



Honour Based Violence and Abuse, Forced Marriage and Female Genital Mutilation: Shaping Services for Priority Victims in Hertfordshire

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1 Executive Summary

1.1 Context

1.1.1 Research Project Context

From 1 April 2015, the responsibility for commissioning victim services passed from the Ministry of Justice to local Police and Crime Commissioners (PCC). In response, Hertfordshire PCC launched a new multi-agency initiative – Beacon - the Hertfordshire Victim Care Centre – to ensure victim services are as accessible as possible and that priority groups can be assessed, across a variety of parameters, and receive the support they need.

The Ministry of Justice Victims’ Code of Practice (VCOP) defines priority groups as those affected by the most serious crime; those persistently targeted by crime; those vulnerable by age, or physical or mental health; and, intimidated victims. These groups receive a priority service involving rapid needs assessment and are entitled to an enhanced support service. The VCOP includes victims of honour based violence/abuse (HBV/A), forced marriage (FM) and female genital mutilation (FGM) as a priority group. This research project was undertaken to inform the commissioning of services for this group within Beacon. Its recommendations are aligned with the county’s Domestic Abuse Strategy.

Local initiatives like Beacon form part of a wider UN strategy towards ending violence against women and girls (VAWG) – a strategy supported by the UK government. The VAWG approach recognises not only that victims of HBV/A and FM crimes are disproportionately female but also that violence against women and girls is a fundamental abuse of human rights – and, most specifically, of women’s rights. Chief Constables who are members of the National Police Chiefs’ Council (NPCC) have overall responsibility for the investigation of alleged criminal activity in their individual force area. They published their revised Strategy on Honour Based Abuse (HBA), Forced Marriage and Female Genital Mutilation for 2016-18 in December 2015. Issues raised there and in cognate initiatives shape this report.

The Office for the Police and Crime Commissioner (OPCC) for Hertfordshire and the Domestic Abuse Partnership Honour Based Abuse Subgroup commissioned this research

project. Its purpose is to enhance understandings of the support needs of victims of honour based violence/abuse, female genital mutilation and forced marriage.

1.1.2 Research overview

This research project has been completed by an academic team spanning relevant specialisms and drawn from the Universities of Roehampton (Gill) and Essex (Cox and Weir) with consultant input from the University of Liverpool (Walklate). The research was conducted during February and April 2017. Secondary data was gathered from a wide range of national and local sources and includes unique local GIS mapping data created by the team. Primary data was gathered from interviews with ten women victims of HBV/A and/or (attempted) FM who had all engaged at some level with Hertfordshire services in recent years. The majority were recruited through local practitioner networks. They were aged between 18 and 50 years and seven of them were mothers of a total of thirteen children. These children should be regarded as secondary victims in many cases and further research is required to address their needs. Additional interviews and focus groups were completed with fourteen multi-agency practitioners working with this client group in the county and beyond. Two interviews were conducted with medical professionals who had dealt with a small number of local FGM cases. Despite many attempts, it was not possible for the team to identify or interview any women or girls currently living in Hertfordshire who have directly experienced FGM.

1.1.3 Key findings

- **Recognising the distinctive features of HBV/A**

While HBV/A and FM share features in common with domestic abuse and gender-based violence more broadly, our victim engagement project highlights the critical and distinctive role that perceived 'honour' plays in shaping the context of this abuse. This is an aggravating factor that increases risks to the victim and potentially involves multiple perpetrators. Some victims expressed concern that the police did not appreciate this aggravating element, and pointed out that speaking to the authorities was in itself considered a violation of community norms of honour. Issues such as this illustrate the difficulties associated with identifying the true levels of HBV/A. Furthermore, they highlight the risks that police and other public services run of making the wrong assumptions about the circumstances surrounding reported incidents and, therefore, taking the wrong course of action, thereby potentially inadvertently increasing the threat of harm to victims through their interventions. Nevertheless, whilst the

police appreciate and act upon the distinctions in HBV/A, they do investigate cases of HBV/A in a similar way to that followed for mainstream offences of violence, and this approach can result in successful outcomes.

- **Supporting victims/survivors of HBV/A and FM**

The research finds that, on the whole, victims of HBV/A and (attempted) FM who reported their situations to an external agency generally received a supportive response. The interventions of teachers, police, health professionals, safeguarding officers, refuges and support organisations helped most of our 10 interviewees to leave, or reduce their risk from, a (potentially) dangerous domestic situation. Significantly, the support offered could extend over a period of months and, in some cases, years. Ongoing support was particularly likely if the victim was also a mother who was required to maintain some level of (in) direct communication with her (ex) partner through family court proceedings regarding paternal contact with children. The ‘open-ended’ nature of mothers’ needs as victims (as well as those of their children) in these circumstances requires further attention.

The research identifies a number of factors that contribute to a supportive practitioner response: rapid response; listening; establishing trust; being accessible and available; offering clear guidance to victims as well as to perpetrators and extended families; an awareness that personal experiences of HBV/A and (attempted) FM can vary greatly; and, the consequent use of discretion and professional judgement in developing a tailored, client-centred approach whilst operating within statutory remits.

Nevertheless, the research also indicates that some victims felt that they had received a poor service from Hertfordshire police and other agencies and they were highly critical of elements of their contact with them. One stated that the police “need to take more notice of the victim as opposed to the perpetrator” and that “they could do a lot more,” while another thought that the police had given no credence to her side of the story after her husband had outmanoeuvred her by calling them first and casting her in the role of the abuser.

- **Barriers to and vulnerabilities around reporting**

A powerful cultural norm which holds that ‘family’ problems should be resolved within the family, or at least within the community, constrained victims from reporting. For some victims, reporting to the police resulted in a heightened sense of vulnerability and in the fear, and the very real risk, of serious harm. This fear was particularly acute in situations of intra-familial marriage. A decision to leave their homes and to be housed in temporary accommodation, such as hotels and bed and breakfasts, was also problematic for some victims. At least one woman was concerned about how she was going to pay for her stay and described feeling isolated and at risk. Even when moved to more permanent accommodation, this woman remained under effective house arrest as she feared venturing outside in case she was found.

- **Inherent risks around reporting**

Interviewees strongly emphasised the point that the involvement of the police and other agencies could carry a number of risks for them. They stressed the importance of appreciating these very real risks in the context of honour-based communities and in terms of victims’ motives and the implications of their reporting.

1. Police need to understand that a visit by them can be seen as bringing ‘trouble’ to the family in a very public way – potentially invoking shame in the eyes of the community – and that this shaming will often have ramifications for the victim.
2. Attempting to interview the victim in her home or in front of the perpetrator/s puts her at significant risk of harm.
3. If the police are unable to see the victim or if they decide that no further action is needed and leave the premises, they can put the victim at significant risk of harm.

- **Underreporting to the police**

In line with allied work, this research finds that underreporting of HBV/A, FM and FGM remains a major challenge. Victims typically disclose their situations to friends or sympathetic family members. Although some victims approach teachers, helplines, refuges or even immigration authorities, only a minority go on to report to the police and even fewer

pursue a formal criminal or civil intervention against perpetrators. Of our 10 victims, one pursued an injunction and two took out non-molestation orders. None of those who were aware of the option of seeking a Forced Marriage Protection Order wished to do so. Thus, while it is vital that victims are made aware of the interventions available to them and their VCOP rights, it is equally important that the reasons behind their decisions not to pursue these options are better understood and respected.

Although HBV/A is known to share features in common with domestic abuse and gender-based violence more broadly (HMIC, 2015), our research project highlights the critically important role that the notion of perceived 'honour' plays in this form of abuse. The aggravating element of honour not only shapes the context of HVB/A, but also compounds the risks to the victim because it potentially involves not just one but multiple perpetrators. Indeed, some of the victims we spoke to expressed concern that the police did not appreciate this aggravating feature, nor the fact that speaking to the authorities was itself considered a violation of community norms. Reporting in this context is particularly fraught; however, the reluctance of victims to report can result in police and other public services making incorrect assumptions about the circumstances of reported incidents and subsequently taking the wrong course of action, thereby potentially – albeit inadvertently – increasing the threat of harm to victims. However, while the police generally appreciate and act on the distinctions between HBV/A and other forms of domestic violence and abuse, some similarities with how they deal with mainstream offending can be observed (HMIC, 2015). If violent offences, particularly those against women and girls, are investigated as a matter of course, this approach can result in successful outcomes also being achieved in HBV/A cases.

Women in black and minority and ethnic (BME) communities face numerous barriers to reporting violence in relation to honour and coercive control in relation to forced marriage. Such difficulties include victims being denied access to reporting structures, a lack of reporting mechanisms and victims' ignorance of the resources available to them. The reasons why people fail to report this kind of abuse are both numerous and complex. They include embarrassment, thinking the police will do little to help, believing the incident was 'too trivial or not worth reporting' and seeing the offence as a 'private/family matter and not police business' (HMIC, 2015). Although these barriers transcend gender, age and ethnicity, they can also be compounded by them. Additionally, it is worth noting that it is not uncommon for women to delay reporting abuse related to honour (Harrison and Gill, 2017).

However, not all victims find it necessary to report abuse to the police in order to move on; some may not report because they feel the criminal justice system will re-victimise them, while others may believe that they will receive better support from counselling and other support services.

While acknowledging that not all the factors gleaned from conversations with respondents in this study are necessarily representative of all victims of honour based violence and abuse, a number of the difficulties faced are particularly pertinent to women in such communities. Barriers mentioned during our interviews included: language; honour and consequential shame, including repercussions and consequences; victims not realising they actually had the right to choose who to marry, at a time of their own choosing; and fear of not being believed.

The most influential barriers for our interviewees were honour and consequential shame. This finding reflects the fact that the numerous women and girls living in these communities bear the responsibility for the honour of their families (Harrison and Gill, 2017). As Abraham (1999) explains, South Asian, African and Middle Eastern cultures assigns a higher value to purity than do some Western cultures, as represented in the expectation that women will remain virgins until marriage. If virginity is lost, even through sexual violence, the woman will encounter loss of family honour, along with shame, stigma, public ostracism and, in some cases, forced marriage and honour based violence (HBV/A). The social construct of virginity is, therefore, one of the ways in which a potential husband measures the honour of the woman's family and kin (Abraham 1999).

- **Agency gaps, HBV/A and FM strategy, services and challenges in Hertfordshire**

The findings on agency gaps, HBV/A strategy, services and challenges in Hertfordshire suggest that agencies do achieve **basic** levels in terms of tracking and monitoring offenders and responding to the needs of victims. Many agencies do have effective referral procedures. However, many cited the problems of prevention and meaningful early intervention. They were concerned about system fragmentation which resulted in uneven reform among agencies, because there was a lack of shared vision, problem identification and the challenges of inter-agency communication. As a result, victims and survivors could be caught up in uneven agency responses compounded by a paucity of perpetrator sanctions and insufficient attention to victim safety.

The experience of the victims interviewed suggests that Hertfordshire police have developed system-level responses to HBV/A and FM, in part through the work of specialist police officers, that goes beyond securing the immediate safety of victims. For instance, examples involving police officers, GPs, district nurses, and those working at the Sunflower service show that many of these agencies have gone further by connecting victims with community, health and counselling services, and advising on financial support. However, resource and time restrictions can often make it difficult for agencies to create a fully victim-centred service.

The research suggests that a number of considerations are necessary when providing services to those experiencing HBV/A, FM, and FGM. For example, it is critical that health professionals and other agencies i.e. law enforcement, social services and advocacy services are able to work together to plan and review interventions. While acknowledging that Multi-Agency Risk Assessment Conferences (MARACs) are costly and it is unlikely that these could be provided for all victims who contact agencies, expanding the opportunities for practice and risk assessment review is likely to bring improved outcomes.

- **More effective collaborative cross-agency working**

Our research indicates that there is a need for more effective collaborative cross-agency working. Collaborative service delivery is essential when considering the harmful effects of HBV/A, FM, and FGM for both victims and their families. The most effective way to enforce offender accountability, increase victim safety and significantly deter further violence is to pursue inclusive system-level collaborative efforts that coordinate criminal justice efforts with advocacy agencies' services. Here:

- Resources should be sufficient to implement and run any additional collaboration without the loss of essential facilities and services.
- Agency staff should take time to communicate fully so they know each other well, and are familiar with, for example, each other's norms, standards, ethics, resources, legal restrictions and language. Having a broad knowledge of these will enhance decision-making and mitigate implementation and resources issues that affect not only the individual services but also the partnering agencies.

- Measures for monitoring the response including systematic case-tracking of victims who have experienced HBV/A, should be instituted. More rigorous procedures for perpetrator accountability should also be introduced.

- **Working in partnership with service users**

We found little evidence that HBV/A service users were involved in the further development of services tackling HBV/A. Our findings indicate that victims are often keen to give feedback on relevant services and want their views considered.

There are many different methods whereby survivors can participate in services without necessarily having to be the lone representative at a forum meeting. Other models include consultation exercises on specific issues or setting up survivor forums to shadow the multi-agency work in the county.

- **Data monitoring and data sharing difficulties**

There are gaps in the baseline data on HBV/A, FM and FGM in many of the key statutory and voluntary agencies. Data is lacking in key agencies such as education, refuges, social housing and the courts, which makes it difficult for these agencies to identify the scale of the problem and to work effectively with client needs.

If agencies do not have the same definition of HBV/A, it is difficult to collect data. The lack of data across agencies also makes it even harder to monitor the value of an intervention because clients ‘fall through the cracks’ and disappear. This is especially a problem for the criminal justice system and for children’s services. Services and agencies are reluctant to refer and pass on information because of concerns about client confidentiality and data protection issues. These concerns are often unfounded and, as the tragic murder of Shafiea Ahmed showed (ref), are usually misguided. As this research reveals, professionals need readily accessible guidance on data sharing, data protection and human rights.

There is a lack of data on the outcome of agency interventions. Whilst it may be possible to argue from police data that the level of repeat contacts to the police has declined, that data does not really tell us whether or not the violence actually ceased as a result of police involvement. There is also a major gap in the data in terms of service user feedback on ‘what works.’ We are aware that this research has barely scratched the surface as regards this area of work in Hertfordshire. Exit services are needed to provide this information. We contend that the money invested in exit surveys will be money well spent as it will provide useful information on what really works for priority victims.

Baseline data on the prevalence and incidence of HBV/A and on client needs is particularly sparse for the hard-to-access groups we have discussed in this report. There is also a pressing need for better information on: people in gay, lesbian, bi-sexual and transgender relationships; men who experience HBV/A and forced marriage; children and young people; and, people with disabilities and their needs. Better data is needed to shift attitudes so that work to prevent HBV/A becomes mainstreamed and fully integrated into the practice of key agencies.

We firmly believe that there is a need for data and research evidence to turn around thinking about HBV/A so that the issue is no longer viewed primarily as being a problem of service delivery. HBV/A, FM, and FGM are a basic human rights issue. Victims who experience crimes predicated in the name of honour suffer infringements of their human rights – the right to life and the right not to be subject to cruel or inhumane treatment. The scale and consequences of this abuse of human rights can be seen not only in worldwide health consequences, in social exclusion, in children’s educational disadvantage, but also in the scale of the fear that victims, or potential victims, of these crimes can experience for the rest of their lives.

1.1.4 Main Recommendations

We would like to make five main and ten further recommendations. Our major recommendations are summarised below and our full list appears in the final section of this report.

1. **The commissioning of a dedicated service to tackle HBV/A, FM and FGM in county hotspot areas:** This is best done through the expansion of current services already overseen by the Hertfordshire Domestic Abuse Partnership. Such a service should include: a 24/7 dedicated team with excellent multi-agency links; clear referral pathways; resources to ensure victims are fully aware of their rights; and an agreed evaluation plan.
2. **Improved data sharing and case management:** There is a need for improved data sharing between agencies dealing with HBV/A, FM and FGM not only within the county but also between counties and countries. We recommend a review of Hertfordshire's current multi-agency case management system for these client groups. Here, Essex's new Joint Domestic Abuse Team (JDAT), which comprises police and social care practitioners and which can be accessed by vetted partner agencies, may provide a useful model. Such a review should ensure that there is adequate flagging, review and follow-up of all reported incidents of HBV/A, FM and FGM, as recorded through the Hertfordshire police data and mandatory health reporting (in the case of FGM).
3. **Review of the efficacy of existing risk assessment practices.** Victims of HBV/A and FM are all likely to have suffered lengthy, ongoing coercion and abuse prior to reporting. Their initial reports may, however, incorrectly indicate that these individuals face a 'low risk' of further abuse or violence, because they may find difficulty in articulating or sharing the full extent of this historic abuse. The current flagging of risk in HBV/A and FM cases via DASH and/or MARAC should be reviewed.
4. **Co-ordination through cross-referrals for women affected by HBV/A, FM and FGM:** Recognising the limited support role of the police exposes the importance of taking a co-ordinated approach to cases of HBV/A, FM and FGM and of having professionals make cross-referrals to available specialist support agencies. A co-ordinated approach to such referrals offers an important way of improving local responses to those affected by crimes related to honour.
5. **Engagement of stakeholders working with HBV/A, FM and FGM survivors in the framing of a planned FGM referral pathway for the county.** The health professionals we interviewed advised us that they are currently making developments

in this area and that they expect to be able to share the resulting pathway more widely in the summer of 2017. We strongly recommend that this pathway is created and followed.

1.1.5 Broader benefits

Extending services for the victims of HBV/A, FM and FGM has the potential to generate broader benefits. It can:

- enhance the wellbeing, capabilities and life-course outcomes for women and children in Hertfordshire;
- allow the OPCC and Hertfordshire Domestic Abuse Partnership to promote greater access to justice for victims of HBV/A, FM and FGM and DA more generally;
- allow the OPCC to develop a local strategy to contribute to the cross-governmental [Ending Violence against Women and Girls \(VAWG\) Strategy: 2016 to 2020](#);
- allow the OPCC and Hertfordshire Domestic Abuse Partnership to help local agencies to meet their obligations under the Equality Act 2010 by working to ensure that residents with protected characteristics enjoy their right of equal access to high quality services; and,
- reduce the significant financial and emotional costs of unreported gender-based violence and child abuse.

1.2 Honour Based Violence and Abuse

There is currently no statutory definition of either the term ‘honour based violence’ or ‘honour based abuse.’ Since many agencies use both terms, this report employs the combined acronym HBV/A.

The NPCC (National Police Chief’s Council) has defined honour based abuse as “a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community.” Such crimes can include harassment, assault, false imprisonment, threats to kill, rape and murder. HBV/A is not a specific statutory offence. Rather, it is a collective term encompassing various offences such as forced marriage, female genital mutilation, male child preference and male privilege. HBV/A is prosecuted according to the laws regulating the specific offence committed.

HBV/A can be distinguished from domestic abuse and other forms of violence as it is committed with some degree of approval and/or collusion from family and/or community members in response to perceived immoral/shameful behaviour. It may also be linked to misconceptions about culture, and/or religious belief. It is predominant across a range of male-dominated cultures, for example, Turkish, Kurdish, Afghani, South Asian, African, Middle Eastern, South and Eastern European and traveller communities.

The types of oppression a woman might face within honour systems take different forms depending on her location, regional culture and family’s socio-economic status (Dobash and Dobash, 2000). They can encompass control of women and girls’ intimate, sexual, personal, social and economic choices. For example, in some South Asian families, women’s participation in professional and/or academic pursuits contributes to the family’s honour while, in others, a sister or daughter who works outside the home is a source of shame.

The vast majority of victims of HBV/A are women (typically girls and young women), while the perpetrators are most often the victim’s male blood relatives or in-laws: i.e. the victim’s,

husband, partner, father, brother(s), cousins and/or uncle(s). Meanwhile, although older women – especially mothers and mothers-in-law – may play a part in the perpetration of HBV/A, it is usually men who carry out acts of violence. Such acts can be seen as virtuous and as affirming a man’s capacity to exert control over his female relatives (Ertürk, 2012).

Although most victims of HBV/A are female, there is also evidence of victimisation among young men (Chesler, 2010; Oberwittler and Kasselt, 2011). Like women, young men are under pressure to respect and heed the wishes of more senior, usually older, male relatives (Abu-Lughod, 2011). Subordinate men are most likely to cause dishonour as a result of their behaviour towards women, especially regarding (i) choice of dating or sexual partners; (ii) refusing an arranged marriage; (iii) coming out as gay, bi-sexual or transgender (Jaspal and Siraj, 2011; Ozturk, 2011); and/or, (iv) refusing to commit an act of HBV (Roberts et al., 2014).

Awareness of HBV/A shifted significantly in the late twentieth century and led to the first concerted national and international efforts to address it as a form of VAWG. In Western countries with large multi-ethnic communities, HBV/A is no longer seen as a ‘foreign’ issue faced by others; in Britain, it is now recognised as a significant problem.

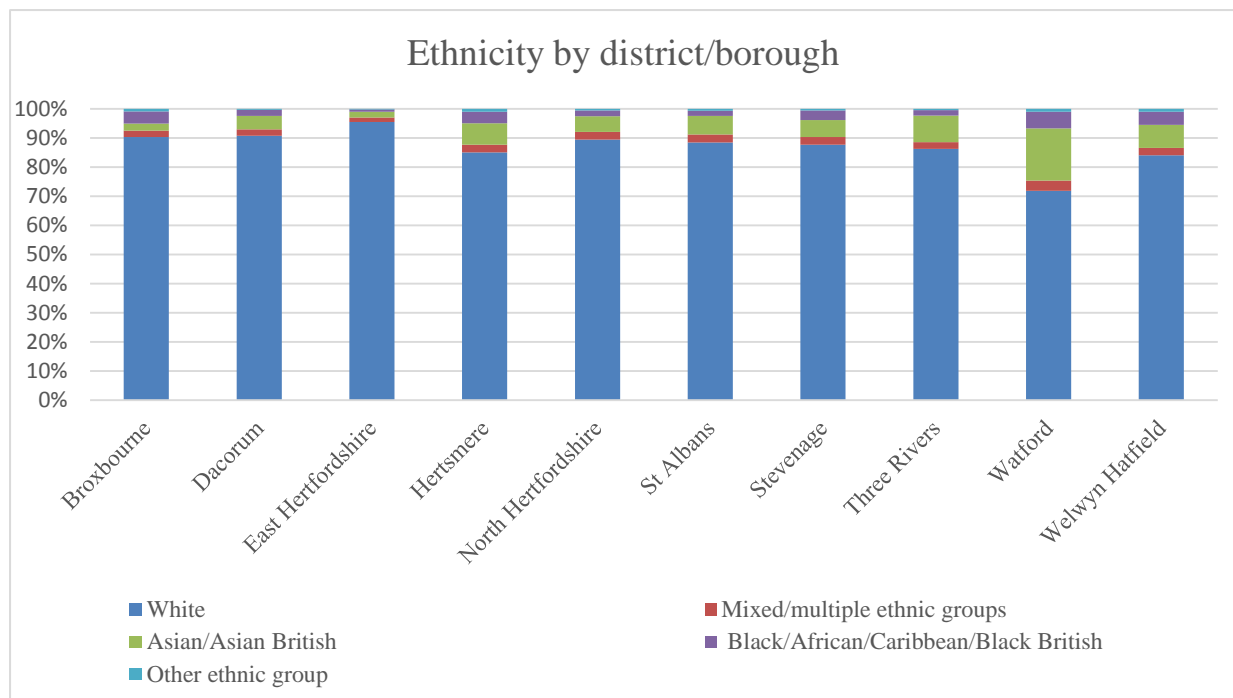
A Freedom of Information request by the British-based Iranian and Kurdish Women’s Rights Organisation (IKWRO) revealed that “more than 11,000 incidents of HBV between 2010 and 2014 were reported to police across the UK” (IKWRO, 2015). When Britain’s 43 police forces were asked to disclose incidents of ‘honour’ violence that had been recorded during this period, 39 police forces responded, citing a total of 11,744 incidents. The five areas with the highest rates were London (2,188 incidents), the West Midlands (1,269 incidents) and Bedfordshire (1,106 incidents) (IKWRO, 2015).

1.2.1 HBV/A in Hertfordshire

Patterns of diversity are a key part of understanding varying patterns of HBV/A in Hertfordshire. The 2011 census found 12 per cent of the usual resident population of Hertfordshire to be from black and minority ethnic (BME) groups. The most ethnically diverse area is Watford, with 28 per cent of the population coming from BME groups. Within this grouping, the largest BME (black Asian minority ethnic) group in Watford is Asian or Asian British, accounting for 6 per cent of the population.

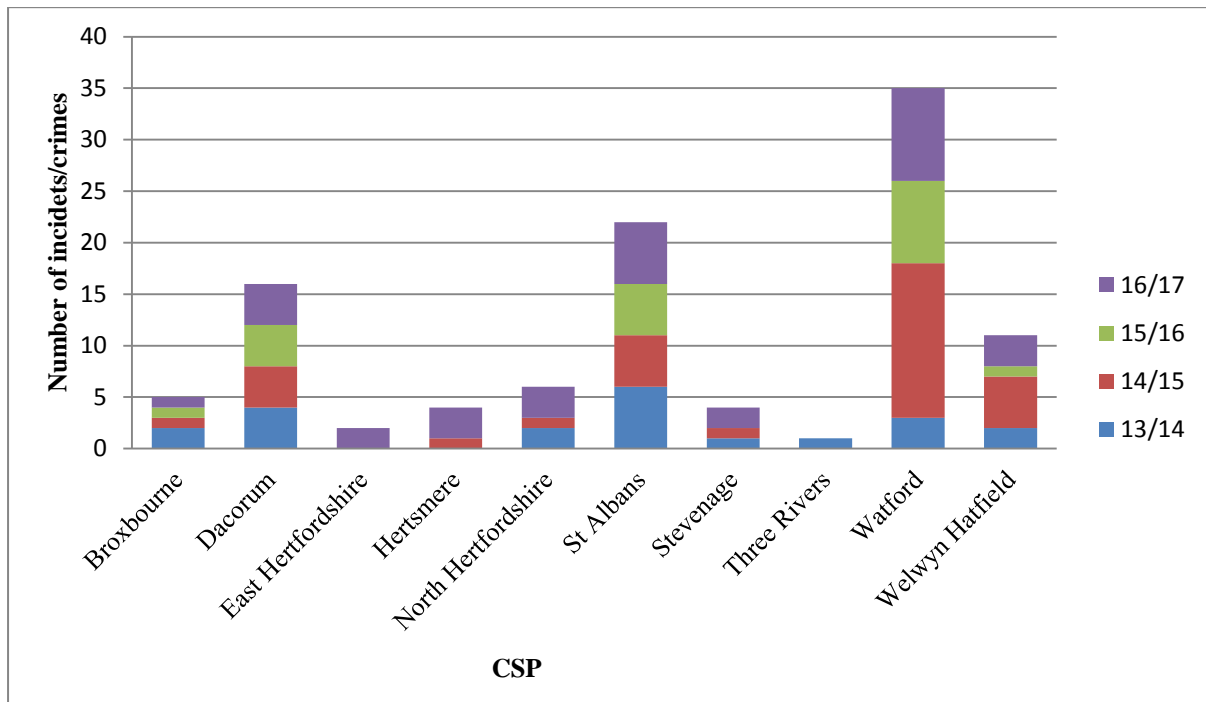
Ethnicity is recorded unevenly and often inaccurately by agencies working to meet these challenges. That said, ethnicity in itself should not be treated as a particularly reliable risk factor in this field. Available data for Hertfordshire identified in the course of this research suggests that 32 per cent of police-recorded HBV/A crime involves alleged perpetrators from Pakistan. Furthermore, 43 per cent of recent Herts FM cases involved the Pakistani community.

Figure 1: Usual resident population by district/borough in Hertfordshire; ONS, 2011. N= 1116062



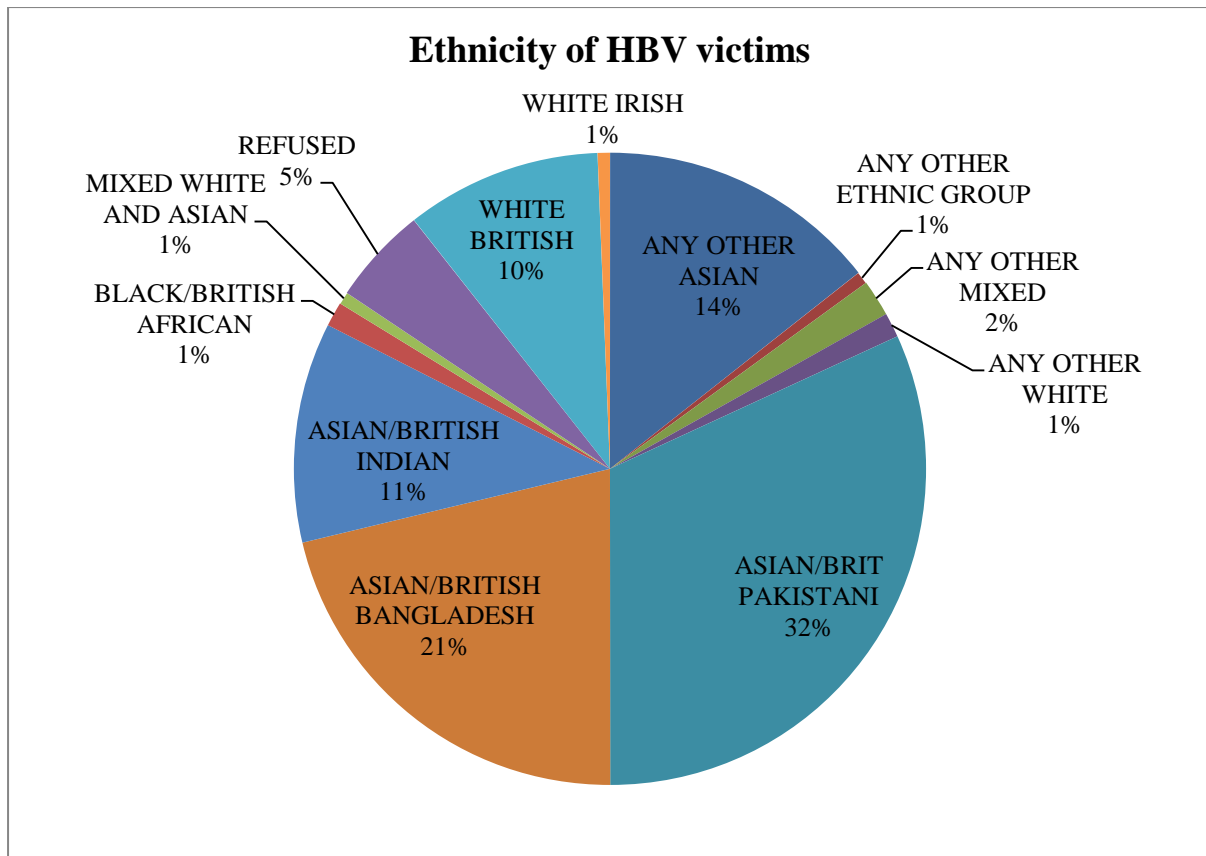
HBV/A is either recorded by the police as a crime or an incident. More information is available about the victim of a recorded crime than for incidents. Between April 2013 and 14 February 2017, the Hertfordshire police recorded 160 crimes and 110 incidents of HBV and FM. Seventy-seven per cent of crimes were flagged as domestic violence; 77 per cent of victims were female. The highest numbers were recorded in Watford, followed by St Albans.

Figure 2: Police recorded incidents/ crimes of HBV by year (note 16/17 only up to 14/02/17), Hertfordshire Police, 2017. N= 270



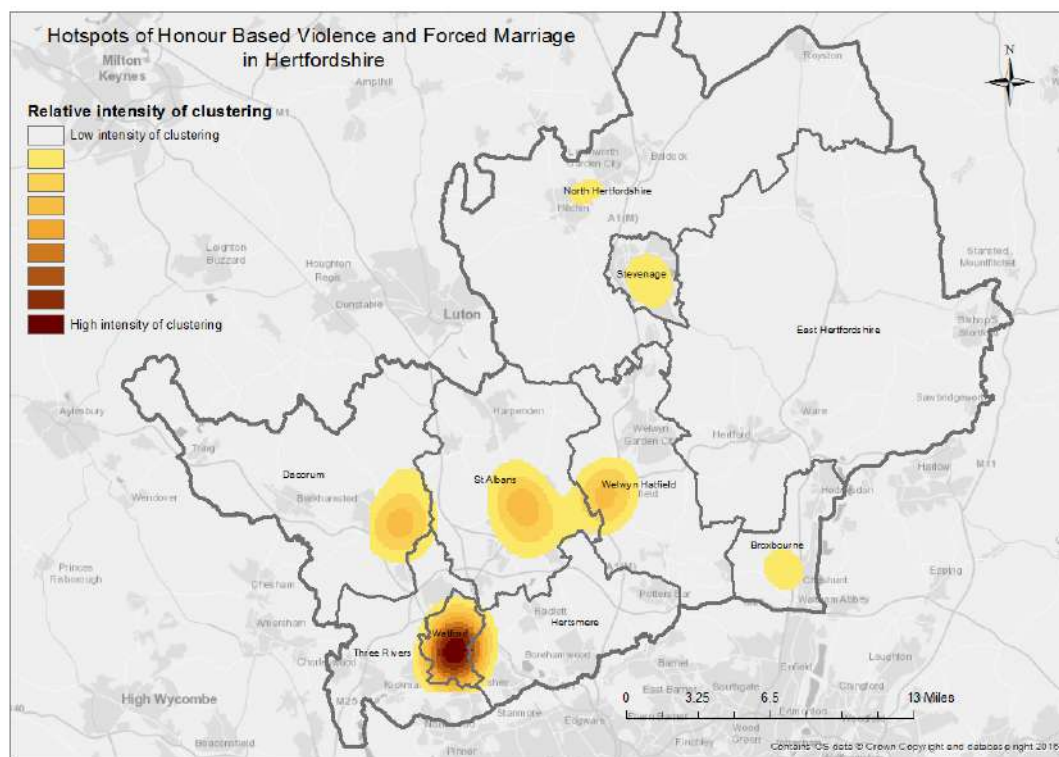
Thirty-two per cent of victims were described as Asian or British Pakistani, followed by 21 per cent Asian or British Bangladeshi, 14 per cent other Asian and 11 per cent Asian or British Indian. Ten per cent were described as White British.

Figure 3: Police recorded ethnicity of HBV victim (note only available for crime – not incidents), Hertfordshire Police, 2017 N=138



Using ArcGIS mapping tools, it is possible to identify honour crime ‘hotspots’ within Hertfordshire (see Figure 4). Overall 270 incidents or crimes were recorded as HBV or FM. Of these, 248 were recorded as HBV, 10 as FM, 11 as both HBV and FM and one as unknown. The highest intensity of clustering was found in Watford with six smaller hotspots in Hemel Hempstead, St Albans, Hatfield, Stevenage, Cheshunt and Hitchin. These hotspot maps should, however, be treated with some caution given the low numbers involved and the unevenness in the recording of ethnicity across the agencies involved. Nevertheless, they should be used as a key resource in the location and development of any future specialist services in this field.

Figure 4: Hotspots of HBV and FM in Hertfordshire (crimes and incidents combined); Hertfordshire Police, 2017. N= 270



1.3 Forced Marriage

A forced marriage is one that is carried out without the consent of both parties. It is distinct from an arranged marriage to which both parties consent. The 'force' may take different forms in different cases and may be physical, emotional or financial.

The Forced Marriage (Civil Protection) Act 2007 (FMCPA) enabled British courts to issue new Forced Marriage Protection Orders (FMPO) against those who attempted or conspired to force someone into marriage. FMPOs are a form of injunction made by a court to prohibit persons from performing particular acts that might lead to a named individual being forced into marriage.

Where the police obtain an FMPO, arrangements are usually made for the victim to remain in contact with the police and vice versa. The local authority and relevant education authorities are also alerted, and often remain closely involved. Since being named a relevant third party under the FMCPA, local authorities have been vigilant in working to identify, and take immediate action in, cases of FM by using the FMCPA, in conjunction with care proceedings, to obtain the appropriate orders to protect victims and those at risk. However, it is important to recognize that the majority of victims wish to return home once an FMPO, and any protective orders made under the Children Act 1989, has taken effect. Suggesting that victims should always be removed from their family home ignores both victims' wishes and also the difficulties of being removed from one's normal environment.

In a further contentious development, FM became a specific offence in England and Wales in June 2014 under the Anti-Social Behaviour, Crime and Policing Act. Prior to the introduction of this new offence, prosecutors would have dealt with these cases using existing legislation, such as false imprisonment, kidnapping and offences of violence.

Forcing someone to marry now carries a maximum penalty of 7 years' imprisonment in Britain, while breaching the terms of a civil-law Forced Marriage Protection Order (FMPO)

has become a criminal offence carrying a maximum penalty of 5 years in prison.² Since the criminalisation of FM in the UK, however, only one individual has been convicted. In June 2015, a 34-year-old man was jailed for forcing a 25-year-old woman to marry him under duress. The Merthyr Crown Court in Wales heard that the Muslim man³, who was already married, repeatedly raped his victim over a period of months, threatened to publish footage of her having a shower and told her that her parents would be killed unless she agreed to become his wife. The defendant was put on the sex offenders' register and sentenced to 16 years in custody, to be released under an extended licence for another five years thereafter. This important case raises questions about whether these offences, including rape, voyeurism and bigamy⁴ alongside FM, could have and should have been prosecuted under the existing criminal law.

There are also a number of civil orders that can be made to protect those threatened with, or already in, an FM. For instance, victims can seek (i) a protection order (e.g. to protect them from harassment), (ii) a non-molestation order, or (iii) an order concerning their right to occupy the matrimonial home.⁵ When the victim is a child, an application for a care or supervision order can be made under the Children Act 1989. Wardship proceedings may also be granted by the High Court. However, the Home Affairs Select Committee has recently raised concerns that the legal framework provided by the Child Protection Act and the guidance provided by the Forced Marriage Unit (FMU)⁶ are not being followed consistently by schools or local authorities to identify at risk children⁷.

The UN Resolution on Child, Early and Forced Marriage was adopted in November 2014 with the broad-based, cross-regional co-sponsorship of 116 countries. The resolution

² See: Honour Based Violence and Forced Marriage http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/ [accessed 15 April 2017].

³ Muslim prosecuted under new forced marriage law after repeatedly threatening and raping victim if she did not wed him <https://themuslimissue.wordpress.com/2015/06/10/uk-muslim-prosecuted-under-new-forced-marriage-law-after-repeatedly-threatening-and-raping-victim-if-she-did-not-wed-him/> [accessed 15 April 2017].

⁴ UK Legislation on bigamy: <http://www.legislation.gov.uk/ukpga/Vict/24-25/100/crossheading/bigamy> [accessed 15 April 2017].

⁵ Parliament (1996) Family Law Act 1996, section 30, available at: <http://www.legislation.gov.uk/ukpga/1996/27/part/IV/crossheading/rights-to-occupy-matrimonial-home>.

⁶ Forced Marriage Unit, available at: <https://www.gov.uk/forced-marriage#forced-marriage-unit>.

⁷ Parliament (2013) Home Affairs Committee Report on Forced Marriage, available at: <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/news/110517-forced-marriage-report/>.

recognises that child, early and forced marriage severely impairs girls and women's human rights and is a threat to their health, education, economic and social status.

In the UK, FM is a problem that primarily affects women and girls originating from South Asia⁸ although it also impacts on those originating from Iran, Iraq, Afghanistan, Turkey and Somalia, as well as Irish traveller communities. Reliable figures are difficult to obtain, in part because of difficulty in distinguishing between coercion⁹ and consent. As with all other forms of violence against women and girls, the extent of FM is also hidden due to underreporting.

The UK government's task force on forced marriage recently stated that "[d]espite there being a number of mechanisms available to monitor this appalling practice, including help lines set up by NGOs within the UK, little is really known about how prevalent forced marriage is within the UK."¹⁰ It added that in 2012, the Forced Marriage Unit (FMU) "provided advice or support in almost 1500 cases" but was aware that "many more cases are not reported as a large majority of victims are too intimidated to ask for further assistance."¹¹

FMU statistics nevertheless provide useful information about the 1,428 cases of FM in 2016 involving British nationals, and those with dual nationality, both inside the UK and overseas. The data show that victims ranged from young children to post-retirement age adults, with 15 per cent of cases involving those under 16 years of age¹². The largest percentage of cases (35 per cent) concerned 18-25-year-olds. FMU data shows that within the UK, London was, as predicted, the region with the highest number of FM cases (307 in total). Although the report

⁸Foreign and Commonwealth Office (2013) Forced Marriage, available at: <https://www.gov.uk/forced-marriage>.

⁹ Home Office (2013) Circular: new government domestic violence and abuse definition, available at: <https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition>. The new definition of domestic violence and abuse now covers "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality." The definition goes on to clarify: "This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional. Controlling behaviour includes a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour constitutes an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." See Crown Prosecution Service (2013) Domestic Violence (including Aide-memoire). Legal Guidance, available at: http://www.cps.gov.uk/legal/d_to_g/domestic_violence_aide-memoire/

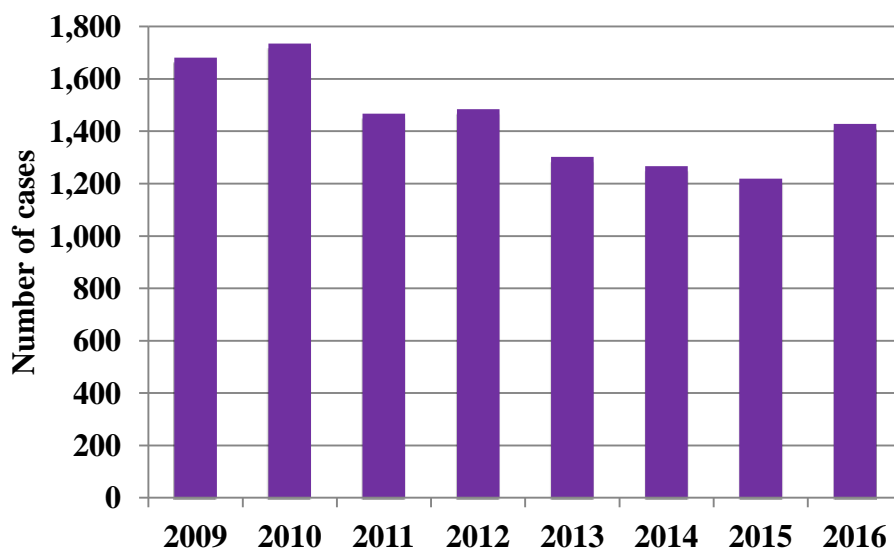
¹⁰ Information received by author 1 in an email communication, August 2013.

¹¹ Information received by author 1 in an email communication, August 2013.

¹² Forced Marriage Unit (2016), Forced Marriage Unit Statistics, <https://www.gov.uk/government/statistics/forced-marriage-unit-statistics-2016>

specifies that FM is “not a problem specific to one country or culture” as it covers cases relating to over 90 countries, it does list ‘focus’ countries with the highest rates of forced marriages. Pakistan had by far the highest incidence of FM, topping the list with 612 cases (43 per cent). Bangladesh came second with 121 cases, representing 8 per cent of all recorded UK forced marriages, followed by India with 79 cases (6 per cent). Somalia and Afghanistan both accounted for 3 per cent of the UK’s forced marriages in 2016, while Saudi Arabia accounted for 1 per cent. It is notable that 11 per cent of forced marriages (157 cases) occurred within the UK itself and involved no overseas element. Of the 1,428 cases of FM the FMU dealt during 2016, 80 per cent involved female victims and 20 per cent involved male victims, proving that forced marriage is not solely a women’s issue. In 2016, 279 applications for Forced Marriage Protection Orders were submitted and 229 orders were made.¹³

Figure 5: Number of cases reported to the FMU between 2009-2016 FMU, 2016



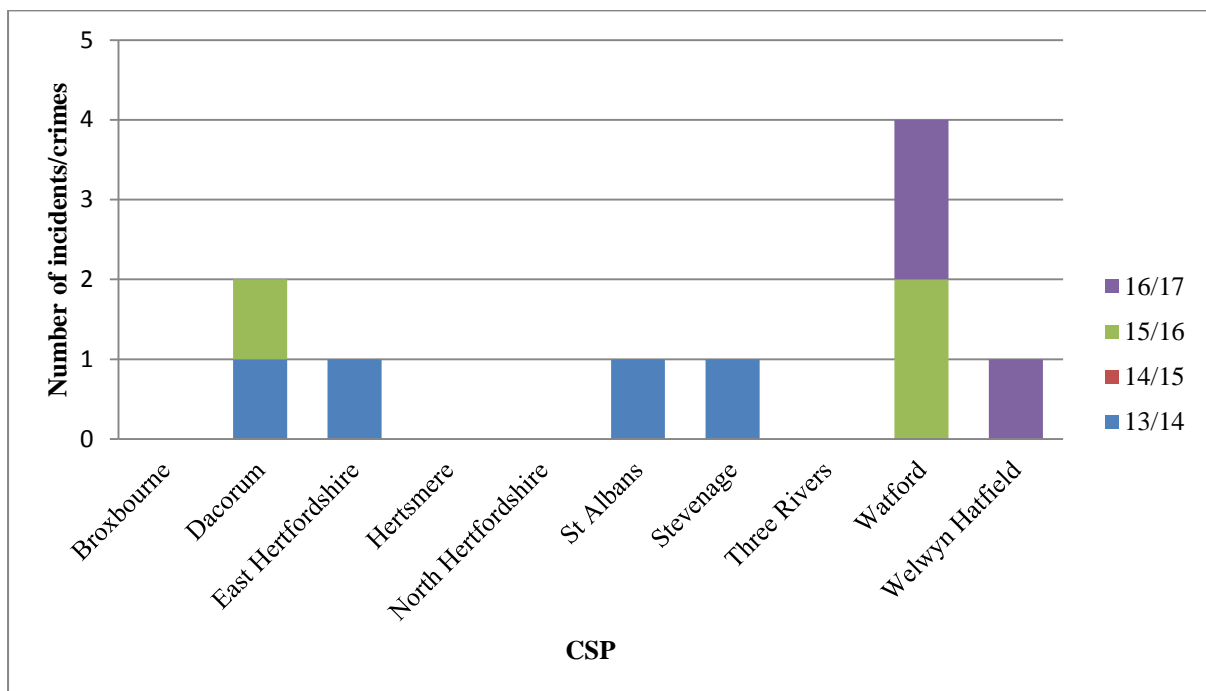
In 2016, as noted above, 157 (11 per cent) of the cases handled by the FMU had no overseas element, with the forced marriage activity taking place entirely within the UK. Five per cent

¹³ Source: <https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2016>

of cases where the FMU gave advice or support were from the Eastern Region. Forty-six per cent of victims were 21 years-old or younger, with 15 per cent being younger than 15 years of age.

Hertfordshire police have recorded just 10 instances of FM (incidents and crimes) since 2014 (see **Figure 6**).

Figure 6: Police recorded incidents/crimes of FM by year (note 16/17 only up to 14/02/17), Hertfordshire Police 2017 N=10



1.4 Female Genital Mutilation

The term ‘female genital mutilation’ (FGM), also referred to as ‘female genital cutting’ (FGC), ‘female circumcision’ (FC), and ‘female genital mutilation/cutting’ (FGM/C), concerns all procedures involving partial or total removal of the external female genitalia or other damage to the female genital organs for non-medical reasons. It is practised by Muslims, Christians, and Jews and is not restricted to any particular ethnic or religious sect. Although often associated with Islam, FGM is not practised in a large number of Islamic countries, including Morocco, Algeria, Afghanistan and Saudi Arabia and so it should be considered a cultural practice and not as a fundamentally or inherently religious one (Banks et al., 2006).

Beliefs associated with the practice of FGM usually centre on traditions concerning the rite of passage into womanhood (Gallo, 1985). In some cultures, FGM is seen to ensure social acceptance and marriageability through preserving a woman’s virginity and thereby protecting her family’s honour (Gill, 2014). As a result, FGM largely defines a woman’s future as a wife and mother. Accordingly, it is performed so that women can conform to longstanding social and cultural norms. Not circumcising a daughter is equivalent to condemning her to a life of isolation as it shames her and her entire family. Here it is also useful to understand why women, particularly older women in practising communities, tend to be the most vocal supporters of FGM – particularly where the honour of families is intrinsically linked to the sexual purity of their female members and the in-marrying of women under its protection (Gill, 2014).

In these communities, proof of virginity is regarded as a prerequisite of marriage and infibulation is taken as an index to both physical and social virginity. This fact is evidenced, for instance, by the practice of reinfibulating women after childbirth or upon later marriages in some parts of Somalia (Moxey and Jones, 2016). If not properly channelled, female sexuality is considered to be the greatest possible source of shame to the elders in the family – especially those who are female. For this reason, women infibulate their daughters to protect them from their supposedly inherent sexual desires which they believe, if left uncontrolled, could lead to rape, social disgrace, illegitimate children and even retributive

death. In such a context, this practice, carried out by women on women, can be interpreted as a pragmatic response to the pressures of conforming to particular gender-related social norms and as a conformity which is necessary for surviving everyday life as a woman in these communities and maintaining one's social status in its kinship hierarchy.

Eighty-five per cent of global cases of FGM fall under Type I/II, which entails partial or total removal of the clitoris, prepuce, labia minora and/or labia majora. Fifteen per cent fall under Type III/infibulation, which involves narrowing the vaginal orifice with a covering created by the cutting and apposition of the labia minora and/or the labia majora, with or without excision of the clitoris (Gallo, 1985; UNICEF, 2005; WHO, 2008) Type IV/unclassified involves all other harmful procedures performed on female genitalia for non-medical purposes (e.g. pricking, piercing, incising, scraping, and/or cauterisation) (Abdulcadir, Rodriguez and Say, 2014). FGM/C is associated with a variety of health risks, including severe pain, bleeding, shock, infection, and difficulty in passing urine and faeces. There are also associated birth risks, such as delivering the baby through a caesarean section, blood loss, and increased perinatal mortality. Women who have been subjected to FGM/C are more likely to experience pain during sexual intercourse, reduction in sexual satisfaction and reduction in sexual desire compared with women who have not been subjected to FGM/C (UNICEF, 2013).

There has been a considerable decline in the prevalence of FGM over the last 25 years due to worldwide educational campaigns and the fact that FGM has increasingly been the subject of legislative developments at domestic and international levels (Macfarlane and Dorkenoo, 2014). Nevertheless, approximately 200 million women and girls worldwide have undergone some form of FGM (World Bank, 2015). In Africa alone, the figure is in the region of 91.5 million with 3 million girls at risk each year (World Bank, 2011). FGM has been documented in 28 countries in sub-Saharan Africa, as well as in a number of countries in Southeast Asia and the Middle East (UNICEF, 2005; 2013).

1.4.1 Measures to Combat FGM in the UK

The Female Genital Mutilation Act 2003 makes it an offence for anyone to perform or assist in carrying out FGM in the UK, assist or coerce a girl to carry out FGM on herself, or take someone out of the country to subject them to FGM. It is also an offence for UK

nationals/permanent UK residents to perform FGM on any person overseas, even in countries where it is not a criminal offence. As of October 2015, a professional must report to the police if a girl under 18 has disclosed she is a victim or is suspected of being a victim of FGM.¹⁴

An FGM Protection Order is a civil measure which offers the means of protecting victims or potential victims from FGM under the civil law. Applications for an FGMPO can be made to specialist courts (Hertfordshire uses Luton County Court) by the potential victim, a representative of a local authority (known as a Relevant Third Party – RTP), or any other person with the permission of the court (for example, the police, a voluntary sector support service, a healthcare professional, a teacher, a friend or family member). The court may also make an order without an application. For example, if it is prosecuting an FGM case, it may place an order to protect other family members such as siblings. The FGMPO may impose prohibitions, requirements and restrictions in order to protect an individual. Terms may include ordering that a person surrenders his or her passport or any other travel documents (including that of the potential victim), or ordering that family members or other named individuals should not aid, abet, counsel, procure, encourage or assist another person to attempt to commit, commit or conspire to commit an FGM offence. Breach of a FGMPO is a criminal offence under the 2003 Act. As an alternative to prosecution, breach of an FGMPO may also be dealt with by the civil route as contempt of court with a maximum penalty of up to 2 years' imprisonment. Due to the nature of FGM, special courts have been designated to deal with FGMPOs and anyone who breaches a FGMPO faces a heavy penalty. Following their introduction on 17 July 2015, 121 applications and 94 orders for FGMPOs were made between July 2015 and December 2016.¹⁵

Despite the strengthening of legislation, and despite difficulties in determining the number of cases involving FGM, it is possible to say that there have been no convictions for FGM in the UK to date. This is a situation that criminal justice agencies are working hard to address at both national and local level. It should, however, be noted here that in February 2015 the UK's first prosecution of a medical professional for undertaking a female genital mutilation

¹⁴ Source: http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/

¹⁵ Source: <https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2016>

(FGM) procedure collapsed amid accusations against the Crown Prosecution Service of staging a “show trial” in response to political pressure (Jefferson, 2015).

FGM is arguably primarily a child protection issue. In January 2015 in *B & G (Children) No 2* [2015] EWFC 3, the President of the Family Division provided guidance for future cases where, in the context of care proceedings, a child may have suffered from FGM. This recent case makes the point that a child who has suffered from FGM could be considered to have reached the care proceedings threshold. However, that possibility is not a given, and each case should be considered on its facts, since section 31 of the Children Act 1989 states that when seeking a care or supervision order a local authority must be able to show that the “threshold criteria have been met: that the child must be suffering, or likely to suffer, significant harm. And that the harm or likelihood of harm must be attributable to one of the following: the care given to the child, or likely to be given if the order were not made, not being what it would be reasonable to expect a parent to give; or the child being beyond parental control” (Sloan, 2015).

1.4.2 FGM Prevalence in the UK

Article 11 of the Istanbul Convention highlights the need for parties to the Convention to collect reliable data on a regular basis to measure the prevalence of all forms of violence against women and girls. Collecting evidence on the extent and nature of FGM can assist policy makers and NGOs in their efforts to address the practice. In the UK, female genital mutilation is seen in some ethnic groups that have migrated to this country. The majority are refugees, with the main groups coming from Egypt, Eritrea, Ethiopia, the Gambia, Iraq, Kenya, Kurdistan, Liberia, Mali, Nigeria, Northern Sudan, Sierra Leone and Somalia (UNICEF, 2013). Precise figures for the number of girls and women who have undergone, or who are at risk of, genital mutilation in the UK are, however, hard to establish due to the secrecy surrounding the practice. It is, therefore, hoped that better data will become available as a result of this agreement being enacted by the UK government.

In 2011, the number of women in England and Wales born in countries where FGM is regularly practised and who are estimated to have been or to be at risk of being subjected to the practice was 103,000 for the 15-49 age group and 24,000 for the over 50 age group, while a further 10,000 girls in the 0-14 age group had undergone the practice or were at risk,

meaning that in 2011 up to 127,000 women who had undergone FGM and 10,000 girls below the age of 14 who had undergone or were at risk of FGM were permanent residents in England and Wales, compared to an estimated 66,000 in 2001 (MacFarlane and Dorkenoo, 2015).

An earlier Department of Health funded study found that in England and Wales:

- In 2001, 65,790 women had undergone genital mutilation, with the highest numbers being in women from Kenya and Somalia. The study noted that “their numbers are likely to have increased since then.”
- In 2004, there were 9,032 pregnant women, and women who had just had a baby, with genital mutilation.
- In 2005, over 21,000 girls under the age of 15, in England and Wales, were at high risk of genital mutilation.

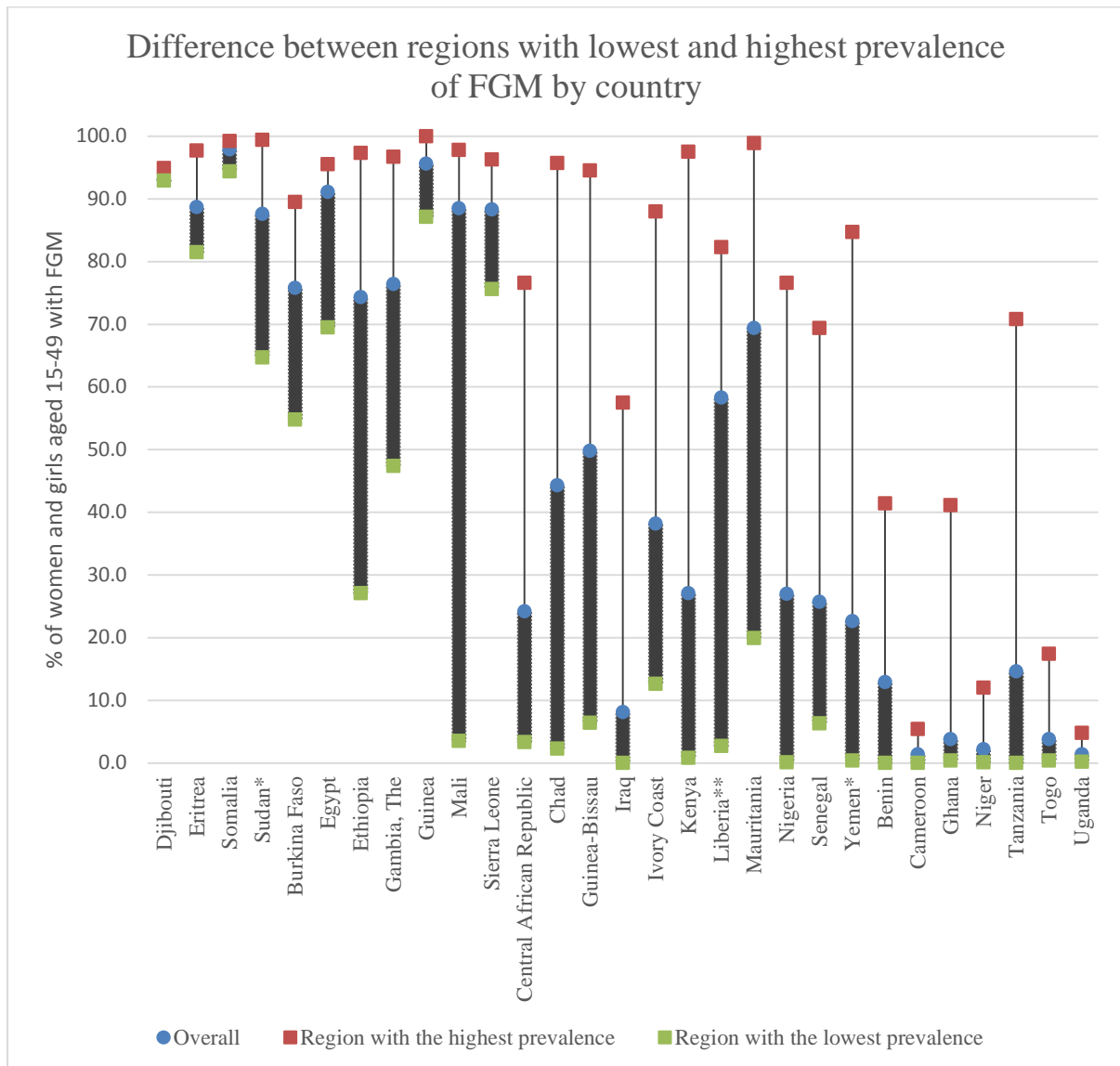
However, government guidance notes that “it is possible that, due to population growth and immigration from practising countries...FGM is significantly more prevalent than these figures suggest” (Ministry of Justice, 2015).

In April 2015, Her Majesty’s Inspectorate of Constabulary was instructed by the Home Secretary to review, for the first time, the police response to honour based violence. The report entitled “Depths of Dishonour, Hidden Voices and Shameful Crime” was based on HMIC inspections and research. In addition, it drew on a study in which researchers from the University of Roehampton and the University of Bristol’s Centre for Gender and Violence Research interviewed victims and survivors of honour based violence, forced marriage and female genital mutilation in order to uncover how they felt about their dealings with police officers (Hester, Gangoli, Gill and Mulvihill, 2015). The study included 50 interviewees. Around a third (n=14) of the sample had experienced FGM, all as children and all in their (or their parents’) country of origin. None of those who had experienced FGM had reported it to the police in the UK or elsewhere. Those participants who had experience of FGM had mixed feelings about reporting new cases that they were aware of to the police. Some feared retribution from the wider community, and some were concerned that reporting would represent interference in private family life. All the participants in that study who had

experienced FGM agreed that FGM is a cultural practice and not a religious requirement and they claimed that they rejected FGM for their own daughters (Hester, Gangoli, Gill and Mulvihill, 2015).

Macfarlane and Dorkenoo's (2015) report suggests that the overall number of women aged 15-49 who were permanently resident in England and Wales, but born in FGM-practising countries, increased from 182,000 in 2001 to 283,000 in 2011. The report estimates that in 2011 there were 137,000 women and girls across all age ranges (with 103,000 in the 15-49 range) with FGM – of those born in countries where it is practised – permanently resident in England and Wales. The estimated rates per 1,000 population varied considerably by region (ranging from 21.0 per 1,000 in London to below 1 per 1,000 in some rural areas). The report estimates that, in 2011, approximately 60,000 girls aged 0-14 resident in England and Wales were born in England and Wales to mothers with FGM.

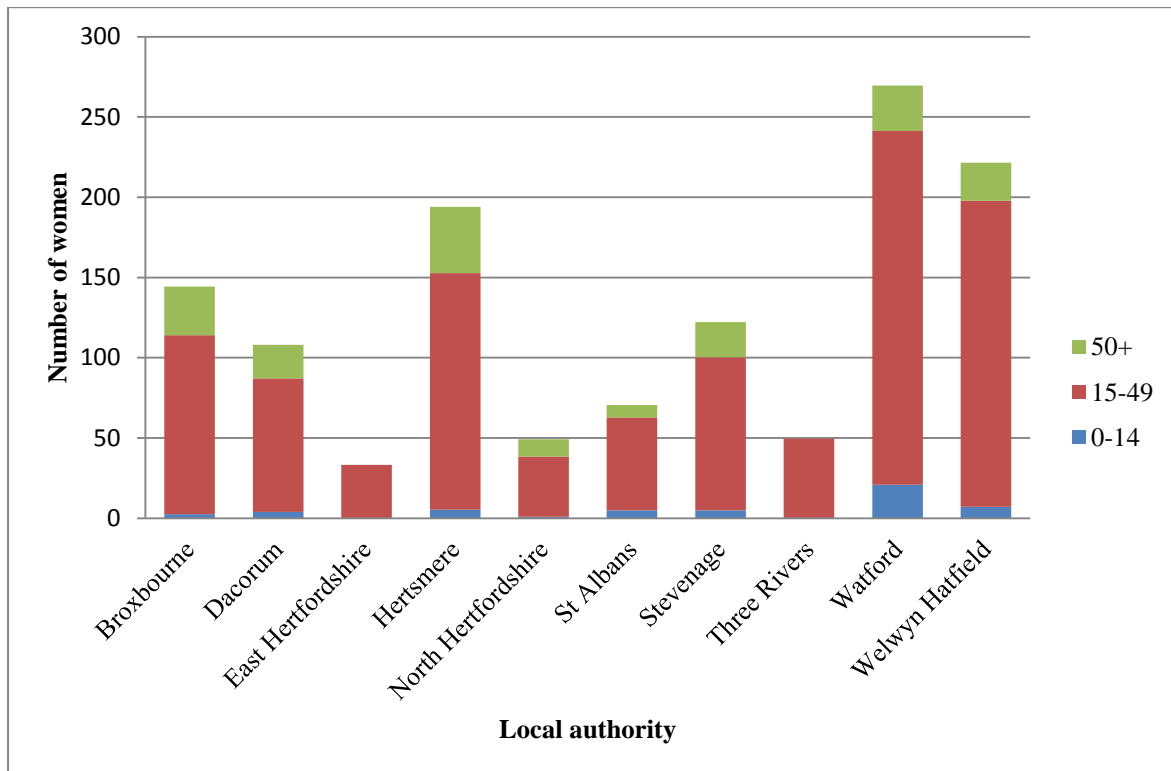
Figure 7: Difference between regions with lowest and highest prevalence of FGM by country; Macfarlane and Dorkenoo (2015).



1.4.3 Estimating FGM in Hertfordshire

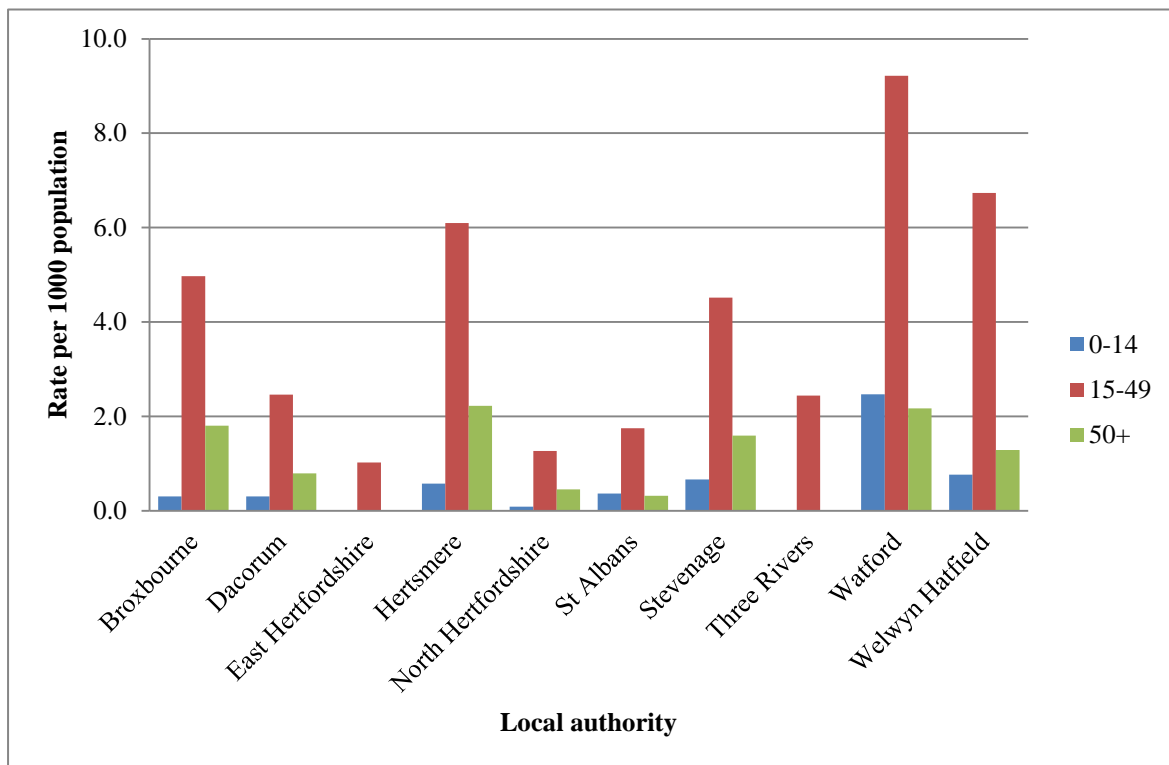
There are 12,000 women living in Hertfordshire who come from countries with high FGM rates. The 2013/14 data indicates that around 400 women from these countries give birth in a year in Hertfordshire, and so about 200 girls are born. By law, NHS services are required to report all cases of FGM.

Figure 8: Estimated number of women with FGM in Hertfordshire by age; Macfarlane and Dorkenoo, 2015



Macfarlane and Dorkenoo (2015) examined the prevalence of FGM in England and Wales and produced local authority level estimates. These estimates were calculated by combining prevalence data with census and birth registration data. According to these estimates, Hertfordshire experiences lower than the national average (3.8 vs 4.8 per 1,000) FGM but its prevalence there is almost twice the regional average (1.6 per 1000). The report estimated that there are 1,295 women in Hertfordshire with FGM (Macfarlane and Dorkenoo, 2015) with, as Figure 8 shows, the majority of those estimated victims, across all local authorities, being thought to be aged between 15 and 49. At a district level, Watford (5.9), Welwyn Hatfield (3.9) and Hertsmere (3.8) are at the top end of the range, while East Herts (0.6), St Albans (1.0) and Dacorum (1.5) are at the lower end (Macfarlane and Dorkenoo (2015).

Figure 9: Estimated prevalence per 1000 population; Macfarlane and Dorkenoo, 2015



Since 2011 there have been 22 cases in Hertfordshire where FGM has been suspected or flagged up. Further analysis found that two were definitely not FGM (one male circumcision and one consensual clitoris piercing); the majority of cases, therefore, saw no role for the police and many did not identify a risk of FGM. Only one case resulted in an interim FGM Protection Order. The police report that a small number of cases are likely to have been referred to Children’s Services. Where the ethnicity was recorded, four of the cases involved Egyptians, three involved Nigerians, two involved Ghanaians, two involved Sri Lankans, with one case involving families from Sierra Leone, Afghanistan and Eretria respectively.

1.4.4 Hertfordshire Health Data on FGM

The collection of data on the incidence of FGM has been mandatory in health since September 2014 (although we could only find it disaggregated to the upper tier local authority level from April 2015 onwards). Although data is available for the period April to June 2016, no referrals were recorded in Hertfordshire.

From April 2015 – March 2016, however, there were 35 health referrals for FGM in Hertfordshire. Five of these referrals were from GPs, 10 from midwives and 10 from obstetrics; the source of the other 10 referrals was not recorded. Ten were Type 1 FGM, 5 were Type 11, and 15 were listed as type unknown. Twenty-five of the women were pregnant and 5 of them were recorded as having daughters. Five women were aged 25-29; 10 were 30-34 and 10 were 35-39 (NHS, 2015)^{16 17}.

There are a lot of missing fields in the health data. For instance, the country of origin was recorded for only five women (all from West Africa) and no data has been collected on the age the women were when the FGM was carried out, or on the number of daughters that they have.

¹⁶ FGM is classified into types by the WHO: Type 1-Clitoridectomy: partial or total removal of the clitoris and in very rare cases, only the prepuce. Further details at <http://www.who.int/reproductivehealth/topics/fgm/overview/en/>

¹⁷HSCIC (2016) Female Genital Mutilation (FGM) - April 2015 to March 2016, Experimental Statistics <http://www.hscic.gov.uk/article/7180/First-ever-annual-statistical-publication-for-FGM-shows-5700-newly-recorded-cases-during-2015-16> accessed 28 April 2017

2. Research Methodology

2.1. Research methods summary

- National-level literature review
- Hertfordshire ethnicity, crime and service mapping using ArcGIS
 - Ethnicity data from the 2011 census was mapped using ArcGIS software at census Lower Super Output Area level (approx. 1,500 residents).
 - Hotspot surfaces of HBV and FM were created using Kernel Density estimation within ArcGIS.
 - Ordnance Survey Points of Interest (POI) data was mapped for selected health and education service categories.
- Interviews with 24 respondents (10 victims of HBV/A and/or FM; 14 Hertfordshire-based practitioners working across HBV/A, FM and FGM)

Headline findings from our literature review and our ArcGIS crime mapping of HBV/A and FM in Hertfordshire have been presented in earlier sections of this report. In this section, we outline the compilation and characteristics of our interview sample.

2.2 Interview sample

Between 1 February and 31 March 2017 the research team interviewed 10 women victims/survivors of HBA/V and/or FM. Those located across Hertfordshire took part in face-to-face semi-structured interviews and those located elsewhere were interviewed by phone. The victims were aged between 18 and 50 and of British Pakistani, British Bangladeshi and broader South Asian heritage. The HBV/A they had experienced included domestic abuse (physical, sexual, emotional and financial) and coercive control. While HBV/A shares features in common with broader forms of domestic abuse and VAWG, it also clearly

distinguishable from them in being a form of violence that draws directly on the rhetoric of ‘honour’ and ‘shame’ within the family and wider community.

Despite repeated attempts to do so, we were unable to recruit FGM victims. However, we did interview a number of health professionals who had worked with such victims and they made useful recommendations.

Victims of HBV/A can be ‘difficult to reach’ for a number of reasons.¹⁸ Working in collaboration with Hertfordshire police and other stakeholders afforded the research team both access to participants and an assurance that these women were being supported during and after the interview. We contacted local NGOs and were able to organise participant interviews through three of these organisations¹⁹. We also identified a small number of (supported) participants through recommendation. This approach to building (or adding to) a sample of research participants is known as ‘snowball sampling’ and it is commonly used where potential participants are “hard to reach”.

Potential participants were initially contacted by these stakeholders and provided with information about the aims and objectives of the project and an outline of the interview question schedule. Those who agreed to participate then signed a consent form. This included their right to withdraw from the research within seven days; none, however, withdrew. The research project was granted ethical approval by the University of Roehampton Ethics Committee.

As the research team had significant language capacity, including Urdu, Punjabi and Hindi, the participants were interviewed in their preferred language. Project information and consent documents were translated, where necessary, before the interview. All interviewees were compensated for their participation, with each receiving a £20 gift card at the end of each session. All interviews were audio recorded, transcribed and anonymised and the data was coded under relevant thematic headings. Please note that the responses quoted are from spoken speech and so are not always grammatically correct. We offer our sincere thanks to all those who shared their experiences with us.

¹⁹ These include Herts Sunflower Project, The Hertfordshire Domestic Violence/Abuse Helpline and Aanchal for Asian women.

The research team also interviewed 14 Hertfordshire-based practitioners working with victims of HBV/A and FGM (see Table 2) drawn from the police, health, education and partnership agencies.

The interview questions used with each group of participants explored the following themes: awareness and understanding, in terms of initial contact with the police and other agencies; initial and longer-term response of those agencies; victims' awareness of their rights; experiences of engagement and enforcement; and, barriers to engagement. The findings presented in this report draw on our interviewees' responses to these questions and themes.

Table 1**Project sample: 10 female victims with experiences of HBV/A and/or FM**

Participant number	Interview code	Profile	HBV/A	FM	FGM
1	'Rozina'	age 26, British Bangladeshi, mother of 2	x	x	
2	'Shazia'	age 47, British Pakistani, mother of 3	x	x	
3	'Naheed'	age 50, British Pakistani, mother of 1	x		
4	'Laleh'	age 32, British South Asian, mother of 2	x		
5	'Malika'	age 23, British South Asian	x	x	
6	'Zara'	age 18, British Pakistani		x	
7	'Tabassum'	age 34, British Pakistani, mother of 1	x		
8	'Zareen'	age 22, British Pakistani	x		
9	'Aliya'	age late 30s, British Indian, mother of 2	x		
10	'Fatima'	age 40, Pakistani, mother of 2	x		

Table 2**Project sample: 14 practitioners with professional experience of cases HBV/A, FM and/or FGM cases**

Participant number	Interview code	Profile	HBV/A	FM	FGM
11	152	Police officer	x	x	x
12-17	155	Police officers (group of 6)	x	x	x
18	156	Child protection officer	x	x	x
19	157	Domestic Abuse Partnerships Manager	x	x	x
20	158	Designated safeguarding nurse	x	x	x
21	159	Vulnerable Young People lead	x	x	x
22	160	GP			x
23	161	SENCO, Designated Safeguarding Teacher		x	x
24	168	Midwife			x

3. Findings

All 10 victims reported some level of engagement with one or more statutory or non-statutory agency. Younger respondents were more likely to have engaged with an agency earlier in their experience; this finding is likely to be reflective of the higher profile that these cases now enjoy. In most cases, the victims' engagement involved agencies across two or more counties and, in many cases, that engagement was ongoing, a feature which is indicative of the long-term and complex nature of interventions around HBV/A.

3.1 Hertfordshire victims' experiences of current services

3.1.1 Initial contact with services

Family and friends had encouraged and helped some of the participants to contact the police. Others said that their decision to report was prompted by work colleagues, teachers or NGOs. Tipping points varied. Some younger respondents had decided to report to prevent attempts by their families to force them into an arranged marriage or in response to attempts to restrict their freedom, for example, by preventing them from pursuing further education. Despite having suffered HBV/A for many years, older respondents were more typically driven to report as a crisis measure taken to preserve their own life or safety or that of their children.

Case study: Participant 'Zara' attempted FM victim, aged 18

From the age of 14, Zara's parents had pressurised her to agree first to a future marriage to a man 10 years her senior and then to a younger second cousin²⁰ (the son of her grandmother's brother). Both men were resident in Pakistan at the time. At the age of 15, she disclosed her fears about what was happening, first to friends at school and then to a teacher who subsequently informed Hertfordshire police. After a period of time, the police contacted, and then visited, her parents. After the visit, her parents made her leave the family home, despite the fact that she was in the midst of her GCSE exams. She spent the first night away from home at the house of her boyfriend's family. Social services then arranged a local foster care placement and then sought to move her to a London refuge. She had a difficult relationship with her social workers after leaving home and felt that they did not believe her or put her needs above those of her family. She was very reluctant to move to the refuge; her foster care arrangement was subsequently extended and remains in place today.

In the extracts below 'Zara' describes how she first disclosed to friends and then to a teacher who then informed the police. At each stage, she describes her understandable reluctance to take each step:

Zara: It started off when I was in school and I was crying to one of my friends, and one of my teachers overheard, and so she called me into the office and asked me what was going on. I asked her to promise me that she wouldn't tell anyone, or say anything, because I was really scared, and then I told her, and two weeks afterwards – obviously, the Christmas holidays – they got a bit worried at that point, and then that's when they got the police involved.

Zara: Yeah, well, obviously, my teacher was concerned, so, obviously, she got the police involved, but when I saw the police there, because I didn't know what was happening, then I was, like, why have you called the police. What's going on? I didn't want all of this to happen, it's just going to go right out of hand; but she said to me, we're only just doing what's best for you. Then I think when I came back, and then

that's when I sort of seen [Herts police], and I think I was seeing them quite regularly. Every few weeks. They were speaking about it, and then [they] said to me, we need to speak to your parents about it. I was just like, 'No, it's not going to happen. I'll sort it.' I just didn't want things to get worse but no, but in the end, we had to go and tell my parents. It was a bit scary but I think, yeah, they listened, my parents.

A crucial learning point from her account is that she felt that her teacher, the police and her foster carers put her needs first and listened to her at crucial junctures. Notably, however, she felt that her social workers did not do so.

Case study: Participant 'Zareen', HBV/A victim, aged 22

This young woman left her family home after suffering sustained violence from her older brother which went unchallenged by her parents who also placed unreasonable restrictions on her freedoms. Her parents sought to block her staying on at college and applying for higher education. At the age of 19, she opted not to return home after leaving her boarding sixth form college in the Midlands. She contacted the police herself just hours before leaving the college to let them know that they should not regard her as 'missing', even if her parents reported her as such. It is not clear what support, if any, was offered by her college.

She then went to live for a period with a friend in Hemel Hempstead. As she was 19, Hertfordshire police took no further action and she did not request further action on their part, although she was in touch with them during this time. In the course of securing a university place, correspondence was (in error) sent to her at her parents' home address. Her parents thus discovered the university she was to attend. Her father then attempted to arrange to meet her there. Fearing that he would intercept her and make her return home, she contacted the police and followed their advice to take out a Harassment Order against her parents. She later dropped out of university (temporarily). She was again assisted by Hertfordshire social services to find housing in the county that met her visual impairment needs. It is not clear precisely why or how social services became involved at this stage given her age (over 19) but their involvement may have been linked to advocacy on the part of her university or to her visual impairment. She has now resumed her university studies.

Zareen describes the family barriers that prevented her from reporting her experiences of HBV/A at the hands of her brother which occurred prior to the events related above:

Zareen: I never had the courage to report it to the police, and anyone else. My parents downplayed it. I suppose they were never really...maybe once or twice I can remember them actually being present when he was being violent, but I think they always, sort of, said to me, you know you shouldn't have answered him back. You shouldn't be abusive. You shouldn't be so mouthy. You can't blame him if you're going to wind him up, type of thing.

Below she describes her initial contact with external agencies (most likely her teachers in the first instance and then the police) in terms of her fear of returning to the family home after leaving her boarding college and in terms of her desire to pursue her own aspirations:

Zareen: [W]hen I lived at home with my parents, it was very restrictive. I wasn't allowed to go out on my own, or couldn't really do anything outside of the house on my own....

Zareen: My dad didn't want me to continue with my education...He thought that the woman's place was at home, to get married and have children. To be a wife basically. I thought if I took another year at [sixth form] college they might come round, but then when they didn't, I made the decision to leave and put in an order²¹ to continue my education.

Other respondents described contacting the police in a moment of crisis,²² often after a lengthy period of HBV/A. Some explained that they found it very difficult to articulate to the police what had happened. They described their 'decision' to report less as an active decision than as an act of desperate self-defence. Some also explained their fear of pursuing the legal options open to them.

Case study: Participant Malika, at risk of FM, aged 23

At the age of 20, after repeated sexual assault and harassment by her brother-in-law and the prospect of an arranged marriage to his brother, this young woman contacted the police whilst at work. She reports that her parents had taken possession of her mobile phone and her passport around that time and that she feared that marriage plans were being made without her knowledge. The police arranged for her to stay in refuge accommodation and informed her of her right to take out a Forced Marriage Protection Order which she, however, opted not to do. The police continued to support her for a long period afterwards and she has since assisted them with awareness-raising campaigns.

Rather than disclosing to friends or family first, Malika chose to disclose to the police directly:

I live at home with my parents and I was going through a lot of trouble at home. I didn't know how to go about telling anybody else, including best friends, or a sister. After it got too much for me I contacted the police whilst I was at work, and I contacted them whilst I was at work because I felt that was the safest place I could contact them. That's where I was collected from, from work.

Case study: Participant Rozina FM and HBV/A victim, aged 26

This young woman left school at 16 and gained work as a traffic warden in Birmingham. She was sent to Bangladesh for an ‘arranged marriage’ at the age of 17 and soon after became pregnant. She was then sent back to the UK to give birth. Her family forced her to return to work when her baby was just six weeks old so that she could provide pay slips as evidence that she could support her husband’s migration application. Her husband then moved from Bangladesh to the UK. He was abusive towards her and she left the family home with her young son. She first moved to a women’s refuge in the Midlands and later re-located to Dorset and formed a new relationship with a white British man and had a second child with him. The couple then moved with the children to Devon on local MARAC advice after receiving death threats from her father and other family members. She is, however, obliged to maintain (in) direct communication with her ex-husband as he continues to seek contact with his son through the family court. Her case illustrates the complexity and long-term nature of these cases. Here, safeguarding and protection measures are still in place, nearly 10 years after the initial FM and over 5 years after she left her husband for the refuge.

Rozina describes her forced ‘arranged’ marriage and the violence that caused her to leave it:

I felt, like I know for a fact, that it was forced marriage. People might look at it as arranged. I felt it was forced because I physically had my passport taken away; I had no other choice and the only way I could come back to this country [UK] was if I got married.

She describes her contacts with the police and other authorities, recounting how she herself called the police after a year of abuse in the marriage and after a particularly violent incident. She describes the moment that she now feels changed her life:

Rozina: I took a year of it until I had the courage to pick up the phone and call the police. It was in my head but I never thought I’d do it. I’ve always read about things like this in magazines. I grew up reading girlie magazines and reading Agony Aunt columns and things; I never thought I’d be the person that something like that happens to and when it did happen to me it was so surreal. When I picked up and called 999 and I said, ‘Look I’ve never spoke about this before, please come and

help me, I think he's going to kill me'...[I]t's recorded and when he was breaking the door down I was fearing for my life and my son's. That's when push came to shove and literally that was the day for me.

The fact-finding judgement in this case showed that her husband inflicted domestic violence repeatedly throughout the marriage and that she was subjected to rape.

3.1.2. Immediate support

The interviews with these victims highlight the different factors that make for supportive – and unsupportive – responses on the part of the police and other agencies. Central to a supportive response for victims was the immediacy and consistency of that response as well as, crucially, being listened to and being believed. Some participants welcomed frequent follow-up calls, especially in the initial days and weeks after disclosure. Ending that follow-up support could make victims feel very exposed and vulnerable. Respondents also felt that it was important that they were informed of their rights and options; however, they also felt that it was important that their decision to pursue or not to pursue legal avenues was respected.

Some victims recalled feeling exceptionally vulnerable when they reported the abuse to the police. They explained how an extended period of enforced helplessness and dependency, where their freedom had been severely constrained by their partner and/or extended family, meant that they needed extra support and reassurance.

Malika elaborates on the importance of the daily phone calls she received from the police and the support organisation that was helping her and the harm caused when that support broke down:

Malika: The organisation that was helping me out, they were really, really good. They used to ring me up every single day. I remember in the beginning I used to always say, 'They're only calling me, so really, they can't help me'. They used to ring me every day, and I used to think, 'Why are they calling me?' I was with one specific lady who used to ring me every day, 'Hi, how are you, what are you doing today, what's your plans?' I used to think – nothing, I've got no money, I've got no family, I don't know anybody, I'm in a refuge. But...because of her, having phone calls every single day, I got through. When I was in my second refuge, the police officers around that area didn't even have a clue that I was there, or about my protection, or even the protection in general of other ladies I'd come across. It was

only when I got in touch with my original police officer to say, 'I don't feel protected'. I felt I had to go through him to get all the other support, otherwise I couldn't have got through it.

Zara too emphasises that the emotional support offered by her teacher and the police was crucial in helping her to overcome her fears of the consequences of disclosure. This support made her feel that the professionals concerned had her best interests at heart rather than being driven by 'procedure' alone.

Interviewer: What was your experience like? How did you feel about the police response in relation to your experience as a...being a victim and survivor of being forced into a marriage?

Zara: At first I was saying, 'Oh my God...why do you have to go to my parents' house. It's just going to get 10 times worse'. At that point I was, like, 'oh my God, I don't know what's going on', but I think it was, like, because they cared about me, and they just wanted what was best for me. Then even when I left, they were still staying in contact with me. Still met up with me and made sure I was okay, sending me messages asking if I was okay. I got a lot of support. A lot of support.

Some victims pursued formal orders against their abusers with the help of external agencies (for example, participants Rozina and Fatima). However, others said that, despite the support received, they felt unable to take things further. For example, neither of the young women in the sample who were advised of their right to take out a Forced Marriage Protection Order opted to do so. Participant Malika describes her case as follows:

Malika: I chose not to take it out, and it's only because I felt at the time there was just so much going on that I didn't want to take it out.

Participant Zara went into more detail:

Interviewer: Do you know if there was a Forced Marriage Protection Order taken out?

Zara: I refused to get one.

Interviewer: Okay, could I ask why? Is it okay to explore that with you?

Zara: Yeah, because I just didn't want my family to be taken, like, down to court. I just didn't want to make things worse than what they already were. Then once I left home, I got asked again if I wanted to, and I refused then because I knew I wasn't going to go back, so I thought, what's the point, if I'm not even going to go back and get a Forced Marriage Protection.

3.1.3 Longer-term support

Other victims, who acknowledged that they had received considerable and welcome support and who had engaged with formal processes (including MARAC procedures), still felt vulnerable. This vulnerability was particularly notable among those who were required to maintain (in) direct contact with their ex-partners through family court proceedings in order to establish contact with their children.

Participant Rozina had to move at least three times with her young son: first to a refuge, then to a new address in South West England and then to another address when the police advised her to move for her own safety following death threats from her family. Her new house in South West England was safeguarded by local police for several months under MARAC arrangements, including the installation of a panic box. However, this was removed once the level of threat facing her and her son was deemed to have lowered. Although she has found the support offered very reassuring, she still feels that her life, and potentially the lives of her new partner and children, are under threat:

Rozina: I had a PC that I was emailing to update her. I had someone, a domestic abuse officer, he was coming to visit me, so I had all the bases to help me and to give me that confidence. Also, security measures...I had my doors chained, locked and all sorts, so I felt safe enough...– but don't get me wrong, I still fear for mine, [and my family's life] because it's gone quiet and I think it's the quiet before the storm because they haven't got their revenge.

Her ex-husband has since initiated family court proceedings to gain access to his son – proceedings for which she claims he is receiving legal aid and for which she cannot claim legal aid. She feels very let down by the family court system and feels that the full implications of her decision to agree that her husband should have contact with her son were not explained to her. With no access to legal aid, she represented herself in court and she feels that that was a serious mistake. She feels that the Domestic Violence Perpetrator

Programme has had no impact on her ex-husband as he still seeks to control her through the family court proceedings and has confronted her and her new partner outside a child contact centre.

Interviewer: And you feel your life is at risk?

Rozina: Yeah, yeah genuinely, I genuinely do and it doesn't help he's done the DVPP programme and he's still in court walls intimidating me. And what scares me the most and what frightened me the most was, that if he's capable of doing that just outside court premises – [the] – contact centre. It's only a matter time – he will use [my son] to find me.

I didn't know there was an exit plan. I never knew of that because I was representing myself. I thought because I was a single mum I was legally aided but obviously when my circumstances changed when I got married, our incomes came together and I'm privately funded, so I'm privately funded for everything and the family are kindly helping me out, my new family. So I never knew until it was put into perspective that – [then I thought], 'Hang on a second, you do realise that when you start a contact centre they have an exit plan so eventually it will be no contact, though you will be contact centre supervised, unsupervised and then it will be 'off you go for the day' and I never knew that, so I blindly agreed to something that I didn't know in the long run...would have a massive impact on my life.

Her account highlights the need for family court and allied services to offer mothers in these situations much clearer longer-term advice.

3.1.4 Negative experiences with services

A number of victims reported negative experiences with services. Two accounts stand out here.

Case study: Participant Aliya HBV/A victim, aged in early 40s

For 20 years, this British Indian woman has lived – and continues to live – in an abusive relationship with her British Pakistani partner. They reside together with their two children, aged 19 and 9, in a housing association property. She has reported his abusive, coercive and controlling behaviour to the police and other agencies many times. This abuse includes extreme control of her everyday behaviour and close monitoring of her movements and use of her phone. Charges have been pressed against her partner at least twice. However, she has never felt able to attend court and these charges have, therefore, not been pursued. She reports that she has always been afraid to attend court because of her fear of being attacked by her partner's family and that relevant services, including Independent Domestic Violence Advisors, have been unable to accompany her. It would be useful to gain a view from the local IDVA team and the police on this situation. The housing association has investigated her case but, she says, cannot remove her partner from their property. She herself cannot move to a refuge because her son is now aged 19 and refuges will not admit adult men. Her view is that it is her partner who should be required to move out, not she and the children.

She feels that the police now routinely pass her frequently expressed concerns on to local children's service teams because the latter have a duty to safeguard her 9-year-old daughter. She feels she is no longer the focus of police concern and, although she acknowledges that this may be linked to her past unwillingness or inability to pursue charges against him, she also feels that she needs more support to do that. She also feels that the police are not aware of how to evidence controlling and coercive abuse as opposed to physical or sexual abuse. Her dealings with social workers have been largely negative, partly because she feels that they make her (and by implication, her past unwillingness or inability to pursue charges against her partner) the focus of their concerns, rather than him. Her account suggests that her needs as a victim of HBV/A, and those of her children as secondary victims of HBV/A, remain unmet.

Aliya describes her fear of going to court alone, without legal aid or representation:

Aliya: ...[In] court he's got a solicitor fighting it and I go to court and I've got nobody, because even when I was due to go to court last time I was meant to have the IDVA turn up with me, [and] they let me down; they said 'you've got

to go on your own'. I said, 'but I don't know anyone, what do I do? Do I go into court? How do I do it?' No. I phoned up the police, I said 'can someone come with me?' 'No, sorry, you've got to go on your own'.

Interviewer: Is that what they said, and there's no IDVA support either?

Aliya: No. No, and then I phoned the other IDVA, because the lady that was meant to come with me, she didn't come. I phoned up her other lady that works with her. I said, 'can I come?' She went 'no, you can't. No, I can't, I'm sorry, I'm busy'. I said to her 'what, do I have to go?' She went, 'yeah, you do, you've just got to go and deal with it'. That's what I got off her. And that's what I've had every time, every single time, and I don't call them and because I don't call them something is going to happen.

This account would benefit from external corroboration. However, it indicates the barriers that victims perceive in terms of their in/ability to exercise their full rights in these very difficult situations. This victim has been left feeling let down by Hertfordshire police:

Aliya: Hertfordshire police are the worst. Worst, worst. My friend has gone through exactly the same thing as what I've gone through in Buckinghamshire, and the police removed her partner straightaway; he's never been back since, and they've really acted on it. Brilliant. Came round. Fantastic. Hertfordshire, forget it.

Many studies show that women's risk of harm escalates after police involvement – especially where this does not offer a resolution. Aliya feels her vulnerability acutely:

Aliya: I just deal with it because nothing's done. They can't remove him so me and my children have to live with him because nothing's done.

Aliya: [The police] know him and they know, because they know the records that they've got for me; they've got 20 years' worth of records of reported domestic violence. Even when I lived on my own there were still reports of domestic violence because he used to turn up at my house. They've got 20 years' worth of records so they know what he's like, but every time he's allowed back in the house. They never will remove him straightaway. Last

time they removed him he was allowed back within a couple of hours, so, obviously, he came back and I got the abuse again. ‘You fucking bitch, you fucking called the police, you did this, you did that, der-der-der’ and they don’t understand. It doesn’t end there.

Our second example of very negative victim experiences is more mixed. The victim’s initial experience of police involvement was very poor, but later improved greatly, as she was referred, via her GP and via a DV helpline, to the Hertfordshire Sunflower team.

Case study: Participant Fatima HBV/A victim, aged 40

This woman grew up in Pakistan and married a Pakistani man 14 years her senior when she was 24. Their families own considerable assets in that country. They lived in Saudi Arabia for some years with their two young children and then moved to the UK where she was able to use her professional nursing qualification to find work, first in Nottingham and then in Hertfordshire. Her husband found it harder to gain and sustain employment. He was emotionally and financially very controlling and abusive to her and their children. She approached their GP with her concerns about his mental health.

In 2011, he assaulted her while the children were in the house because she refused to give him her bank card. She fought back. Soon after, he called the police to report her for assault. She reports that the police who attended the call handled the situation very badly and threatened to arrest her, which had a very detrimental effect on her and her belief in her ability to change her situation.

Her husband’s abusive behaviour escalated to the point where he more than once threatened her with a knife. She again approached her GP, this time on her own behalf for stress-related treatment. The GP – and her children – encouraged her to discuss her domestic situation and the full extent of the physical abuse she had suffered was revealed for the first time. The GP put her in touch with DV helpline support workers who, in turn, put her in touch with the Hertfordshire Sunflower team. She had additional support from local Citizens’ Advice workers.

Thereafter, her experience of working with services and agencies improved dramatically. She was advised how to apply for a Non-Molestation Order (ultimately not activated). She was also supported in gaining a two-year Restraining Order after her husband was arrested at a

UK airport on his return from a short visit to Pakistan following a tip-off from relatives there warning her that he intended to remove their daughter. Collaborative working between the Herts team and immigration officials was crucial here.

Following the granting of the Restraining Order, her husband left the family home. She has retained the house, although at considerable personal financial cost. The family court has granted him indirect contact with his children on the grounds that they do not wish to see him and that he refuses to complete a DVPP. She found Cafcass to be very supportive in this respect. The couple are now divorced and her ex-husband has since remarried. However, he is still living in the same area and she and the children take routine steps to avoid encountering him.

Fatima's story highlights the challenges faced by professional, financially-independent women. Her earlier reluctance to report her husband's long-standing abuse was rooted in her fear of losing her job and her ability to support her children. Her fear and reluctance were seriously compounded by her first encounters with the police who responded to her husband's reports that she had initiated an assault on him. While she may have presented herself to these officers as uncooperative, she explained that she was holding back significant information about her husband's abuse, partly through fear of the consequences for her of disclosure, partly to protect her children, and partly because she felt bound by a community 'honour' code that construes reporting to the police as a betrayal of the marriage.

3.1.5 No or little contact with the police

Some of the 10 victims interviewed had had little or no contact with the police. Some were older and their experiences of HBV/A had begun in the 1980s and 1990s. They offered valuable insights regarding the development of future services in this field.

Some victims said that fear or blackmail prevented them from reporting to the police. Intimidation such as this was compounded by the need to maintain family 'honour', by close family ties, poor language skills and simply not knowing where to go for help. Indeed, a small number of the participants who came from overseas either did not know how to contact the police or did not know that matters such as HBV/A fell within the remit of the police. Other victims explained that they had reported incidents to the police in the past but, due to a poor experience, had decided not to do so again. Making this decision is particularly harmful

for victims as violence commonly escalates after their contact with the police, as this participant demonstrates.

Case study 'Zaheed' FM, HBV/A and sexual abuse survivor, aged 50

This woman was born in Pakistan and moved to the UK as a baby in the late 1960s, first to the Midlands and then to Bedfordshire. She became engaged in 1980 at 13, married at 16 and was a mother at 17. Her husband was a first cousin who was twice her age, had previously abused her as a child and was violent towards her during their marriage. She reports that her mother was the 'driving force' behind the match to which she 'had to' give her consent but she now regards the marriage as 'forced'. After her marriage, she moved to Hertfordshire with her husband who had more recently arrived from Pakistan. In an effort to end the marriage, she reported her husband to the immigration authorities and this led to his return to Pakistan for three years. Shortly after he came back to the UK, she and their 5-year-old daughter moved to Scotland with the help of an older family friend. She later secured a divorce, gained a degree and had a career in education. She never disclosed the child sexual abuse or the domestic violence that she experienced.

Reflecting on why she did not seek support from the police or related agencies as a victim of FM or DV, she says that she felt that the marriage was 'inevitable'. She adds, 'looking back – it would have been easier to speak to a woman rather than a man.' Honour was a powerful contributing factor:

Interviewer: To what extent was honour a contributing factor in your experience?

Naheed: Yeah. Honour contributed when I wanted to leave him, more because I think when I wanted to leave him, I felt I couldn't go to the police because it would bring shame on the family, yeah, but when I was getting married I didn't think it was for the honour of the family; I just thought it was inevitable – I'm a woman. I'm going to have to get married and have children and I'm Pakistani so I'm not going to have a choice. That's how I felt.

Interviewer: Perhaps you could talk to me about some of the reasons why – not reporting to the police...

Naheed: Yeah. I think in retrospect, there were two things; one, it felt disloyal to the community. It just felt – and I was scared of being ostracised by the community because I was very young still and the other one [I] felt, was the shame of it all. You do feel ashamed of the situation you manage to get yourself into and even though it's not your fault, you've been told since you were a child that it was your fault, so you think it is.

She believes that it is difficult for those outside her community to 'understand' the values that sustain HBV/A:

Interviewer: In your opinion, how should victims and survivors of forced marriage in particular be treated by the police and what should they do to make a survivor victim safe?

Naheed: I think they should be –how should they be treated? I think it's difficult for Westerners, to be honest, I think it's difficult for them to understand, so I think they should be treated patiently and kindly because it's not something they have experience of; they chose who they want to marry; they chose where they want to go to school; they chose which university they want to go in and they've had these choices from when they were a child. They can't understand that someone else has completely different experiences and still live in the same country as them.

Interviewer: Yes. So, you talk about the need to be patient, compassionate.

Naheed: And understanding and kind. I suppose they need some sort of training, don't they?

Interviewer: And what would that training, from your point of view, look like?

Naheed: They need to speak to community leaders and stuff and they need to have an understanding of the religion because I think that's a major factor in it.

3.1.6 Victims' Key Insights and Suggestions

3.1.6.1 Awareness and Understanding – Initial contact with the police and other services

- When making their initial contact with victims, our participants suggested the need for police and other practitioners to be mindful that victims may be withholding the full extent of their abuse. They may do so due to fear of retribution or of

‘dishonouring’ the family, or they may be struggling at the scene to articulate what has happened, given the unfolding trauma. We noted that for some participants, their first report (and, for a few, their only report to police) came after a significant period of abuse. The initial report, therefore, presents an important opportunity for police to intervene and disrupt the violence.

- Victims also highlighted the impact of family pressure on their decision-making when, for example, they are asked by police if they want the perpetrator(s) to be arrested or if they wanted to accompany officers to safe accommodation.
- Two victims described their discomfort at being interviewed in their home and in the presence of the family (including perpetrators)
- Victims stressed that, in the context of HBV/A, there are often multiple perpetrators. We heard cases, for example, where the victim identified a mother-in-law, sister, sister-in-law, father-in-law, brother and brother-in-law as co-perpetrators of serious physical abuse or coercive control, but where these individuals were not arrested along with the main perpetrator.
- In terms of awareness and understanding, victims wanted responding and investigative officers to be sensitive to the dynamics of HBV/A, including how coercive control can be exercised not only by the woman’s partner as the perpetrator, but also by the extended family (and possibly community networks). Similarly, participants wanted officers to be alert to perpetrators who claim victim status as part of their controlling behaviour.

3.1.6.2 Protection– ‘Assessment and Help’ and ‘Trusted Professionals’

- While victims appreciated the immediate securing of physical safety that police offered, they felt that their ongoing and longer-term safety was taken less seriously. There was a sense among some participants that the role of the police was to move women to safe accommodation and then withdraw.

Case example: Aliya

Interviewer: So, your experience of Hertfordshire police is not a positive one?

Aliya: No. No. I think they could do a lot more than they're doing, to be honest.

Interviewer: What do you think they should be doing?

Aliya: They need to take more notice of the victim as opposed to the perpetrator.

After reporting to the police, victims of HBV reported feeling in a heightened state of vulnerability through both the fear of, and the genuine risk of, serious harm. This ongoing fear was particularly acute in situations of intra-familial marriage. A number of victims felt financially vulnerable and found the experience of being housed in temporary accommodation, such as hotels and bed and breakfasts, problematic. At least one was concerned about how she was going to pay for her stay and described feeling isolated and at risk. Even when moved to more permanent accommodation, this woman remained under effective house arrest as she feared venturing outside in case she was discovered.

Case example: Rozina

Interviewer: Yeah, [I] just want to get a sense of that, to what extent do you fear violence on you as a consequence of what's happened? Do you know what I mean?

Rozina: I won't set foot in my home town again because I will get hunted or I will get found by my dad, or they will find out and I will get punished for it, because [of] what I've done. Not only have I got divorced from a family member, or their nephew, not [only] has that caused shame upon the family just as they're getting over that, they've now found out that "oh not only has she got remarried, now she's living with a supposedly Englishman...she's actually married to him."

When victims experienced what they saw as proactive, meaningful and supportive police contact during their stay in temporary accommodation and beyond, their wellbeing and confidence were significantly enhanced.

Case example: Fatima

I was knowing that I'm at risk and my children are at risk but I was not able to do anything because police weren't there for support... I felt down. At that point, they didn't help at all. No, not at all and if, you know, if that time, they could catch that point instead of threatening me, they could, you know, speak to him, you know, so he might be, you know, become a better person if he wanted to. Because it would have given him more courage to abuse me when I was threat[en]ed that I will lose my job and I will lose everything. You know, it made me so, you know, vulnerable to that situation that I was thinking that there is no support around even if everyone is saying, there is no support around. But when I, you know, met Sam, and that domestic violence advisor, she was, you know, she was the one who then spoke to Richard and spoke to, you know, whatever places, MARAC.

- Good experiences were characterised by timely, personal updates on the progress of the case in the following days and weeks and, where appropriate, additional security measures such as a tescos phone.
- Victims appreciated having not only a dedicated officer who knew the case, because that meant that the victim did not have to repeat her story, but also having a second officer who was similarly well-briefed.
- Those participants who had been contacted by the force HBV specialist were particularly happy with the support they received.

3.1.4.3 Enforcement and Prevention – Identification and management of those who pose a risk to victims

In summary, participants felt that the police could be more proactive in investigating their cases. Otherwise, victims said, perpetrators of HBV would continue to act with impunity.

- Victims' accounts revealed that perpetrators of HBV and their families employed the withholding, theft or destruction of possessions (including passports, wedding jewellery and personal documents) as ways to exercise control. Rather than being told

that such behaviour is a ‘civil matter’, victims wanted police support. When a victim tried to retrieve her belongings, she wanted this support to include recognition of the trauma involved when a woman returns to the home where the abuse has occurred, and where the perpetrator(s) still lives.

Would you (not) advise someone else to report?

When responding to this question, some participants said they would recommend reporting to the police, with the majority citing the value of securing the victim’s immediate physical safety as their reason. Some were sceptical about the prospects for prosecution or for the capacity of the police to follow up cases effectively. Others felt, as mentioned above, that it depended in part on which officer you were allocated. Still others would recommend that women go first to an NGO whom they believed offered practical, sympathetic support.

Where victims had themselves had particularly bad experiences, it is unsurprising that they did not have confidence that the police would help others. Our data suggests that what particularly colours these women’s experiences of the police are poor understanding, poor communication and poor follow-up action, rather than, for example, no charges being brought against the perpetrator.

3.2 Hertfordshire professionals’ experience of delivering current services

There have been some impressive developments in practice and policy on HBV/A, FM and FGM in the UK. However, these developments run alongside an often glaring lack of general attention to the issue resulting from ignorance and institutional failings (Gill, 2014). These problems derive from inadequate understandings of HBV within relevant statutory agencies and underfunding of specialist services. Consequently, despite some excellent areas of practice and policy work, a failure to protect those at risk is still all too common.

It is also the case that progressive work at the strategic level has yet to be fully implemented in everyday practice nationwide. According to our interviewees, a good start has been made in Hertfordshire. However, despite focused and determined efforts in recent years those working on the ground generally agree that much remains to be done to improve the quality of policing and criminal justice responses, not least in terms of ensuring that effective responses are not a ‘post-code lottery’. It is vital that victims are consistently referred to

appropriate sources of care, including specialist NGOs and women's support organisations, and that these are properly funded. However, the opposite currently appears to be the case, with many specialist women's services currently being under serious threat as a result of cutbacks in government funding (EVAW, 2017).

3.2.1 HBV/A and FM services

The professionals recognise that there is now a much greater awareness of the issues surrounding HBV/A and FM. Nevertheless, those we interviewed also identified challenges within current procedures and practices. Hertfordshire has mainstreamed some of its earlier specialist provision around honour based offences, but with mixed results. At one level, this mainstreaming has encouraged a broader connection between honour based abuse and domestic abuse more generally. However, at another, some felt this approach has eroded the time available to deal with complex cases, case management focus and general expertise in this field.

One police officer was concerned about the lack of time that could now be devoted to these issues:

I'm limited by time, I'm limited by custody time limits, I'm limited by PACE clocks, I'm limited by so many different things as to when I can do stuff; I have to go to court on a certain day, I don't have any option, so if I have an appointment to see a victim of honour based violence on that day and I get called to court because it's a bail application, I have to go, so I let that person down. I find it really, really difficult now, and I find it quite uncomfortable to try and manage a safeguarding case to the degree that I used to. Now with the honour based violence there is no specific individual, there is no specific team that deals with it...People have different understandings, they have different levels of experience, they have different levels of commitment; there are so many variables that affect the level of support and outcomes.

The officer was also concerned about the quality and consistency of case management:

Basically, Hertfordshire have a process to follow, and people try and follow that as best they can as to how to deal with it. But I think the processes locally are still quite fallible, and the biggest issue as far as I'm concerned locally, is there is no focal point. There's no direction, everyone says they know all about honour based

violence, they know all about forced marriage, but if you go and ask someone, ‘Right, what’s happening with this case?’ ‘Where’s that case recorded?’ ‘What’s happening with it, who’s managing it?’ I would be very surprised that they’d be able to tell you whose managing it.

Other officers discussed the intensities, practicalities and challenges of their safeguarding role – especially as this becomes longer-term in character:

Trying to keep the victim on board at all times, just making sure up to a certain degree when you know they are safe and they have moved on, it’s just keeping them on board and calling them, being in contact with them. Sometimes it is a pain, wanting to know exactly what you have been up to for the last two days, who has been in contact, who hasn’t been in contact, any messages from family members, friends, but sometimes it has to be done just to ensure that they are safe, so even though there might not be a police prosecution, but we need to keep them on board and make sure that if they are moved out of our area into a different area, that they are getting the appropriate help there, with an individual who obviously knows the full extent of it, so they can, kind of, move on smoothly. It’s just a matter of keeping an eye on them really, it’s like mothering them.

I think the problem with safeguarding – which is unusual for the police in the sense that it’s not a question of you have done your prosecution and you more or less move on to the next job – the safeguarding remains there for the future doesn’t it, however long that is and that could be months, years, and I don’t think, in all honesty, I don’t think we have really got the structure to allow for that long-term safeguarding. We are very much focused on, like, what do we need to do now, right, we need to refer them to NCDV, we need to do this, we need to do that but in long-term monitoring, I don’t think we manage that sufficiently at the moment.

Other practitioners, beyond the police, acknowledge challenges in this field. The collection, management and sharing of specific data is one key challenge. One respondent working in the child protection field noted this challenge:

I don't think we'd have distinct data in relation to FGM, honour based violence. We obviously, you know, we keep a record, we tend to keep a record of data of what we have done with it, whether it's been a CP referral or not, whether it's advice, so we haven't done specifics in relation to any of the kind of categories of abuse or specific safeguarding issues in collection of that data.

A respondent with cross-cutting responsibilities for domestic violence work in Hertfordshire appeared to underestimate the total number of cases of HBV/A in the county, suggesting that the national police figures recorded 'about 12 cases a year on average'. This figure is considerably lower than the figure produced by our own analysis of recent Hertfordshire police data (see section 1.2.1) which indicates that there have been 270 HBV/A crimes and incidents since 2013 (although some of these have involved the same victim²³). It is a matter of concern, therefore, that this respondent was also involved in establishing extensive and valuable training and awareness campaigns around these issues.

3.2.1 FGM services

Article 12 of the Istanbul Convention 139 specifically prescribes that state parties must "take the necessary measures to encourage all members of society, especially men and boys, to contribute actively to preventing all forms of violence covered by the scope of this Convention" and that "culture, custom, religion, tradition or so-called 'honour' shall not be considered as justification for any acts of violence" covered by the Convention. The Convention lays out a number of concrete obligations for the prevention of violence against women and these are also relevant to preventing FGM.²⁴

These are:

1. awareness-raising at all levels, including with the public at large – Article 13;

²³ Whilst there was no repeat victim flag in the crime data, the date of birth field suggested that of the 160 crimes here were 10 victims who reported two crimes, two victims who reported three crimes and one victim reported four crimes (18 crimes had no date of birth recorded and the remainder were not repeat victims within the study timeframe).

2. the inclusion of teaching materials to prevent violence against women in education curricula – Article 14;
3. training for relevant professionals – Article 15;
4. preventive intervention and treatment programmes – Article 16; and,
5. Participation of the private sector and the media – Article 17.

Many of the organisations that work in the area of FGM have stressed the positive aspects of the recent civil remedies that have been introduced such as the Istanbul Convention. However, they have also made the case for the need for a diverse range of responses to FGM and related abuses. They believe that specialist outreach services, education and awareness-raising work in schools and the community, welfare services, childcare facilities, and the provision of specialist refuge spaces are all necessary if FGM is to be tackled effectively.

Hertfordshire's services around FGM focus on training and awareness campaigns in schools, child protection, health services and the criminal justice system. Only a small number of practitioners, most of them health professionals, have dealt with FGM victims directly.

One GP described the one case that she had encountered in the county:

160: So, it's a 26-year-old educated lady of Sudanese background who was going to be getting married and she had questions about her FGM and what to do, and she had discussed it with her fiancé [also Sudanese] – it was an introduction marriage – and she wanted to be very open with him that she had been cut and she didn't want to be uncut until after her marriage day. She didn't want to do anything about it because she wanted him to see her and see how distressing it was and how awful it looked and how the tradition is very...it didn't have any reasoning behind it, and also just to get an idea that if they had female children in the future that this is something that she wouldn't practice. So, he did ask her if she was cut and she said yes, and she didn't want any surgery until after her marriage.

Unfortunately, she was moving away, so she was going to North London, and so any details I gave her were really for Whittington Hospital. Recently moving to Highfield, near Islington, which has a higher population of sufferers there. But that's it really. She's left my practice now. Hertfordshire doesn't have a large community of probably people from the Arab backgrounds or the African origin.

She highlighted the fact that GPs can struggle to find time in a 10-minute appointment to deliver the safeguarding element of their role:

160: Certainly, for us it's a very difficult job just to, kind of, cover everything. So, general practice has got a lot of tick boxes, a lot of processes and predominantly we're kind of looking at health. When it comes to health prevention stuff we always struggle with it a bit and one because we're not funded for a lot of the outside questions like safeguarding so it kind of has to come from all these aspects of childcare, or healthcare really, from antenatal appointments, having children, health visitors, schools, and especially in predominant areas any involvement between a child and a service, so I'd like to say that when a child leaves a hospital, a baby is born and leaves hospital, a mother has all the information of a particular background with that information and the information leaflet there and a midwife or a nurse saying to them 'okay, this is really important, because of your background we need to let you know X, Y and Z' and then the health visitor who comes to visit the baby should reiterate that information. The GP does the six-week baby checks so, in my practice in particular, we have a box – again, more tick boxes – but we originally ask whether the child or the sibling is on the child protection register. We ask if there's any domestic violence in the family and we now have a specific question which the doctor can choose which person they ask, which is 'do you belong to a community that practices FGM?' So, again, there's lot of questions because on top of that you need to ask 'are you breast feeding? Are you feeling depressed? Is the baby smiling?' There's a lot of questions to ask and then suddenly there's this extra bit which comes very much out of context. You're talking about a physical assessment of a baby and then suddenly you go into this very sensitive discussion all in 10 minutes.

A midwife now working in the county estimated that she had dealt with over 50 cases of FGM over the course of her career but fewer than 10 of these were in Hertfordshire. They were all, by definition, pregnant women and most were Type II or Type IV FGM. She reported that she is involved in developing a new FGM Pathway for the county which is due to be completed in July 2017. This is a very welcome development and one that all locally interested parties should track.

While appropriate sanctions are required to punish the perpetrators of FGM, it is equally important that there is adequate support for victims and those at risk. However, political and financial support has increasingly centred on law enforcement responses to FGM, an approach which has resulted in a decrease in funding for specialist services. To protect victims, a change in emphasis is required.

4. Recommendations

1. **The commissioning of a dedicated service to tackle HBV/A, FM and FGM in county hotspot areas:** This is best done through the expansion of current services already overseen by the Hertfordshire Domestic Abuse Partnership. Such a service should include:
 - a) a 24/7 dedicated team with excellent multi-agency links, including links to relevant local multi-agency case management system and those managing local MARAC and DASH processes.
 - b) oversight of a clear referral pathway for victims and practitioners seeking general advice or immediate response;
 - c) encouragement for practitioners to exercise professional discretion within statutory remits to build trusting relationships and tailored/flexible responses that meet the varied needs of victims;
 - d) a commitment to follow through all enquiries to ensure that victims are fully aware of their rights, available resources and options;
 - e) an agreed set of service goals and outcome measures to assist periodic evaluation of the service.

2. **Improved data sharing and case management:** There is a need for improved data sharing between agencies dealing with HBV/A, FM and FGM not only within the county but also between counties and countries. We recommend a review of Hertfordshire's current multi-agency case management system for these client groups. Here, Essex's new Joint Domestic Abuse Team (JDAT), which comprises police and social care practitioners and which can be accessed by vetted partner agencies, may provide a useful model. Such a review should ensure that there is adequate flagging, review and follow-up of all reported incidents of HBV/A, FM and FGM, as recorded through the Hertfordshire police data and mandatory health reporting (in the case of FGM).

3. **Review of the efficacy of existing risk assessment practices.** Victims of HBV/A and FM are all likely to have suffered lengthy, ongoing coercion and abuse prior to reporting. Their initial reports may, however, incorrectly indicate that these individuals face a 'low risk' of further abuse or violence, because they may find

difficulty in articulating or sharing the full extent of this historic abuse. The current flagging of risk in HBV/A and FM cases via DASH and/or MARAC should be reviewed.

4. **Co-ordination through cross-referrals for women affected by HBV/A, FM and FGM:** Recognising the limited support role of the police exposes the importance of taking a co-ordinated approach to cases of HBV/A, FM and FGM and of having professionals make cross-referrals to available specialist support agencies. A co-ordinated approach to such referrals offers an important way of improving local responses to those affected by crimes related to honour.
5. **Engagement of stakeholders working with HBV/A, FM and FGM survivors in the framing of a planned FGM referral pathway for the county.** The health professionals we interviewed advised us that they are currently making developments in this area and that they expect to be able to share the resulting pathway more widely in the summer of 2017. We strongly recommend that this pathway is created and followed.
6. **Training:** Front-line staff in key agencies need continuing training so that they are able to respond professionally and courteously to women who are experiencing the threat of HBV/A, FM and FGM. Training for such professionals needs to take them beyond awareness and offer the opportunity to work with vignette examples that are relevant to their everyday practice.
7. **Awareness campaigns:** Targeted community awareness campaigns on HBV/A, FM and FGM should continue to be run through schools, health facilities and community facilities in hotspot areas.
8. **Regular continuing professional development training on HBV/A, FM and FGM for practitioners:** This should include training on immigration/visa expertise; family court proceedings; and, the specific needs of victims of HBV/A, FM and FGM who are parents and the needs of their children as secondary victims.
9. **More consistent recording of ethnicity:** Improved recording of the ethnicity/heritage of all victims, including those experiencing HBV/A, FM and FGM would help to target services and awareness campaigns more effectively.

10. **Enhanced visibility of existing county services:** Awareness of these services should be heightened in hotspot areas. Greater use could be made of social media. The public profile of the Hertfordshire Sunflower website should be raised.
11. **More support and therapeutic services for young people affected by forced marriage:** The lack of services for young people affected by honour based violence and forced marriage was noted by the researchers. Support services for affected groups were especially under-developed. This deficiency was also a concern in relation to traveller communities.
12. **Greater attention should be paid to the experiences of children as secondary victims of HBV/A.** Our 10 respondents had a combined total of 13 children – many of whom had had their lives greatly disrupted by their mothers’ experiences of violence and abuse, including having to leave their homes, schools and friends.
13. **Greater public awareness/more ambassadors:** Where possible, organisations and professionals involved at a local and national level could explore the development of targeted campaigns and championing of local ambassadors who work directly with affected or higher risk communities.
14. **Funding for asylum-seeking victims:** Asylum seeking women who experience HBV/A, FM, and/or FGM find it very hard to get advice and emergency protection. Agencies’ concerns about their immigration status can override concerns about their rights. A lack of funds for immigrant women fleeing violence and abuse means that even refuges turn women and children away or run the risk of paying for their support out of their own limited funds. Women should be exempt from the ‘no recourse to public funds’ rule, particularly those under the 2-year probationary period. This is a national issue to which Hertfordshire services need to be alert and for which they should make provision.
15. **Male victims and LGBT victims of HBV/A and FM** find it difficult to access sources of help and advice. Information and monitored services need to be accessible for these groups.

References

1. Abdulcadir, J., Rodriguez, M., Say, L. (2014) Research gaps in the care of women with female genital mutilation: an analysis, *BJOG: An International Journal of Obstetrics and Gynaecology*, Vol 122 Issue 3. Available from:
URL: <http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.13217/full>, accessed 25 April 2017.
2. Chesler, P. (2010). 'Worldwide Trends in Honor Killings', *Middle East Quarterly*, Spring, 3–11.
3. Dobash, R. and Dobash, R. (2000) 'The Politics and Policies of Responding to Violence against Women', in Hanmer, J. and Itzen, K. (eds), *Home Truths about Domestic Violence*, (London: Routledge).
4. Ertürk, Y. (2012) 'Culture versus Rights Dualism: A Myth or a Reality?' *Development*, 55(3), 273–276.
5. ERAW (2017) ERAW appeals to Mayoral candidates - pledge to act on abuse <http://www.endviolenceagainstwomen.org.uk/evaw-appeals-to-mayoral-candidates-pledge-to-act-on-vawg/> , accessed 30 April 2017.
6. Forced Marriage Unit (2016), *Forced Marriage Unit Statistics*, <https://www.gov.uk/government/statistics/forced-marriage-unit-statistics-2016>, accessed 25 April 2017.
7. Gallo, P. (1985) Female circumcision in Somalia: some psycho-social aspects. *Genus* 41(1–2):133–147.
8. Gill, A. K. (2014) "All they think about is honour": The murder of Shafiea Ahmed. In A. Gill, K. Roberts, and C. Strange (eds), "*Honour*" *Killing and Violence: Theory, Policy and Practice*. London: Palgrave Macmillan.
9. Gill, A. K. (2017) Women murdered in the name of 'honour', *The Handbook on Homicide*, in Wiley-Blackwell Series of Handbooks in Criminology and Criminal Justice, Wiley Blackwell.
10. Harrison, K., Gill, A. K. (2017) Breaking down barriers: increasing sexual abuse reporting rates in British South Asian communities, *British Journal of Criminology*, (forthcoming).

11. Hester, M., Gangoli, G., Gill A. and Mulvihill N. (2015) with Bates, L., Matolcsi, A., Walker, S-J. and Yar, K. (2015) *Victim/survivor voices – a participatory research project.: A Report for Her Majesty’s Inspectorate of Constabulary 'Honour'-based violence inspection.*
Available online: <https://www.justiceinspectrates.gov.uk/hmic/wp-content/uploads/university-of-bristol-hbv-study.pdf>
12. HMIC (2015) *Depths of dishonour: Hidden Voices and Shameful Crimes*, Her Majesty's Inspectorate of Constabulary (HMIC), London: UK.
13. Home Office (2016), *Mandatory Reporting of Female Genital Mutilation – procedural information*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf, accessed 25 April 2017.
14. Iranian Kurdish Women’s Rights Organisation (IKWRO) (2015) *Nearly 3000 Cases of ‘Honour’ Violence Every Year in the UK*, <http://ikwro.org.uk/2011/12/nearly-3000-cases-of-honour-violence-every-year-in-the-uk/>, accessed 25 April 2017.
15. Jaspal, R. and Siraj, A. (2011) ‘Perceptions of “Coming Out” among British Muslim Gay Men’, *Psychology and Sexuality*, 2(3), 83–197.
16. Macfarlane A., Dorkenoo E. (2015) *Female Genital Mutilation in England and Wales. Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates.* London: City University London.
17. Ministry of Justice (2015) *Factsheet – female genital mutilation*, London, Ministry of Justice, available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416323/Fact_sheet_-_FGM_-_Act.pdf, accessed 25 April 2017.
18. Moxey, J., Jones, A (2016) *A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England*, doi: 10.1136/bmjopen-2015-009846.
19. NHS, 2015 *Female Genital Mutilation Datasets*, <http://content.digital.nhs.uk/fgm>, accessed 30 April 2017.
20. Oberwittler, D. and Kasselt, J. (2011) *Ehrenmorde in Deutschland. Eine Untersuchung auf der Basis von Prozessakten* (‘Honour Killings in Germany. A Study Based on Prosecution Files’) (Polizei + Forschung, Bd. 42, hrsg. vom Bundeskriminalamt). Köln: Wolters Kluwer Deutschland.

21. ONS (2011), 2011 Census data; <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/2011census/2013-05-16>, accessed 25 April 2017.
22. Ozturk, S. (2011) Sydney's Killer: The Gay-Hate Epidemic that Claimed 80 Men, <http://www.starobserver.com.au/news/local-news/new-south-wales-news/sydneys-killer-the-gay-hate-epidemic-that-claimed-80-men/107657>, accessed 25 April 2017.
23. Roberts, K., Campbell, G. and Lloyd, G. (2014) *Honor-Based Violence: Policing and Prevention, Advances in Police Theory and Practice* (London: Routledge).
24. UNICEF (2005) Female Genital Mutilation/Cutting: A Statistical Exploration. New York, NY: UNICEF, available from http://www.unicef.org/publications/files/FGM-C_final_10_October.pdf accessed 4 April 2016.
25. United Nations Children's Fund (2013) Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change. New York: UNICEF.
26. World Bank, United Nations Population Fund (2004) Female Genital Mutilation/Cutting in Somalia. Washington, DC: World Bank, United Nations Population Fund, available from: http://siteresources.worldbank.org/INTSOMALIA/Data%20and%20Reference/20316684/FGM_Final_Report.pdf accessed 4 April 2016.
27. World Bank (2015) Development Goals in an Era of Demographic Change available from <http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/10/503001444058224597/Global-Monitoring-Report-2015.pdf> accessed 25 April 2017.
28. World Health Organization (2008) Eliminating female genital mutilation, an interagency statement, WHO, Geneva.

Appendix

Figure 1: Hertfordshire residents born in Pakistan; ONS, 2011. N= 5,774

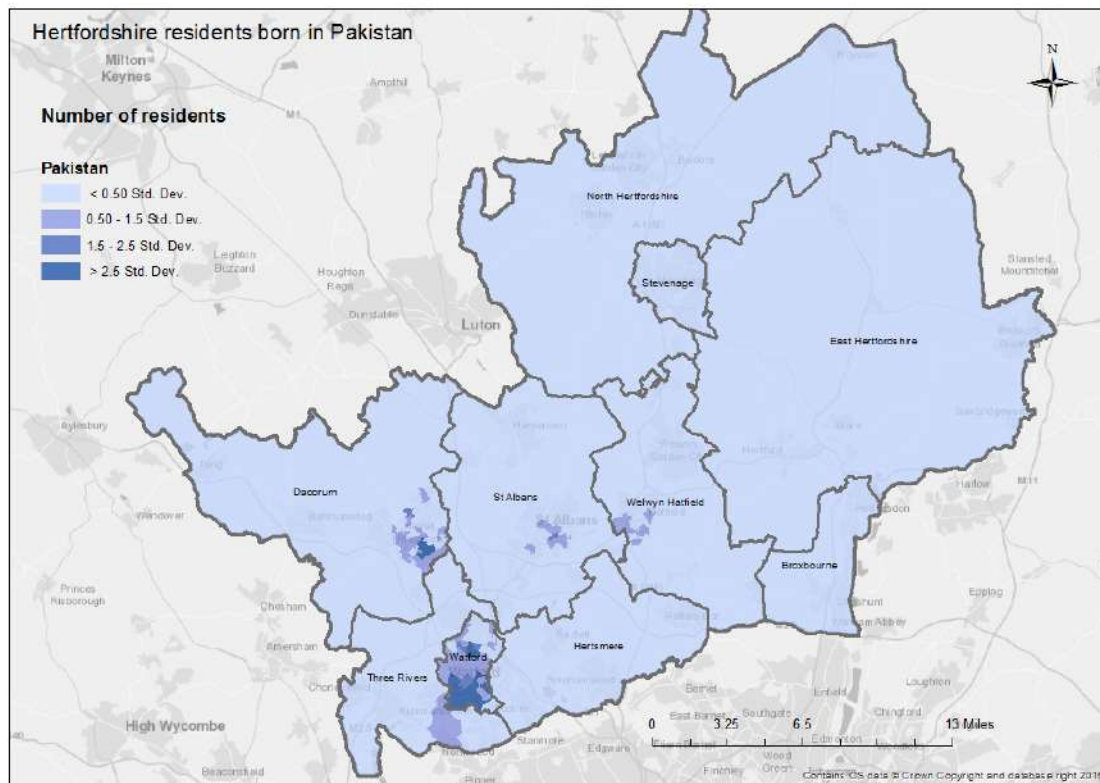


Figure 2: Hertfordshire residents born in Bangladesh; ONS, 2011. N= 2,779

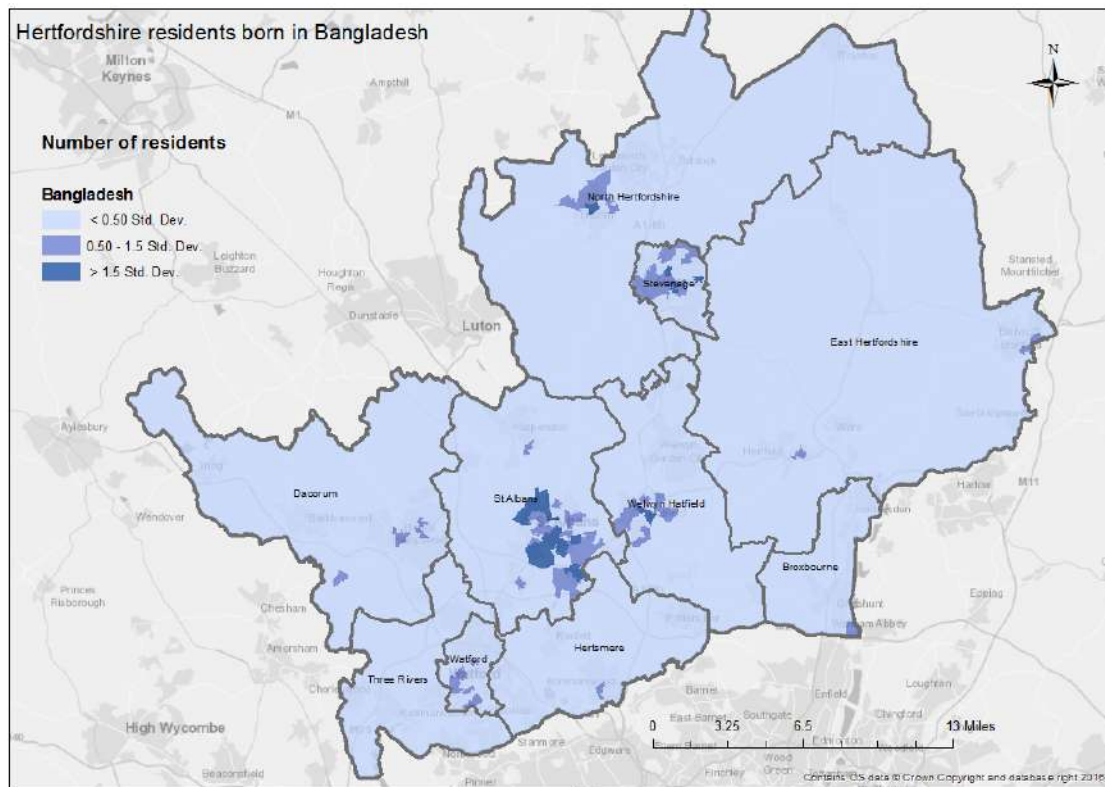


Figure 3: Hertfordshire residents born in India; ONS, 2011. N= 12,447

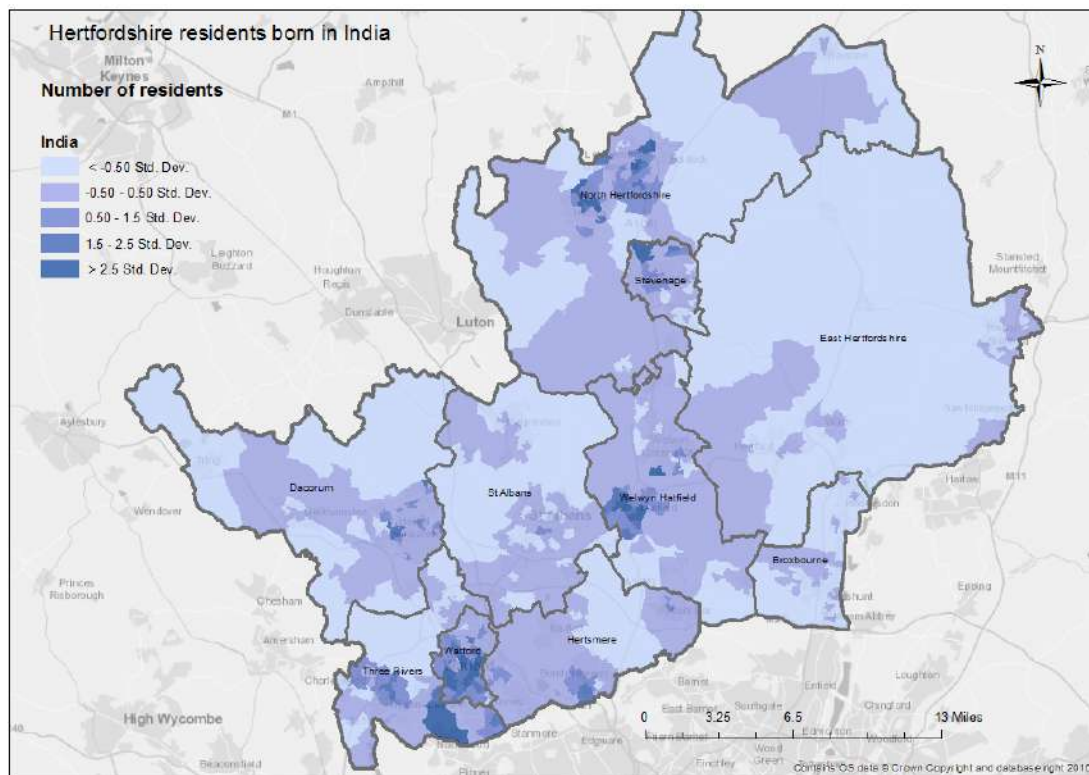
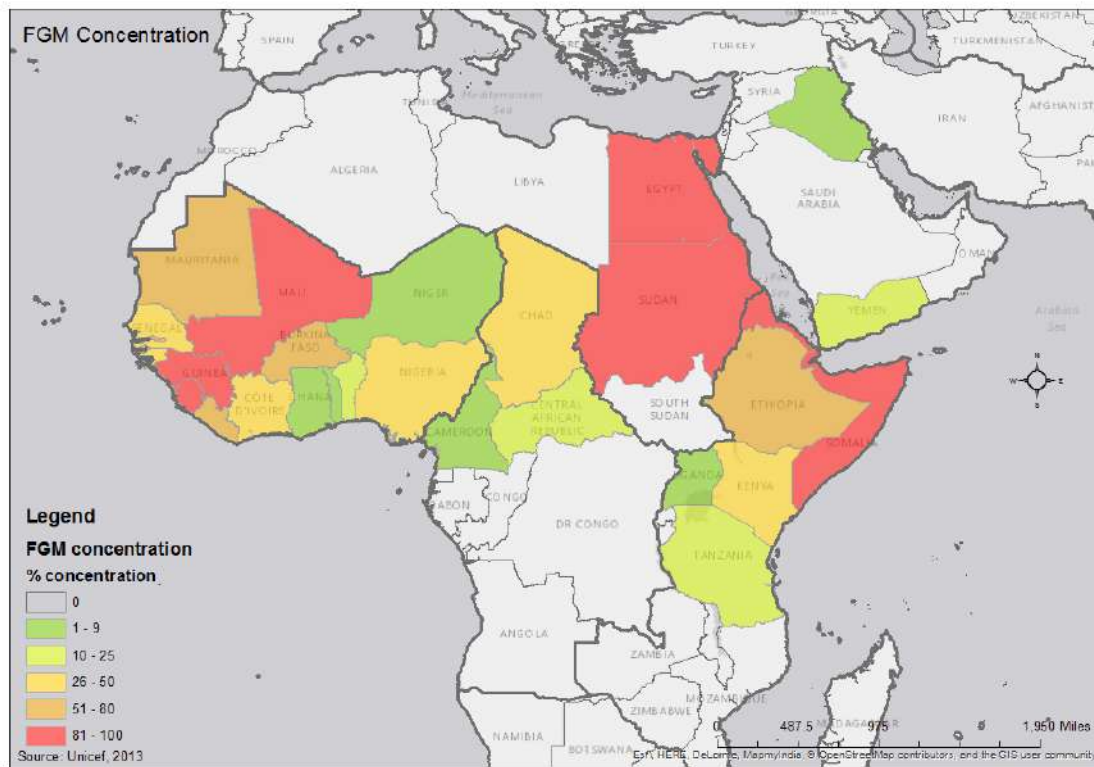


Figure 4: FGM concentration; UNICEF, 2013



Using Census Mapped Data to Estimate the Prevalence of FGM in Hertfordshire

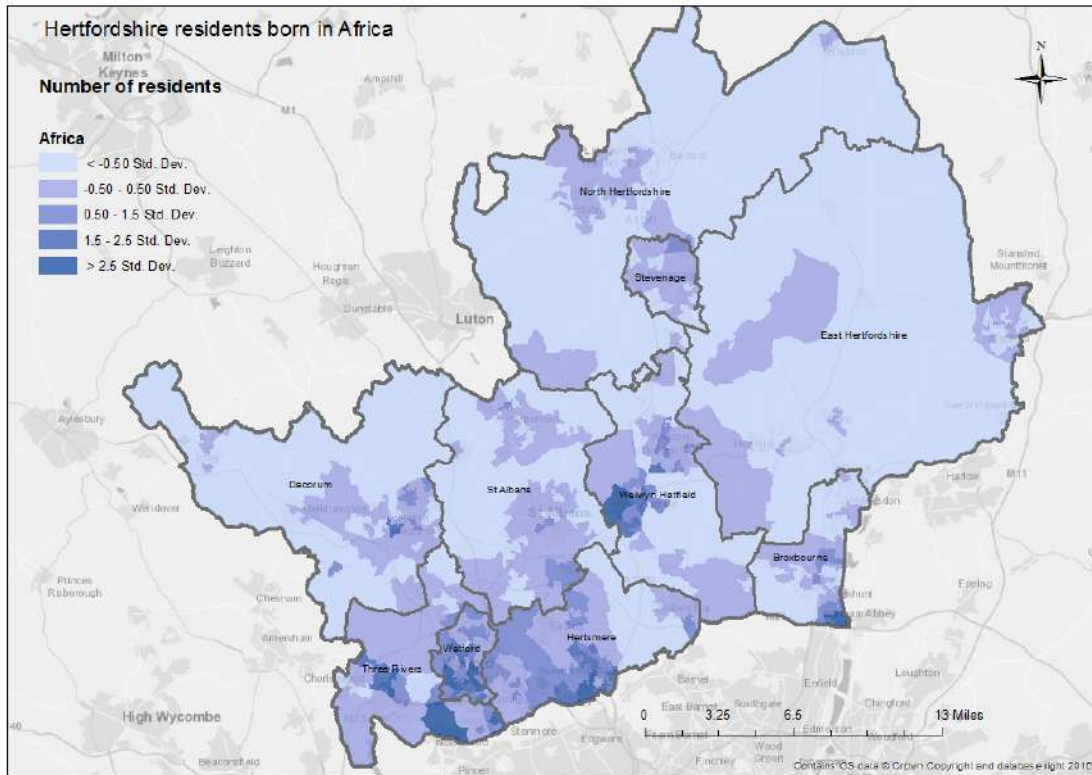
To estimate the number of women who might have undergone FGM and/or whose daughters might be at risk of being subjected to FGM, it is necessary to have an understanding of whereabouts in the UK ethnic groups with a high prevalence of this practice reside. The following section, therefore, draws on the 2011 UK census data for Hertfordshire by way of example.

The 2011 census mapped data on country of birth by county. In the case of Hertfordshire, Somalia is, however, the only individual country for which data is available. All other countries are grouped into regions. Consequently, these groupings include countries where FGM is not highly prevalent.

- The 2011 census data does not include anyone who has moved to Hertfordshire since 2011 or children born there since 2011. Nor does it factor in any potential out-migration from the county.

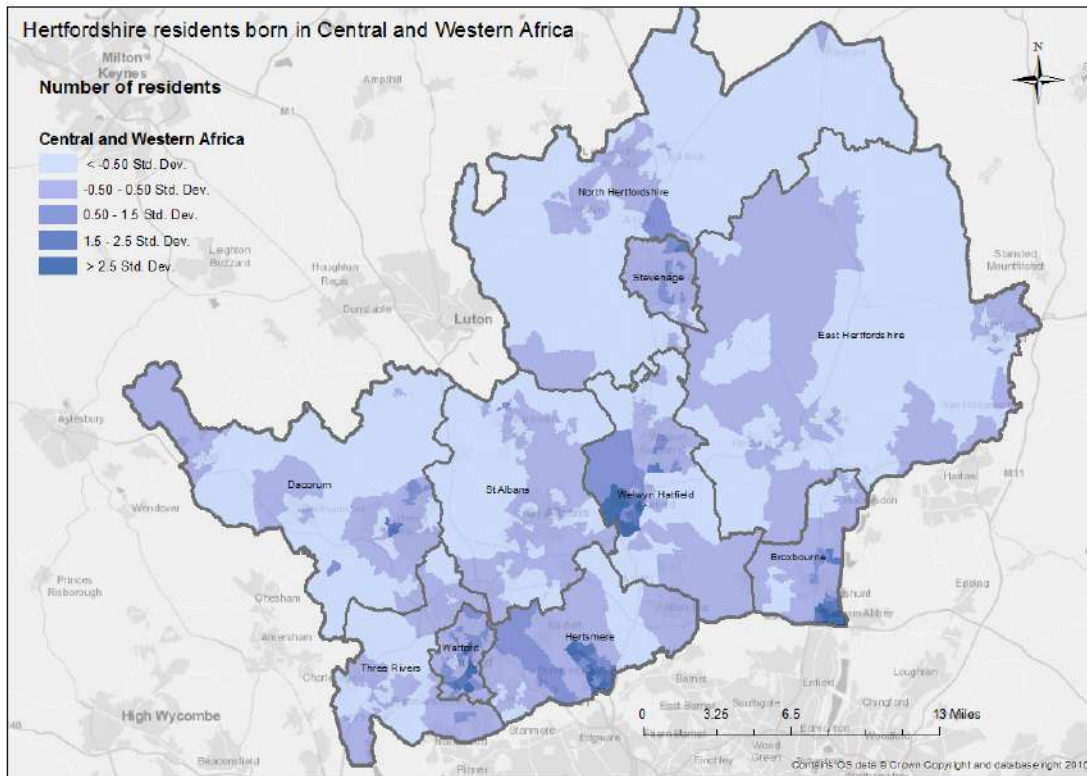
- Record swapping occurs in Census Lower Super Output Areas (LSOAs) where there are low numbers of an ethnic group.

Figure 5: Hertfordshire residents born in Africa; ONS, 2011. N=30,671



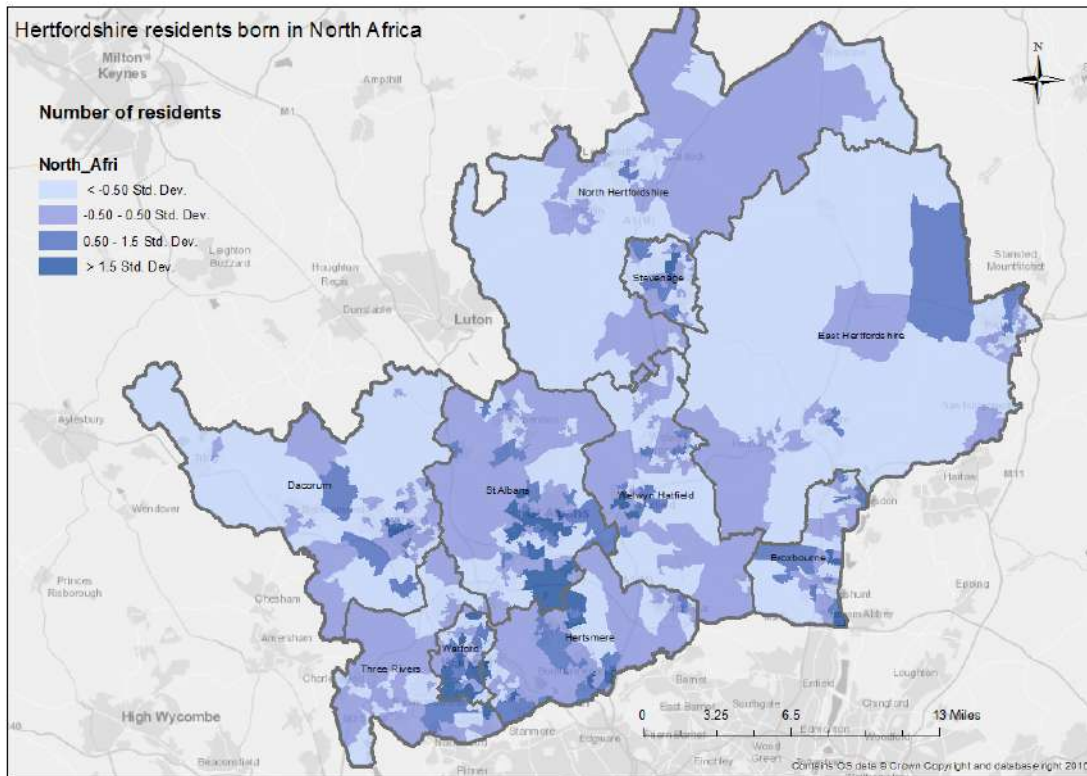
The census recorded 30,671 Hertfordshire residents as having been born in Africa. The highest concentrations of African-born residents are found in Watford, Hertsmeare, Three Rivers, Welwyn Hatfield and small areas of Broxbourne and Dacorum.

Figure 6: Hertfordshire residents born in Central and Western Africa; ONS, 2011. N= 7,946



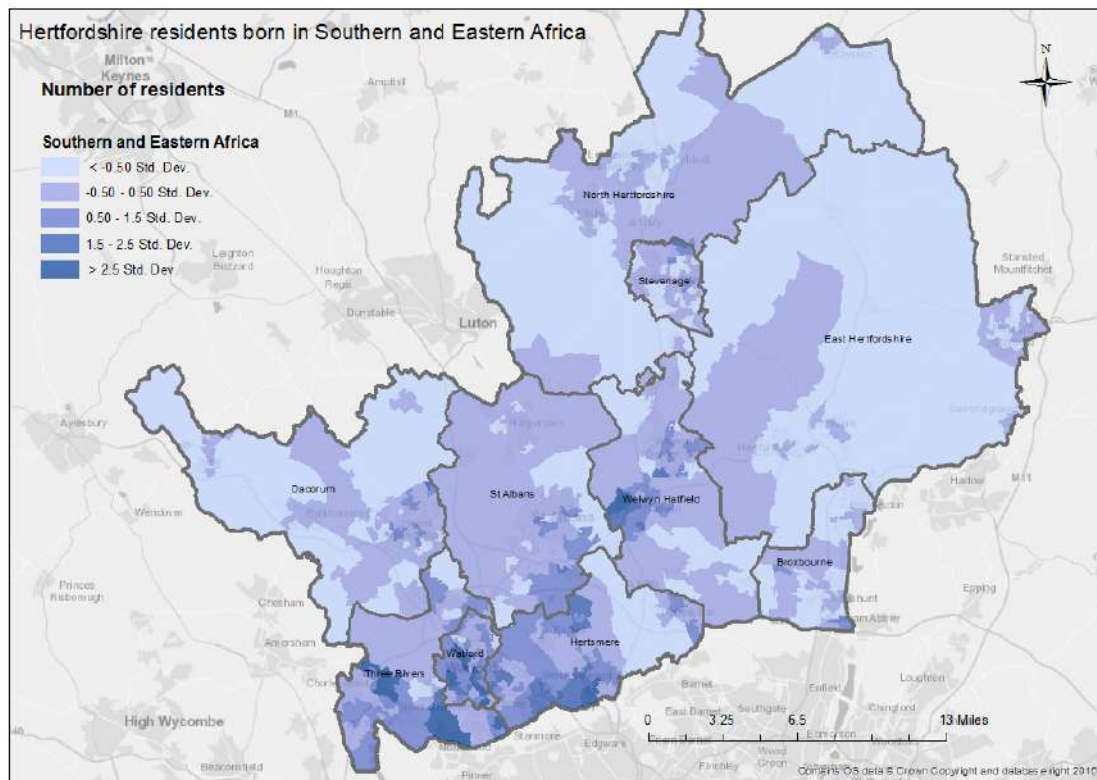
Similar pattern to Figure 5

Figure 7: Hertfordshire residents born in North Africa; ONS, 2011. N= 1,854



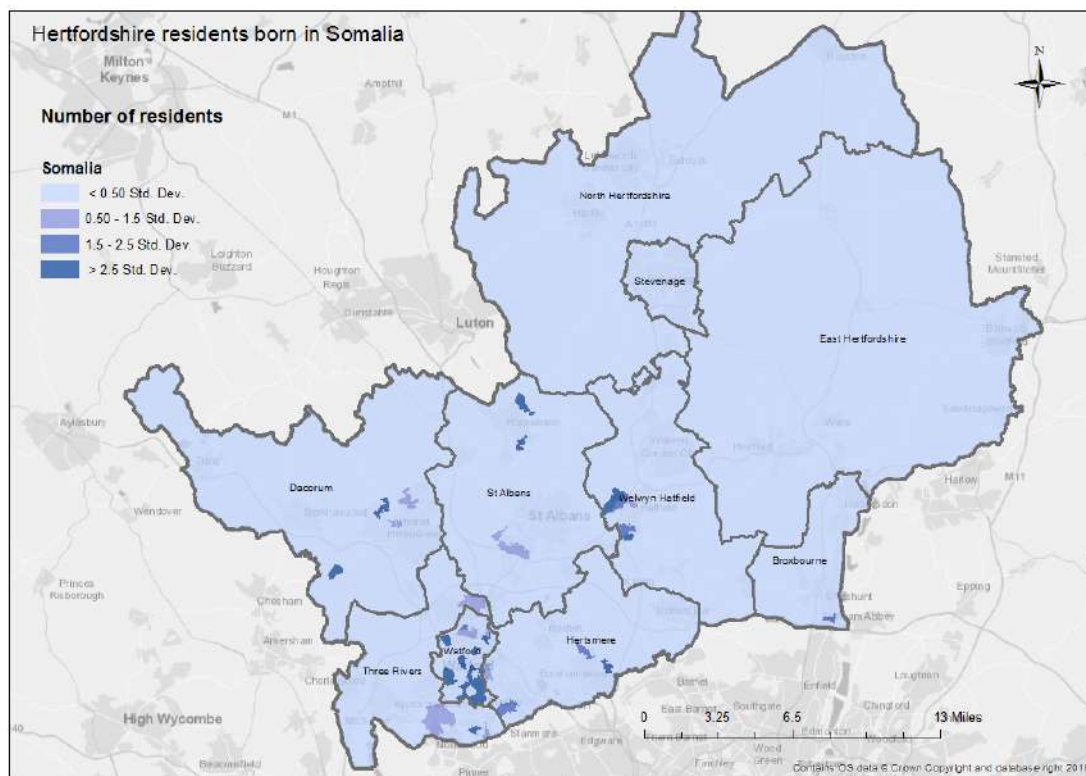
This map shows the highest concentrations of North African residents in urban areas across all of Hertfordshire's districts.

Figure 8: Hertfordshire residents born in Southern and Eastern Africa; ONS, 2011. N= 20,657



The highest number of Southern and Eastern African residents is to be found in Three Rivers, Watford, Hertsmere and Welwyn Hatfield.

Figure 9: Hertfordshire residents born in Somalia; ONS, 2011. N= 228



There is only a very small Somali population, with most residing in Watford.

Points of Interest

Figures 10 through to 18 illustrate the existing health services and schools within Watford and 2 miles outside the borough boundary. The points of interest data has been superimposed onto the map showing the number of residents born in African countries.

Figure 10: Health services in Watford and the number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

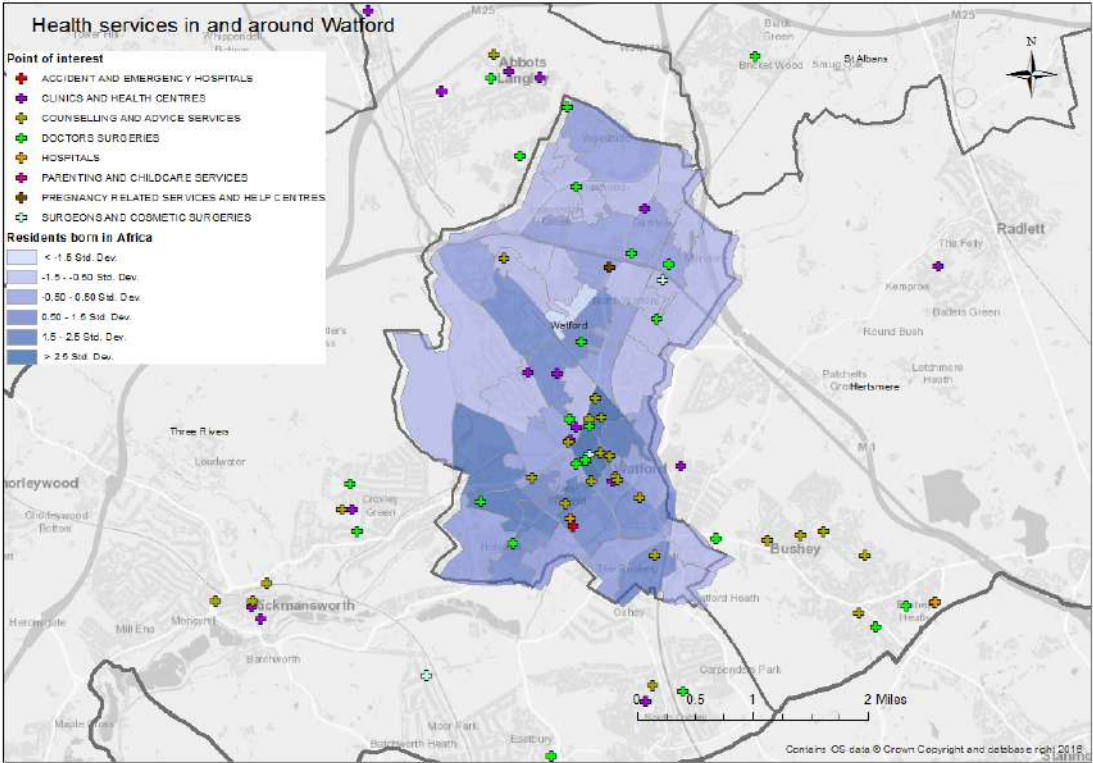


Figure 11: Clinics and health centres in and around Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

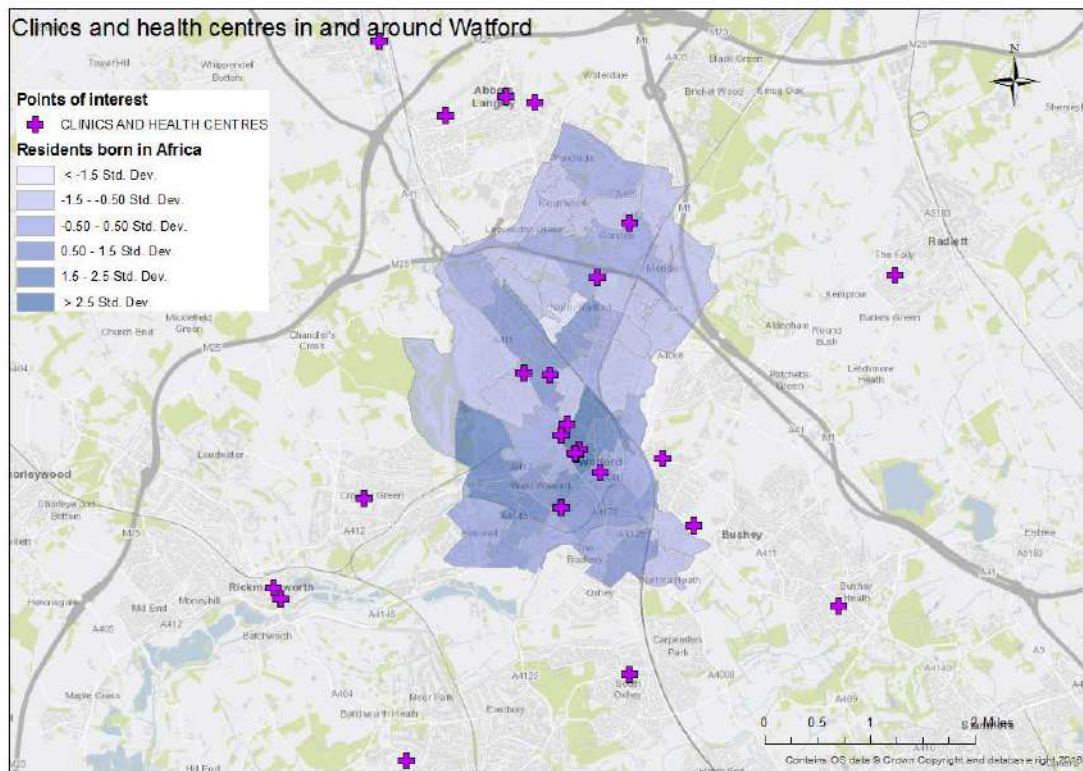


Figure 12: Counselling and advice services in and around Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

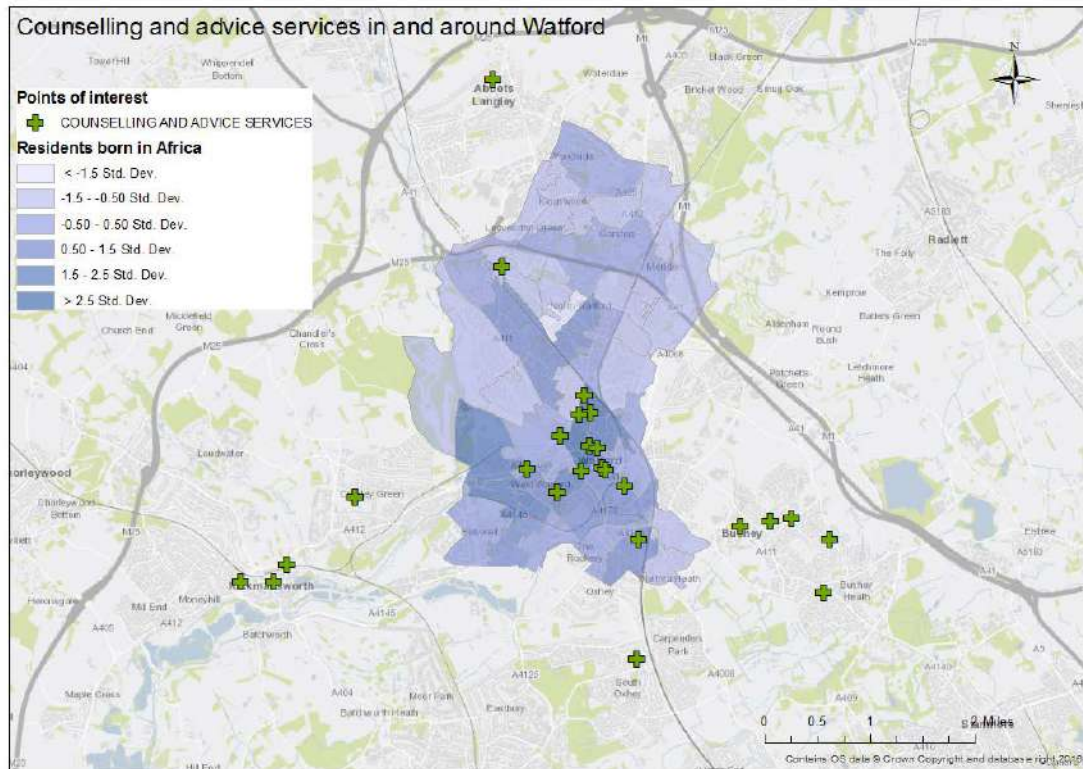


Figure 13: Doctors surgeries in and around Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

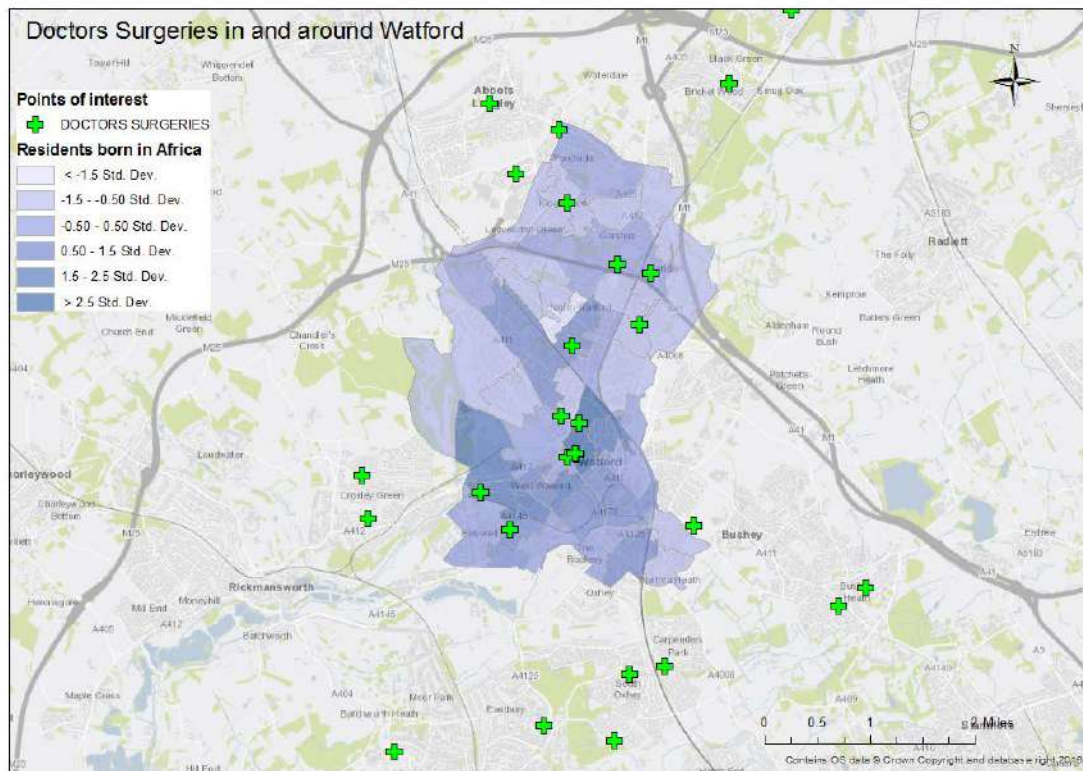


Figure 14: Hospitals in and around Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

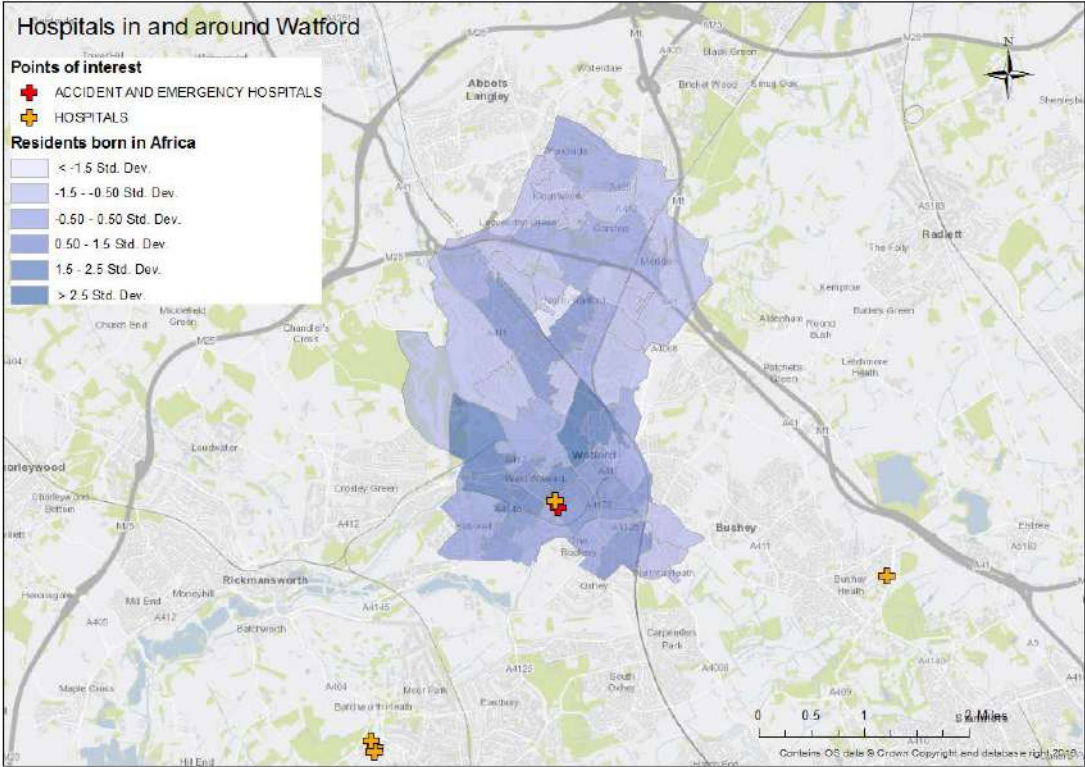


Figure 15: Parenting and childcare services in and around Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

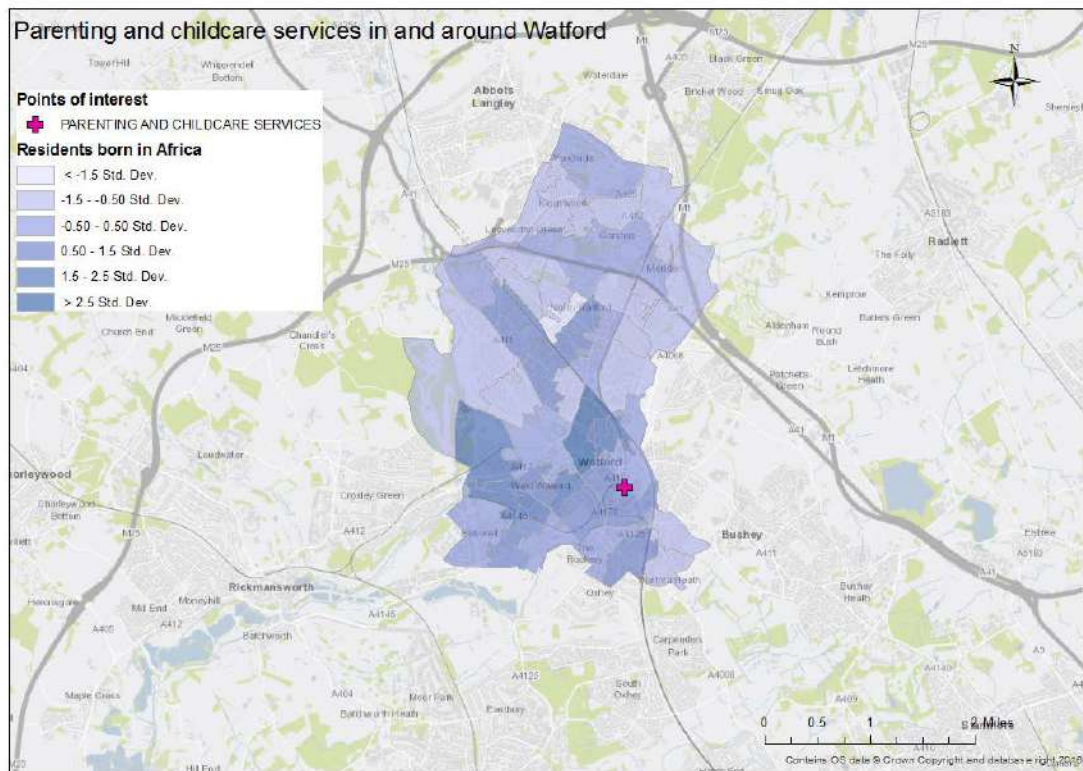


Figure 16: Pregnancy related services in and around Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

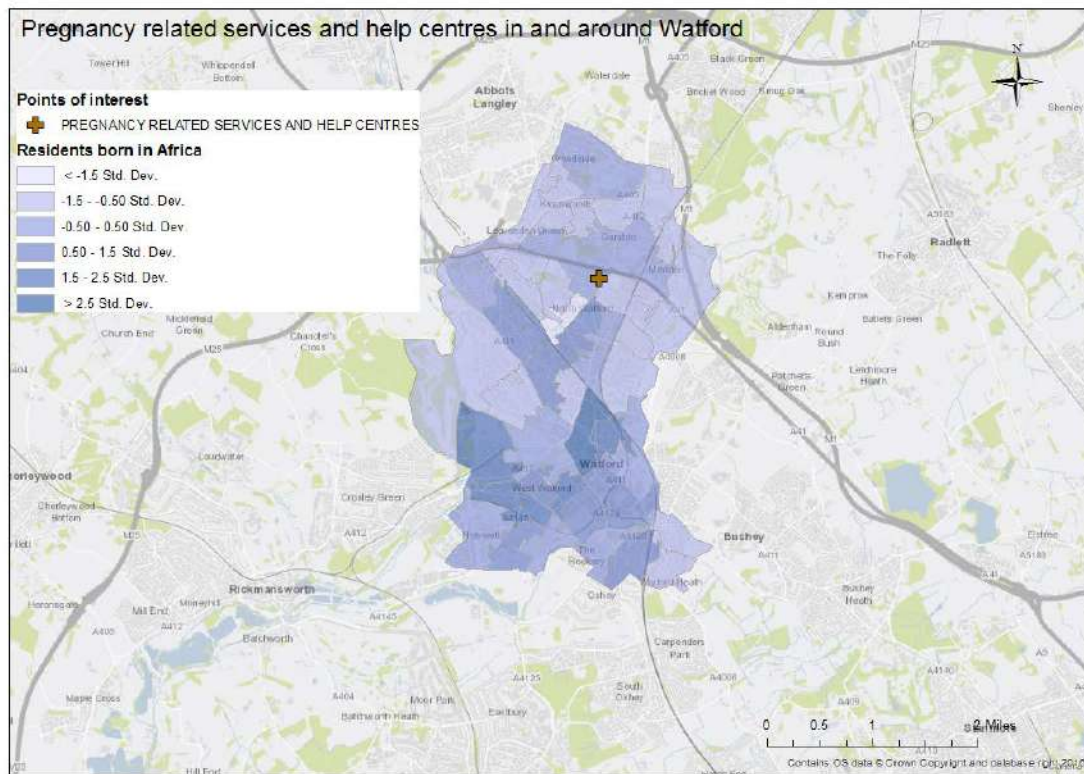


Figure 17: Surgeons and cosmetic surgeons in and around Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011

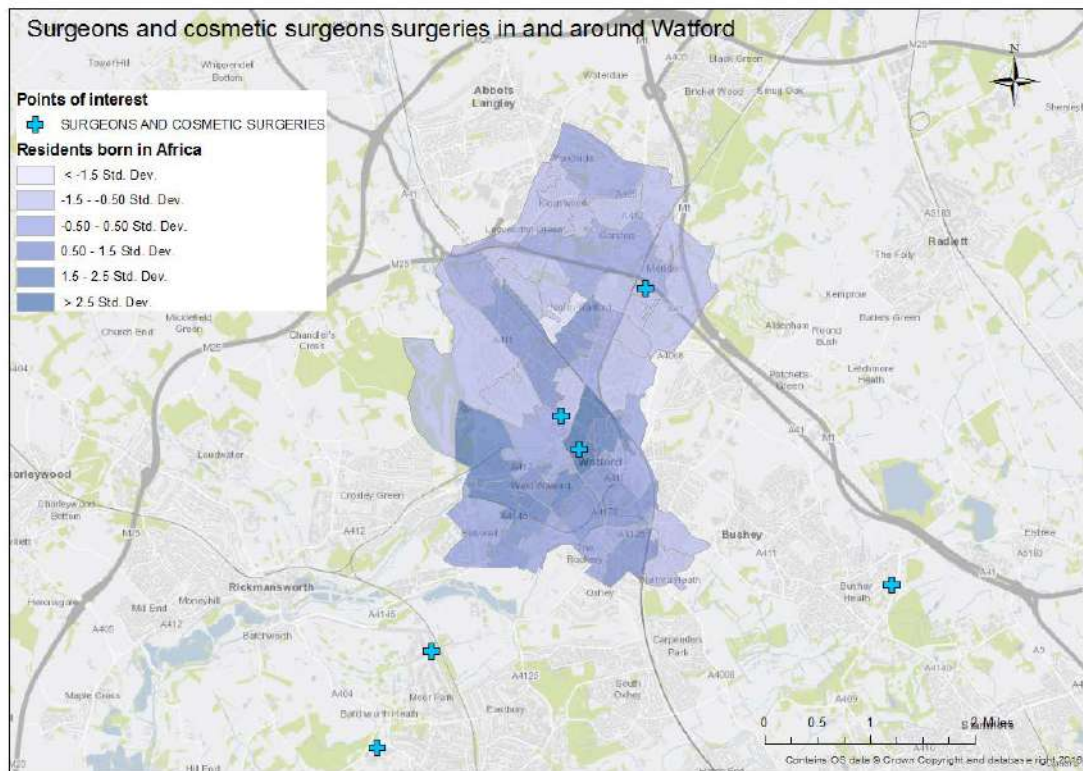
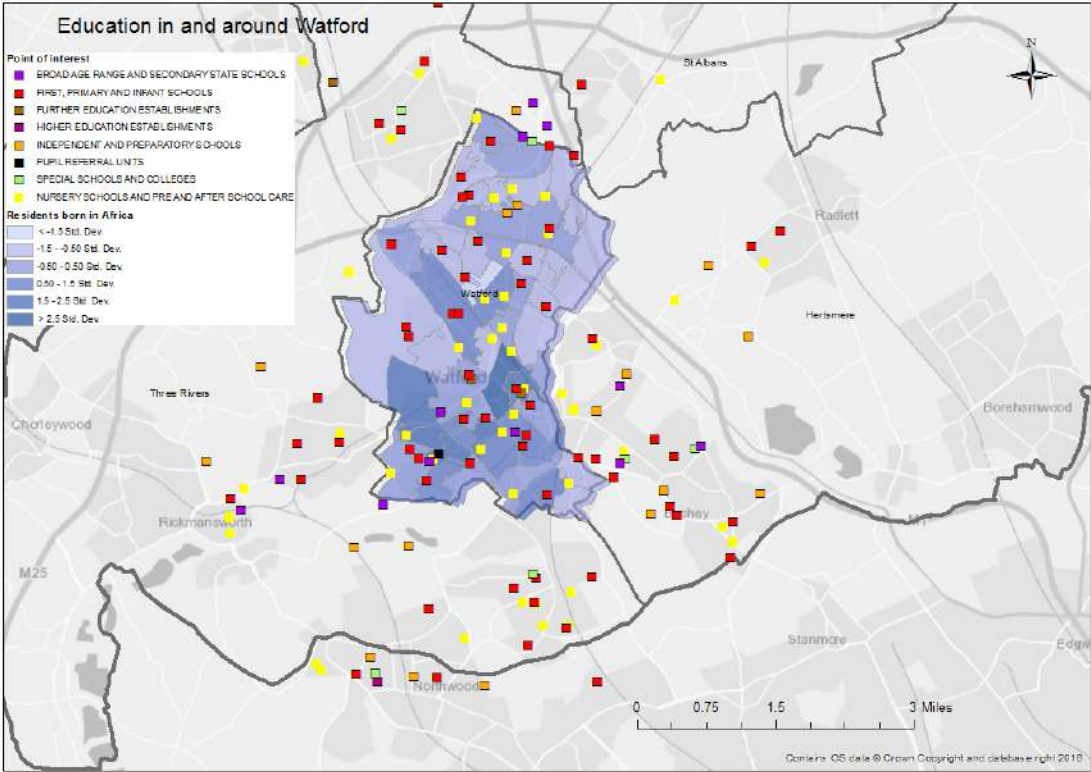


Figure 18: Schools and nurseries in Watford and number of residents born in Africa; Ordnance Survey, 2016 and ONS, 2011



FGM Process Map

Figure 19: FGM mandatory reporting process map; Home Office, 2016 (Annex A)

