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

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## 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 the 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).

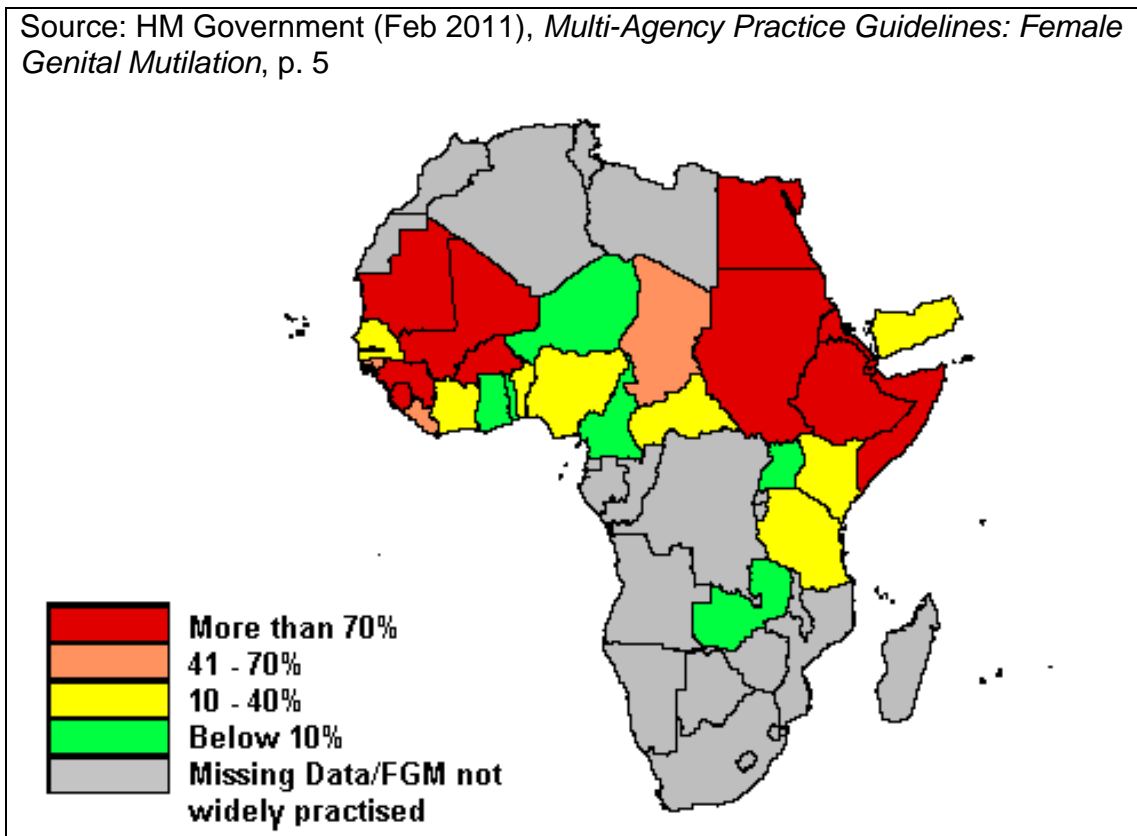
### ***Prevalence Worldwide***

- 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 9<sup>th</sup> 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.

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.

<b>Table 2 – List of Languages and Associated Prevalence Rates</b>		
<b>Language</b>	<b>Country/Region</b>	<b>Prevalence Rate (%)</b>
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:

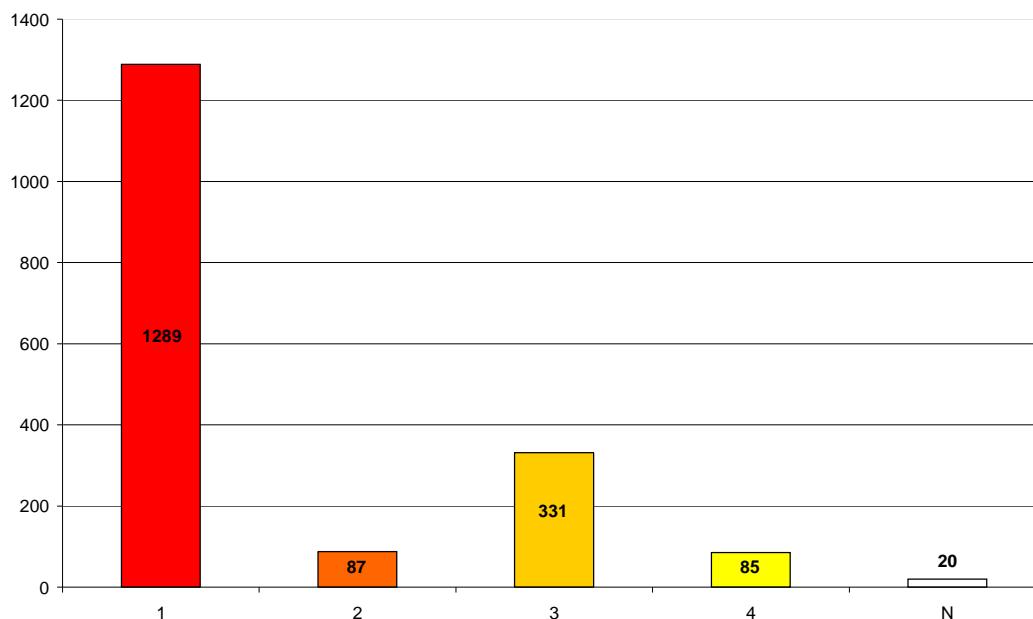
Language	No. of Girls	Language	No. of Girls
Afar-Saho	3	Krio	6
Akan/Twi-Fante	69	Kurdish	104
Amharic	85	Lingala	3
Arabic (Egypt)	19	Nigerian (lang not known)	30
Arabic (Iraq)	16	Nzema	1
Arabic (Sudan)	40	Oromo	2
Arabic (Yemen)	6	Pashto/Pakhto	2
Bambara	2	Somali	1092
Berber (Tamashek)	3	Swahili/Kiswahili	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
<b>Grand Total</b>			<b>1812</b>

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.

Category	Description
<b>1</b> (Universal Prevalence)	85 – 100%
<b>2</b> (High Prevalence)	75 – 84%
<b>3</b> (Medium Prevalence)	25 – 74%
<b>4</b> (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:

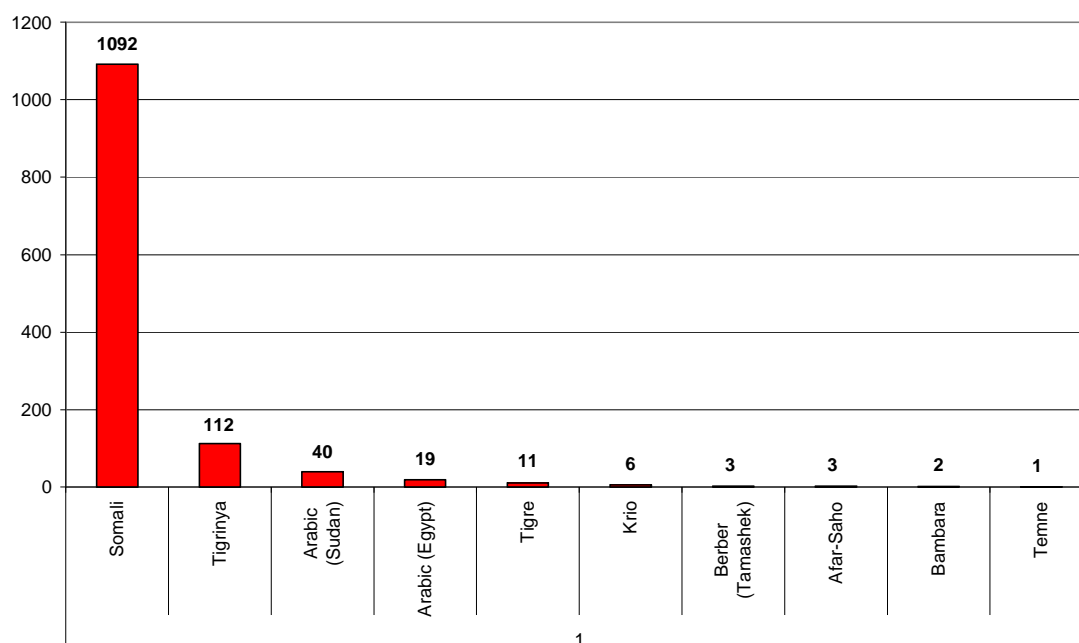
**Chart A – Number of Girls by FGM Prevalence Category**



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.

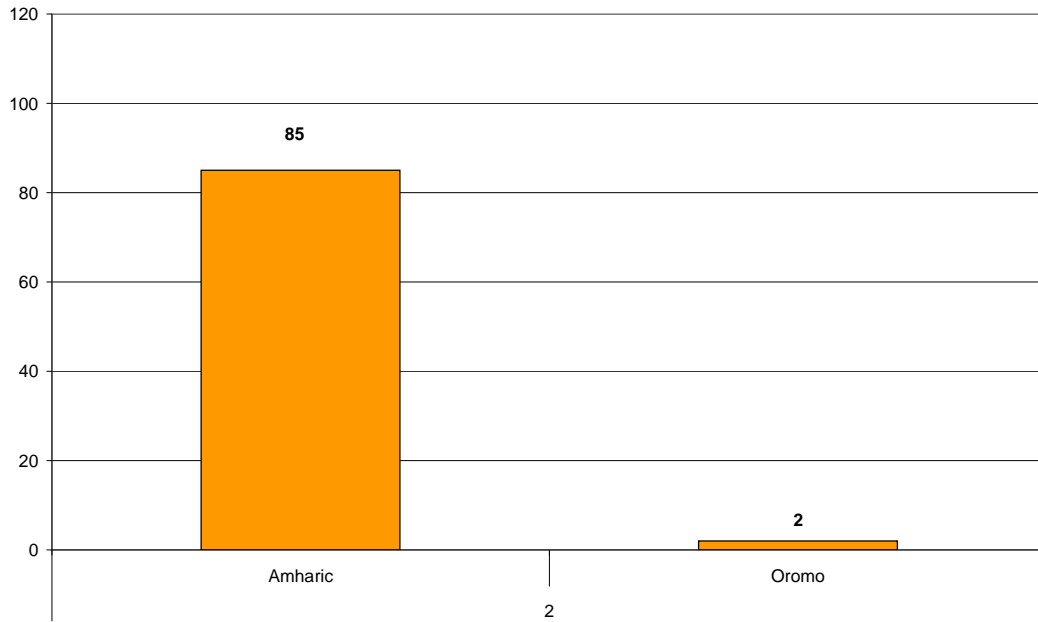
4.7. Charts B – F show a breakdown of the languages in each FGM prevalence category.

**Chart B – Language Breakdown in Category 1**



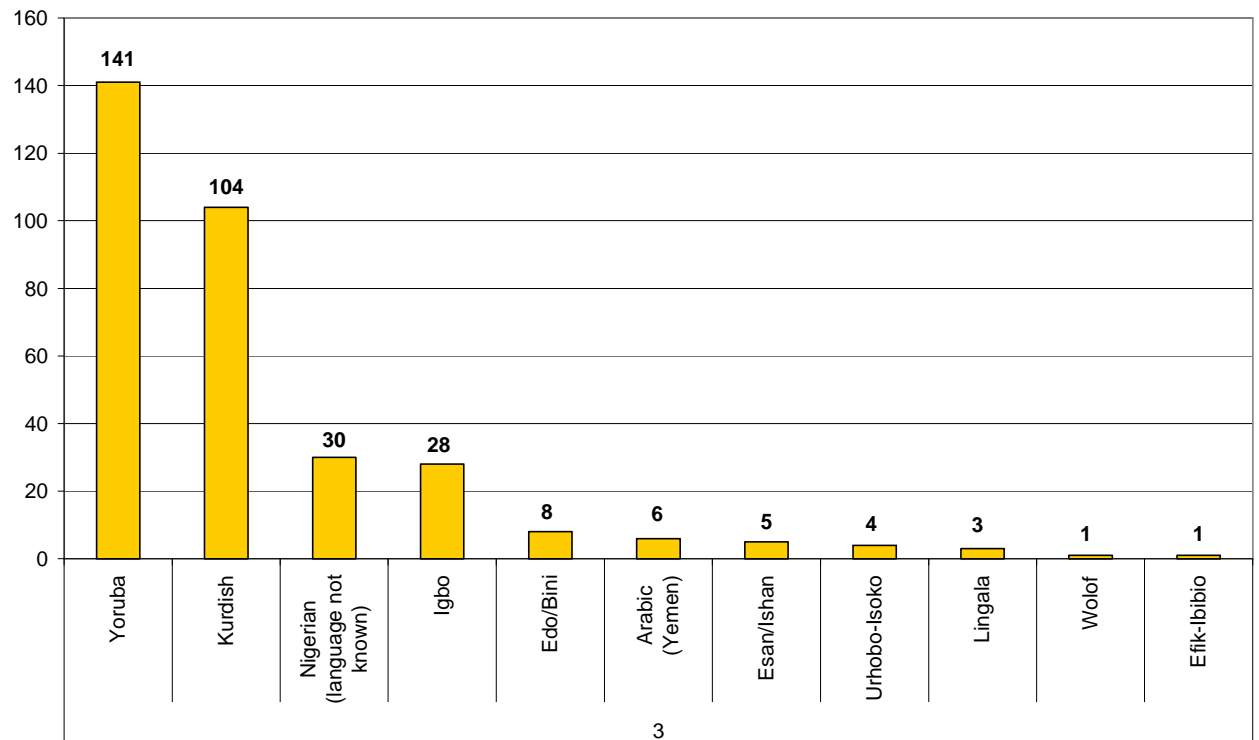
4.8. Chart B illustrates that Somali speakers make up a very large majority of those in the highest risk category where the FGM prevalence rate in country of origin is classed as universal.

**Chart C – Language Breakdown in Category 2**

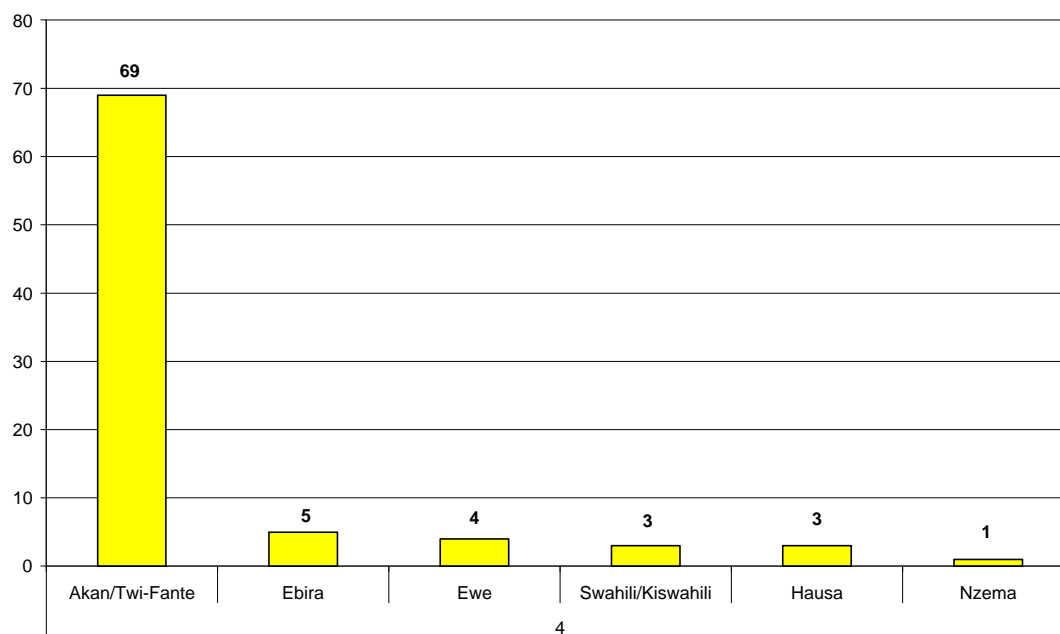


4.9. Chart C shows just two languages; Amharic and Oromo, both primarily spoken in Ethiopia, a country with an FGM prevalence rate of just over 74%.

**Chart D – Language Breakdown in Category 3**



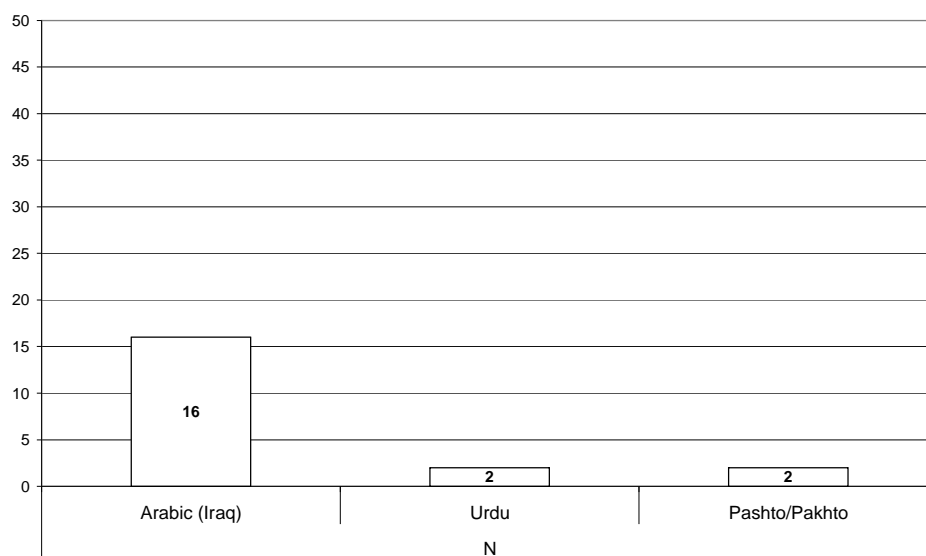
**Chart E – Language Breakdown in Category 4**



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).

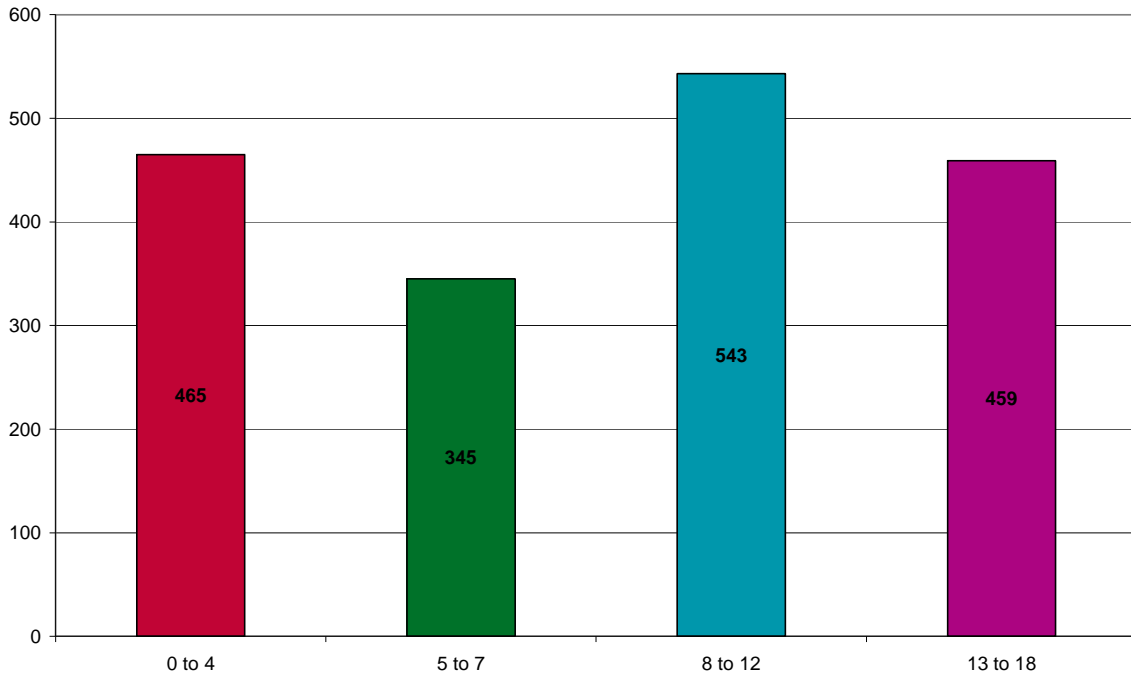
4.11. Chart F shows the number of girls speaking languages from communities where there is not enough information available to estimate prevalence rates. The numbers in this category are very low overall. Arabic speakers from Iraq are the majority, and although there has been one study looking at prevalence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



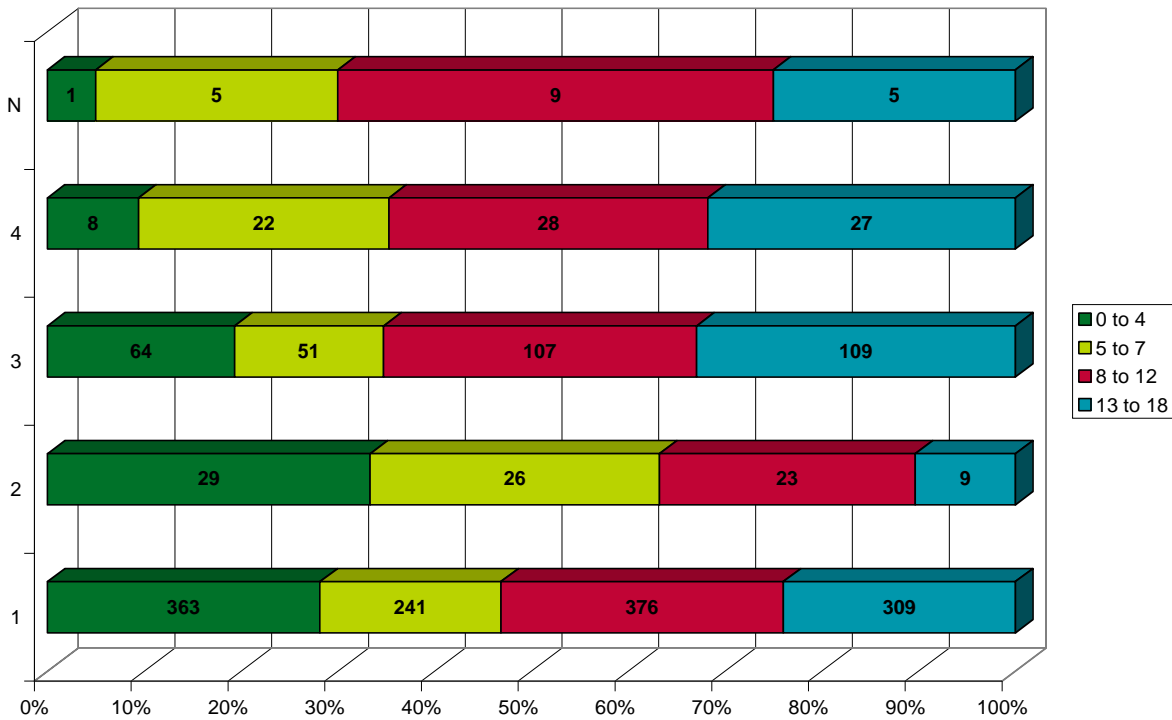
4.12. The ages of the girls identified are shown below in Chart G in four categories: 0-4, 5-7, 8-12 and 13-18. As the chart shows, there is reasonably even distribution across all the age groups.

**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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