OFFICIAL REPORT
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Equalities and Human Rights Committee

Thursday 12 September 2019

Session 5

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EQUALITIES AND HUMAN RIGHTS COMMITTEE

20th Meeting 2019, Session 5

CONVENER

*Ruth Maguire (Cunninghame South) (SNP)

DEPUTY CONVENER

*Alex Cole-Hamilton (Edinburgh Western) (LD)

COMMITTEE MEMBERS

*Angela Constance (Almond Valley) (SNP)
*Mary Fee (West Scotland) (Lab)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Oliver Mundell (Dumfriesshire) (Con)
*Annie Wells (Glasgow) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Hassan Darasi (Community InfoSource)
Patrick Down (Scottish Government)
Dr Ima Jackson (Glasgow Caledonian University)
Dr Saffron Karlsen (University of Bristol)
Jan MacLeod (Women's Support Project)
Andy Sirel (JustRight Scotland)
Anne Spiers (Multi-Cultural Family Base)
Angela Voulgari (Sacro)
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

Claire Menzies

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Equalities and Human Rights Committee

Thursday 12 September 2019

[The Convener opened the meeting at 08:45]

Subordinate Legislation

Historical Sexual Offences (Disregarded Convictions and Official Records) (Scotland) Regulations 2019 [Draft]

The Convener (Ruth Maguire): Good morning, everybody, and welcome to the 20th meeting in 2019 of the Equalities and Human Rights Committee. I ask everyone to switch off their mobile phones and put them away.

Under agenda item 1, the committee will take evidence on the draft Historical Sexual Offences (Disregarded Convictions and Official Records) (Scotland) Regulations 2019. I welcome the Cabinet Secretary for Justice, Humza Yousaf, and his officials Linsay Mackay and Patrick Down, who are policy officers in the criminal justice division of the Scottish Government. The item is a chance for members to put any points to the cabinet secretary and officials or to seek clarification on the affirmative instrument before we formally dispose of it. The motion that seeks approval of the instrument will be considered under item 2. I refer members to paper 1 in their packs and invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Justice (Humza Yousaf): Good morning, convener, and thank you for the invitation. I will keep my remarks brief.

The regulations that the committee is considering are an important final step in implementing the Historical Sexual Offences (Pardons and Disregards) (Scotland) Act 2018, which will come into force on 15 October this year. Members will recall that that act provides for a system of disregards in which applications can be made to the Scottish Government for convictions to be removed from official records if certain criteria are met, as laid down in the act. The purpose of removing convictions is to ensure that they can never appear in any future criminal record disclosure check.

The purpose of the regulations is to provide for the different means by which the disregarded convictions may be removed from official records. Flexibility in the method of removal is important, because records that relate to historical convictions are in a range of different formats, and straightforward deletion of the record might not quite be possible. For example, information about a disregarded conviction may be kept on a physical microfiche document, and it might not be possible to delete material that is contained in a document of that sort. That is why the regulations provide that a disregarded conviction can be removed by deleting the record, redacting the part of the record that relates to the disregarded conviction, or annotating the record to make it clear that the conviction has been disregarded and that it should never be disclosed in response to a request for information about a person’s convictions.

The regulations specify the bodies that are to be treated as relevant record keepers with responsibility for removing information about such convictions from official records that are held by them following a successful application for disregard. Relevant record keepers are organisations that may hold information about disregarded convictions that could, in certain limited circumstances, be disclosed to a third party that is seeking information about a person’s criminal history.

The regulations provide that Police Scotland, the Scottish Courts and Tribunals Service, the Crown Office and Procurator Fiscal Service and the Scottish ministers acting in their capacity as the holder of official records maintained by Disclosure Scotland are to be regarded as relevant record keepers for the purpose of the disregard scheme. All those bodies are content to be specified as relevant record keepers in that way.

The removal of disregarded convictions is an important practical measure to address the discriminatory effect that those convictions can potentially continue to have on a person’s day-to-day life by ensuring that the person cannot be prejudiced in the future by their disclosure.

I am, of course, happy to take questions.

The Convener: Thank you, cabinet secretary. Do committee members have any questions or comments?

Alex Cole-Hamilton (Edinburgh Western) (LD): I would like to ask a small follow-up question.

I am sure that I speak for the rest of the committee in saying that the cabinet secretary has our good will with this Scottish statutory instrument. I will certainly support it.

The cabinet secretary has talked about historical records that are contained on microfiche and other things that are much harder to locate or change physically. Is there a scale to that, or is that a seldom happenstance?

Humza Yousaf: Police Scotland will be the primary record keeper. It will primarily have the information that we would expect on a person's convictions.

On the scale of what is involved in deletion, redaction and annotation, if the police records are on an information technology system, for example, deletion will be the easiest and simplest approach. However, I am not entirely sure of the scale, so I will look to the officials to see whether they have an idea of the numbers. Police Scotland would certainly have the most information in its systems.

The more historical records that are held by the National Records of Scotland and, potentially, the Scottish Courts and Tribunal Service might be kept on microfiche. I confess that I have never seen a microfiche in real life, but I am sure that I will at some point. Annotation or redaction might be required. Patrick Down might want to come in about the scale—

Alex Cole-Hamilton: Before you bring in Patrick Down, I guess that my first question was not clear. I am surprised to hear that there are still criminal records that are held only on microfiche and that they have not all been translated to IT files. I understand if they are historical files about people who are dead but, for files on people who are living, is that work still on-going or just not planned?

Humza Yousaf: I will ask Patrick Down to come in in a second. Families can apply posthumously for somebody who has passed away to be recognised for a pardon. They will get a letter of comfort in that regard, so there is that element. Patrick might have more detail.

Patrick Down (Scottish Government): Perhaps it is helpful to draw a distinction between the police criminal history system, which is the primary source of information about the criminal records of a person and is now all on IT, and records about historical cases, which are usually held by the National Records of Scotland on behalf of the Scottish Courts and Tribunals Service.

Occasionally, when organisations such as the General Teaching Council for Scotland or Social Work Scotland are doing background checks, they go to the Courts and Tribunals Service for information about a person's criminal convictions, rather than going to the police. I do not know how common that is and we might be addressing a problem that is theoretical rather than real. However, we need to provide assurance that all the possible sources that people might go to for a person's criminal history are covered, whether that is the formal disclosure check system or bodies that have various powers to look into people's criminal history. I expect that, in practice, people go almost exclusively to the police records, but we cannot be certain of that.

Alex Cole-Hamilton: That makes things much clearer. Thank you.

Mary Fee (West Scotland) (Lab): When we were considering the Historical Sexual Offences (Pardons and Disregards) (Scotland) Bill, we took evidence from Tim Hopkins, who I am sure everyone around the table knows well. Although he was supportive of the bill and the disregard scheme, he raised the point that it was important that we did not rewrite history by deletion or redaction. Is the cabinet secretary confident that what is being proposed and what is being done will not alter the history of what happened to men over the years in this country?

Humza Yousaf: That is a good point. Like all the committee members, I have much time and respect for Tim Hopkins and his views, which clearly carry weight.

That is why it was so important for us to have flexibility in how the records are treated. It is almost precisely the point that Patrick Down made. People might go to the National Records of Scotland, look at the microfiche documents of court cases from the 1970s, 1980s and, perhaps, before, and see a pattern of laws that were used discriminatorily against gay men. That is why annotation might be important. Even if they took place in the lower courts, we would not want to delete all those cases. If we deleted them, people might say, "What the heck is the problem?" That is why annotation or redaction is so important.

I am confident with what we have. We took that into consideration. That is why there is a degree of flexibility in how the records can be amended, deleted, annotated or redacted.

Mary Fee: Thank you.

The Convener: To be clear, in relation to the option for removal by annotation, is it the Scottish Government's intention that any annotation makes it clear that the annotated material is to be treated as having been removed?

Humza Yousaf: Yes.

The Convener: Thank you.

If there are no further questions or comments, item 2 is formal consideration of the motion on the affirmative instrument. The Delegated Powers and Law Reform Committee has considered and reported on the draft regulations and had no comments on them. The motion will be moved and then there will be an opportunity for formal debate, if that is needed.

Motion moved,

That the Equalities and Human Rights Committee recommends that the Historical Sexual Offences (Disregarded Convictions and Official Records) (Scotland) Regulations 2019 [draft] be approved.—[*Humza Yousaf*]

The Convener: Are there any further comments from committee members?

Members: No.

The Convener: Cabinet secretary, do you need to wind up or are you content?

Humza Yousaf: I am content. As people have said, the draft regulations are hugely important in relation to the 2018 act. The pardon and the disregard are important both symbolically and in their practical effects for the individuals involved, so I have been delighted to move the motion and I hope to get unanimous committee support for it.

Motion agreed to,

That the Equalities and Human Rights Committee recommends that the Historical Sexual Offences (Disregarded Convictions and Official Records) (Scotland) Regulations 2019 [draft] be approved.

The Convener: That concludes consideration of the instrument. The committee's report will note and confirm the outcome of the debate. Does the committee to agree to delegate to me as convener authority to clear the final draft of the report?

Members *indicated agreement.*

The Convener: Thank you. I thank the cabinet secretary for attending.

I will suspend the meeting briefly to allow a change of witnesses.

08:56

Meeting suspended.

08:59

On resuming—

Female Genital Mutilation (Protection and Guidance) (Scotland) Bill: Stage 1

The Convener: Welcome back. Agenda item 3 is oral evidence on the Female Genital Mutilation (Protection and Guidance) (Scotland) Bill. I welcome our first panel. Dr Ima Jackson is senior lecturer in the department of nursing and community health at Glasgow Caledonian University, Andy Sirel is head of the Scottish refugee and migrant centre at JustRight Scotland and Dr Saffron Karlsen is senior lecturer in social research in the school of sociology, politics and international studies at the University of Bristol.

You are all very welcome. Thank you for being with us. I start by asking you about your experience and knowledge of female genital mutilation and asking you to say a few words on whether you support the bill's aim to strengthen the existing legal protection for women who are at risk of FGM. Who would like to go first? Everyone is looking at you, Dr Jackson.

Dr Ima Jackson (Glasgow Caledonian University): Thank you for the opportunity to speak this morning.

My experience is working as an academic with communities, looking specifically at the processes of policy engagement and the research that is done on them as opposed to with them. I have come to this evidence session because I undertook a piece of research that ended in February this year with the communities of colour, some of whom are practising communities. The research project was funded by the Scottish Government and the European social innovation fund and it looked at the experience of the communities within the process, of which this is a part, as well as their experiences as community organisations. The Kenyan Women in Scotland Association was the lead organisation in the project and my colleague Julie Wasige and I developed and undertook the research.

The main issue is that the communities have faced challenges with the processes. I am asking the committee to recognise the expectations of communities within our processes, and that there are risks to them because of how they are asked to engage in the processes. There are real risks to the communities, and that came out strongly in the research.

There is a feeling of being co-opted and there are concerns about the bill and the actions, but the communities welcome the Scottish Government not bringing forward legislation on anonymity of

victims, the duty to notify police and the failure to protect. They understand, respect and welcome the approach.

Although the women are supportive of the statutory guidance, they are concerned about the reasons why the protection order is needed for FGM over and above existing child protection legislation. I came to that because of how our systems position the experiences of women, particularly those from African diasporic communities, as different from everybody else's experiences.

That is part of how the research that I do works. It looks at why that perspective is positioned as different. The issue might be different, but why is the perspective seen as different? Why do the solutions that we already have in place, particularly for child protection, require something specific for FGM?

The Convener: Thank you. That is helpful, and we will come back to those points.

Dr Saffron Karlsen (University of Bristol): Thank you for inviting me to join the panel. I have spent the past 20 years doing different sorts of academic research trying to better understand ethnic and religious inequalities in a range of different social phenomena such as health and socioeconomic status and other sorts of experience. I have looked at outcomes in people's lives and their lived experiences, as well as the impact on their sense of groupness—their group identity—and the interrelationships between those.

The research that brings me to the panel is the work that I did as part of a team at the University of Bristol and Cardiff University last summer, looking at the experiences of ethnic Somalis living in Bristol with FGM safeguarding services within the city. The project was led by academics but motivated by a call from local Somali groups to talk about what they felt to be negative experiences of services, which they did not feel were being voiced in the conversations that were going on among the policy makers and practitioners.

It was an independent, ethical, university-led study, but it was very much driven by the calls of the local community, although the research did not engage only with the groups that had called for it—we aim to take a much broader position. I will come on to talk—over the next few minutes and as we come to questions—about what we found in that research.

My feeling about the bill, which seconds a lot of what Ima Jackson said, is that it is appropriate that measures are taken to protect those who are at risk of genital or indeed any other form of mutilation, particularly without or when they are not able to give their consent, but our and other research suggests that there is a range of ways to provide that protection and there is far greater potential than is generally realised for the involvement of FGM-affected groups in the development of those policies. That is for a range of reasons, which, again, I will come on to, but the important point is that policies around the issues can be much more effective if we approach them in a more collaborative way.

Our and other research suggests that some policy responses to FGM that are already in practice in the UK and elsewhere have led to the stigmatisation and criminalisation of many innocent families. That is problematic in and of itself, but our research suggests—this is why I mentioned the work that I have done around ethnic identities—that it has directly undermined not only relationships in those families and communities, but people's sense of Britishness and inclusion in British society. The things that we are talking about today have far bigger implications than we might realise and—this is important—than are necessarily reflected in the bill.

None of us wants a more divided society. You have a really valuable opportunity not only to develop approaches to the management of FGM risk that can be more effective in achieving our longer-term aims of ending the practice of FGM in the United Kingdom and elsewhere, but to do that while minimising the negative impacts that current approaches are having on people from FGM-affected groups.

Our research suggests that people from FGM-affected groups are very keen to collaborate. They really want to be involved, and they have tried to be involved. A lot of the frustration that was noted in the study was due to people feeling that there was a collaborative approach that had somehow lost its way.

There is real potential in Bristol, and most likely in Scotland as well, as Ima Jackson said, to have more conversations about effective approaches to these issues.

Andy Sirel (JustRight Scotland): Thank you for the opportunity to be here. I will provide evidence from a legal perspective, drawing on my and my colleagues' long-standing practical experience and expertise in providing legal information, advice and representation to women and girls who are seeking international protection and who have survived gender-based violence.

We work with women and girls across a range of issues in UK and Scots law, including immigration and asylum, child protection, and human trafficking and exploitation, and we sit on the Scottish Government's implementation group on FGM. We are also the legal providers for the

Government-funded Scottish women's rights centre, through which we have extensive experience of advising on and obtaining protective orders for women who are affected by gender-based violence, including forced marriage protection orders.

For the avoidance of doubt, I echo what my colleagues have said about the use of the law as a tool in preventing and combating FGM. The law should be handled with care, I think. Our view is that we require a broader focus on creating broader change and the law is only one tool in that process. That said, I am a lawyer and I am here to speak about the law, and we believe that the proposals in the bill will improve effectiveness in the fight to combat FGM and safeguard those who are at risk.

FGM has been a criminal offence for 34 years in the UK. Although that has sent a clear message of intolerance, it is not controversial to say that our criminal response will not, by itself, eliminate FGM. We all know that no successful prosecutions have been brought in Scotland and the first one brought in England was only a few months ago.

We agree that FGM protection orders would be a useful and important tool. I have mentioned that our primary experience is working with women and girls who have survived or are at risk of FGM through their interaction with the asylum process. I am happy to answer questions on that today. Our view is that the existence of FGM protection orders would play a positive role on whether a woman or girl receives international protection.

We also work with women and girls at risk of other forms of so-called honour-based violence, such as forced marriage. To some extent, many of the same cultural and social factors are at play. Through the Scottish women's rights centre, our solicitors have first-hand knowledge of forced marriage protection orders and the importance of that type of remedy. Because of that experience, we believe that protection orders would add value to the current approach, and we are happy to expand on our reasons.

Our experience highlights that a particular gap or barrier might exist for the protection of girls who are 16 and 17 years old. We acknowledge that younger children are predominately at risk of FGM, but the risk persists for teenage girls.

The definition of child varies in different legal contexts. Our experience tells us that 16 and 17-year-olds are often caught in between the legal protections available for children under 16 and those for vulnerable adults. Sometimes, 16 and 17-year-olds operate in the middle. That makes the existence of specific protection orders, whether that be forced marriage protection orders or FGM protection orders, all the more critical as a tool for local authorities, for example, to keep all girls in their care safe. It is vital that local authorities understand when such orders can or must be used, and we look forward to seeing the statutory guidance that will help local authorities understand what their role could be. I am happy to answer any questions.

The Convener: Dr Jackson, you said that the existing legislative framework for protecting children and adults is sufficient to protect women and girls. You also spoke about risks to the community because of how they were involved in the engagement process. Will you expand on that a little?

Dr Jackson: My expertise is on the process. Although I undertook a research project related to FGM—and there are specific reasons for my undertaking that research—my expertise is on the policy-making and research processes in Scotland. I am particularly interested in issues to do with the racialisation and marginalisation of people whose voices we should be hearing.

My understanding is that we would be adding to the existing child protection framework in a specific way. I do not know the details of that, but I understand that the existing child protection legislation is the strongest legal framework within which measures on FGM would sit. If that is the case, I am interested in why a bill on FGM has been introduced.

I want to explain that our research was to support the existing work of the women who took part and to allow them to look at the processes of how they participate in what becomes a consultation and a framework. The consultation call came during the lifetime of the research and gave the women an opportunity to respond collectively because of the project that we were developing at the time.

09:15

There were issues about how the women's voices could be heard in the process, because it was complex for them to articulate their experiences in that timeframe. It came out clearly that all of us—the women, policy makers, researchers, academics and politicians—are learning about how to engage with this issue, particularly in Scotland. That is related to whose knowledge is viewed as expert in the process. I did the research project with the communities because the intimacy of the unique issue and the demographic change in Scotland highlighted many issues about processes in Scotland. We are not used to engaging with those issues, so the research was developed with the communities to help us all to understand how we experience engagement with our processes.

I want to talk about the pressures that the communities felt when they were asked to participate. One woman who took part in the research said:

> "In my head I said I cannot do this on my own."

She wanted to open it up so that she was part of a group. She said:

> "You want to be with other sisters".

She also knew that it was a really important decision-making process.

> "They're going to put it as a law. You don't have to take that single decision by yourself ... I said to myself ... how can we three of us sit here ... and make a decision?"

What was important was the speed, the timing, the thinking required and the support needed for the women to be able to speak about the issue.

The research was intergenerational; the schoolgirls were from Notre Dame high school in Glasgow and older women worked with them to support one another in the processes that we created. Some were from communities that were practising or potentially practising, and some had come to live in Scotland. The older generation of women understood and had experience of how to manage and fight against FGM in their communities.

How to speak about it with families, friends—your best friend—and schools is complicated. When we ask for something to happen, our processes have to recognise that it is really complicated.

Dr Karlsen: You have asked us to comment on the potential equalities and human rights issues in the bill. Some participants in our research on the policy felt strongly that there was evidence of racial profiling in the provision of safeguarding protection, which follows on from what Dr Jackson has said. There is not much consideration of those concerns in the current bill, although there has been reflection on gender discrimination and the need to protect women.

The committee will have to be mindful of the need to mitigate racial profiling, which includes consideration of and careful reflection on how the bill will add to current protection for different forms of child abuse. People in our study felt that they were being identified because they were Muslim and African, regardless of any established level of risk to their children. Why do we need additional attention and surveillance over and above those horrific things that people are experiencing? That is a serious question.

There may still be a clear purpose for a specialist bill, but if that decision is made, clarity about why would be useful, to show how the bill provides additional coverage that is needed over and above current legislation.

You also asked us about prevalence. Figures from Africa and Asia are generally used, but from our research on FGM prevalence in the UK, particularly among the under-18 resident population, we know that most cases are genital piercing and there are rising rates of cosmetic labiaplasty; those are all considered to be part of the World Health Organization FGM types but they are absent from the bill. That raises the question why the bill focuses only on practices that are considered to originate in Africa and Asia, particularly given that some forms of pricking or scraping could be considered much less mutilating than genital piercing and other things that are absent.

I do not know the legislation particularly well, but there are suggestions that the Prohibition of Female Genital Mutilation (Scotland) Act 2005 does not include some forms of intervention that might be considered to be less severe.

The Convener: I will bring in questions from committee members now.

Alex Cole-Hamilton: I thank the panel—this is incredibly illuminating. I have a couple of questions about your evidence. Dr Jackson referenced—and the convener followed it up—that child protection provisions might be enough to deal with the issues that we are talking about. However, a bill team briefing suggested that FGM is not limited to children and that, sometimes, a woman might be mutilated again, particularly after childbirth. Is that assumption wrong? Is the issue solely to do with children?

Dr Jackson: I am not able to answer that question. I understand it, but I am not sure of all the legal aspects.

Alex Cole-Hamilton: I will expand the question slightly. The bill is about preventing FGM for everyone. We need to be confident that everybody is protected by the laws of this land, and nobody over the age of 18 is protected by child protection legislation. That is what I am trying to ask about.

Dr Jackson: I am uncertain of that reach. The challenge in using the bill as a tool is its effect on other work that is going on to engage and develop. A decision about that has to be taken.

Alex Cole-Hamilton: You have inferred that the bill would single out cultural communities and that the protection order seems quite unique in that. However, there are examples of such orders that Parliament uses quite readily, such as risk of sexual harm orders that prevent young people and vulnerable adults from being groomed sexually online. That is an example of another group being singled out, but the order is a necessary tool of

protection that we, as lawmakers, try to extend to vulnerable groups. Do you accept that point?

Dr Jackson: I accept the point, but my research comes from the perspective of how the system can create an experience of marginalisation and racialisation. It may not intend that to happen, but that comes from its approach to specific issues, however it is intended to function. Because of those issues, we have to be extremely careful about what we do in this area.

For me, one of the issues is the documentation that comes with the bill. I have read many documents, but I have not always seen graphic examples in them. Although they are helpful, is it usual practice to have such diagrams and explanations in the submissions to committees? I am not sure. Maybe it is usual practice to explain the issue in that way.

Alex Cole-Hamilton: I am grateful for that contribution, which will inform the tone with which the committee will proceed. We recognise that, in this area, we have to proceed with a heightened level of sensitivity.

I have one final question, which is for Dr Karlsen. You opened up an interesting point about the fact that the vast majority of female genital mutilation in this country, whether it is piercings or labiaplasty, is consensual and is sought out by the individual. Is the issue—the difference here—about consent and the question of whether it is a conscious decision by someone who has attained maturity? Is there a disaggregation of two kinds of FGM, and do we need to reflect that in the bill?

Dr Karlsen: That was going to be my exact response in following up your question to Ima Jackson. We were talking about whether child protection legislation is enough, and that goes back to my point about why cosmetic labiaplasty and genital piercing might not be included. There is a written submission that questions whether we should have laws about the age at which people can have genital piercing.

Those points are all about whom we perceive as being in a position to provide consent. Generally, we assume that we are talking about those aged under 18, although the evidence around the prevalence of FGM is problematic—I will talk about that in a minute. The evidence suggests that the prevalence is concentrated in under-15s and under-18s. Therefore, allowing for what you say about further reconstructions—or whatever you might want to call them—as far as we can tell, a first incident tends to happen during childhood.

There is then the question of when we perceive that people are informed and responsible enough to provide consent. If we do not include clinical or cosmetic labiaplasty and genital piercing in the bill, because we assume that people who have those procedures are providing consent, it is difficult to understand why we do not consider women who make other decisions about what they do with their bodies—when they are older or after having children—in the same way. People from affected communities and people who are conducting the research are asking those questions.

Also, some of the concerns come from misunderstandings about the current prevalence. You asked for information about the prevalence of FGM in Scotland. You also acknowledged that there is not a lot of evidence and that the evidence is problematic. I have not looked at that data in particular, but we have just finished a study that looks at the available data in England and Wales. I am also aware of other research that has been done in the UK and in Europe. All the evidence suggests that the level of FGM risk is much lower than we generally assume. We have figures showing that 98 per cent of Somali women and girls are at risk; but, although we should protect those who are at risk, we should also recognise that all the research suggests that the majority of UK-resident people, including those from FGM-affected groups, do not support FGM and are committed to working to end it.

The policy memorandum says that there is a lack of evidence, but then it relies on prevalence rates from different parts of Africa and Asia and extrapolates directly from that information to establish a risk: it takes the number of women from those countries who are living in Scotland and the number of children those women—who may or may not have had FGM—have had, and it uses those figures to make an assessment of risk. It assumes that the risk in Somalia transfers to Somali mothers in Scotland and the UK, and then on to their children. However, the research suggests that that approach is not appropriate. Using those figures to establish the level of risk in the UK is not efficient. That does not mean that we should not protect those at risk, but it does shift the balance between the number of people who will be protected by the legislation and the really serious impacts that it will have on innocent families that get caught up in the legislation—as our research shows.

09:30

Research suggests that people who migrate to and live in the UK and other low-prevalence countries, such as Sweden, Australia and other countries in Europe, have much more negative attitudes towards FGM than people who live in the countries from which they migrated. The cultures are changing. It may be that the people who move have much more negative attitudes towards FGM before they move, or it may be that their attitude changes once they have moved into this

environment, where the attitudes towards FGM are very different—in the UK, people are stigmatised for having FGM in a way that they are not stigmatised elsewhere. Reflecting on the issue in that way gives us a very different sense of the scale of the problem. One case is too many, but we are talking about far fewer people than was first thought.

The Convener: I am conscious that we are coming into the last half hour, and I want all committee members to get a chance to speak.

Angela Constance (Almond Valley) (SNP): I have three questions, which I hope to direct to the appropriate witnesses. For the committee to carry out our role, we need to focus and distil the issues.

Dr Jackson, you pointed out that, as practitioners, policy makers and politicians, we are learning the best ways to engage with the issue. Do you think that practitioners—health professionals, social workers, teachers and so on—have a residual anxiety about beginning to engage with the issue? Are we still nervous about, and resistant to, talking about it and raising issues because people feel disempowered and do not know the best way to go about it? If so, how would guidance help?

Dr Jackson: Yes. The eradication of FGM will happen only if it is inspired by the communities who are involved—they know that. The communities that I have been working with have been working really hard to engage, although they have little resource or infrastructure to support themselves to do that.

Your question was about practitioners and policy makers who are relatively new to the issue, but there is anxiety about how to talk about FGM within the communities. That anxiety was really clear in the research that we carried out with the young girls. Their task was to go home and try to speak to their mother, father and a friend about the issue of FGM. It was a huge process for them to learn how to speak about it. The anxiety is not just on the part of the service planners.

Angela Constance: Yes. I heard that loud and clear in your earlier evidence on the needs of communities and on how we need to be better tapped in, to really listen to them. However, my question was specifically about whether professionals worry that they might be accused of being racist or culturally clumsy and whether we should help to address that.

Dr Jackson: We need to address that. The point that I was trying to make is that the knowledge and expertise that exists in the communities will help us. We need mechanisms and levers to ensure that the perspective on how to speak about FGM, what to speak about and who controls the decisions made around it is theirs.

I know that the Scottish Government is trying that approach in other areas—I see it with the children's hearings and poverty action, for example—and we desperately need it here, in order that policy makers and service planners become confident. With support, the women are confident about what they are deciding. When the national action plan committee was set up, there were three community members among the—I think—16 people who were on it. In the research, the women spoke specifically about how that balance already offset whatever they produced.

Angela Constance: If I can paraphrase you, Dr Jackson—correct me if I am wrong—you are saying that we need to really listen to the community and ensure that its lived experience is baked into our policy and legislative responses from the start.

Dr Jackson: Yes. We have to trust them and trust that they know.

Angela Constance: Okay, thank you.

As Mr Sirel is a lawyer, I will pick up with him some of the issues relating to our children's hearings system. The FGM protection orders are for children and women of all ages. I would like to hear Mr Sirel's view on the question of whether children's hearings should be able to grant an FGM protection order. We know that the courts can refer back to the children's hearings system, and I personally am a bit concerned about folk bouncing around between two systems. I know that there are already a range of civil orders. However, is there an argument for the children's hearings system having an FGM protection order as a potential disposal?

Andy Sirel: My position is that, if properly applied, the existing tools in the children's hearings system—such as compulsory supervision orders—are already sufficient to do the job here. That is an important point, which relates to what Dr Jackson said about our needing to not racialise the issue. For younger children who are before the children's hearings system, existing procedures may well be sufficient if they are properly applied. The problem is that the children's hearings system only goes up to 16 years old.

Angela Constance: Forgive me—I heard your evidence about 16 and 17-year-olds loud and clear. I and my committee colleagues will certainly come back to that point.

Are you saying that, if a legal route is being pursued for children who are under the age of 16—and ideally for 16 and 17-year-olds—the first place of reference should be the children's hearings system as opposed to an FGM order?

Andy Sirel: The children's hearings system is a specialised and child-friendly legal process. It was designed for the specific purpose of keeping children outside extremely adversarial sheriff courts and whatnot. On the basis that that is a strength of the system, we should keep it within the realms of the mechanisms that are already in existence.

Angela Constance: I have one final question, convener. I am very conscious of the time. Dr Karlsen, could you summarise what we should learn from the Serious Crime Act 2015? There are a few years of learning, based on the experience of England and Wales, that we can benefit from. On the basis of the experience south of the border, what should we definitely do and what should we definitely not consider doing in relation to the proposed legislation?

Dr Karlsen: As that is not my area of expertise, I do not feel that I am in a position to respond in relation to the 2015 act. However, in response to the questions that you directed towards Dr Jackson, I will say something about the professionals that relates to some of the more specific things that we can think about.

Some professionals are concerned about being seen to be racist or Islamophobic. Going back to what I said about the prevalence of FGM, we found that the participants in our study felt very strongly that professionals are far more concerned about missing children and not protecting children in their care. Sometimes, that leads to a tendency for professionals to jump to conclusions out of a genuine desire to protect children, but that means that many more innocent families are brought into the system than is necessary.

It is important that the bill is clear about the guidelines for professionals and that its implementation is straightforward. Families should not be referred without there being a reasonable level of concern, which should be established through communication with the family regarding the individual case and the individual risks. For example, the fact that someone comes from a family that has a heritage from, or that goes on prolonged holidays to, FGM-affected countries or communities is not an adequate factor in establishing risk in relation to the policies that are being developed by policy makers, particularly those in Bristol.

Other potential risk factors are much more ambiguous. We should bear in mind the fact that conversations about a girl becoming a woman might involve conversations about menstruation. We all have secrets in our families—it might be about surprise birthday parties or presents—and we all have conversations about becoming a woman. It is important to recognise that some factors are not suspicious and might not be related to criminal activity.

Angela Constance: I am conscious that some of my colleagues might want to explore the risk assessment that professionals undertake. You have raised an important issue.

Dr Karlsen: That is as much as I wanted to say on the matter.

Angela Constance: I turn to Mr Sirel and Dr Jackson. What are the top three lessons that we have learned from implementation of the 2005 act south of the border about what we should be doing and what we should definitely not be doing?

Andy Sirel: Is your question about implementation of the 2005 act?

Angela Constance: I am sorry—I meant the Serious Crime Act 2015, which contained FGM provisions and applied only to England and Wales. There have been a few years for the provisions to be implemented and put in practice. Are there any lessons to learn from that?

Andy Sirel: The 2015 act has multiple provisions on which the Scottish Parliament consulted, but which it opted not to go for in the end: those relating to anonymity, the offence of failure to protect and so on. The reason why we came down against a specific anonymity provision for people who are at risk of FGM, against the offence of failure to protect and against the duty to notify is that, with respect to the last two measures, we did not see any evidence from England and Wales that they were effective.

There has been a pretty high number of FGM protection orders in England and Wales. The numbers are quite interesting. Between July and September 2018, 36 applications and 40 FGM protection orders were made in England and Wales. Since FGM protection orders were introduced in July 2015, 296 FGM protection orders have been granted. We can compare that with, for example, the number of forced marriage protection orders in Scotland: between November 2011 and January 2017, 12 such orders were granted. There is clearly a difference in the numbers of those types of applications being made. I appreciate that the issues are separate, but there are some commonalities and there may be lessons to learn from the approach that has been taken in England and Wales—from good practice and bad practice—in order to ensure that the tool is effective. If it is not effective, we should not have it.

Recent research in England is covered in the 2018 report, "Perception and barriers: reporting female genital mutilation". The report goes through a list of barriers and gaps, as described in

interviews with 14 survivors. I refer members to that report.

I cannot really say more beyond that.

09:45

Oliver Mundell (Dumfriesshire) (Con): I have listened carefully to Dr Jackson. The bill has been published. A lot of work has been done on it and you are here to talk about it with the committee. How do we capture points that you have raised?

Dr Jackson: I was going to ask you about what can be done now. I do not know what capacity there is within the development of the statutory guidance to implement what we have been talking about. What opportunities are there within existing processes to do that? I do not really know what the processes are. I want to know how we can use the processes for creating statutory guidance to enable communities to affect what will become the statutory guidance.

Oliver Mundell: That is really helpful. You are saying that we really need to hear the voices of lived experience in development of the statutory guidance.

Dr Jackson: Yes—those voices need to take the lead. I do not know how creative and imaginative the process can be, but decisions are being made about what will constitute whatever this thing is that we are all talking about, so it is important to include those voices. Traditionally, the people—the voices—that all this work is trying to bring in are not there when decisions are made. That must not happen in this case.

Oliver Mundell: That is helpful. I have a broader question for all three panel members. Why have there been so few prosecutions under the existing legislation? Connected to that, in the context of England and Wales, why have we seen people coming forward for protection orders, but we have not necessarily seen the prosecutions to go with those? What is the difference?

Andy Sirel: That question is difficult to answer. To be honest, I do not know why there has never been a successful prosecution in Scotland or why there has only recently been one in England. I suspect that the answer is rooted in interactions between the police, local authorities and communities—barriers to reporting, lack of trust and so on. However, I am not an expert in those issues, so I defer to my colleagues on this and the next panel.

Oliver Mundell: Does anyone else have comments on why we do not see prosecutions?

Dr Karlsen: It is important to say that the one successful prosecution was not about a family that had a heritage in an FGM-affected country, which links back to the problems with the risk factors that I mentioned.

The participants in our study say that the lack of prosecutions is testament to the fact that FGM does not happen very much and that all the investment is to address what is essentially a small problem. It is a significant problem for the people it happens to—I am by no means diminishing the impact of FGM on individual lives and the lives of families and communities—but that is the reason for the lack of prosecutions that is given by our participants.

The other problem with assuming that the lack of prosecutions is due to a lack of police attention or enthusiasm or anything else, which has been the traditional assumption, is that it encourages the feeling that there is a criminal underbelly of people who are committing FGM, or who would be trying to commit FGM if only they were given the opportunity. That really impacts on how the affected communities are responded to by various authorities and by society in general. That has impacted on their sense of inclusion. It reinforces their distrust in all sorts—education, healthcare, police, legal services and social services. Again, delicacy is imperative.

Oliver Mundell: I am trying to ascertain why hundreds of people look for protection orders—although many are sought by police and local authorities—if FGM is not prevalent.

Dr Karlsen: I am not in a position to comment on that in an informed way, but protection orders not leading to prosecutions or not being granted might suggest something about the evidence, to a layperson.

Andy Sirel: I will add a point in support of what Dr Karlsen has said.

The vast majority of women and girls with whom we have worked, who have survived or been at risk of FGM, are seeking international protection, because if they are sent back to their country, there is a risk that FGM might occur. They are seeking protection from something that happens in their home country; they are not necessarily seeking protection from something that will happen here. When we talk about stigmatising communities, that is an important point to bear in mind. The women and girls with whom we have worked do not want FGM to happen. Their community is being accused of the very thing from which they are seeking protection. That is a common issue across immigration and asylum, more generally.

Oliver Mundell: That is helpful. Thank you.

Fulton MacGregor (Coatbridge and Chryston) (SNP): The panel members have been very informative. As Dr Jackson said earlier, the

evidence is helping to shape my journey towards understanding the issue.

Dr Karlsen mentioned the risk being low. How confident are you in that assertion? During the committee's pre-engagement process, I spoke to a group of people who were involved in the issue, which was an informative visit. Some of the men whom I spoke to were 30 or 40 years of age and had lived in their community all their lives but had not realised that FGM was going on until they spoke to other people. They then became involved in supporting people in communities in Glasgow, Edinburgh and other parts of Scotland. If it is difficult for people who are living in those communities to get an understanding of the issue, how can we have faith in any risk assessment?

Dr Karlsen: The data that we use to make the risk assessments is a long way from being what we want. We will make recommendations on how we can generate more effective risk assessments based on the research that we have just been doing.

At the moment, I cannot say categorically that there are or were so many cases, what types they were or where they happened, because the data that is collected as part of Government statistics does not enable us to say that.

However, we have research studies that have been done with groups from FGM-affected communities, who have talked about their attitudes to FGCM. Surveys have been done around the world to engage on changing attitudes to FGCM. People talk about it as something that happened in the past—it is something from their history that they do not consider to be relevant to their lives or their children's lives. Part of the frustration in the on-going engagement on protection is the fact that those people are just British people who are living British lives and who want to go on holiday and visit their families. They are being prevented from doing that by a system that does not reflect how their culture has changed, as all cultures change all the time.

Fulton MacGregor: I will move that point on a wee bit. Do you and other panel members think that if we do—

The Convener: I am sorry—but I will just cut in for a second. Did you use the term "FGCM"?

Dr Karlsen: "Female genital mutilation" is the term that is traditionally used in statutory services, but it is quite a loaded and problematic term. Other people use "female genital circumcision" or "female genital cutting". We would prefer to use FGC, but FGCM is for completeness.

Fulton MacGregor: Based on what has been said by the panellists on discussions that we have had, and following my previous question, if we do not get the bill right with regard to bringing the community on board, is there a risk that understanding of the matter could be pushed even further out of reach?

Dr Jackson: My work as an academic all focuses on communities' experiences. If something is so serious that it warrants the committee's work and legislation, I have to look at what has been put in behind that work. My research project with communities worked really hard to engage them, develop trust and support their work has ended. Where has that expertise gone? The issue is so important that there is a bill about it, but many community groups and many people like me—a black academic in Scotland who is working really hard to bring that voice through—are in project-bid land. We need to grow the knowledge and expertise.

I do not know whether the statutory guidance can develop and recognise our knowledge base in Scotland, but I hope that it can, so that we can become more knowledgeable about how to manage such intimate issues in our lives. We need to increase confidence in our mechanisms, such that policy and processes are able to make everybody feel confident about them.

Consideration of how we fund such work is really important. Our demographics have changed forever, so we really need to think about that deeply within our processes, in order for us to get the knowledge. We are learning how to do that, but there are risks in what we do and how we process that. If we build the resources, five years from now we will not be saying the same things.

Dr Karlsen: That risk was raised by our participants, who were anti-FGM campaigners and also regular members of the community who were interested in, and keen to see the end of, FGM. People who were referred from schools were people who had handed in their holiday forms to say that they were taking extended leave—they were ticking the boxes and filling in the forms, as they had been asked to. The concern is that if we start to criminalise those innocent families, the people who want to do FGM will go underground.

However, the issue is bigger. We have had Somali-led anti-FGM campaigners in Bristol for decades, who have had a massive impact on education on FGM. I do not have the statistics on the impact on prevalence, but it has been significant. Those campaigners feel that FGM safeguarding procedures have caused cleavages in the community and have undermined the work that has been done. Communities feel stigmatised and unfairly criminalised, which has undermined their sense of Britishness, encouraged their sense that they are living in a hostile environment and undermined their trust in services, as I have explained. The issue is not only about FGM, but

the impact that the bill could have far beyond the specific legislation, by the ways in which it could reinforce many other things that are happening in society.

The Convener: Thank you, Dr Karlsen. We have all heard your point loud and clear.

10:00

Annie Wells (Glasgow) (Con): Thank you all for coming along. I have listened with great interest to everything that you have said.

Do you know of any countries that have made successful interventions that have not involved legislation?

Dr Jackson: That is a good question. No, I am not aware of any, but it is not my area of expertise.

Dr Karlsen: Education initiatives are far more effective than punitive ones. We want to catch criminals and protect children who are at risk, obviously, but long-term solutions are about community-led and community-engaged collaborative education. The bill needs to be part of an armoury, but it is difficult to see now how the bill will fit with your wider services for FGM protection. In general, moving away from punitive measures and towards educational measures is the way to go.

Annie Wells: Do you know of any countries where they take a different route with their FGM interventions?

Dr Karlsen: Generally, interventions are pretty heavy handed and are not very positive.

Andy Sirel: I do not have much to add. In Europe, the most well-known country in the issue is France, which pursues ruthless criminalisation of FGM and has the highest number of convictions for FGM in Europe. The panel might agree that that is not a particularly effective method. That is just an observation from our research.

Mary Fee: I thank all the panel members for their evidence. Many of the questions that I would have asked have been covered already, so I will be brief.

I would like to start with Mr Sirel. Should legal advice be free and freely available to anyone with a query on FGM protection orders?

Andy Sirel: Yes.

Mary Fee: That is very helpful.

Andy Sirel: Not only should they get that, but—perhaps guidance could help with this—there should be comprehensive access to legal and non-legal support, including local authority support, and referral pathways to access free legal information and advice. It is not just about free access to a lawyer, but broader access to legal information.

Mary Fee: So, there should be wraparound support that does everything that is required.

Before I ask the other panel members the same question, I ask you, given your background, how much weight is placed on the risk of FGM in the asylum process?

Andy Sirel: That is an interesting question. We can learn from England and Wales on that, because the High Court in England and Wales ruled on it in 2017. The High Court said that, in the context of an asylum claim, when the Home Office is assessing risk on return to the home country, it is not bound by the existence of an FGM protection order, but must take that into account. The Home Office has published guidance on that that states that an order can provide strong evidence in the context of a claim for asylum.

Our strongly-held view is that, in that context, if we are trying to demonstrate a past risk, a risk in the UK and, most important, a risk on return to the home country if there is a forced marriage, an FGM protection order being in place would be helpful, because it might have elicited further evidence and will have produced a result on a higher burden of proof.

Mary Fee: Do other panel members have a view on legal advice? I would be grateful for answers that are as short as possible, so that I can ask my second question before we run out of time.

Dr Jackson: It is not my area of expertise, but I completely support there being a broad umbrella of legal support.

Dr Karlsen: I very much support free legal advice, and legal aid more generally, but something else that came from our research is the need to be really clear about the guidelines. For example, there is the issue of how people access the advice. There is also the issue of pathways. We had a number of people who have been involved in FGM protection orders, who said, "I didn't know what evidence they had", "I didn't know what was happening", or "I didn't know how long they were going to hold my passport for." The lack of knowledge was really frustrating and problematic for families.

Mary Fee: The second thing that I want to ask about is guidance, which is a word that has come up frequently in the past hour. I have a bit of a bee in my bonnet about guidance, because it can either be incredibly useful or it can be a complete and utter waste of time. Multi-agency guidance about FGM already exists. I am keen to hear the panel's views on what guidance should come with the bill. Should it be statutory? I get what Dr

Jackson said about consultation of the community. Whether or not the guidance that comes with the bill is statutory, it seems to be really important that the community be heavily involved in developing it.

I would also be keen to hear the panel's views on whether, in addition to the guidance, something should be built in to the bill to say that there should be on-going community engagement and education, and that provision should not just be about acting when there is perceived to be a risk, or doing a bit of work in schools or with community groups and then nothing else.

Dr Jackson: The question about guidance is helpful. I do not understand all the ramifications and potential of statutory guidance, but I know that the issue is creating ways of engaging in policy that require us to think differently. From working with the women, I understand how deep their knowledge is of how to engage with the issue. Instead of just being consulted, they should have authority and be decision makers. We have to rethink our processes about who makes guidance and whose voice is allowed to influence what it becomes. That is where we can make real change in Scotland. As I said, I have seen attempts to do that in committees on other matters, but I have not often seen it happen around people of colour or around migrants. They are so far from that process. That engagement is allowed to happen in other areas, so I am saying that this is an area where there is a real opportunity to do something.

Mary Fee: That is very helpful.

Dr Karlsen: I completely agree. The populations who are affected by the issues that are under discussion need to be involved in the framing and identification of the problem and in identification of the solutions. I do not know whether you would call it evaluation, but there needs to be on-going, long-term co-production. This is partly about undoing some of the problems that have arisen as a result of less communicative approaches. It would be very valuable if authorities could be very proactive in being seen to be communicating.

Andy Sirel: We are in favour of statutory guidance. Robust and clear guidance would complement the measures that are already in the bill. Such guidance could provide clarity around the risk assessments that should be undertaken in this area, and when legal orders to protect children must be applied for. In the past 18 months, our experience in respect of forced marriage has shown us that there are times when authorities have not acted and the consequences of that have been severe. Guidance would help local authorities to make decisions.

The last thing I will say is that I agree with what my colleagues have said about community engagement on developing the guidance. It is not possible to talk about risk factors on a subject that is so closely connected to cultural, social and familial issues without involving the community.

The Convener: Thank you all very much for your evidence this morning. It was really helpful.

10:09

Meeting suspended.

10:16

On resuming—

The Convener: I welcome our second panel to the committee: Jan MacLeod, manager, Women's Support Project; Angela Voulgari, gender-based violence services manager, Sacro; Anne Spiers, deputy chief executive officer, Multi-Cultural Family Base; and Hassan Darasi, project manager, Community InfoSource. Good morning, everyone. Some of you were here for the first panel. We have a lot to get through and I will try to be disciplined with my questions, as will other members, so that we can hear all that we need to hear from you.

Can you give us a brief comment on the work that you do in relation to FGM and your views on the bill? I will start with Angela Voulgari.

Angela Voulgari (Sacro): Good morning. I am here today because I work for Sacro, the lead partner for the bright choices project, which was a partnership between Multi-Cultural Family Base, Sacro and the Edinburgh and Lothians Regional Equality Council. The project was funded by the National Lottery Community Fund between 2015 and 2019 to provide support to individuals, families and communities affected by any form of honour-based conflict or honour-based violence. Under that umbrella, we realised that there was an overwhelming need for support, both for women who had survived FGM and children in Edinburgh who might be at risk of the practice.

My colleague Anne Spiers from the Multi-Cultural Family Base was one of the partners for the delivery of bright choices. The FGM support and protection worker for bright choices is still placed in the Multi-Cultural Family Base. That is our connection to that work.

Jan MacLeod (Women's Support Project): Good morning. The main issue for the Women's Support Project is violence against women. We became involved in work on FGM after being approached by women survivors of FGM who wanted to be involved in community engagement work because they believed that there was a significant number of people who were not aware of the law in Scotland or the negative impacts of

FGM on women's physical and mental health. Through that we got drawn into work at the local and national levels.

It is important to acknowledge that we are all here today because of the grass-roots work, which has been led by African women in particular. We have tried to use that to guide our work. I caught the end of the previous panel and I agree that the involvement of the communities that are potentially affected and of women who have experienced FGM is vital.

We have been working within the wider context of violence against women and girls and human rights. We have tried to remain aware that, although FGM is a serious form of child abuse and can have a lifelong impact on the health of some women, in the vast majority of cases, parents believe that it is the right thing to do or is what is expected of them and that not carrying it out might have immediate negative consequences for their daughters.

That is a difficult issue for child protection systems here to struggle with. It also leads to an understanding that, in order to work effectively with communities or for community-led change to take place, we need to amend our approach slightly. For example, if someone genuinely believes that their religion requires them to carry out FGM, the law might not change their behaviour, but if we can work with their faith and show that no religion requires or condones FGM—as far as I am aware—we can get change for people overnight. We try to have those principles inform our work.

The work that we have delivered has included developing resources and training materials for practitioner training and public education, and supporting networking between statutory, voluntary and community sectors through newsletters and meetings. Last year, we had a national conference, which had a trauma focus. We have done a small bit of community engagement—we always try to do that in partnership with black and minority ethnic or survivor-led organisations. For example, we have worked with the Kenyan Women in Scotland Association, which has done excellent work in communities; Hassan Darasi and Community InfoSource; Saheliya; and the violence reduction unit. Although we do not have funding for a support service for women, we get a gradual trickle of referrals from lawyers, social workers and health visitors because we are involved in public education, so we are aware of the lack of services for women.

Anne Spiers (Multi-Cultural Family Base): Thank you for inviting us. I work for the Multi-Cultural Family Base, which is, among other things, a social work training agency, so we work with social work students from all over Scotland. We also provide family support services to black and minority ethnic communities, from age naught to adulthood, across our various projects. We have always had a focus on new and emerging communities and on people who move to Scotland. Twenty years ago, we worked with Sikh and Pakistani communities, which are well resourced and self-supporting these days. We now work with a lot of refugees and asylum seekers, for example from Syria.

As Angela Voulgari said, we were part of a collaboration, partnership and philosophy that was called bright choices. Through that, we have in place our FGM support worker, who works with women, girls and families. MCFB also has an honour-based violence support worker, so we have two workers who work specifically on those issues. A Venn diagram would show that there is quite a big overlap between the two issues.

Hassan Darasi (Community InfoSource): I am the project manager for challenging violence against women, at Community InfoSource. As a company, Community InfoSource started in 2006 and has a legacy of working with disadvantaged communities, particularly black and minority ethnic groups. I am one of the people who has benefited from Community InfoSource. I came here as an asylum seeker and helped to start the Scottish asylum seekers residents association, which was unique in the United Kingdom, given that asylum seekers were tenants and the landlords were white people. We have been working on a lot of pilot projects, such as the living well in Glasgow project. Our projects have benefited a lot from working in partnership with Jan MacLeod and the Women's Support Project.

In doing that work, we discovered a need to work with men. We brought the issue to one of our partners, Saheliya, but, given that Saheliya works only with women, it said that it would give the work to community social workers, who deal with all genders, and we tapped into that work.

We work in a very challenging environment in which we deal with men from east and west Africa as well as some men from the middle east—many people from places in the middle east, such as Yemen and Kurdistan in Iraq, also practise FGM.

The work that we do with men is very challenging. The need to work with men came because we stand little chance of doing away with FGM if we work with only one gender. The involvement of men is therefore very important. That is where we come at the issue from.

The Convener: Thank you—that is very helpful. I will go straight to committee members for questions. Not every witness has to answer every

question, but if you wish to contribute, you can. I will start with Oliver Mundell.

Oliver Mundell: We heard from the previous panel about how the protection orders have been working in England and Wales. I note that only 3 per cent of those orders were made at the request of the person who was to be protected. As we bring them forward in Scotland, how do we empower more people to come forward and seek protection themselves?

Angela Voulgari: We do that through education, first of all. The approach that we as a partnership have taken—it has also been taken by many partner organisations around Edinburgh and Glasgow—is about not jumping in and telling people what to do but making sure that people are on our side through an understanding of why FGM is a damaging practice and of the lifelong effects that it will have on the child, the girl and, later, the woman in her adult life. A lot of the time, once people understand those impacts, it becomes a lot easier to get them on our side and to get them to say, "That's not the future I want for my child and I'm prepared to work towards protecting her." I believe that my colleagues will agree with that to a large degree. It is about education, raising awareness and making sure that people understand that we are here to support, not punish.

Anne Spiers: To clarify the original question, was it about how we encourage people to engage with and seek protection orders themselves?

Oliver Mundell: Yes, that was the thrust of my question. In England and Wales, 39 per cent of orders were requested by local authorities and 58 per cent—I think—were requested by the police or other third parties.

Reflecting on the first panel's evidence and on other evidence to the committee, I think that there is a feeling that the process is something that is being done to communities, rather than people coming forward themselves and having confidence in the process.

Anne Spiers: My starting point, which was reflected in the discussions that I had with my colleagues in the run-up to today's evidence session, is that, like the previous panel of witnesses, we have some questions, not necessarily about whether the protection order is required but about what teeth it would have and whether it would be useful in addition to orders that already exist, such as child protection orders. Obviously, we are more familiar with some of those orders at Multi-Cultural Family Base.

If we could go back the way, we would change the title and call it a protection and support order, because if we are asking people to come forward and request something themselves, there needs to be something in it for them. Our experience of intervention is that it is best received when it goes alongside tangible support to people, so the order needs to offer people support as well as protection.

Although I take on board some of the points that the previous witnesses made about the prevalence of FGM, our view as an organisation that works directly with people who are affected by FGM is that if we have a child who is at risk of FGM, we have a circle of people around that child who are at various levels of risk as well. If one of the additional risks to them is of prosecution or criminalisation, they will not come forward or engage. Who would? If it is likely that it will put someone's other children at risk of having a parent who is prosecuted or criminalised, the hope that they will engage on that level with a protection order is reduced. We have a lot of concerns about that area. If we offer protection and support, there is a better chance that people will engage more readily.

10:30

Jan MacLeod: I agree with the replies from Angela Voulgari and Anne Spiers. When we had meetings with women from communities that are affected by FGM and we asked about the protection orders, the number 1 response was, "You can have as many laws as you like but if people don't know about them or if they don't believe that you are going to use them, it doesn't matter what the law says."

On how we increase the number of people at risk who apply for protection orders, the first thing is that they need to know about them. I can imagine situations in which both young women and adult women are at risk, because there can be a link with forced marriage. In some cultures, FGM is carried out on the eve of the marriage. The Rosa project research suggested some years ago that the age of protection should be raised to at least 25. That is an important gap in people's thinking.

For children or younger women, the fact that somebody else applies for the order is not necessarily a bad thing. It is a huge step for anybody to take. Given the overlaps that sometimes exist in relation to domestic abuse, honour-based violence or cultural attitudes, it can be a help for family members if they are able to say, "Well, it wasn't really us; it was that social worker that did it," or, "The police made us do it." Otherwise, it can cause a huge fall-out in the family.

Another thing that struck me about the discussions that we have had is that women often say that a woman cannot say no to her husband or

her mother-in-law. That came across strongly—it is relevant to a different point, which was the suggestion of an offence of failure to protect, which was a huge concern in communities.

Hassan Darasi: I agree with what my colleagues have said. We have also been discussing the issue with other groups. We had the same view as Anne Spiers that we should call the orders protection and support orders. We did not say it that way but I like that expression.

We said that the measure is a real contribution to prevention. The strategy provides a deterrent and not just punishment. One of my colleagues used a nice expression: "If you are going only to punish, it is like closing the stable door after the horse has bolted." Deterrent measures are far more important. People should be educated, and we should raise awareness in all communities. That is what is needed. Do not bolt the door by jumping to the punishment. We agree with having a protection order.

Oliver Mundell: To follow on from that point, will people see the protection orders as being sufficiently distinct from criminal prosecution, or will people see them as being connected to the criminal process?

Anne Spiers: It is hard to judge that. The understanding of the legislation and powers that might be brought to bear could be minimal among communities. In my experience, that is certainly the case in the white Scottish community. It is the same for all of us; unless something is specific to us, we might not have much interest in it. There could be a deal of confusion. Who delivers the information and in what way is probably more important to individuals and communities. I do not know whether my colleagues would agree with that.

Jan MacLeod: It is hard to say. In discussions, people have understood what the orders are trying to do, which is to be a first stage that can protect people without it criminalising their parents or close family. The forced marriage protection orders do not seem to be a huge issue, so the orders should be workable.

Annie Wells: The committee sent out a call for evidence on the bill, and we received 13 submissions, which were pretty mixed in their views on the additional protections that should be in the bill. Three provisions come to mind: lifelong anonymity for the victim, the offence of a failure to protect, and a mandatory duty to report. Should those provisions be included in the bill, or does it go far enough?

Jan MacLeod: The bill has gone far enough. We had huge concerns about the failure to protect, and it came out in all our discussions that there might be serious unintended consequences. I am not a legal expert, but that seems to be contrary to everything else that we do in law. How can it be proved that someone failed to do something?

To go back to my original point, I have heard stories in which parents did not wish to carry out FGM but came under huge pressure when they went back home. I am sure that the committee can imagine a situation in which someone would say to them, "You should have just said no." However, as I have already said, women have told us strongly that there are circumstances in which a woman cannot say no and stay safe or have her children stay safe.

On anonymity, our view was that it is not helpful to pick out FGM when we do not have similar legislation about child sexual abuse, incest, rape and sexual assault. If something is needed, it should cover all victims of gender-based violence—males and females. I am not convinced that that is necessary.

Angela Voulgari: Our view was that, for FGM, lifelong anonymity should be guaranteed for any victim or complainer purely because of the further risks for them and their extended family members and community as a result of having spoken out against a centuries-old practice. There could be further repercussions from the wider community, and there could be all sorts of unintended consequences should the name of the person or the family be made known to the public.

The question on the failure to protect was quite divisive. Overall, we responded "Yes", but our answer contained seven or eight considerations that need to be taken into account. Although we can see the benefit, it is not black and white. We need to be able to ask whether we have considered the specific circumstances in which the situation came to be what it is, and, if so—as Jan MacLeod suggested—how we prove that one way or another.

You also mentioned the mandatory reporting duty. That was another question for which answering why took a very long time. As Anne Spiers mentioned earlier, it is not just about making the reporting mandatory; it is about making the support for the child, woman or wider family and community mandatory. If we do not provide that support, further generations and potentially other members of the family will suffer, too. We need to step back and consider both sides of the argument.

I am sorry if that is not a very clear answer. However, it is not a very straightforward question, unfortunately.

Hassan Darasi: I agree with what my colleagues are saying. The proposals were discussed at the FGM summit in July, and there were many issues. The phrase "failure to protect"

is very elastic and cannot be defined. What is meant by “failure to protect”? It might even put the victim in the same boat as the culprit. There were other issues, such as the question of anonymity.

I think that the bill goes too far. There is no clear guidance for various issues, including the failure to protect. The third sector does not have any clear guidance. On Tuesday, we were in a meeting about the national action plan. Even the statutory bodies are not clear about all those things, so how can we expect communities to be clear about what the law says? We do not know whether there will be some guidance for the third sector.

The language is too technical, as well. It will be hard to deliver to communities at the grassroots level, for example, where English is not people’s first language. All the technical language would be very hard to understand for the people whom the law is aimed at. There could also be some profiling of communities or stigmatising of people. If you are going to use the legislation only for certain categories of people, how will the communities perceive that?

As Jan MacLeod said, there are some similarities with people’s perceptions of the forced marriage legislation, but that affects only certain communities in the Asian community, not the community as a whole. The bill could be different from the forced marriage legislation. It would have an effect on the wider community.

Alex Cole-Hamilton: In the previous panel session, Dr Jackson made the interesting point that there is potentially sufficient protection coverage in existing child protection legislation to at least make the protection orders unnecessary. However, as I mentioned to Dr Jackson, we heard in a briefing from the bill team that sometimes adult women are subjected to FGM. Obviously, no adult is protected by child protection legislation. Can you talk about the prevalence of FGM among adult women if you have knowledge or evidence of that? Is there another route that we could go down instead of using a protection order which would not single out cultural groups in that way?

Jan MacLeod: On prevalence, nobody can say for sure how many women in Scotland are affected by FGM, because that information is not collected anywhere.

On whether FGM protection orders are absolutely necessary, I know that, when we first discussed the issue at a multi-agency meeting in Glasgow some years ago, there was a feeling that it was already possible to effectively protect children. However, I think that I am right in saying that, as discussions have developed, there has been a feeling—certainly among the women and some of the workers from other organisations that we have discussed the matter with—that there would be a benefit in having something specific on FGM. It would bring to people’s attention that this is very much an issue for Scotland and for Europe because of migration, and it will continue to be an issue. Various pieces of research have been done that show that migrant communities sometimes hang on to their cultures and traditions much more strongly than they would in their home countries.

We could certainly protect children and young people without those protection orders, but there might be advantages in having FGM-specific protection. One particularly problematic issue—again, I could not give the committee the national numbers—is that the asylum system’s approach to FGM risk is very definitely at odds with what you are all trying to do and what Scotland is trying to do to end FGM.

I will give an example of that. It involves a woman who was married in her home country. Her people did not practise FGM, but her husband’s family did. They were Christian and believed that it was part of their religion and that it was rooted in other traditions. They expected the woman to undergo FGM before her marriage, but her husband did not want that to happen.

10:45

Everything was fine—they brought up their family for 12 or 15 years, and then the husband died. The daughter was 11 at that point. The family had just arranged to come to the UK to visit the mother’s sister. They got an unexpected visit from the husband’s family, who had the attitude that the husband had died prematurely because he had broken the family traditions and who believed that they could remove the bad luck and prevent any further bad luck in the family by restoring the traditions. They had arranged for the daughter to be married at the age of 12 and for the woman to be married to her husband’s brother. I almost forgot to mention the key thing, which was that the daughter overheard that conversation. When they came to the UK, the sister said, “You need to go to a lawyer.” The lawyer in London told the daughter, “You don’t need to worry—you’ll be protected in the UK.” Since then, their asylum claim has been refused again and the mother is terrified to tell her daughter that, because she is very concerned about her daughter’s mental health.

When that family came to us, a social work referral had been made, but months had gone by. I am very interested to know whether an FGM protection order would have some weight in such cases. I heard the response that the previous panel gave. In that particular case, FGM was not just a possibility but was planned. Despite that, the claim failed. That makes me wonder what communities make of the fact that, even though

legislation has been put in place that is directed at their cultural practices, another section of British society says, “No, you’ll be fine—just move to a different town.”

I am sorry that that was a long answer, but I think that that example highlights the point.

Alex Cole-Hamilton: That has opened up several new avenues of inquiry for us, particularly as regards the interrelationship between our deliberations on the bill and the deliberations in relation to the UK immigration system.

I want to ask a question that I asked the previous panel, which is about the fact that FGM is a spectrum. There is the brutal mutilation of young girls, which happens against their will, right up to women from all cultural groups choosing to have changes made to their genitals, such as piercings or labiaplasty. Is there a danger that, by singling out one cultural practice, we might create an artificial racial barrier? There are cultural practices in our culture that are not traditions, but which are more prevalent. Do we need to reflect that in the bill, particularly in the context of consent?

Anne Spiers: That goes back to the previous question that you asked, with which there is a connection. You asked about the protection of women as well as girls and the extension of protection orders to women. With protection orders under other pieces of legislation, such as the adult support and protection legislation, the issue of consent for adults is a primary consideration. There needs to be a different approach when it comes to consenting women and offering protection to people with capacity so that a choice is involved.

I am sorry—I have slightly lost track of what your second question was, because I was working on the previous one.

Alex Cole-Hamilton: I asked whether the bill needs to be more nuanced in relation to the spectrum of FGM and whether it might need to refer specifically to consent. If what is regarded by the WHO as FGM is undertaken with consent—I am talking about a procedure such as labiaplasty—do we need to disaggregate that within the bill?

Anne Spiers: I was very interested in what our colleagues said previously on the issue. I am not sure that I have any answers, but some of the discussions that we have had have been about the risk of racial and ethnic profiling being too much of a consideration when FGM protection orders are looked at. We are talking about ethnic profiling that can go hand in hand with people who come from particular areas of the world. It can look like ethnic profiling, and we are concerned about that. On a spectrum, we have a mild, unconcerning area at one end. I am not concerned about what causes people to be influenced to undertake cosmetic FGM, for want of a better term, but I certainly have concerns about ethnic and racial profiling, which my colleagues spoke about earlier.

Alex Cole-Hamilton: I will clarify my question, which is about my growing thoughts about potential changes to the bill. If it explicitly referred to consent, all of that issue could be covered. We could remove some of the racial stereotyping that we are rightly worried about by saying that this happens in increasing numbers of cultures and most of it may be consensual and the person’s decision, but there might be times when a woman in our culture in Scotland will be forced by an abusive and coercive husband to have changes to her genitals, and she will probably need protection.

Anne Spiers: Yes.

Jan MacLeod: That is like changing the world. If you could do that, please do.

The issue comes up quite a lot in our training. We ask practitioners to think about being challenged when they say that they are a social worker and that FGM is against the law. A person might say, “How come? If I wanted to, I could just go and get labiaplasty.”

The bottom line is that there are women, including young girls, who are eagerly waiting until they are old enough to get it done because of social and cultural pressures, and also the impact of pornography. When I grew up, we rarely saw pictures of genitals, but now young people see them all the time. That has an impact on girls who have had FGM and did not realise how much they had been changed, and on girls and young women with regard to body image. There is a perfectly solid and strong argument that cultural pressures are leading to the same impact. However, most practitioners and people in general are clear about the matter. Although there might be concerns about people’s reasons for cosmetic genital surgery, the key thing is that it is not generally intended to limit women’s sexual pleasure or control their sexual behaviour.

References to piercing can be confusing. My understanding—I might be wrong—is that the original World Health Organization wording about “pricking” or “piercing” did not refer to jewellery, but was about tightening the vagina or something like that. That is unhelpful now. Sometimes, when midwives ask the question, it might be easier for people who are a bit uncomfortable to focus on the jewellery side, which is not really what the question is about.

Alex Cole-Hamilton: That was very helpful.

The Convener: That is an interesting issue and your response was helpful. The first thing that

popped into my mind was that we need to be careful not to say, "That stuff that's done in a cosmetic surgeon's studio is fine—it's a free choice—but that other thing is bad," because all those things are related to the same structures in which women are not valued.

Lots of colleagues are waiting to come in—I am trying to remember in what order.

Angela Constance: I want to go back to the issue of anonymity. Do Ms Voulgari and other members of the panel have a view about whether, in the context of the bill, anonymity for victims should be automatic? How might that work in practice? At the moment, the courts can grant witness anonymity under the Criminal Procedure (Scotland) Act 1995. Four criteria must be met for that to happen.

You support witness anonymity. How would that work in practice? Are the existing provisions for the court granting anonymity sufficient?

Angela Voulgari: We firmly believe—this goes back to Alex Cole-Hamilton's question, too—that automatic anonymity should be provided immediately. Many victims are children, but we have worked with women as old as 43 or 44 who were at risk of FGM and—if they refused to undergo the practice—at risk of an honour killing. We need to be aware that we are not just talking about children. The provision must be extended to adult women, including those in their late teens and early 20s.

Another consideration that influenced our response is that it is sometimes not necessary to state someone's name, especially when they are a member of a community that is quite small and tightly knit. People in such communities know one another very well, and one of the issues that we raised in previous discussions was the way—

Angela Constance: I understand the arguments for automatic anonymity—they have come through well in your responses. What I am trying to get at is how it would work in practice if the current act was amended by the bill, and why the current provision is insufficient with regard to the courts providing anonymity when women or girls are the victims, or at risk of being the victims, of FGM. The Government will say that the existing law provides for the courts to grant anonymity. I am asking you why that is insufficient.

Angela Voulgari: If I am perfectly honest, I am not entirely familiar with the four conditions. We based our response with regard to this particular type of abuse on what we thought would be the most appropriate course of action as a stand-alone process.

Angela Constance: Thank you. Ms MacLeod, do you want to comment on that issue?

Jan MacLeod: I am a bit like Angela Voulgari in that I am not the best person to inform you about the details of the law.

The point that was just made came up strongly in a recent case in Bristol involving a Somali family. People in Glasgow knew which family that was from the way in which the media reported the case, even though no names were mentioned. People said that they could not imagine how additional legislation could be constructed that would stop the spread of information on social media. They talked about how quickly it spreads from one country to another, which has implications, such as family back home being threatened. I do not know how you could ensure anonymity.

Angela Constance: We can perhaps bottom that out with the Government.

Ms Spiers, given that your organisation supports the training of social workers, do you have any views on whether it would be useful for the children's hearings system to be able to grant FGM protection orders?

Anne Spiers: If FGM protection orders end up coming into being, I would agree with the children's reporter having the power to grant them as part of the children's hearings system. It would be really useful for such orders to co-exist with the other orders that are available to the reporter.

I would say that it would be useful for the children's hearings system to have the ability to grant FGM protection orders for all the reasons that have been mentioned, and because of what Andy Sirel said about the benefit in the children's hearings system not taking children and their families further into the judicial system—the courts and so on—than is necessary. That would be a more supportive approach.

11:00

Fulton MacGregor: I want to follow up on questions that I asked the previous panel. The academics on that panel were not sure how prevalent FGM is in Scotland. From my experience of the issue, it would seem that there is not a body of evidence on FGM. Many of the services that your organisations provide are front-line services. How prevalent is FGM in Scotland?

In the interests of time, I will combine that with another question that I asked the previous panel. If we do not get the engagement right with communities, does the bill have the potential to make it even harder to reach people? Might the practice be pushed even more underground, for want of a better term?

Anne Spiers: I completely agree. In our direct practice, we are in the business of building

relationships with people who are vulnerable; at MCFB, they can be vulnerable for lots of different reasons. However, if we ignore the fears among communities or individuals, we will be in danger of driving practices underground, alienating our services from communities and not being able to offer support to the people who really need it. We already work very hard to engage with people, and if they associate that engagement with some sort of accusation or insinuation of criminal behaviour, we will be on a really sticky wicket.

Angela Voulgari: I agree that we need to get it absolutely right. The last thing that we want is to perpetuate the fear of engagement, not just with statutory services but with any kind of service.

To go back to your question about prevalence, that really is the golden nugget. Unfortunately, I do not think that there is an answer, partly because a lot of the numbers that we have come from maternity services, and not every woman who is a survivor of FGM will access maternity services. We tend to try to estimate the numbers using extrapolation based on census information, and prevalence in countries of origin. When it comes to women who are not going to access maternity services, are other professionals aware of what questions to ask in order to establish whether FGM is present? That includes not just health professionals but teachers, social workers and people working in services across the board that women are likely to access.

Jan MacLeod: Nobody can say for sure what the numbers are, but we have one Glasgow-based project, rights and choices, which, although not FGM specific, works with asylum seekers, refugees and migrant women. About 70 per cent of the women there have undergone FGM, and a significant number of them would have had type 3. We regularly—month in, month out—come across women who have been in touch with services and who have not been asked the questions or given the information that has allowed them to talk about physical or mental problems—health impact, rather—or problems in the family, some possibly relating to child protection. There are definitely significant numbers of women, and families, who have been affected, and who could have more negative impacts that are not being identified. We have made a big difference in raising awareness, certainly in the central belt, but I agree that we need to continue that work.

The answer to getting a better idea of the prevalence of FGM and to improving engagement is to target resources at key points of contact. Not everybody has children, but everybody should have a general practitioner, and women should be part of the national smear testing programme. Key points of contact include registration with a GP, the smear testing programme and maternity services. We should also ask whether there is an opportunity, when children go to nursery or school, to include something in every parent's pack of information and to engage at that early stage, so that we start to build up a better picture. It is particularly important to do that in parts of the country where the percentage of the population who are at risk is very low, because if FGM does take place, it could have a catastrophic effect on girls.

On the argument about FGM being driven underground, I do not think that the bill will do that. However, if the law was badly applied in the first instance, that could certainly happen. Skills and training will require to be provided. My view is that if the first orders that were placed were seen as the family was just planning to go on holiday, that would have a really negative impact and would have unexpected negative consequences. At one meeting, a woman made the point quite strongly that, if a family really wanted FGM to take place, they would send the girl abroad and not bring her back. Families who are really committed will be able to do that anyway, but the bill could protect other young people.

Hassan Darasi: It is very hard to know how prevalent FGM is. I work with men, so it is very hard to know. Three weeks ago, we had a workshop where there were people from a number of communities. There were three people from the Yemeni community, who argued that there is no FGM in their country. They said that not even one person had been affected, although the rate of practice is 23 per cent in Yemen. We spent half an hour arguing with them, by showing them websites and googling. We showed them newspapers from their own country, but they said that they could not be relied on. We showed them other resources from their own country, but they were still adamant that the rate was not even 1 per cent there. If people do not know that FGM is happening in their own country, it could be happening in this country without their knowing.

The same is true for me. I have two daughters, and it was only when I engaged with these issues that I knew that FGM had occurred with them. In our communities, although there are some cultures in which men are involved, mostly, these things are done through the women. People do not necessarily know that it is happening, so it is very hard to know about the prevalence.

The other question was about whether protection orders will lead people to go underground. The answer is yes and no. A protection order could be empowering for people, if it is used correctly.

As Jan MacLeod said, many people perceive FGM as a religious thing. For our projects, we bring in some imams for Muslims, as well as some

priests, to educate people, because there is a wrong interpretation of some religious sayings. For example, some sayings in Islam make it seem as though such things are acceptable. We bring in religious men to talk to people, and we give some examples. For example, Saudi Arabia is a totally Muslim country, but nothing is happening there. If FGM was related to Islam, Saudi Arabia would be one of the countries in which these things are done. North Africa is a predominantly Muslim area, but FGM is not practised there, except in the north-east, in Egypt, where the rate of practice is more than 90 per cent.

Protection orders will be a blessing if they are used properly to empower communities and raise awareness. A lot of work is needed, so we should not rush the introduction of the orders, because that might have a negative impact.

The Convener: While we are talking about the protection orders specifically, do panel members have a view on what length of time they should cover?

Jan MacLeod: They would need to be very flexible and potentially long term.

The Convener: Sometimes it is helpful for us to understand a scenario or a circumstance—it can seem a bit abstract just to talk about orders being out there. Can witnesses think of examples of women whom they have worked with and what type of intervention would have given them the protection or space to take action?

Anne Spiers: I am probably competing with my colleagues to give you examples—yes, we have examples. One involves a woman who was referred to us as a survivor. She was receiving support from us and she declared her fear that FGM would be performed on her two-year-old when the family returned to its home country after a period of study; they were in the country on a study visa. The two-year-old of the family would be at risk, as that had been declared to be the plan of the extended family back home. Her husband was, at best, ambivalent. He saw it as a tradition and—as has been said—did not feel that he had much of a part in it. For him, it was just something that was going to happen.

My colleague, the FGM support worker, worked with the woman closely, to the point at which we felt that the child was at risk and that the woman had very little agency to do anything to protect the child. At that point, following the getting it right for every child guidelines, we involved our statutory colleagues. The family then engaged with specialist social work services—in that case, asylum and immigration. The family went forward, engaging voluntarily, because there was a six-year-old little girl in the family who was an FGM survivor and the woman was an FGM survivor. She also had male children and she was in great fear.

An issue for her was that she came from a relatively affluent and well-educated family. She lived comfortably while she was here with her children, who were settled at school in Scotland. In pursuing the protection of her child, which was her number 1 priority, she faced, in all likelihood, the prospect of losing her husband, who would go back home without her. He may have attempted to take the children with him; however, secure arrangements were made to prevent that from happening. In her view, she would certainly be abandoned in a country that was not her own, speaking a language that—although she could speak English—was not that familiar to her. Her family would be uprooted because she would have to seek asylum. The children would be taken out of school and nursery, and they would be moved to and accommodated in Glasgow, where they knew absolutely nobody. That would be the result for her—she would be on her own in Scotland, where she did not choose to come in the first place, in order to protect her child.

That is where we talk about protection and support. The little bit of breathing space that a protection order might have provided in the first instance would perhaps have given her some time to think about her options, with some protection. However, it would not have changed her options much, because of the concern that we have all expressed about the interface between protection orders and the legislation that we have in Scotland and Home Office legislation. Hypothetically, there was the potential for that woman's immigration and asylum situation to change and for asylum to be denied to her. She would then have been an abandoned woman going back to her home country with her children, and all that we would have done would have been to increase her vulnerability and the vulnerability of that child.

The Convener: How would a protection order make such a situation better?

Anne Spiers: I know that that sounded like a very well-rounded case study, but that is the question that I came here with.

The Convener: It is the key question, and it is one that we will certainly put to the Government. Does anyone have anything else to say on that question?

11:15

Jan MacLeod: That is the scenario that I would have picked. I gave you the other example—the most common referral that we get is when there are quite urgent child protection concerns, especially when the family states that plans are

definitely in place and it is not just a theoretical risk.

An FGM protection order might help only with winning an asylum claim. It might not help at all in relation to having an impact on the family, and what is needed is support for the family.

The Convener: Thank you. That is helpful.

Mary Fee: I thank you all for your evidence, which has been very helpful. I will ask you—as I asked the previous panel—about the guidance that will come with the legislation. That guidance will be incredibly important, and the committee can make suggestions about what we would like to see in it. I am keen to hear your thoughts about whether there is something in particular that should be included.

Mr Darasi, I was particularly interested in some of your comments about the work that you do with men in communities. We cannot exclude men from any of the learning, education and support for families. I appreciate that we do not have a huge amount of time, but I am keen to hear whether you know of any good practice in communities that we could recommend including in the guidance. If you cannot go into all the detail today, I would be grateful if you could contact the committee later, to let us know about that.

Hassan Darasi: We have discussed this in a group as well as with some people from here who visited us. What is available is a little porous, and it is not very clear. First, there is no clear indication of what the guidance is and whether the third sector will have its own guidance. We put something in writing about that. For example, it is not clear in the bill which people can apply for an FGM protection order. The list of people who can apply includes "any other person", but only with the permission of the court. We are not clear about what that means, and we need some answers on that. If we do not have those answers, it will be hard to know what to do.

There should be some examples of what triggers the protection order. For example, as Jan MacLeod said, if a girl is going away for a longer period during the summer, that could give an indication that something might happen, but it could happen in an even shorter time. There are many things to consider.

We also want to know whether there are scenarios from other parts of the UK that could help us in our work on guidance. We work with different cultures—for example, some men come from the middle east and are Arabic speaking. There are some Kurdish people, and we deal with people from different parts of east Africa—Somalis, Eritreans, Ethiopians, and Sudanese people—and from west Africa. We deal with some Egyptians as well. It is very challenging.

It is mostly those people who come from east Africa who depend on their religious teachings, saying that type 1 FGM is a religious requirement, whereas in west Africa it is mostly cultural. The topic needs more time, and maybe I can give more feedback on it later.

Mary Fee: That would be very helpful. Thank you. Ms Spiers, do you want to comment?

Anne Spiers: My view of guidance is influenced by our training role. If guidance is issued, it needs to be accessible for training purposes. As you would expect from the third sector, we would say, "Could that please be resourced?", because we cannot carry the burden of that training. In my previous role, I was a learning and development adviser, so I understand the importance of training as it comes down through the statutory sector to the workforce. Sometimes, in the third sector, we carry that burden ourselves. Angela Voulgari and I worked in partnership, and a big part of the bright choices initiative was to offer local authorities advice, training and support in relation to a number of the topics that we have covered today. Any guidance that is issued needs to be resourced in such a way that it can be disseminated.

Mary Fee: Okay. Do other panel members have a view?

Jan MacLeod: The existing guidance has a lot of helpful information in it, which can be built on. Obviously, we need to keep working on general awareness and, if the legislation comes into force, promoting it. However, there is a lack of practice skills such as how we ask the question, whether people are clear why we are asking it and what should follow from a positive response.

We need something that would get key organisations to have regard to the development, at key points, of appropriate skills such as going to the GP, using maternity services and entering education. Every family will do one of those things. If they have kids, they will have to use maternity services. We need to concentrate the resources, because just saying, "We should do more training" will have no impact.

I am not sure how it could be done, but we should highlight the importance of carrying out community engagement even if, initially, it is just engaging with organisations, so that practitioners are aware of organisations such as the Kenyan Women in Scotland Association—KWISA—the my voice project and the other projects that have submitted evidence. We should not talk to communities just when we have a crisis; communities should be able to inform us.

Work that was done in Glasgow about engagement was really informative. The good practice guide that came out of the Rosa-funded multi-agency initiative has strong and clear

guidance for community engagement, and I recommend it. The guide recommends highlighting positive change, because African communities have demonstrated that they can change attitudes to FGM. It is not a simple story, but there has been a significant fall in its prevalence. If this initiative could be linked to positive, community-led change, that would go a long way to avoiding possible negative consequences and a bad start to the legislation.

Angela Voulgari: You asked for specific examples that can be used to inform further guidance. In July 2017, the Edinburgh child protection committee published the "Edinburgh and the Lothians Inter-Agency Procedures for the Protection of Girls and Women at Risk of Female Genital Mutilation (FGM)", which has been instrumental in our work. It is a supportive, detailed and informative document that, as Hassan Darasi said, has been helpful because it breaks things down into the specific responsibilities for each professional. For example, what would a health professional, a social worker or a third sector worker do? It is clear about what they are expected to do. I highly recommend that, in any consideration, it would be a good document to consult.

Mary Fee: That is helpful. Thank you.

The Convener: I thank the panel members for their evidence. It has been very helpful and we are grateful to have had them here.

At our next meeting, we will continue to take evidence on the Female Genital Mutilation (Protection and Guidance) (Scotland) Bill.

11:24

Meeting continued in private until 11:37.

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