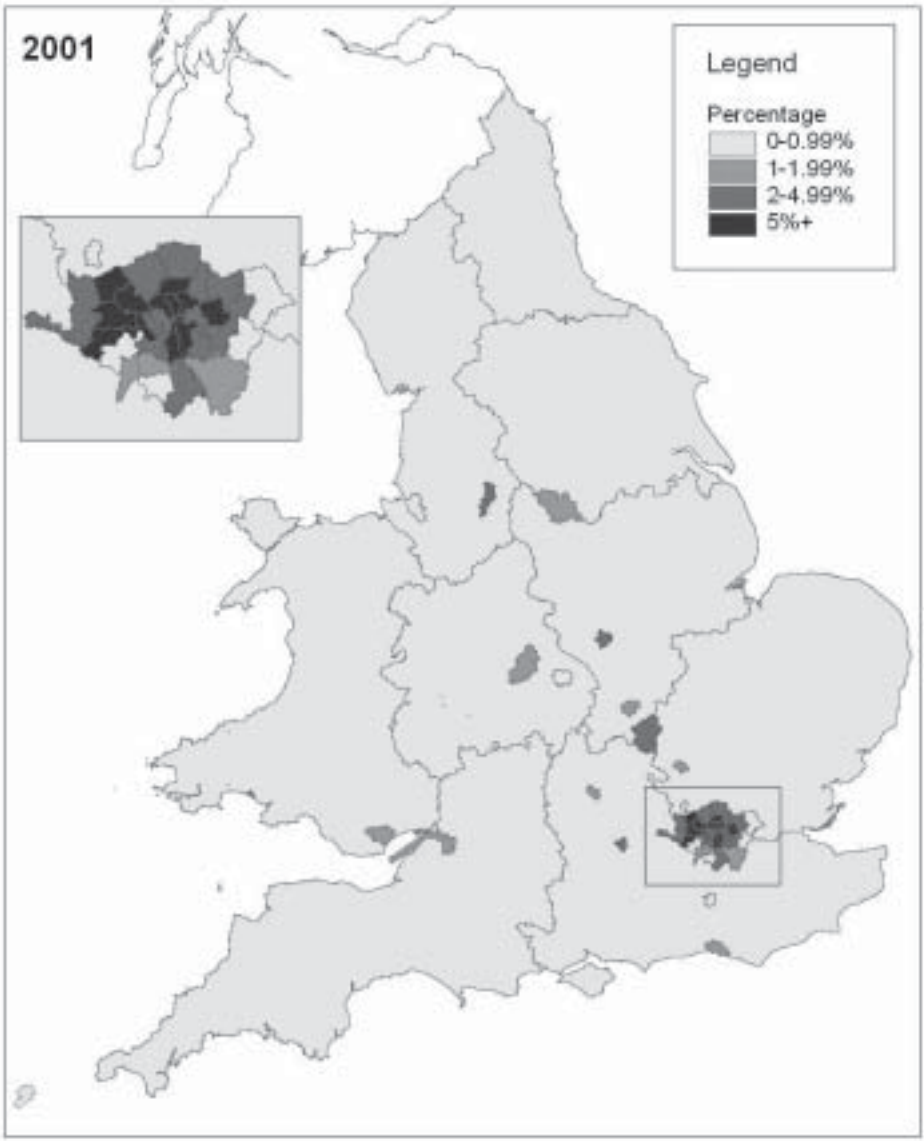
Year of birth	Number of maternities to			Percentage of maternities to women with FGM
	Women born in FGM practising countries	Women with FGM	All women	
2001	13,328	6,256	588,868	1.06
2002	14,666	7,109	590,453	1.20
2003	16,890	8,090	615,787	1.31
2004	19,356	9,032	633,651	1.43

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 or region of residence	2001 Number	%	2002 Number	%	2003 Number	%	2004 Number	%	Total 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.

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