

EQUAL OPPORTUNITIES COMMITTEE

Tuesday 18 January 2005

Session 2

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CONTENTS

Tuesday 18 January 2005

Col.

PROHIBITION OF FEMALE GENITAL MUTILATION (SCOTLAND) BILL: STAGE 1	771
DISABILITY DISCRIMINATION BILL.....	804

EQUAL OPPORTUNITIES COMMITTEE

2nd Meeting 2005, Session 2

CONVENER

*Cathy Peattie (Falkirk East) (Lab)

DEPUTY CONVENER

Nora Radcliffe (Gordon) (LD)

COMMITTEE MEMBERS

*Shiona Baird (North East Scotland) (Green)

Frances Curran (West of Scotland) (SSP)

*Marlyn Glen (North East Scotland) (Lab)

*Marilyn Livingstone (Kirkcaldy) (Lab)

*Mrs Nanette Milne (North East Scotland) (Con)

Elaine Smith (Coatbridge and Chryston) (Lab)

*Ms Sandra White (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Jackie Baillie (Dumbarton) (Lab)

Linda Fabiani (Central Scotland) (SNP)

Patrick Harvie (Glasgow) (Green)

Carolyn Leckie (Central Scotland) (SSP)

Mr Jamie McGrigor (Highlands and Islands) (Con)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Inge Baumgarten (World Health Organisation)

Bob Benson (Disability Rights Commission)

Dr Pamela Buck (Royal College of Obstetricians and Gynaecologists)

Rosemary Burnett (Amnesty International Scotland)

Bill Campbell (Inclusion Scotland)

Norman Dunning (Enable)

Susan Elsley (Save the Children Scotland)

Kate Higgins (Capability Scotland)

Simon Hodgson (Scottish Refugee Council)

Comfort Momoh (Royal College of Midwives)

Lynn Welsh (Disability Rights Commission)

CLERK TO THE COMMITTEE

Steve Farrell

ASSISTANT CLERK

Roy McMahon

LOCATION

Committee Room 1

Scottish Parliament

Equal Opportunities Committee

Tuesday 18 January 2005

[THE CONVENER *opened the meeting at 10:09*]

Prohibition of Female Genital Mutilation (Scotland) Bill: Stage 1

The Convener (Cathy Peattie): Good morning and welcome to the second meeting in 2005 of the Equal Opportunities Committee. I remind members, witnesses and members of the public to ensure that all mobile phones are switched off, as they interfere with our sound system. We have received apologies from Frances Curran, Nora Radcliffe and Elaine Smith.

Item 1 on our agenda is consideration of the Prohibition of Female Genital Mutilation (Scotland) Bill. Many of our witnesses have travelled far to be here, which is humbling given the struggle and moans that we had when coming in through the snow this morning. I offer a warm welcome to Rosemary Burnett of Amnesty International Scotland, Susan Elsley of Save the Children Scotland, Simon Hodgson of the Scottish Refugee Council and Inge Baumgarten of the World Health Organisation. Before I give members an opportunity to put questions to you, I invite you to make statements on behalf of your organisations on the legislation that we are considering.

Rosemary Burnett (Amnesty International Scotland): Thank you for inviting me to give evidence to the committee. Amnesty International broadly welcomes the legislation, which will have the effect of outlawing FGM on a similar basis throughout the United Kingdom. There are some points that we would like to cover.

Susan Elsley (Save the Children Scotland): We welcome the attention that has been given to scrutinising the bill, because we do not see the bill as standing by itself. We believe that it should be accompanied by sensitive approaches to providing information and education. That information and education should be targeted both at communities for whom the issue is relevant and at health and other professionals who work with them.

Simon Hodgson (Scottish Refugee Council): The Scottish Refugee Council welcomes the proposals. However, we are concerned that protection is not extended to asylum seeker children in Scotland and we would like that issue to be addressed.

The Convener: We will pursue the matter in questioning.

Dr Inge Baumgarten (World Health Organisation): Good morning. The World Health Organisation welcomes the committee's activity and believes that it is necessary to involve in a comprehensive, multisectoral way all the different stakeholders that are engaged in protecting children from this harmful traditional practice.

The Convener: We will consider the bill and how it may be implemented, so there may be questions that it is not appropriate for the World Health Organisation, for example, to answer.

Do the witnesses have a view on the consultation process that the Scottish Executive carried out? We have heard that the consultation period was very short and covered a holiday period. Did you have enough time to respond to the consultation? Would you have responded differently if you had had more time?

Susan Elsley: Save the Children Scotland had enough time, as it was able to access information quite straightforwardly. However, I am concerned about whether there was sufficient opportunity for information to get out to communities that may be particularly affected by the bill and whether that information was presented to them in an appropriate form and in appropriate languages. Over the past few years, the Executive has shown a great deal of commitment to consulting children and young people on legislation that will apply to them. I wonder whether anything appropriate could have been done to explore the bill's impact on children and young people and their views on it.

The Convener: Were you aware that information was available in languages other than English or that there was a process whereby translation could be sought? Over the past few weeks, we have heard that, although information was available to many communities, it was quite difficult to access. Do you think that there are better ways of ensuring that there is wide consultation?

Rosemary Burnett: One way of extending the consultation might have been to work orally with the groups of women and young girls who may be affected by the bill. In many communities, that is the traditional way of communicating. Had the consultation period been longer, more community work of that type could have been done.

10:15

Dr Baumgarten: The World Health Organisation was made aware of and invited to take part in this process only last week. That is very short notice and did not give us sufficient time to prepare and consult member states.

I notice that some important information is missing from the reading list that has been supplied to the committee by the Scottish Parliament information centre and in supporting materials. I highlight the fact that there has been a study of legislation in Europe regarding female genital mutilation and the implementation of the law in Belgium, France, Spain, Sweden and the United Kingdom. The study was produced by the international centre for reproductive health in Ghent. I offer that information so that the committee can include it in its further deliberations.

The Convener: That is helpful. The information that you received last week came from the committee, rather than from the Executive. The committee thought that it needed to know what was happening elsewhere in Europe and the world. Your input this morning is very valuable. We will include the study that you have mentioned in our information gathering.

Mrs Nanette Milne (North East Scotland) (Con): My question is directed specifically at Inge Baumgarten and the World Health Organisation. Estimates of the incidence of FGM in Africa show that it potentially affects a huge number of women. In some areas, more than 90 per cent of women may be affected. Are we winning the battle internationally to reduce the incidence of FGM? Is legislation of the sort that we are considering the right way in which to go about that? What effect do you think it will have on perceptions of FGM in the countries where it is prevalent?

Dr Baumgarten: Are you asking whether the legislation will have an impact on the perception of FGM in the countries from which people originate?

Mrs Milne: Yes. Is this the right way in which to affect how people think about FGM?

Dr Baumgarten: Since the 1990s, the world conference on women in Beijing in 1995 and the international conference on population and development in Cairo in 1994, it has been recognised globally that it is necessary to deal with FGM not just as a traditional practice that is harmful to the health of the women and girls affected but as a human rights issue. From the point of view of those who want to protect girls and women who are potential victims of the practice, it is helpful to have as much legislation as possible that aims to prevent them from being mutilated. However, it is important to educate people as well as to have legislation. If we aim to change perceptions in countries of origin, we are likely to need a network that links together activists, women's groups and national, regional and international non-governmental organisations, so that the legislation becomes known to people living in those countries, regardless of whether they migrate here or stay in their countries of origin.

Mrs Milne: Is the legislation having any effect yet, or is it too soon for that?

Dr Baumgarten: I presume that it is too soon, but I am not aware of any evidence on the matter.

Mrs Milne: What is the biggest challenge that we face when seeking to achieve our target of eradicating FGM?

Dr Baumgarten: The WHO's experience over the past few decades of supporting activists and countries that seek to abandon the practice suggests that if we address the issue only from a health education point of view, we miss important elements relating to culture, tradition and people's perception of gender and female and male roles in society. We need to co-operate closely with the practising communities so that we can understand why they practise FGM and we need to have strategies that are in harmony with their lines of thought.

Mrs Milne: Even if we are successful in reducing the incidence of FGM, many women will suffer from its consequences. In your experience, how much work needs to be done throughout all health service areas to ensure that effective and sensitive treatment is available to those women?

Dr Baumgarten: In the African region in which the WHO is most active in trying to prevent female genital mutilation, there is a big challenge in offering good-quality services to those who have been affected by the practice and who are suffering from long-term or immediate consequences. There must be trained experts and the maximum possible educational sensitisation of health providers so that they know what they must do if they are confronted with the difficulties and problems that are associated with female genital mutilation.

In Europe, we have become aware through consultative meetings with technical experts in the health field that health care providers in many countries—whether doctors, midwives, nurses, paediatric nurses or others—still have insufficient knowledge. They do not know what to do if they are confronted with FGM—they are embarrassed and afraid to take action that might result in their being labelled as having a racist attitude and they might not know how to deal with problems. It has been stated in your papers, rightly, that some people might try to organise a Caesarean section rather than a spontaneous delivery because they are embarrassed or do not know what to do. There is certainly a need for further sensitisation of health care providers and for educating them about the reasons for the practice being conducted in different communities in different countries. There is a need to understand better what the practice is about and how to deal with complications that may arise.

Mrs Milne: Are you aware of the extent to which legislation against FGM internationally depends on the World Health Organisation's definition of FGM?

Dr Baumgarten: I am not sure whether I understand your question. Would you rephrase it?

Mrs Milne: The bill is guided by the definition of FGM and its four types. Are other countries also guided by that definition?

Dr Baumgarten: The WHO definition is internationally recognised as the standard definition of what we mean if we talk about female genital mutilation, female genital cutting or female circumcision. Usually, the countries that have legislation refer to that definition, although some countries make exceptions in respect of piercing in the area of the vagina, for example. However, they all refer to the four types of female genital mutilation.

Mrs Milne: Thank you. That is helpful.

The Convener: What do you think about the terminology that is used? Some people would prefer that the word "circumcision" was used in the bill rather than "mutilation". Is it important to make that change? What effect would such a change be likely to have on the communities that practise FGM?

Dr Baumgarten: The World Health Organisation decided with other United Nations agencies to use the term "female genital mutilation" to highlight the human rights dimension of the practice. The WHO wanted to have a clear position. As an international agency, the WHO does not support any form of FGM being practised by a health care provider or any paramedical person in the health sector.

The term "female genital mutilation" is used at the policy level and to sensitise decision makers. However, one must start a dialogue at the community level, and if a term is used that is offensive to a community, it is likely that that community will react defensively and will not try to understand why FGM is being reasoned against. Communities usually use their own terms. One will say "l'excision" in a French-speaking country, or one may use the words "bolokoli" or "kene-kene" if one is using a native language.

Things vary according to the ethnic group to which one is talking. Somali people often use the word "sunna". The term that is most acceptable to the community is used in order to have a dialogue and to change things, but we have decided to use the term "female genital mutilation" at the policy level. Organisations that are based in the States also use the term "female genital cutting"—FGC—but the WHO, in line with other UN agencies, such as the United Nations Population Fund and the

United Nations Children's Fund, uses the term "female genital mutilation".

The Convener: Do other witnesses have views about the terminology? People have certainly raised the issue with the committee.

Susan Elsley: Save the Children works internationally, including in African countries, on issues relating to female genital mutilation and totally supports the WHO's position, which is that the phrase "female genital mutilation" should be used. However, people who work in communities must use sensitive language and terminology, although that should not undermine our concern about female genital mutilation.

Mrs Milne: Do the witnesses believe that the new law will protect girls and women from FGM? Will it provide more protection than the existing law does?

Rosemary Burnett: The new law will go a long way towards plugging some loopholes in the previous legislation, but I would like to make a suggestion. The committee might want to look into the UK's ratification of the UN convention against torture in order to cover situations in which, for example, a girl is sent back to stay with an aunt or grandmother and that aunt or grandmother allows or encourages the operation to go ahead. The UK's ratification of the convention allows the prosecution of any person of any nationality in the UK if they are shown to have committed, or to have aided and abetted, an act of torture anywhere in the world. The committee and the lawyers who are drafting the bill might want to consider that possibility as a way of extending the protection of girls.

Mrs Milne: That is something to consider.

Susan Elsley: The law has an important role to play in laying down principles and in creating a punitive position if the law is broken. However, it is important that the law is backed up by education and information to communities and that it is seen as having an educative lead.

Simon Hodgson: I reiterate our point about who is protected. It seems to me that the bill still will not protect children who are seeking asylum. If the practice is regarded as a breach of human rights, those rights should be applied universally and not only to people who fall within a narrow definition of UK nationals. It is clear that it will be difficult for such things to be prosecuted in the future and that there are technical difficulties, but it seems bizarre to me that if, for example, I arranged a business to transport children who are seeking asylum out of the country in order for FGM to take place, I would not be guilty of any offence under the bill. I might be guilty of other offences such as those relating to immigration or people smuggling, but I would not be committing any offence under the bill, which

seems me to be a human rights bill. I am sure that it would be possible to close that gap by recognising that a person's family still being in Scotland is sufficient connection for them to be protected under Scottish legislation. However, that seems to be specifically excluded.

The Convener: That is an area of concern, and we will ask the Executive for a paper on it. Members have expressed concern about protection for the children of asylum seekers. The answer that we have received so far is that if the parents leave the country, they will no longer be asylum seekers. We are not sure whether that would be the case if people arranged for their children to be taken back to a family member in another country.

10:30

Simon Hodgson: Surely the point is that if we are talking about a human right, that right must be universal—one cannot be selective and say that only some people have it.

The bill will cover some fairly unlikely scenarios. For example, it will deal with the scenario in which someone who has had a sex change operation might be subject to FGM. A scenario that is much more likely is that asylum seeker children from some of the communities that live in Scotland would need to be protected. That is the point that I addressed in my submission.

Dr Baumgarten: I think we all agree that the introduction of a law is an important step forward in reaching the objective of protecting girls from being the victims of FGM, but although having such a law is an important pillar, other activities are necessary. Enforcement of the law is a problem in many African countries in which, even though there is a law that prohibits FGM, the practice continues. The prevalence rates are still quite high; they are not dropping automatically.

For the law to be effective, sensitisation measures are necessary. There is a need to make the law known to the communities that practise FGM and to make them understand why it has been introduced. There needs to be multisectoral provision on how to identify cases of FGM and to find out who the victims and potential victims of the practice are. It is necessary to consider what other measures must be taken to accompany the law and to make it effective in the long run.

Marilyn Livingstone (Kirkcaldy) (Lab): My first question is for Rosemary Burnett, as it is about Amnesty International's evidence. In your submission, you say:

"The Bill should make it an offence for a person to permit a woman or girl to be placed in a situation that poses a threat of the commission of FGM or any other offence under the proposed Bill or for a person to allow such commission or offence to take place."

Will you expand on that and tell us what situations you had in mind?

Rosemary Burnett: There might be occasions on which a young girl was sent abroad and the parents were not aware that while she was abroad, various relatives were thinking about having the operation done on her. That is the sort of situation that we had in mind.

Marilyn Livingstone: Thank you for that clarification. The rest of my questions are open to the rest of the panel. Amnesty International suggests in its submission that the bill should include two additional offences: attempted FGM and incitement to FGM. What are the panel's views on that?

Rosemary Burnett: We believe that it is important to include in the bill a provision on incitement to FGM. "Incitement" is a very strong word. We are dealing with a cultural practice that has been deeply rooted in many communities for many generations. Many people, especially older people, in those communities are deeply committed to the practice—for very good reasons, as far as they are concerned.

I will illustrate my point with a story. I was working with an Amnesty International colleague in Ghana. His mother, who had suffered horrendous gynaecological complaints that could be traced back directly to the practice of FGM, asked him what his work in human rights meant—she wanted an example of it. He described to her the work that Amnesty was doing in Ghana to eradicate FGM. As it happened, she was the senior woman in her village and was responsible for guiding the other women in the village on the practices that they followed. In that village, the women believed that if a young girl had not been genitally mutilated, she would not get married and that any marriage that she might contract would result in deformed offspring. They also believed that if that cultural practice ceased, it might have an effect on the crops and the community's general well-being.

My colleague's mother went back to her village. That day, six girls were being prepared for the operation, but she put a stop to proceedings. She said that she now believed that the practice was wrong, because of the conversation that she had had with her son. The operations on the six girls did not go ahead, in spite of the complaints of the rest of their families. Within a year, three of the girls had got married and produced perfectly normal children, and the crop rotation had been perfectly normal. Within another year, the rest of the girls had got married and produced normal children. That had the effect of convincing the rest of the village that all the things that they had believed about FGM were false. They learnt through experience that not carrying out the practice did not lead to the consequences to which they had always believed that it would lead.

“Incitement” is the word that we have used to describe the very strong encouragement that older women in particular give to younger women or to their parents. They say things such as “Your daughter will never get married” and “You will ruin your daughter’s life.” As all members of the panel have said, the best way of eradicating the practice is through education and through the methods that were used in Ghana, which I have just described. However, to deal with situations in which someone is particularly insistent or in which a religious leader has directed that the practice should carry on, there should be an offence of incitement as a last resort.

The Convener: Do other panel members have a view on that?

Susan Elsley: Save the Children broadly supports Amnesty’s position, with the codicil that we always highlight, which is that it is important to work closely with communities. Legislation should not be seen as punitive or as failing to understand the long tradition of cultural practices. It is a question of working with communities.

Simon Hodgson: We, too, broadly support Amnesty’s position.

Marilyn Livingstone: The policy memorandum notes that there is anecdotal evidence that FGM is practised by members of the Somali community in Glasgow. Are you aware of any other groups or communities in Scotland in which the practice is likely to be carried out?

Simon Hodgson: I got notice of the question yesterday, so I tried to do a bit of checking with our community workers in Glasgow. It is unfortunate that the statistics that the Convention of Scottish Local Authorities publishes on the breakdown of asylum seekers in Glasgow by nationality are a couple of years out of date. Although it is not impossible to get the latest figures, they are not published on COSLA’s website. Recently, such a breakdown has been done by council ward but not by nationality.

A few years ago, there were groups of about 50 or 60 such families in Scotland from African countries, such as Ghana, Liberia, Kenya and Cameroon. I tried to find out whether there were any other groups. I know that the Somali women’s action group assisted by coming to give evidence and that there is a Cameroonian association. To return to the first question, we have not had time to do a lot of work on FGM with all those groups. If we had a bit more time, we might be able to go back to some of the other community groups to ask them whether FGM is practised. Other than that, the answer is that I do not know.

Rosemary Burnett: All the evidence shows that refugee flows come from areas in which there have been wars and disasters. The present

situation in Sudan means that it is probably reasonable to assume that in the future there could be a refugee flow from Sudan, where FGM is practised.

Susan Elsley: I talked about this to my colleagues who work with young asylum seekers and refugees in Glasgow, but they have no evidence on the subject. That flags up the need for some sensitive research to be undertaken; there is a lack of information on the practice in Scotland.

Marilyn Livingstone: The explanatory notes to the bill say that there have been no prosecutions under the existing legislation and that the Scottish Executive does not expect many prosecutions under the new law. What are your views on that subject?

Simon Hodgson: That shows how difficult it is to get the evidence that is required to bring successful prosecutions. I have read about some cases in other countries that have come to light as a result of difficult hospital births, for example. Those examples have been used as test cases and learning opportunities for communities, with the aim of highlighting the potential for someone to get into trouble if they do something wrong. I recognise how difficult it is to get evidence in these cases.

Marilyn Livingstone: If the bill is enacted, will it act as a huge deterrent?

Simon Hodgson: Yes.

Shiona Baird (North East Scotland) (Green): Does Inge Baumgarten know of prosecutions in other countries?

Dr Baumgarten: The international centre for reproductive health, which I mentioned at the beginning of my evidence, studied five countries—Spain, France, the United Kingdom, Sweden and Belgium—that have specific FGM legislation. Its report found that those countries are no more successful in punishing FGM offences than are countries who try to do so under more general criminal law provisions.

Marilyn Livingstone: The bill includes a proposal to increase the level of punishment by increasing the length of sentences. Will that have an impact?

Rosemary Burnett: It is important to send out a signal that the practice is wrong. We need to be clear that the practice constitutes torture and that it will not be countenanced in Scotland. The bill sends out that signal. Although the difficulty of bringing a prosecution under the bill is a factor, the most important factor is the deterrent effect that the bill will have.

Dr Baumgarten: From the material on the bill that I downloaded from the internet, I can see that

the intention is not to increase the number of court cases but to protect girls from being victimised. I agree with Rosemary Burnett that the bill sends out an important signal. It should act as the basis for further action and activity by women's groups, public health authorities and so on.

Mrs Milne: I have a follow-up question. I presume that the study document of which I have a copy is the report to which you referred. France is the one country that stands out in the report as having had some success with prosecutions. Do you know how that was achieved in France?

Dr Baumgarten: From the WHO perspective, and given that we are not a legal agency, I am unable to comment. I am happy to hand over the document to the committee for further reading. The committee could get in touch with the contacts in the report—some contacts are given for France, for example—and find out how they went about it.

Mrs Milne: Thank you; that is helpful.

Marilyn Livingstone: In its submission to the Scottish Executive, Glasgow City Council mentioned the pressure on African women who live in Glasgow to send their daughters abroad to have FGM carried out. What difference will the bill make to those women?

Susan Elsley: I return to the point that panel members have mentioned in our contributions this morning, which is that the bill gives an important lead in flagging up the legal position in Scotland. If it also provides councils with the impetus to work more closely with communities on the issue, it will be a productive step forward in banning the practice of FGM in communities. Again, I agree that the bill sends out a clear signal and that that needs to be backed up by some good work in communities.

10:45

Marilyn Livingstone: In common with the evidence from previous witnesses, panel members have talked a lot about education and how the debate on that subject has to go hand in hand with the debate on the bill. All committee members are supportive of that suggestion and are aware of the reasons that lie behind it. However, how do we publicise the issue to relevant communities in Scotland? How do we reach those communities and let them know about the change in the law so that people know that they are committing a punishable offence if they send a child abroad to undergo the procedure? Panel members have stressed the importance of getting the message out to communities, but what is the best way in which to reach them?

Simon Hodgson: I spoke to one of our community development workers yesterday on the

subject. We have a network of groups across Glasgow, including women's groups, groups from different nationalities and local area groups, some of which come together already. Therefore, we can access the networks that exist through us and others who work with groups in Glasgow. For example, Glasgow City Council also knows where the asylum seekers are and which countries they come from.

In the past, we have managed to send out letters to individuals in their own language. For example, we have sent letters to every household in an area, inviting people to come to specific meetings. There are fundamental things that we could do in that respect. We have also discussed whether information on the subject should be put into the welcome pack that people receive when they arrive in Scotland. Instead of producing lots of leaflets and leaving them in the places that people might go to—which we can do as well—we can communicate directly with people. Given that we are not talking about hundreds of thousands of people or about doing things in loads of different languages, we can identify the people whom we need to reach and their language.

I am aware that, when we produce material in different languages, it should be produced not only in written form but in tape and video format. That would allow material to be shown to groups, for example.

Dr Baumgarten: Given that the WHO has some experience in the field of health promotion, we know about how to reach communities and convey messages to them. One of the lessons that we have learned in the context of FGM from our experience in European as well as African countries is that the message is more effective if it is integrated in strategies for sexual and reproductive health or child and adolescent health. Instead of focusing only on FGM, it is more effective for an integrated approach to be taken, as the subject of FGM can be integrated into a broader package.

A woman from an ethnic minority community who is living in a European region could have a variety of health needs: she might need to attend sexual health, reproductive health or antenatal clinics. Ample opportunities exist for an issue such as FGM to be addressed in such a context without simply confronting women with information about a special service only for FGM. The lesson that we have learned is to take an integrated approach.

The WHO has collaborating centres in the field of women's health and gender mainstreaming, one of which is at the University of Glasgow. If required, the centre could support any further work that the committee might undertake on identifying appropriate measures. The committee is about to hear evidence from Comfort Momoh that will

include information on the African well woman clinic in London. She can tell the committee about her experience of good practice in reaching ethnic minority women and girls.

Marilyn Livingstone: Finally, how should the information on good practice be made available to the services and professionals who deal with communities in Scotland that are affected by FGM?

Rosemary Burnett: Such information should be incorporated in training for gynaecologists and other health professionals who work with women. The subject should also form part of continuing professional development for doctors, as it is an important element of delivering women who have had FGM practised on them. I know that at a previous evidence session the committee discussed what impact the legislation would have in the circumstances of a doctor being asked to reinfibulate a woman who had just delivered. That is part of the training that would need to be given to doctors.

Susan Elsley: We have been talking a lot about girls and women, but Save the Children's experience is that it is also important that boys and men are able to access health and information. Working with health professionals in the integrated way that Inge Baumgarten mentioned and getting information to male members of communities is important as well.

The Convener: There is lots of community pressure.

Dr Baumgarten: I have three points to make quickly so I do not forget them. It is important to involve men rather than focusing only on women and girls. That is the lesson that we have learned. In the end women always say, "We do it for the men." We have to convince community leaders and fathers and ensure that we do not forget them.

The WHO has a clear policy that no medical personnel at any level should carry out reinfibulation. From a UN-agency point of view, reinfibulation should not be supported in any country that is aiming to end FGM.

I wanted to answer Marilyn Livingstone's question, but I have forgotten it.

Marilyn Livingstone: I asked how we should disseminate information to services and professionals who deal with affected communities in Scotland.

Dr Baumgarten: The WHO has produced three brochures that are aimed specifically at midwives and nurses. One is a teacher training manual, the second is a student manual and the third contains policy guidelines for nurses and midwives and information on international human rights instruments relating particularly to the right to

health. Those three important manuals, which can be downloaded, have been produced in consultation with people in African and European countries. The WHO is more than happy to support you in educating medical students, midwives and nurses and in providing on-going in-service training and support.

Shiona Baird: My first question is for Susan Elsley of Save the Children, but other witnesses can comment if they wish. The Save the Children submission refers to article 12 of the United Nations Convention on the Rights of the Child, which states that it is a child's right to express an opinion in matters affecting them and to have that opinion heard. The submission adds that the provision of appropriate information and education is essential. What action would you ask of the Scottish Executive in that regard?

Susan Elsley: In relation to article 12?

Shiona Baird: Yes.

Susan Elsley: Article 12 is one of many articles in the convention; other articles also apply to children and young people in relation to FGM, including the right to protection. On article 12, our experience, and my colleagues' international experience in particular, is that girls who experience FGM often do not have their views taken into account. They do not know what is going to happen to them and they do not have access to information. We are saying clearly that it needs to be seen as essential that young girls have the opportunity to express their views and have them taken into account.

I have brought along a piece of research, which I have not forwarded to the committee, called "Rights of Passage: Harmful cultural practices and children's rights", which contains the views of girls who have experienced female genital mutilation and describes their shock and horror because they had no idea what they were about to undergo. The issue is highly sensitive and we have raised the complex issues of working closely with communities and young people on their sexual health, to which article 12 is relevant.

Rosemary Burnett: We should see the legislation as the apex of the pyramid; it should be part of an integrated strategy to protect girls and young women from harmful cultural practices. It will not work in isolation but will be part of an integrated approach from the Scottish Executive.

Shiona Baird: It has been interesting to hear from Inge Baumgarten how much information is available. From a health point of view, do you think that we have enough people in Scotland with the experience to carry out the type of work that is required to raise awareness and be involved with the women concerned?

Dr Baumgarten: I am not sure whether I am in a position to judge what expertise you have in this country. My impression is that a lot of groups here are active on the issue and there is a lot of experience at UK level. Support from the WHO or other active and experienced agencies would make it easier for you to develop your own strategy that could be adapted to your needs and qualifications and the setting here.

Simon Hodgson: Inge Baumgarten is right that there is loads of expertise in Scotland, although the practice is a relatively new thing for us to deal with, particularly in relation to the numbers. As a Glasgow resident, I know that there have been big changes in relation to the new communities arriving in Scotland that were not here in significant numbers before—apart from students at universities. Previous witnesses gave you lots of information about experiences in England, which I am sure can be shared. There is enough knowledge about community development and medical knowledge; we just have to put it all together, which is not impossible.

Shiona Baird: My final question is about information gathering. The policy memorandum states:

“There is no evidence that this practice is widespread within communities in Scotland, although evidence is hard to establish because FGM is a private practice”.

It is clearly not easy to gather information on FGM in Scotland. How should the Executive approach that?

Dr Baumgarten: The WHO has a lot of experience in that field, not in Scotland but in African countries where female genital mutilation is a concern. There are various possible approaches. One is through KAB studies—studies into the knowledge, attitude and behaviour of people—which can be carried out with students or women for example. We interview them about what they think of the practice, why they are undertaking it, whether they intend to have their youngest daughter cut and their plans for the future. In that way we are able to inquire about people’s attitudes and the knowledge that they have about the negative impacts of female genital mutilation. If the outcome of the survey is that they do not know about the negative impacts, we can say, “Okay, we need more health education messages at community level.” If we find that they still support the practice, we take what we call a behaviour-change approach, which involves dialogue and finding out why they do the practice and whether it is possible to change their cultural practices. If that is possible, the question then is how they want the strategies to be designed.

The other opportunity, of course, which I am sure we will hear about later from Comfort Momoh, arises in antenatal clinics, in which gynaecological

examinations can ascertain what type of FGM has been conducted on a woman. Therefore, it is possible to integrate our survey with the standard procedure of clinical examinations in antenatal clinics, which can inform us about the number of women from particular communities who are affected by FGM. There is much discussion in France about whether girls should be gynaecologically examined in their school medical check-ups. No agreement has been reached on that yet, as far as I am aware.

There are examples, therefore, that make it possible for you, in your Scottish setting, to decide what is appropriate in your country and how you want to go about making more information available. From a public health point of view, if you want to design strategies, you must have more information to be able to design them appropriately.

11:00

Ms Sandra White (Glasgow) (SNP): I have listened intently to the evidence and I want to ask about two particular issues regarding penalties, which I think were referred to earlier. I believe that you all agree that it is acceptable that the maximum penalty should be raised from five to 14 years’ imprisonment. However, I am interested in Amnesty International’s written submission and its reference to situations in which parents or relatives do not know that FGM is going to be carried out when a child is taken abroad. Does Rosemary Burnett think that the penalties should apply to such a situation, which Amnesty regards as a crime? Does Amnesty believe that the penalties should be wider than just raising the maximum possible term of imprisonment from five to 14 years and that they should deal with what Amnesty regards as incitement and coercion?

Rosemary Burnett: I do not know that I am qualified to say what the penalties should be. We are merely trying to point out that it would be possible to put in place an offence of incitement and that such an offence should be included in the bill. The bill should say not only that it is wrong to practise FGM, but that it is wrong to encourage and incite others to practise it. I remember that the committee received information from some Somali women who said that they believed that the practice of FGM was tied up with their religion, and you can imagine that there might be encouragement by religious leaders to continue the practice. If it were an offence to incite the practice, we might not reach the stage at which prosecution was necessary. The possibility of prosecution might act as a disincentive to any incitement.

Ms White: I understand your point, which is that although you would like a law against incitement, you would rather speak to people and try to stop

the incitement or encouragement of FGM and its practice without parents' knowledge. You mentioned religious issues, which leads me on to the exemption for mental health reasons and the age of consent. I have read what the panels' written submissions, including Amnesty's, say on exemptions. Do you think that the proposed exemption for reasons of physical or mental health is reasonable?

Rosemary Burnett: As we have heard, many mothers are under a great deal of pressure to carry out the operation on their children. They could cite mental health as a reason for ensuring that the practice was carried out, or the children themselves could be encouraged or incited to claim that. We need to be very careful that the bill's wording ensures that mental health actually means mental health and not such pressure.

Dr Baumgarten: I do not have a legal background, so I am not sure that I understand the bill perfectly. However, I have a couple of concerns about it. The first relates to section 1(2), which states that

"an approved person who performs ... a surgical operation on another person who is in any stage of labour or has just given birth, for purposes connected with the labour or birth"

should be excluded from punishment. It is likely that the clitoris is included in that provision, but I am not aware of any surgical operation in relation to labour and delivery that would justify the excision of the clitoris.

My other concern is about the mental health aspect and whether the bill would offer a loophole that would, for example, allow a woman to get a certificate from a doctor that stated that, for mental health reasons, she would have to have FGM. We do not have any evidence that the excision of the clitoris, the labia minor or whatever has any benefits for a woman's mental health. Perhaps it has such benefits for the mental health of a man, such as the woman's husband, but it certainly does not for the mental health of the woman or girl concerned.

I am also concerned about another aspect; I am not sure whether you have covered it, but you might intend to discuss it later. In Africa, there is an increasing problem with what we call medicalisation, when skilled personnel—whether doctors, midwives or nurses—offer services and perform FGM. That happens partly because the education strategies that have been conducted over past decades focused only on the health aspects of FGM. Those strategies said that FGM was bad for children's health because it is conducted in very unhygienic settings, with unclean knives and so on. People decided that they did not want to expose their daughters to unhygienic conditions and have them fall ill, so they went to health care providers and had FGM

done with anaesthesia and disinfectant. Therefore, there are now health care providers—paramedical staff—who conduct FGM.

Section 3(2) of the bill states:

"No offence under section 1 is committed by a person who ... in relation to the operation, provides services corresponding to those of an approved person."

Irrespective of the definition of "approved person", somebody from an African country could say that a medical doctor conducted the operation. However, from our international point of view, FGM would still be a human rights violation even if a doctor conducted it. Those are my concerns about the bill, not only as a public health person but, from the legal point of view, as a lay person.

Ms White: The bill would impose an age limit of 18 for the offence of FGM, which is the age limit that most other countries have imposed. If a qualified medical person performed FGM on a girl under 18, that would be wrong under our bill.

To return to the mental health issue, do the panel members have concerns regarding young girls being pressurised by their communities into having FGM? Is there a danger that a girl herself could say that, because of pressure from her community, it would cause her mental health problems if she did not get FGM carried out?

Rosemary Burnett: In many communities, FGM is regarded as a rite of passage and a girl is not regarded as a woman until she has had the operation. It is probably fairly easy to extrapolate from that that if a girl is regarded by her community as a girl, even though she is 20, because she has not had the operation done, it is not impossible that that could lead to feelings of low self-esteem and mental health concerns. As I said, the mental health exemption is a loophole in the bill as drafted.

Susan Elsley: I have a point that is not totally connected with Sandra White's question, but which follows on from Rosemary Burnett's point about the rite of passage. It must be strongly acknowledged that FGM plays a role in girls' rites of passage in their communities, which are about giving them access to rights as young women. Our colleagues at Save the Children Canada have explored alternative rites of passage and different ways of looking at moving to young adulthood in the communities with which they work. The communities accepted those new rites of passage, which became an alternative to FGM.

Ms White: My final question is on the age limit. In most countries that have laws against FGM, the age limit is 18, but you have questioned whether that will suffice. An issue arises in relation to consenting adults having cosmetic surgery. Should the law in Scotland contain an age limit in relation to female genital mutilation? Should

cosmetic surgical procedures be regarded as a separate issue? When we first looked at the bill, we talked about the distinction between cosmetic surgery and female genital mutilation, which is entirely different. There are two questions. Should there be a cut-off point at 18 years of age? Also, where should we go on the cosmetic surgery issue, which could be used as an excuse for FGM?

Rosemary Burnett: We are talking about harmful cultural practices that are normally done to girls. In international law, when a girl reaches 18, she is no longer a girl and she has the right to decide what she wants to do with her own body. That is the international legal take on the matter.

Dr Baumgarten: The WHO says that the practice should not be supported in any way—that is its clear position. I am aware that in some countries, such as Ethiopia, there is a wide range of practices in relation to female genital mutilation. It might be done in one ethnic group at the age of 1 month, in another group at seven to nine years of age and in a third group after marriage and prior to delivery. There might be women who are older than 18 who are put under a lot of pressure by their mother-in-law or their family to have the practice conducted close to delivery so that the family is satisfied that things are being done according to their cultural values. There are cases of FGM in women who are over 18 years of age, but it is not easy for the law to cover everything.

The WHO does not have a stance on surgical operations yet. I think that the issue could be raised by the UK's health delegation to the WHO's regional committee meeting in August. The UK could ask the WHO to consider the issue and to hold a consultative meeting on what it understands by FGM. At the moment, with UNFPA and UNICEF, we are in the process of rethinking and reformulating the type I to IV definitions of FGM and it might be the right time to consider whether vaginal surgeries fall under the definition of female genital mutilation, which is an issue that the Scottish Parliament and other organisations have identified.

Marlyn Glen (North East Scotland) (Lab): My first question is on costs to local authorities. It is anticipated that the bill will not create any additional costs for local authorities' social work systems, but we are all agreed that, following enactment of the legislation, there will be a need for education and guidance on matters that include but are not limited to child protection measures. What is your view on the cost implications of the production and provision of such education and guidance? Do you envisage that local authorities will incur any other costs in relation to the legislation?

11:15

Simon Hodgson: Obviously, there will be some costs for producing materials and bringing in expertise, as has been mentioned, but I do not think that they need be immense. We are not saying that the whole population of Scotland needs to be briefed immediately on all the details. At the moment, the requirement is focused in Glasgow, although a little bit of work needs to be done outside Glasgow.

I do not have a figure for how much it will cost to build certain aspects into the basic training of doctors, nurses, gynaecologists and so on, if that is what members are looking for, but clearly there will be some additional costs. However, it would make sense for such measures to be part of a wider, integrated, public health programme. After all, broader issues such as the integration of new communities need to be addressed, and it should not be hugely expensive to make them part of a package. Additional translation of material might be required, but we and the Executive already carry out much of that work. We would not be talking about vast amounts of money.

Dr Baumgarten: I support those comments. It is unrealistic to assume that we will be able to do what needs to be done without any additional funding. For example, if we want to know more about the prevalence of the practice in Scotland, we will need to carry out research, which will require money. If we want to train people, we will need money. An integrated approach that brings together representatives from the various sectors will need time and resources to be allocated to it to ensure that people can attend meetings, for example. Producing material will also require funding.

The WHO regularly holds consultations with member states on sexual and reproductive health issues. It might be interesting to hold a consultative meeting on the sexual and reproductive health needs of immigrant women in Europe to harmonise legal, community and health sector strategies. The committee could certainly make its interest known and ask formally for some support in that area.

The Convener: I thank the witnesses for their helpful evidence this morning. I know that Inge Baumgarten in particular has travelled some distance to be here.

I suspend the meeting for five minutes.

11:17

Meeting suspended.

11:24

On resuming—

The Convener: We continue our evidence gathering on the Prohibition of Female Genital Mutilation (Scotland) Bill. Our second panel of witnesses is now seated and I thank them for coming along. They are Dr Pamela Buck and Comfort Momoh. I understand that Comfort was up at 4 o'clock this morning, so a big thank you for getting here. Your evidence is important to us. If you wish, will you both outline your views before we go to questions?

Comfort Momoh (Royal College of Midwives): As you said, I had to wake up at 4 o'clock to be here, which is very early, but I am pleased that I am here. Thank you for inviting me to provide evidence. Before I begin, may I say that the building is lovely? It is great and unique.

As you said, my name is Comfort, and I am an FGM specialist midwife and public health specialist based at Guy's and St Thomas' hospitals. I chair an organisation called Black Women's Health and Family Support, which enables me to work in the community, and I am also the vice-president of the European network on FGM, of which I am sure you are aware.

I know that members are aware of FGM and its complications. FGM has no medical or health benefits. It is irreversible, and its effects last a long time. I know that because I work closely with women and children with FGM. FGM denies a child her fundamental human right, hence it is a cause for concern, and has resulted in working together to safeguard children within the UK. FGM is commonly performed by traditional birth attendants, and can be performed by anybody within the community, as well as by professionals.

It is important that the law is revisited. I am happy to take questions and to comment on my experience.

Dr Pamela Buck (Royal College of Obstetricians and Gynaecologists): I reiterate what Comfort said: there is no medical foundation for FGM. It is condemned by medical practitioners in this country, and in particular by the Royal College of Obstetricians and Gynaecologists, whose representative I am today. Our college is currently reviewing its curriculum and syllabus, such that FGM will have an even higher profile than it has had in the past. Female genital mutilation is covered in our training, as is the current legislation in England and Wales. The forthcoming Scottish act will be incorporated, because we train Scottish obstetricians as well.

The Convener: I will start by asking about terminology. What is your view on the change of terminology in the law, from the use of

"circumcision" to "mutilation"? Is it important to make that change? How is it likely to affect communities that practise FGM?

Comfort Momoh: Changing the terminology is important. Some people will argue against it. However, you have heard from the WHO about its stance on female genital mutilation. From my experience of working with the community and as a professional, I know that it is important to call a spade a spade.

Many activists have been campaigning for many years and have been using the softer phrase. We have gone into the community and have tried to sensitise it for more than 25 years. It is about time that we changed the terminology. When we are with the community, we have to use the terminology that people are comfortable with. It is important to acknowledge that. We cannot go into the community and say, "Have you been mutilated?", because the community sees FGM as an act of love; it does not see it in the way that western communities see it—as barbaric and a human rights issue. The committee needs to understand that.

For people's attitudes to be changed, they need to understand why FGM is performed in the first place, so the proper terminology should be used. I am sure that the WHO rightly mentioned that it is called "sunna" in Somali languages, and many other languages use the term "infibulation", while some people feel more comfortable using the term "circumcision". However, it is important that the professional uses the term "female genital mutilation", so that people are aware of the extent of damage to the vulva. From my experience of running conferences and seminars, I am sad to say that only about 70 per cent of professionals in the UK are aware of FGM even if they are not aware of the law. If we so-called professionals are not aware, how do we expect the community to be aware of FGM?

11:30

Dr Buck: I agree; it should be called female genital mutilation and not circumcision. There is one variety of FGM that is comparable to male circumcision where only the prepuce of the clitoris is removed—that would be the nearest equivalent. However, those patients are in the minority in this country. The majority of patients in this country have type III infibulation, which is far more mutilating than male circumcision and has more profound health impacts, so it is not appropriate to call it circumcision. It is a mutilating procedure and it should be called that.

I agree that when we are talking to communities and individual patients, we need to be a little bit more sensitive. The majority of the patients that I

see are Somali and they call it “cutting”. In the group that I meet, we ask, “Have you been cut?” and they know exactly what is meant.

The Convener: Will the new law protect girls and women from FGM and will it provide more protection than the existing law does?

Dr Buck: Yes, but only when the law is combined with education. It will happen not just because of the law, but because of everything the law will bring with it.

The Convener: That is why we are taking the evidence that we are taking; we want to raise the issue to encourage people to consider their role in promoting education.

Comfort Momoh: My answer to your question is yes as well. The law will be used as a deterrent for the practising community. Many women who come to the clinic say that they are against FGM and do not want to circumcise their daughters, but they get lots of pressure from back home. Those women will be able to fall back on the law. However, as Pamela Buck said, we need to have other strategies. The act alone will not help; we need to educate and raise awareness, and we need to collaborate and work with the community.

The Convener: In its submission, Amnesty International suggested including in the bill two additional offences—attempted FGM and incitement to FGM. Do you have any views on including those two additional offences in the bill? I am thinking particularly of incitement.

Dr Buck: I am not a legal person, but if a parent or a grandparent takes a child to Somalia, for example, with the intention of having FGM performed on that child—even though they do not perform it—and the child comes back mutilated, and if the parent or grandparent knew about it or if it was the purpose of the visit, then that parent or grandparent should be punished as well as the so-called surgeon.

Comfort Momoh: As long as the community is well informed, people should take responsibility for their actions.

The Convener: The explanatory notes to the bill say that there have been no prosecutions under the existing law and that the Scottish Executive does not expect there to be many prosecutions under the new law. Do you have views on the lack of prosecutions?

Dr Buck: It is a disgrace. There have been successful prosecutions in France, which is the only country that I know about. I think that there have been some attempts at prosecution in England and Wales, but they have fallen foul of there being a lack of evidence because the child and/or the parent or guardian needs to stand up in court and name a certain man or woman and say

what they did. That is the point at which the attempts to secure prosecutions fall flat.

The Convener: It is easy to say that, because there are no prosecutions, genital mutilation is not happening, but that is not the case; we know that it is happening.

Dr Buck: I believe that it is happening.

Comfort Momoh: We know that it is happening. The law in the United Kingdom is not being taken seriously. Last year, I was part of a team that was working on a case in Sheffield but, because of a lack of evidence, among other things, nothing was done. The police and enforcement teams were unable to do anything. People in the UK have not been taking the matter seriously.

Yesterday, a policeman from Scotland Yard came to see me about some cases that involve a bogus doctor. He wanted my advice on how to tread sensitively around the area, which seems to be the right way to go about things. Not until we start working with the police, child protection teams and others in the community to raise awareness of the law will we be able to prosecute anybody.

Shiona Baird: I assume that there was a considerable amount of publicity around the case in Sheffield. Did that have a beneficial effect in the community? What was the response?

Comfort Momoh: The media tend to blow things out of proportion, but the communities were made aware of the situation because of that. However, because of the sensitivity of the issue, no one was willing to come forward as a witness.

The Convener: That is interesting.

Marilyn Livingstone: Last week, we took evidence from Glasgow City Council, which said that it believes that there is pressure on African women who live in Glasgow to send their daughters abroad for the purposes of undergoing female genital mutilation. What difference would the legislation make to those women? If it will make a difference, how should we get out information about the law?

Comfort Momoh: As I said, the law on its own will not put an end to FGM; we will need to use other strategies. However, a deterrent is lacking. If the bill becomes law, a woman will know that she is in a country that has a law and that the situation is not like the situation back home, where there is no law or where nobody abides by the law. That will be a good step.

To raise the community’s awareness, the community must be involved. I know that the committee has involved the community in the consultation process, but more needs to be known about the prevalence of the practice in Scotland.

Proper data and knowledge of where the women are from are required. Are they from Ghana or Somalia? That information will help in working with them. You need to find out what languages they speak as well. The mistake that was made in respect of the Prohibition of Female Circumcision Act 1985 was that the communities were not aware of it because it was not translated into different languages. I have been working closely with Black Women's Health and Family Support and, together, we have been able to translate the Female Genital Mutilation Act 2003 into different languages. You need to be able to give the translations to all relevant organisations and communities in Scotland.

Somebody on the first panel talked about producing packs for asylum seekers. That would be a useful way of ensuring that people are aware of the laws—not only those relating to FGM—when they get to this country. It would also be useful to disseminate information during seminars, conferences and women's days, such as the one that we have on 6 February, which is zero tolerance day for FGM. One could use such days as opportunities to disseminate information to the community, because most organisations hold events on those days.

Dr Buck: An increasing number of women from communities do not want to have their children taken back home for the FGM procedure. They would be able to use the legislation as an excuse because they could say, "In times gone by, I would have sent my daughter back to you, grandma or uncle, but now, unfortunately, a law prevents me from doing so." The law would enable them to present the situation as not being their fault, which women have told me they would like to be able to do. That is another benefit.

Marilyn Livingstone: Dr Buck, you talked about the training for gynaecologists and paediatricians that is being rolled out and you mentioned that Scottish professionals were involved in that. How would we be able to roll out such training to other professionals who will be working with those communities? Do you have any examples of best practice that you can share with us?

Dr Buck: There is information in the submission by the Royal College of Obstetricians and Gynaecologists that I sent to Roy McMahon in advance of this meeting. Furthermore, parts of the WHO manuals and technical reports are public health oriented, although parts of them are designed more for use in Africa than in cities in Scotland, which have a relatively small number of people to whom they would apply. In London, there is an enormous number of such women; there are also large numbers in Birmingham and Manchester, which are the second and third largest English cities. From what one of the

previous witnesses said this morning, I understand that there is a large number in Glasgow as well.

General practitioners need to know about the subject, as do health visitors, midwives and nurses—the latter three professions being the first port of call because they are the ones who get involved with families. The next port of call is the general practitioners. Most GPs' training will involve some time in obstetrics and gynaecology. Nearly all GPs now get a family planning certificate, within which context FGM is mentioned, although not at any great length. As time goes on and more GPs do such diplomas, we will be able to get through to more of them.

It is likely that GPs of the future will not spend a formal period of six months doing obstetrics and gynaecology in a hospital but will have training that is more oriented towards women's health in a global sense. The Department of Health is introducing a foundation programme for GPs, which will involve a post-registration year made up of four-month modules. We are trying to introduce women's health modules as part of that. They are being piloted from August 2005 and will come into force officially in August 2006. Of course, however, not everyone will do a women's health module.

Comfort Momoh: In general, the subject should form part of the curriculum for all professionals if we are looking to raise awareness of FGM and to put an end to it. At Guy's and St Thomas' hospitals, where I work, we have effectively incorporated FGM into the orientation pack. Whenever new midwives, doctors or senior house officers start, they have to see me and I talk to them about the clinic and about how important it is that they are aware of FGM. I tell them of the importance of identifying FGM during a woman's pregnancy, especially in labour. I suggest that that approach be adopted here, too.

11:45

Marilyn Livingstone: It is clear that work is going on among health professionals, but what about other professionals working in the community? Is there a lot going on in the communities where you work for other professionals who might come into contact with children in particular?

Comfort Momoh: I work with everybody, but I alone cannot be everywhere at the same time. I do a lot of work with teachers, health visitors and child protection teams. Tomorrow, I have a seminar with my local GPs from the Stockwell practice, some of whom are not aware of FGM—I will have a two-hour talk with them, with a video and question time. I do a lot of training to raise awareness and to educate professionals. We need

to train more people to train others—we need training for trainers. We have in-house training and seminars for medical students and other professionals and I do a lot of work with teachers and school nurses.

Ms White: The policy memorandum says:

“There is no evidence that this practice is widespread within communities in Scotland”.

However, we know that it is going on and we have to put a stop to it. One of our problems is that it is not easy to collect information on the subject in the community. What is the best way for the Scottish Executive to go about gathering information from communities in order to get enough evidence of the practice and to put a stop to it?

Dr Buck: The Executive would need to go to the communities. As a member of the first panel said this morning, in Glasgow there is a network of contacts with various ethnic groups and country groups in different situations. That is where you need to start. I can speak only about Manchester, but our Somali women have a group called Haween, which is the Somali for “women”. The group got some funding from Manchester City Council and it holds a monthly luncheon club. The women do the cooking and they invite speakers from the medical profession, the Benefits Agency and child welfare agencies, for example. The group chooses whom it invites to speak on a topic. I have been to speak to Haween twice, on antenatal care and FGM.

In the hospital setting, we have link workers, who act as translators. They do more than that, however; they are also cultural setters of scenes. They have contacts with the language groups that they serve. We can get out into the community through those various groups.

Comfort Momoh: It is important to work with the community. I see a lot of Somali women and they form an oral community. It is important to inform them about your work at the beginning—to introduce yourself, tell them what you are doing and involve them. When I started the clinic, I had to go to mosques, look for women’s organisations and find out what women’s views were. You need to do some research, as the woman from the WHO said earlier, and you need to look into people’s attitudes. You need to work with people and get them involved at the start. If you do not do that, the word will go around: people in those communities will say, “We do not know what the Government is doing; the law is supposed to protect our children and yet nobody has told us about this new act.” Because those communities are oral communities, word will get around very quickly. It is important that communities are involved in the legislation.

Ms White: We have heard evidence from other groups about the medical effects that can result from FGM. What is the panel’s view on that subject?

Dr Buck: The initial problems are caused at the time of the operation: some girls die of shock because the operation is done without anaesthesia. Other immediate health effects include shock, haemorrhage and infection. Traditionally, when the operation is carried out abroad, it is done neither with the use of sterile instruments nor in an operating theatre. As the committee heard this morning, the increasing tendency, especially in southern Egypt, Somalia and Sudan, is to medicalise FGM. The same procedure is carried out but with sterile scalpels and surgical techniques and not with the blunt knives that are used traditionally, shall we say.

In this country, we mainly see the longer-term effects: the physical health problems and emotional and psychosexual problems, including difficulties with relationships and sexual intercourse. Those problems are common. However, because of the sensitivity of the issue and its taboo nature, the effects on women and girls do not come to the fore. Once we have got to know a patient and we are sitting down with them and having a chat, they will tell us about the difficulties, but they will not go to a GP and say, “I have a psychosexual problem; I am not reaching orgasm,” or whatever—people just do not do that.

The facilities that we have in Scotland and in England and Wales are not very good for dealing with psychosexual problems or with people from other cultures. There are subtleties of language and of the cultural aspects of relationships and, in general terms, they are not well dealt with. There are also physical problems: about 5 per cent of FGM cases present with retention cysts where the mutilation has been done; others have problems passing urine or a problem with acute retention of urine.

We see women when they want to marry, prior to which Comfort Momoh and I open up the infibulation. We do not have to do that in all cases: some women do not need opening up because the infibulation has broken down to a degree that allows penetration to take place. We also see them for opening either prior to childbirth or in the late stages of labour when we can see the baby’s head. That said, it is better to open up the infibulation earlier in the pregnancy.

Comfort Momoh: Pregnancy can bring flashbacks and memories, which can cause anxiety for the expectant mother. It is important that professionals are aware of the issue. Some women need a lot of support. Their pregnancy may be the first time that anyone has raised the issue of FGM. In most cases, given that the

women had it done when they were aged five or six and that the subject is taboo, nobody has talked to them about it. Some of the women are extremely anxious during their pregnancy and labour.

Ms White: I have a short follow-up question about the long-term consequences of FGM, which is an issue that Marilyn Livingstone raised earlier. Are we doing enough to educate doctors, nurses and community health workers in this country about the long-term effects of FGM?

Comfort Momoh: Although we are doing something, we are not doing enough. Before I began working at Guy's and St Thomas' hospitals about eight years ago, I had done a lot of work around FGM and, since then, I have been involved in many conferences locally, nationally and internationally. Whenever I go to big conferences, especially here in the UK, I do an exercise to find out how many of the, say, 100 participants are aware of the legal issues or of how to care for women who have experienced FGM. It is sad that only a handful will raise their hands to say that they are aware of the matter, because I have been doing lots of training and other people in the community and other professionals have been raising awareness. We are not doing enough; it is unfortunate that we are not reaching the people whom we are supposed to be reaching. The Government and policy makers need to look into that and provide funding for training and for raising awareness in the community.

Marlyn Glen: My question is on penalties. The new law will increase the possible term of imprisonment for FGM from five to 14 years. Do you have a view on that change? Might it help the issue to be taken more seriously?

Dr Buck: That is an indication of Parliament's view. Increasing the sentence from five to 14 years sends the message that Parliament sees FGM as a serious offence that will incur a sentence comparable to that for manslaughter. That is a good idea.

Comfort Momoh: I, too, think that it is a good idea, because it sends a strong message. It shows that the Parliament has strong views about putting an end to FGM and protecting children. However, at the same time, we need to educate people and raise awareness.

Mrs Milne: I will deal with the proposed exceptions and the age of consent. Do you think that the proposed exception for reasons of physical or mental health is reasonable? We have read in submissions that there are concerns about the mental health exception.

Dr Buck: The only potential argument for the exception for mental health reasons is that, if a young woman has been denied FGM, she might

be ostracised in her community; she might not be deemed marriageable should she go back home—although I do not think that that would be the case in Scotland or England—and would therefore be socially outcast and suffer emotional and mental trauma. However, the physical and mental disadvantages of FGM greatly outweigh that. It is rather perverse, but I have heard it argued that FGM has to be carried out because otherwise the girl in question will not be deemed marriageable and will be socially outcast in her village or town.

Comfort Momoh: We should look into the exception carefully, because it could be open to interpretation.

Mrs Milne: Some countries with laws against FGM have an age limit of 18, which allows for consenting adults to have the relevant procedure carried out. Do you think that we should have such an age limit in our law?

Dr Buck: No. The law should cover all women and girls.

Mrs Milne: Do you have any idea how common such cosmetic procedure is in the UK?

Dr Buck: No. I do not have any information on that.

Comfort Momoh: Cosmetic procedures are common in London. I know that people go to Harley Street to have their labia reduced. People also go to Harley Street to have their perineum tightened—for example, following three or four deliveries.

Mrs Milne: Do you think that such practices are increasing?

Dr Buck: Yes, but we cannot give you any figures. Such procedures are more common in London than elsewhere, but they are becoming fashionable. As a gynaecologist, I think that it is perfectly reasonable for someone whose perineum is slack as a consequence of their having had three or four children to want to have it tightened to improve sexual function.

12:00

Mrs Milne: I would have thought that that was more a medical than a cosmetic reason.

Dr Buck: That is right.

I have problems with some procedures to reduce the labia. I do some such procedures on the national health service—usually on girls who are in their teens or early twenties, who have gross elongation of the labia. Their labia are so big that they catch on clothes and they dare not wear a bathing suit. However, I get requests from people who merely perceive that their labia are big. If I think that the labia look normal, I will not

carry out the procedure. Some of those people may go to the private sector; as I do not practise in the private sector at all, I do not know whether that is the case.

Mrs Milne: The question is about drawing the line between medical and cosmetic reasons.

Dr Buck: That is right. Some people would argue that if an adult woman wants smaller labia—labia that she thinks are prettier—that is no different from wanting a face-lift, an operation to have her nose changed or a breast augmentation or reduction. Those are all image things. The feature that a person wants to change might not be abnormal. If someone has been born with a crooked nose, for example, they might not find it acceptable, even though it is just a variation on what is normal. We would not argue if they wanted to have their nose straightened—as long as they were an adult.

Comfort Momoh: That is where informed choice and consent come in.

At conferences, many African women ask me why what the WHO defines as type IV FGM, which includes what we have been talking about, is not seen as mutilation by the western community when the procedures that African women perform are seen as mutilation. Some will say that the western community is practising double standards.

The issue is informed choice and consent. Someone who has reached the age of consent can get their breasts inflated or do anything that they want to their body. As long as they are aware of the consequences, they have the right to do that. However, when it comes to FGM, it is vital to consider the position of children.

Mrs Milne: The bill does not contain an age limit. Given that it is not an objective of the bill to outlaw such procedures, should the bill make specific provision to allow elective cosmetic surgery to be carried out?

Dr Buck: I do not think that we can say to adults that they cannot have cosmetic surgery done on the vulva when they can have it done on the breast.

The Convener: How do you feel about the fact that the bill will probably outlaw a fair amount of cosmetic surgery?

Dr Buck: Personally, I do not have a problem with that, but I am not in private practice.

Comfort Momoh: I do not have a problem with it, either.

Dr Buck: There are some individuals who genuinely have hypertrophied labia, which are a nuisance because of rubbing or friction, or because they catch on clothing. I have no problem about dealing with that, but I do not do procedures

on people who have normal labia but who want them to be smaller or slimmer, and I cannot argue very strongly for those who perform such operations.

Shiona Baird: In your book, *Comfort*, you refer to WHO figures from 1997; the other figures are from 1993 and 1998. I take on board your point about straw polls and the lack of awareness, but do you get the feeling from discussions—particularly the work of Amnesty International—that you are beginning to see a reduction in the incidence of FGM here and abroad?

Comfort Momoh: Yes, definitely, among the second generation. I was in Somalia about three years ago to research current attitudes. I chose Somaliland because 92 per cent of the women whom I see are from Somalia and I felt that it was important for me to go there and meet the people to find out what their attitudes were. It was interesting to note that, although attitudes are changing in the cities, they are still the same in rural areas and villages.

Marlyn Glen: The bill does not anticipate any additional costs to the local authority social work system. However, given the likely need for education and guidance following enactment of the bill—not only in relation to child protection measures—what is your view of the potential cost implications of the production of guidance and the provision of education?

Comfort Momoh: Why does the bill not anticipate any costs? With any attitude change, you need to think about the cost. You need to provide funds for the community and to give support for people who will raise awareness and campaign. There should be costs, because you need to raise awareness and provide leaflets and other tools and resources. There will be cost implications.

Marlyn Glen: So you challenge the explanatory notes. That is helpful.

Dr Buck: The impact of costs could be minimised. FGM education should be carried out in the context of reproductive health education. With such a package, it would be a question of introducing or strengthening the FGM component within the teaching material, perhaps when it is being reprinted, so that you do not need to scrap all your educational material and start again. That could be phased in, but somebody will have to write the material, somebody will have to translate it and somebody will have to devise and deliver the module on FGM in other health education packages. From colleagues, I have gained some idea of the community gynaecology services in Glasgow, which seem pretty well geared up to deliver.

Comfort Momoh: You can also tap into other resources that are already available, instead of reinventing them, such as the WHO, us at Guy's and St Thomas', and other organisations. I am happy to come back to provide educational support to professionals or to raise awareness at any time. Feel free to call me.

The Convener: We may well call you. Thank you for your evidence this morning. It has been very helpful.

12:09

Meeting suspended.

12:16

On resuming—

Disability Discrimination Bill

The Convener: The second item on our agenda is an evidence taking session on the Sewel motion on the Disability Discrimination Bill, which is currently before the UK Parliament. I warmly welcome to the meeting Kate Higgins from Capability Scotland, Bob Benson and Lynn Welsh from the Disability Rights Commission and Bill Campbell from Inclusion Scotland. [*Interruption.*] I am sorry—I missed out Norman Dunning from Enable. Do not take it personally, Norman.

Norman Dunning (Enable): I certainly will not.

The Convener: Before we start our questioning, I give the panel an opportunity to make an opening statement about their views on the bill.

Bob Benson (Disability Rights Commission): I thank the committee for this opportunity to discuss the Disability Discrimination Bill, especially given that several of its provisions have particular implications for Scotland.

The bill represents a significant extension of the powers and scope of the Disability Discrimination Act 1995 and incorporates the remaining recommendations of the disability rights task force, which was established in 1997, reported in 1998 and preceded the setting up of the Disability Rights Commission. As a result, the bill marks a positive move towards ensuring comprehensive civil rights for disabled people in Scotland and across the UK. In effect, it covers the nine-year window of disability rights legislation, which is now coming to a close.

Of the bill's provisions, we draw the committee's attention in particular to the new disability equality duty on public authorities, the widening of the legal definition of disability and the regulation-making powers that the bill confers on ministers to remove the exemption of modes of transport from part III of the DDA, which concerns access to goods and services.

The public sector duty is designed to foster over time a cultural shift in public authorities' attitudes to disability and how they meet disabled people's needs. The aim is to reach a point at which individuals will have less need to seek retrospective redress for instances of discrimination, because organisations will have proactively addressed the root causes of discrimination. The DRC looks forward to working with the Executive and the Parliament as the Scottish code of practice is drafted and consulted on.

The bill seeks to extend the definition of disability to cover, from diagnosis, cancer, HIV and multiple sclerosis. In future, people will not find themselves unable to bring a case under the DDA simply because their condition has not yet manifested itself. That is significant, given the fact that Scotland has the highest per-capita incidence of MS in the world. The change should benefit many people. The bill will also remove the proviso that a mental illness must be clinically well recognised in order to be covered.

The transport provisions will mean that, in future, disabled people will have the right not to be discriminated against when using public transport. That should be seen against the target dates for train and bus accessibility that the UK Government has set for 2020. However, shipping and aviation will remain subject to voluntary codes—a fact that has particular resonance in Scotland, given the reliance of remote and island communities on lifeline ferry and air services. The transport provisions must also be seen against the wide-ranging administrative reform of transport in Scotland that is proposed under the Transport (Scotland) Bill and the significant new powers that are conferred on Scottish ministers under the Westminster Railways Bill.

Finally, we highlight our desire that the bill amend the DDA to ensure that education discrimination cases will, in future, be heard by the new additional support for learning tribunals that were set up under the Education (Additional Support for Learning) (Scotland) Act 2004. Overwhelming evidence built up over the years suggests that tribunals offer a better forum than the sheriff court in which to resolve education disputes.

Norman Dunning: I have little to add to the statement from the DRC. Enable represents children and adults with learning disabilities, and we very much welcome the new public duty to promote equality, especially for those we represent who have a hidden disability. As Bob Benson said, in the past, too much has relied on people taking action when things have gone wrong, and people with hidden disabilities are less likely to feature and to take their case forward. The new duty is particularly useful.

We are looking to benefit from the extension of the DDA to areas where things can be made more easily understandable. For example, tenancy agreements are pretty inaccessible documents, but there will be a duty on authorities to make them much more accessible. We think that the bill may also have an impact on such things as direct payments, of which there has been a low take-up by people with learning disabilities, sometimes because the processes seem inaccessible. We are concerned about the access that people with

disabilities have to the health service, and we would like more promotional policies and much more thought to be given to that by the health service. We think that the bill will place a duty on those authorities to do that.

We welcome the bill and, in the circumstances, welcome the Sewel motion as a way of pushing it forward quickly.

Kate Higgins (Capability Scotland): Like our colleagues, we welcome the Disability Discrimination Bill, especially as it implements several of the outstanding recommendations that were made some time ago by the disability rights task force. Similarly, we welcome the extension of the definition, but with the same concerns as the DRC. We also welcome the extension of the provisions to cover transport. Capability Scotland has campaigned on and conducted research into disabled people's experience of transport, and it is now widely known how crucial transport is to disabled people's participation in all aspects of daily life. The bill will be an important step forward.

For similar reasons to those given by our colleagues, we too welcome the new duty on public authorities to promote disability equality. We would welcome the committee's consideration of a specific issue that our written evidence picks up on, even if it is only to flag up the need for clarification of the existence of a particular transport mode. However, we have no wish to wreck the chances of the bill; we want it to be passed.

Like all other organisations, we are anxious about the uncertainty surrounding the date of the general election and whether there will be enough time to pass the bill. We certainly want the bill to be passed at Westminster—hopefully with some amendments.

Bill Campbell (Inclusion Scotland): We acknowledge and welcome the Disability Discrimination Bill. We might be coming from a different angle from our colleagues because Inclusion Scotland is an organisation that acts as a conduit for disabled people who represent themselves. We certainly welcome the advances in the bill and worry about it running out of time, given that it has been in the system for more than a year, since the draft stage in December 2003.

We have concerns about some things that have been left out of the bill. We are concerned that people are still referred to as having disabilities. We do not accept that. We certainly have impairments; our disability comes about through society's reaction and attitude to those impairments. I notice that the Sewel memorandum on the bill twice mentions "persons with disabilities" and we are quite sad about that. It might not be important to the legislators, but it is

important to us. If it can be accepted that people are disabled by society's attitude and reaction to their impairments, we would move some way along the road to feeling more included.

We are also not 100 per cent sure about the burden of proof and whether that is going to change. We know fine well—and it has been accepted, although nothing seems to have been done about it—that it is very difficult for disabled people who do not have knowledge of the law or a big enough income to take on employers or companies to get redress for the discrimination that they feel. We really need to feel that that is being tackled. We could use the example—and I hope that I am allowed to do this—of the Ryanair case where there might have been a victory, but we are not too sure who won, because Ryanair still charges a wheelchair levy on every single ticket that it sells. It prints it on the ticket and we are appalled that that is allowed to happen in this country.

We welcome the bill. We are not too sure about the Sewel motion; perhaps the convener could explain that to us. If the bill runs out of time, does that mean that we lose everything?

The Convener: There is a Sewel motion because much of this subject is reserved, so the legislation will have to be done at Westminster. We will examine elements of the bill and when it has gone through Westminster, it will come back to the Scottish Parliament and this committee. We will have another bite at the cherry.

I will start the questions. The DDA is not an old piece of legislation. Why was it considered necessary to make such significant changes to the legislation? What level of involvement, if any, have your organisations had in the development of the legislation?

Bob Benson: The original Disability Discrimination Act 1995 had many gaps and flaws that needed to be addressed. We were pleased when the 1997 Labour Government established a disability rights task force to advise Government on the further development of the DDA and on equality legislation in general. The report "From Exclusion to Inclusion" contained 156 recommendations covering many of the areas that have now been legislated on, such as the Special Educational Needs and Disability Act 2001, and the extension of access to goods and services. We now have the final piece of the jigsaw, which is the move towards a public sector duty. The process has evolved over a considerable period to address flaws in the original legislation.

12:30

Norman Dunning: The original DDA was a long time in its inception; I remember 14 attempts and I

was involved in them all. It was therefore not surprising that we made compromises when it went through, but now is the time to address some of those compromises.

The big thing will be to change people's attitudes and responses. A duty to promote is exactly that, which is why we want it. We do not want to say to people, "Here's a piece of legislation that you'll grudgingly have to adhere to—or else somebody will follow it up with you." The duty to promote is a significant move forwards—perhaps more significant than it seems on paper.

Bill Campbell: Like Norman Dunning, I have been involved in the campaigning since 1981, when the British Council of Disabled People was formed. Our tack was that we were looking for rights, not charity. We lobbied and campaigned for years on end and got the DDA. It was not necessarily what we were looking for but it was a move forwards. Inclusion Scotland, as you know, has been involved since its inception three years ago, but activists and campaigners in the disabled people's movement have been involved for more than 20 years. We continue to lobby and campaign.

Kate Higgins: Further amending the legislation should not be seen as a bad thing; it is positive. The legislation has gaps, and the issue also arises of the place of disabled people in our society. They are now less marginalised, although much remains to be changed. The new legislation will go some way towards redressing some of the flaws and filling some of the gaps. It is good that the Government is prepared to say that the original act did not go far enough and that its scope can be widened. That is positive.

The Convener: When reading the new bill, I was encouraged at how things have moved on; and, as a past campaigner, I am delighted with some of its provisions. Are you content that the bill will result in significant improvements to the lives of people with disabilities in Scotland?

Norman Dunning: Yes.

Bob Benson: Yes.

The Convener: I can see that there is general agreement on the panel.

Mrs Milne: Do the panel members feel that adequate consultation was carried out on both sides of the border before the bill was introduced? Does the bill, as introduced, show that responses to the consultation were taken into consideration?

Bob Benson: The Disability Rights Commission was heavily involved in the lead-up to this legislation. We conducted a legislative review that was well-received by the Westminster Government. From that process, a joint Westminster committee evolved, which undertook

pre-legislative scrutiny of the proposed legislation. That is what has led to the bill that is now being considered. It has already gone through considerable scrutiny, which is one of the main reasons why it enjoys so much support throughout Westminster—and in the comments that we have heard today.

Bill Campbell: In the run-up to this bill, we have worked with the DRC on some of the committees. Obviously, we accept that not everything that we submit in our consultation papers will be accepted, but that is what keeps us campaigning. However, there has been a significant sea change in opinion, and we hope to keep working on that.

You may be intending to ask about the notion that—because of work that public authorities are doing on the implementation of the Race Relations (Amendment) Act 2000—the Disability Discrimination Bill will not have a significant cost. Offering access to buildings, and offering information in accessible formats, may indeed incur costs that will not be incurred by the provisions on race.

The Convener: That is now on record, Bill. We can find out.

Mrs Milne: We heard in the opening statements that Norman Dunning thinks that dealing with the bill by Sewel motion is a good idea but that Bill Campbell has some doubts about that. How do Kate Higgins and Bob Benson feel about it?

Kate Higgins: We do not want the bill in its entirety to be lost. If it did not proceed by way of Sewel motion, there would be difficulty in trying to legislate in Scotland. Lots of areas of the bill could not be covered because they deal with reserved matters, and there might also be an issue about timing. We do not want any of those areas of the bill to be lost.

Whether someone lives in Scotland, Wales, Northern Ireland or England, they are entitled to the same rights and to be treated in the same way. However, we have concerns about specific issues on which we would welcome clarification from the committee and the Parliament. We have raised the transport issue of lifeline ferry services. Shipping may not be covered by the DDA until well into the 2020s or 2030s, and there is an issue about what might happen with those services in the meantime. Nevertheless, we support the Sewel motion as the way forward. We share Bill Campbell's concern that, if the bill falls, we will go back to square one.

The Convener: We understand that there has been some discussion about ferry service tendering. You will be aware that tendering for ferry services is about to take place and that disability access will be high on the agenda. The Scottish Executive will take that forward now, rather than wait for the outcome of the bill.

Kate Higgins: Thank you for that information, convener. Some members may be aware that we raised the issue at that end as well, as we saw that as an alternative route. It is excellent that the Executive has picked up on that and that accessibility will now be a condition of the tender.

The Convener: I apologise to Nanette Milne for hijacking her question.

Mrs Milne: I just wanted to hear from the DRC.

Bob Benson: The DRC is aware of the concerns around Sewel motions; however, we feel that, in this specific circumstance, the Sewel motion is the most appropriate way forward. The powers are reserved to Westminster, but the Sewel motion procedure exists to ensure that questions about how reserved legislation concerning duties on public authorities is implemented in Scotland are decided by the Scottish Parliament and the Executive. By going through that process, the Scottish Parliament will ensure that the provisions are properly scrutinised. The Sewel motion is, therefore, an appropriate vehicle in this circumstance.

Norman Dunning: There are some specifically Scottish bits that we would like to see enacted—provisions relating to consent, which are quite different from what is in the Adults with Incapacity (Scotland) Act 2000. However, our understanding is that it is a matter of ensuring that the regulations are properly drafted to take account of the Scottish situation and that it should not be a matter for the primary legislation.

Lynn Welsh (Disability Rights Commission): As Bob Benson says, it is an unusual Sewel motion because, although the public sector duty provision has to be passed at Westminster because it is a reserved matter, the power will be given to Scottish ministers to add the meat to it. That is different from removing powers and making legislation elsewhere; therefore, it is an odd kind of Sewel motion.

You are right to say that we have to preserve and look after the Scottish end of it. Obviously, Scottish ministers will be able to pass their own regulation, and the DRC is producing a separate code for Scotland because we recognise—as Norman Dunning has said—that specific issues require to be addressed here. There will, therefore, be a separate code and separate regulations to protect the Scottish position.

Ms White: I understand entirely what you are saying with regard to what I would prefer to call the legislation rather than the Scottish bits. I wonder about something that has been mentioned by two members of the panel. If the bill were not passed and the matter were dragged out further—it has been going on for 20-odd years, with bits added on to it regardless of which country the bits

have come from—what would be your reaction? Would you come back to the Parliament to ask for a specific bill for transport and public authority bodies anyway? Obviously, it is the equal opportunity part of it that is reserved, not the rest of it, but that is quite a lot and matters a lot to disabled people. Would you be prepared to come back if, unfortunately, that were to happen? Do you think that you would be prepared to come back with separate legislation?

Bill Campbell: If the bill were lost and we were back to square one, I would be tempted, based on many years' experience, to advise people to go through the European route. It is quite clear that European directives are sometimes the only way that things get done, and we can certainly prove that through the non-discrimination directive on employment. If that had not come from Europe, I am pretty sure that it would not have happened in this country either. It would be very sad if we had to bypass Westminster and go through Europe and then the Scottish Parliament to get things done, but that may well be the only way forward.

The Convener: I understand that, if the bill does not go through, it is a human rights issue and something needs to happen. It is a timing issue, but it will happen, whether this year or next year, although people are clearly impatient because they want it to happen now.

Lynn Welsh: To be fair, the Westminster Government is committed to ensuring that it goes through. That is why the bill has been put through the House of Lords—to try to short-circuit what can sometimes be a long process. The Government is committed, which is good, and we still hope that the bill is on its way.

Ms White: Would you come with separate legislation if it did not go through?

Lynn Welsh: There is very little that the Parliament could legislate on, but there are other ways of dealing with it.

The Convener: Yes, you have mentioned that.

Kate Higgins: May I raise an ancillary point? Although we could not do that, there is sometimes an issue about different pieces of legislation joining up. We have raised concerns in the past about how some of the Scottish Parliament bills sit with UK legislation in relation to the DDA and in relation to how they play off one another. Sometimes they do not seem to match up, and sometimes they seem to contradict one another. We have asked on previous occasions for a provision on the face of legislation that almost reinforces people's rights under the DDA. The Parliament has, to date, been unwilling to go down that route, and we would like to see the Parliament taking a fresh look at that approach and generally doing a bit more joining up, so that in future fewer

questions are left unanswered about how different pieces of legislation interact.

Marilyn Livingstone: Bob Benson alluded to the regulations on public authorities. The provisions of the bill require that Scottish ministers consult the Disability Rights Commission before making regulations to impose specific duties on public authorities in Scotland to promote equality of opportunity for people with disabilities. How do you see that working and what are your views on the requirement? How will that help to improve the situation?

Bob Benson: I shall ask Lynn Welsh to address that, because she will be heavily involved in the consultation process.

Lynn Welsh: I live my life in public sector duty. We are already working closely with the Scottish Executive through the equality unit. We have drafted a code of practice on what we think the regulations will contain, and we have consulted the Scottish Executive about that. The English regulations are coming out in draft form fairly soon and the Scottish ones will follow. We are confident that we have a good relationship with the equality unit in the Scottish Executive, which I am sure will involve us at all stages of creating the regulations, as we shall involve it at all stages of the code.

Marilyn Livingstone: For specific duties to be imposed on cross-border authorities, the bill requires that the secretary of state consult with Scottish ministers and that Scottish ministers consult with the secretary of state. Are you content with those proposals or do you have any concerns?

Lynn Welsh: I do not think so. That is exactly the same system as is in place for the Race Relations (Amendment) Act 2000, and it seems to have worked successfully there, so I do not think that we have too many concerns about that.

Ms White: The consultation document "Delivering equality for disabled people" listed the Scottish bodies that the Executive intended to require to publish disability equality schemes under the bill. Have you seen that list—I am sure that you have, but the paper asks me to ask you—and have you any comments about the bodies that are listed there?

12:45

Lynn Welsh: Yes. Far too few bodies were listed. We have given the equality unit an idea of what other bodies, such as qualifications bodies, should be covered. As part of an on-going process of trying to include more bodies in the scope of the bill, we have spoken to colleagues who also have great ideas. The bodies that are mentioned in the document may originally have been taken from the

list of bodies to which the duty on race applies, but we believe that disability might be an issue for many more bodies. We are consulting on that; we hope that the list will be extended.

Bill Campbell: I can sum it up in three words: all of them.

Norman Dunning: Not surprisingly, our particular concern was that the list did not include any of the qualification bodies, such as the Scottish Qualifications Authority, the Scottish Social Services Council and the Scottish Commission for the Regulation of Care. All those bodies can be discriminatory in the way in which they apply qualifications. That can make it difficult for people with disabilities to gain qualifications, so we very much want all such bodies to be included.

Kate Higgins: I echo what the others have said. When we first saw how short the list was, we wondered whether the long-promised bonfire of the quangos had taken place. However, on a more serious note, Capability Scotland believes that the scope of the bill should be as wide as possible. Otherwise, the impact of the duty on the public sector will be lost and the bill will not effect a change of hearts and cultures. Frankly, the wider the net is cast, the better. Along with the comments of everybody that we can think of, we will feed back to the DRC our ideas on which bodies should be on the list.

The Convener: I am sure that the committee will echo those comments.

Shiona Baird: The DRC submission notes a concern about the problems that many home owners face when they wish to make adjustments to the common parts of their tenements or flats. Did the DRC make representations to Westminster on that? Has it discussed with the Executive the inclusion of relevant provisions in the Executive's forthcoming housing bill, which is also mentioned in the DRC submission?

Lynn Welsh: The answer to both questions is yes. We are pursuing the possibility of an amendment to the Disability Discrimination Bill at Westminster, although I am not sure how successful we will be. We would certainly prefer the issue to be dealt with in Scottish legislation because, apart from anything else, housing is very much a Scottish issue. In our response to the recent consultation on housing, we welcomed the Executive's move to extend the right to make changes to private rented accommodation—that will be a great step forward—and we suggested that the Executive consider the further step of allowing changes to common parts of private properties. We regularly receive complaints from people who want to make small changes to their property, such as by installing a wee handrail at the front door, but who have been refused by other

owners for reasons that they are not sure of. It can make living almost impossible if people cannot have accessible housing.

Bill Campbell: Our concerns on housing reflect those of the DRC. We have two main concerns. One can be illustrated by the case of a young chap from Islay who came to Glasgow to be educated. When his impairment became worse, his mother applied to the council to add an extension to their house, but she was refused on the ground that it would affect the aesthetics of the island. We need to get away from such appalling attitudes. Secondly, we are very much aware that Scotland has about 850,000 disabled people but fewer than 25,000 wheelchair or barrier-free houses. Given those figures, we still have a long way to go, although we appreciate the work that the DRC has done.

Shiona Baird: We have heard a little about the impact of transport accessibility issues on disabled people. What are your views on the transport provisions in the bill, including the proposed timescale for accessibility, and on the use of voluntary codes of practice in relation to aviation and shipping? After all, the tendering document says that "Tenderers must include"—[Interruption.] I am sorry—is it okay for me to read this out?

The Convener: I think that you are quoting the consultation on the tendering document.

Shiona Baird: Right. The document refers to "detailed proposals setting out how"

tenderers

"intend to satisfy this requirement".

I am concerned about whether proposals to improve access will be implemented and whether they simply represent good intentions, rather than actual work that will be carried out. I am aware that that matter is rather detailed.

Kate Higgins: I shall go first—our organisation has probably made the most noise about transport.

During the draft bill stage, people asked for end dates in respect of accessibility to transport. We welcome the fact that the UK Government has given such dates for most forms of transport. Some of them seem to be a long way off, but we appreciate the reasons for that, including cost effectiveness over the lifetime of vehicles and different modes of transport.

We also understand why the UK Government has chosen voluntary codes of practice for aviation and shipping: after all, research is needed on how those measures are working. People must be given time to implement any code to which they sign up and we must find out how the code is working. That said, we in Scotland are concerned

that the voluntary code for small passenger vessels is not yet up and running and we would like some movement on that. Moreover, we seek a commitment from the UK Government that an end date for accessibility to such transport will be given as soon as possible after it concludes its current research on voluntary codes.

We share the member's concerns about the tendering consultation. Any successful bidder for the lifeline routes will need to set out only their intentions with regard to accessibility. Those measures need teeth, with monitoring taking place of whether operators have introduced more accessible facilities on their vessels. Obviously, the ultimate sanction for not implementing proposals should be that the operator will lose the contract. Capability Scotland will respond in those terms to the consultation on the tendering document.

Norman Dunning: I fully support any move to make transport more physically accessible. However, we must also make other aspects of the transport system, such as timetables, easier to understand to ensure that people know where to get on and off. We must also introduce simple measures such as ensuring that buses do not pull off before infirm people can sit down. Such measures are not hugely costly; they come down to the attitude and training of the people who operate transport systems. Enable has been able to introduce the voluntary thistle travel card scheme, which allows people who have an impairment to show a card discreetly to the driver and conductor, who are then able to make allowances for those people; for example, they might not understand where to get off, or might need more time to sit down or whatever. People can find it embarrassing to announce that they have a particular problem.

Such aspects could well come within the scope of the bill's provisions in respect of public authorities. We want those measures to be pushed forward. A voluntary code is fine, but we want the legislation to cover other matters and we want to be able to say to all public authorities throughout Scotland that such schemes should be introduced to make things easier. Although we must continue to work on various physical barriers, some of the other barriers that I have mentioned could be quickly overcome.

Bill Campbell: We deal with disabled people every day; committee members will not be surprised to learn that transport is probably at the top of their list of complaints. This might sound a bit controversial but, as our website points out, we only kind of welcomed the decision that was made a week or so ago about free bus passes for disabled and elderly people. I said "kind of welcomed" because many people will have died

before 2017 or 2020 when the buses are fully accessible. That also seems to add to the perception that disabled people are somehow poor and in need of a bus pass. What we need is money to pay our bus fares. We would have really appreciated it if the Executive had worked with bus companies and helped them with the transition to low-floor buses and then introduced travel cards, if that was seen to be the way forward. We are not too happy about the situation.

We now know that the trains in Scotland have gone to FirstGroup, which also runs many buses in Scotland. What is it going to do about integrated transport? When I get off the train at Irvine, it is always just in time to see the bus driving away, but the buses are owned by the same company. Something has to be done about integration. I will leave ferries to Kate Higgins, who has done more work on that than have I.

On aviation, we must remember that there are two ends to every journey. There is currently a lot of work going on in Europe on codes of practice so that disabled people can be absolutely sure that when they get to Amsterdam, Paris or Brussels, they receive the same treatment as they get here. The Scottish Executive should look at what is happening in Europe. On voluntary codes, my only comment would be that I am very suspicious.

Shiona Baird: I have a question about taxis. There seems to be great emphasis placed on providing bigger taxis for wheelchair access. That raises issues in respect of people with other mobility problems. Capability Scotland's document deals with the Government's intentions and points out that the emphasis on wheelchair access exists almost to the exclusion of people who have other mobility problems or other disabilities. What are your views? Are we going too far down a particular route?

Kate Higgins: The end dates are for what the UK Government has said it will do on accessibility and they apply to the requirements that it will place on transport providers. We share the concerns of Enable, Bill Campbell and everybody else. Everything has been targeted at wheelchair accessibility, which sometimes means things not being accessible to people who have other mobility impairments. There are issues around making things more accessible for people who have visual impairments and the impact that that has on people who have physical disabilities. There is a balance to be struck; we should make our environment more accessible in general. That approach would satisfy more people.

On taxis, the Government said at a conference that we attended that it hopes to introduce new licensing laws or regulations to help in the process of making taxis more accessible, but it is not clear whether that would apply in Scotland. I presume

that it would not, because licensing is devolved. We could end up with a two-tier system if that is not picked up on in Scotland.

I will mention another point that came up at the conference. Someone from the Glasgow subway asked about its being a special case. There are huge issues about inaccessibility there; I am sure that Bill Campbell could talk all day about the experiences of people with a range of disabilities and impairments in trying to use the Glasgow subway. The head of the Department for Transport's mobility and inclusion unit said that the department is aware of the subway's being a special case because of the size of the tunnels and so on. It may be that, ultimately, the subway will be exempt from the DDA. We would be very concerned if a particular transport provider had a total get-out clause. Strathclyde Passenger Transport has made what it considers to be improvements to the subway's facilities but, to be frank, it could have made it much more accessible. The subway has not been made more accessible; in fact, it has become even more inaccessible than it was. We would welcome the committee's taking up that issue.

13:00

Bob Benson: There has been considerable discussion of how we make the social model of disability relevant in legislation, because clearly we can legislate for only so much in the social model. However, as has been said, it is the issues around the widest sense of the word "accessibility" that are in question. The bill will bring about significant changes; for example, it will be illegal to refuse to allow someone who has a learning disability on to a bus. Other conditions will be covered, which are also covered by the DDA, such as communication problems or multiple impairments that people often do not understand and perceive in an unsocial way, as it were.

The powers in relation to the public sector duty could help to raise awareness and educate service providers. On issues relating to taxis, Scottish local authorities have the power to license taxis and, under the public sector duty, they would have powers to ensure, through the disability equality schemes, that we are delivering on accessibility in its widest sense. That issue will be the same for other service providers. The bill is a powerful vehicle for implementing public service provision and it is likely to have spin-offs that relate to the private sector and to contracting out. The private sector would be covered by the same terms as local authorities and other service providers. We have a powerful legislative vehicle, which we should not underestimate. I will return to the other points that I want to make when we are talking about widening of definitions.

Lynn Welsh: Taxi licensing is the only bit of discrimination legislation that is devolved to the Scottish Parliament. Parliament has already passed regulations relating to access to taxis for assistance dogs because of the way that the Civic Government (Scotland) Act 1982 worked, so things can be done and regulations have been passed. The public sector duty can make a huge difference. We have asked for Caledonian MacBrayne to be covered by the public sector duty, which would have a massive impact because it would have to start considering properly how to deal with disabled people and it would have to make its services more accessible. We hope that the Scottish Executive will consider that.

Bill Campbell: It is something of an irony that Glasgow subway is the only transport system in Scotland in which access from the platform to the train is level. Once we get down to the platform, it is accessible; getting down there is the problem. I realise that there are engineering problems and I am told that it would take £12 million to £20 million to make every station accessible. I do not know whether that is a lot of money; it sounds like a lot to me. It is ironic that there is such a level of accessibility in the system already.

There is no audio on the subway—at least there was not when I travelled to the University of Glasgow—and blind people find it difficult to know what station they are at because, if the train stops in the tunnel, they lose count of how many stops the train has made and alight where they do not want to alight.

On taxis, I do not know whether members are aware that in the mid to late 1990s the then Strathclyde Regional Council, with Strathclyde Passenger Transport Executive, ran two pilot schemes for taxi cards in the west of Scotland. One was in Irvine, where I live, and one was in Clydebank. Those two places were chosen because Irvine had no black cabs and Clydebank's taxis were all black cabs. I am sure that if you could access the findings on that scheme, they would show that the more successful scheme was the one in Irvine, simply because it appealed to people who had other mobility problems, and who had been rattled around in big black cabs and had uncomfortable journeys.

There was also a point made about taxi drivers. It was quite clear from both schemes, especially the one in Irvine, that many taxi drivers are in their 50s. They may well be disabled themselves, and taxi driving provides income for them. It was extremely unfortunate that many disabled people wanted taxi drivers to come into the house and wheel them out to the taxi. That should be examined in terms of training for taxi drivers. Disabled people should also understand that if

they need to be escorted from the house to the taxi, they should make their own provision.

Marlyn Glen: Bill Campbell mentioned the difficulty with terminology in the bill, which I will go into further. The general duty on public authorities mentions

“the need to take steps to take account of disabled persons’ disabilities, even where that involves treating disabled persons more favourably than other persons.”

Is there concern that that terminology could impact on good relations between disabled and non-disabled people?

Norman Dunning: It may just redress the balance a little bit. I have no anxiety about the terminology. Too often, an excuse for not advancing better policies for people with disabilities is that such a form of positive discrimination would be unfair on everybody else, but everybody else has been unfair on people who have disabilities for a long time.

Lynn Welsh: I agree with Norman Dunning. The bill advocates positive action; we are trying to get equality of opportunity, not a level playing field. The DDA is asymmetrical legislation—it protects only disabled people, unlike sex and race legislation, which protects both ends of the spectrum—because it is recognised that positive action must be taken just to achieve equal status for disabled people. All our organisations work hard to get the general public and authorities to recognise that that is what we are talking about.

Kate Higgins: We do not have concerns. I echo the sentiment that it is about time that the balance was redressed. In the past, we took issue with measures that were designed to plug gaps. The one that concerned us most was when new rules were introduced on blue-badge enforcement. Our biggest concern was that disabled people were being targeted for offences that were being committed by non-disabled people; disabled people were going to have to prove that they were disabled and therefore entitled to a blue parking badge, but it should have been the non-disabled people who were abusing the system who were gone after and made an example of. Anything that shifts the balance to the other side is welcome in our book.

Bill Campbell: On the DDA, we discussed for a long time the meaning of reasonable. Somebody said that it is reasonable to believe that something is reasonable if it is reasonable.

What does “more favourably” mean? If it means having an advantage over the rest of the community, we would—to be frank—be totally against it. We are asking for inclusion and equality. If “more favourably” means providing my phone bill, my council tax bill and other items in large print to put me on a level playing field with

the rest of society, we are absolutely in favour of it. We need to know what “more favourably” means. I am sorry for being pedantic.

The Convener: That is okay. You are allowed to be pedantic.

Marlyn Glen: That was a robust reply.

You said that you welcome the bill’s changes to the definition of disability. Could you expand on that? Are you now content with the definition, or would you like it to be changed?

Bob Benson: I do not think that we have ever been totally content with the definition of disability. It comes back to a question I asked earlier: how far do you go in defining people? We already officially have 1 million disabled people in Scotland. That is one in five of the population. The spirit of legislation should be about planning in advance and in the knowledge that someone who has a range of mobility or other problems will, at some stage in their life, require equality of access.

We have looked at specific issues, for example in respect of people who have a genetic predisposition to conditions such as Huntington’s chorea. When people with such conditions try to access certain forms of life insurance, they are discriminated against on the basis of some spurious test. That issue remains to be addressed.

It is arguable that provision for disability at the point of need is also important. I am thinking of people with short-term disabilities who might be disabled in their environment for perhaps only six weeks, for example. Again, I suggest that the committee consider that further. It is clear that some good pre-planning needs to take place around the needs of all members of society, in the light of the knowledge that people might, at some stage their lives, have impairments or conditions that could lead to difficulties in accessing services or employment. The issue is significant. I am sure that Parliament will want to ensure that people are covered at the point of need, but it is possible to go only so far in terms of legislation. That said, I am sure that more work can be done around the edges of the issue.

It is becoming clear that people who are discriminated against on the ground of disability are also discriminated against on other grounds. Recognition needs to be given to the fact that disabled people are citizens with multiple identities, which could usefully be applied to wider issues for disabled people. We could, for example, consider harmonisation of equalities legislation through a single equalities act. Although we can improve the Disability Discrimination Bill, the introduction of a single equalities act might take us much further forward.

The Convener: Does Norman Dunning or Kate Higgins wish to comment?

Norman Dunning: No.

Kate Higgins: No.

The Convener: Do you wish to do so, Bill?

Bill Campbell: I agree with Bob Benson that there are certain areas on which we will never reach consensus, including the definition of disability. Inclusion Scotland asks—or demands; the word that is used will depend on how the request is taken—for philosophical consideration of the definition of disability. That is something that the British Council of Disabled People also asked for.

As I have said, constant reference to “people with disabilities” is wrong. People are disabled by society’s attitude to their impairments. The more quickly society accepts that that is the case, the more quickly disabled people can move on.

Of course, we are also concerned about who defines disability. Is it doctors or psychiatrists, for example? Will disabled people be allowed to define whether or not they are disabled? I am not sure that any of the acts take that sort of philosophical look at the subject. Although the legislation is in place and it is workable, it is by no means complete.

The Convener: I thank the witnesses for their evidence this morning—or this afternoon, as it is now after 1 o’clock. Does any member wish to take further action in respect of the Sewel motion?

Members: No.

The Convener: In that case, I suggest that we continue to monitor the process. When the subject comes before Parliament again, the committee will look to being involved in scrutiny of any future legislation that results from the act. Are members content with the suggestion?

Members indicated agreement.

Meeting closed at 13:13.

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