OFFICIAL REPORT
AITHISG OIFIGEIL

Equalities and Human Rights Committee

Thursday 19 September 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 19 September 2019

CONTENTS

EQUALITIES AND HUMAN RIGHTS COMMITTEE

21st 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:

Obi Amadi (Unite the Union)
Katie Cosgrove (NHS Health Scotland)
Vickie Davitt (NHS Lothian)
Esther Kamonji (Kenyan Women in Scotland Association)
Sara McHaffie (Amina—the Muslim Women's Resource Centre)
Girijamba Polubothu (Shakti Women's Aid)
Dr Rachael Wood (NHS National Services Scotland)

CLERK TO THE COMMITTEE

Claire Menzies

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Equalities and Human Rights Committee

Thursday 19 September 2019

[The Convener opened the meeting at 09:09]

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

The Convener (Ruth Maguire): Good morning, everybody, and welcome to the 21st meeting in 2019 of the Equalities and Human Rights Committee. I ask everyone to switch off their mobile phones and put them away. We have received apologies from Angela Constance and Annie Wells.

Agenda item 1 is stage 1 of the Female Genital Mutilation (Protection and Guidance) (Scotland) Bill. I welcome our first panel. Esther Kamonji is from the Kenyan Women in Scotland Association, Girijamba Polubothu is manager of Shakti Women's Aid, and Sara McHaffie is the violence against women development officer at Amina—the Muslim Women's Resource Centre. You are all welcome. Thank you for being with us.

Can you tell us about your knowledge or experience of FGM, and the work that you do in relation to it and, in doing so, say whether you support the aim to strengthen the existing legal protection?

Sara McHaffie (Amina—the Muslim Women's Resource Centre): At Amina, we have a helpline that offers support for women who call us for any reason, including because they have a concern about FGM or have experienced it themselves.

My role involves training our staff and volunteers, including on FGM and related issues, and it involves awareness raising in the communities within which we work. I might, for example, lead a session in a women's group during which we talk about violence against women and girls in general. We would include FGM as part of that, so it is not set off to one side as a stigmatised issue.

We also work with men's groups: we work with sheikhs and imams and show a film that features them talking about FGM and the position on that within Islam.

We do campaigning, blogging and social media, to correct attitudes more widely than among the folk to whom we have time to reach out. Obviously, we also contribute to policy, locally and nationally.

Girijamba Polubothu (Shakti Women's Aid): We provide domestic abuse services and support women who are suffering all forms of domestic abuse, including FGM, forced marriage and dowry-related abuse. We are actively involved in campaigns on those issues.

We have been supporting women from countries where FGM is practised. FGM has already happened to the women whom we support and who have migrated to this country. However, recently, we have also had cases in which mothers are fleeing domestic abuse, and there is an element of fear of FGM happening to their children.

Currently, we have five cases: one mother with three children, a single person and another woman with children. I hope that it is okay to say this: for one woman, FGM took place in Europe and she fled from there to prevent further harm. Those are the types of cases that we support.

We also support other domestic abuse cases; we support the women to get access to accommodation and to financial support, including benefits. If there are issues to do with immigration and asylum seeking, we help the women and children to get them sorted out.

If a woman or child discloses that FGM is happening, we support them to access protection orders, on which we work closely with the police and social work.

The Convener: Esther, could you say a bit about your organisation, please?

Esther Kamonji (Kenyan Women in Scotland Association): Thank you. I am sorry for being late.

Our work is mainly focused on African women. I will give the whole context. Most of the people whom we work with and associate with in respect of FGM come from the African continent and its diaspora, and many come from the FGM-affected areas.

I will briefly give the historical context of the Kenyan Women in Scotland Association and how we came into being. We were not the first to fight FGM. In Scotland, the Prohibition of Female Genital Mutilation (Scotland) Bill was introduced in 2005, and a lady called Khadija Coll, who is still very active today, fought hard until it came into being.

09:15

In 2002, Akina Mama wa Afrika, a group of Scottish African women, came together. They worked on FGM and talked about it, and thereafter even offered training. Akina Mama wa Afrika has since become an international organisation that has its head office in Kampala.

Over the years, many people have become experts on FGM. At one point, everybody was talking about it. However, within the community, people were getting very disgruntled. In 2013, we decided to come together to address the issues because our voices were not being heard and our faces were not being seen in relation to FGM. Everybody else’s fingers were in the pot, but our fingers were not; we were just being dished the food, as we say.

In 2014, KWISA had a seminar in Linlithgow with the assistance of West Lothian Council. Eighty women came from 14 different countries. You will note that KWISA is Kenyan Women in Scotland Association: we had to register some organisations because if you are not registered, you are not known. All those women were involved in fighting against FGM in one way or another, but we did not have a platform. That is how we came together.

At that seminar, we cried and laughed at the same time, but it was clear that we needed to have our voices at the front, and that we needed to contextualise how FGM was being discussed at that time. The issues were about everybody else being an expert, and the language that was being used. Our involvement in the whole discussion was just a token and we were not part of it: people talked about us, but without us. That is how all the women who came to that seminar felt. It was clear that we needed to raise awareness, to talk among ourselves and to be involved with other people.

After that, in one year, women tried to come together on a voluntary basis, but it could not work because of other commitments and because it was voluntary. African women in Scotland against FGM was formed, and it was recommended that, having worked for one year, we really needed to formalise that properly and move forward. Later on, we were funded through a grant of £20,000 from the Scottish Government, which propelled us on in starting the project.

I will show the committee our model later. The KWISA engagement model is not the traditional engagement model that is used, especially in policy making and the process as a whole. You will see that, when we make policy, we start with the policy agenda, then move on to risk assessment, then formulate the policy, then we do consultation, then implementation.

This is a community issue. So that is where we start. That concept has been used in many countries. Our community issue at this time is FGM within the context of other things, so we analyse and prioritise it, and we do community learning, looking at skills and development. Then we consider delivery of services that we have around us and which influence us, and then we look at changing behaviour. We started with the women. We have worked with other stakeholders, but the community is the main stakeholder.

We are insiders. Some of us have been through FGM so we know the context. We wanted to avoid the single story that was being told that there is only one type of FGM—cutting—because there is a lot more to it than that. FGM is not just about cutting.

Looking at the whole picture of what happens, it is critical that we engage men, women and faith leaders, when it comes to FGM. The service delivery organisations also need to be engaged, especially social workers and the national health service, which we have worked with.

The Convener: Esther, I will pause you. Many of the things that you are saying about what has happened in the past will be relevant to what we are doing now. I hope that questions will draw out more of your experience.

What are panel members views on the existing legal framework? Are the approaches that we have to hand at the moment being used effectively, and if not, why not?

Sara McHaffie: The existing legislation describes FGM quite well. It would be ill advised to adopt new language without thinking that through. As Esther Kamonji said, it is a matter of consulting extensively with practising communities. Some of the language in the consultation was quite inaccurate. It included, for example, “vaginal elongation”, which is not a thing.

The existing legislation is quite clear. It covers things such as labial stretching in type 4 FGM. I think that the current legislation is sufficient in how it describes FGM. There are issues related to the fact that we have not had prosecutions. We have to consider whether this is about supporting women and girls who have already experienced FGM, as well as criminalising what might happen, that we might not currently be able to capture. Protection orders might fill that gap through prevention, rather than through retrospective criminalisation.

The Convener: Does anyone else wish to comment on the existing provisions?

Girijamba Polubothu: I agree with most of what Sara McHaffie has said. Before the meeting, we discussed other things. Esther Kamonji referred to the language that is used in describing FGM. Also, demonisation of communities in which the practice happens seems to be a problem.

There is a way to do things better. The bill is good, but as Esther said, we should work with the community and find the words that describe FGM. For example, some of the women whom we support do not like the word “mutilation”; they prefer “cutting”. Sometimes, we push the communities away through the language that we use; they go on the defensive because they have been used to the practice, which has been passed from generation to generation. I am sure that in the past nobody even thought about it as being against human rights or anything else. Our role is to work with communities, while supporting the survivors of FGM.

I will mention one more thing. There is a problem of cases involving domestic abuse such as we support, in which men have used FGM to prevent women from visiting their families. There was, for example, a case involving the death of a family member in which the woman could not go to her family.

The Convener: To be clear, are you saying that abusive partners are using FGM as an excuse to prevent women from travelling?

Girijamba Polubothu: Yes. When women want to visit a family member, the men say no, especially when there are female children. They might say that there is a fear that she is going somewhere for FGM. That creates a problem. That is not the intention of the woman, but it is used.

Alex Cole-Hamilton (Edinburgh Western) (LD): I have a brief supplementary question, but I will come back later with other questions.

Girijamba’s point is really interesting, and we have not heard it before—at least, I had not—so I would like to explore how to deal with that, perhaps through guidance that would accompany the bill.

Further to the convener’s question, we heard powerful evidence last week about dangers in respect of racial profiling and stereotyping, through the bill, and about the creation of a legislative framework that might unnecessarily prejudice a community. We are very sensitive to those issues. The same person also suggested that existing child protection legislation is sufficient to protect young girls in such situations. Do you agree?

Girijamba Polubothu: Sometimes, when we get calls asking for our advice in such cases, we simply say, “I’m not a lawyer, so I don’t really want to comment on something I’m not an expert on.” As a woman and as a domestic abuse worker, I sometimes get so frustrated when people come in and say that a child is at risk of either FGM or forced marriage and they concentrate more on the cultural aspect and whether they will offend the community. In such cases, we ask those people what they would do if the child was part of mainstream Scottish culture and they felt that some harm was going to come to that child. Of course, they would use a child protection order. People should think about the subject in that way, rather than finding barriers and saying, “Maybe I’ll offend them” and “This is a cultural thing”. People get entangled in that discussion. We need both the existing child protection legislation and the bill, because we might need to use both.

Alex Cole-Hamilton: So, you do not oppose the introduction of the bill.

Girijamba Polubothu: No—it would be good to have the bill.

Alex Cole-Hamilton: You think that it would be good to have the bill, on top of the child protection legislation.

Girijamba Polubothu: Yes. I want to make it clear that we support the bill.

Esther Kamonji: I agree with Girijamba Polubothu: the child protection legislation and the bill are definitely both needed. Of course, we can get entangled in the cultural aspect, because everybody has a fear of racial profiling, but it is important to name the problem so that we can frame it adequately. Both measures are important.

Fulton MacGregor (Coatbridge and Chryston) (SNP): I will follow on from Alex Cole-Hamilton’s question about child protection procedures, a big part of which is the children’s hearings system. We have asked previous panels for their thoughts on whether the children’s hearings system should be able to make an FGM order, which is not currently provided for in the bill. What are your thoughts on that?

Esther Kamonji: I am not so sure—I think that it should still stay in the children’s hearings system. Most of the people who undergo FGM are underage. There may be instances when some adult women undergo FGM after marriage or for whatever reason, but most cases involve children below the age of 18, so we should handle them like every other child. That is what we believe.

Fulton MacGregor: Perhaps I can rephrase the question, because I probably did not put it very helpfully. At present, the children’s hearings system can implement legal orders for children who are at risk of harm and in need of protection. That was mentioned in the responses to Alex Cole-Hamilton’s question.

However, the bill proposes that only a court would be able to make an FGM order; the children’s hearings system would not have the ability to do that, although the court could refer the issue back to it. I am trying to find out whether you think that it would be helpful if the children’s hearings system also had that power, or if you feel that it would be best placed with the court.

Sara McHaffie: One answer might be to look at how forced marriage orders are currently implemented. Obviously forced marriage can affect adults as well as children, but since those orders came into being it has sometimes been felt that not enough bodies are able to ask for an order. Perhaps the provisions could be widened to include another body with expertise. That approach could even be trialled—it does not necessarily have to be a black-and-white change. Amina tends to support adults rather than children, so it does not have specific expertise on children’s hearings.

As regards how the bill will be put into place, looking at how forced marriage orders have been used and monitored will definitely be helpful.

09:30

Esther Kamonji: Although we have children’s services, I do not know much about how children’s hearings work so I would prefer not to comment on that.

As Sara McHaffie has said, it is better to widen the number of people who can seek orders. For example, the right to seek forced marriage orders has been extended to the police, which was a development that we supported.

The Convener: I come back to the earlier point about why we would ever treat girls who have been affected by FGM differently from any other girls we were concerned about.

Esther Kamonji: Our argument is that we should treat such children the same as we would treat Scottish children who might be at risk of harm from their parents because of the parents’ drug addiction or similar problems. If a child is at risk of FGM, that is a family issue that we must treat in the same way as any other.

Fulton MacGregor: I want to move on to what are perhaps wider questions. What does the panel think the overall impact of FGM protection orders will be? Will there be a need for training across the various agencies and bodies that are likely to be involved?

Girijamba Polubothu: We find that whenever legislation on FGM is passed, disclosures and reporting increase—and, of course, there is now more awareness of the subject among the public. However, there are no services to support survivors once they have reported cases. It is good that legislation is being passed, but the Parliament also needs to look at how survivors who report cases might be supported.

You also asked about training, which is a very complex subject. Services need to partner with people who come from the practising countries. Organisations represented on this panel offer services. We all have service users who we consult and our workers do that too, so we are quite confident in our training. Unless a person comes from the relevant community they will not be able to answer some of the questions that arise in training. I know that because I have been training myself and have come across such questions. At the same time, I repeat that we do not want to see communities being demonised. FGM has been practised for a long time, but we want to work with communities and survivors to eradicate bad practice.

Esther Kamonji: I agree that there will definitely be a need for training and informing everybody—the community, practitioners and service providers—because the bill adds value to what exists. However, when it comes to training, what Girijamba Polubothu has just said will be critical. I add that the reason for KWISA’s coming into being was that everybody was training back then, in 2013 or 2014, and they have continued to do so. We have discussed before, however, in the context of the FGM national action plan, that there is a need for standardisation, attention to language, understanding and community involvement, because this is not a single story. There are many and diverse reasons why people practise FGM.

Also, the context in which training is done might either offend individuals in the community or allow them to take up the issue. I will give you an example. A housemate of mine, who is South African and has gone back there now, knew that I was involved in a lot of FGM and community work. She once went to a training session somewhere in Edinburgh—I do not know where. She is not from a practising community, but she is a mature woman. In that group, men and women were seated together and a young person was doing the training. The trainer was excellent and knew everything, because she was a highly qualified nurse and she understood everything.

When my housemate came out of the training, she came home raging and said to me, “Esther, in your FGM work, do you actually go out there and tell people to look at what African women look like?” I asked her what she meant, and she said, “I am upset because people are being exposed.” Remember that, under normal circumstances, even within the communities that practise FGM people do not know what is happening. She told me, “I felt that they are telling people that when they meet an African woman they should expose her and check.”

That trainer was well versed with the programme, and with training and the issues, and if my housemate came out feeling that way, what about the person who has absolutely no idea of what is going on? That is my tic. We need to be very careful about how we do things and to partner with the communities so that we can standardise, speak their language and support what is already there on the ground. That is why I talked about the history. Women have been working on those programmes in this country since 2005, but we are still talking about the same things today, in 2019.

Sara McHaffie: My speciality is training, so you must tell me to stop when I have talked too much. As white Scottish people, we need to remember that FGM is not something that one community is doing far away from us, and remember our relationship with those communities. As white westerners we have a long history of fetishising sub-Saharan African women. We can look at what happened with Saartjie Baartman and the way that she was treated and exposed; particularly, the way that her genitals were made a feature of her identity in a way that other women do not experience. Also, we exported Victorian colonial attitudes to other countries and seeing those attitudes reflected back reflects on us more than it does on those communities.

When we talk with women—and men—from practising communities, one of the big concerns is that it becomes their whole story. Those people do not necessarily have a platform or access to ways to tell the stories of their achievements and of themselves as human beings. In effect, the first thing that somebody might assume about a person is that they are from a community that practises FGM. It does not necessarily respect geographical boundaries; we cannot assume that because somebody is from a certain country they have experienced FGM, and we certainly cannot assume that they approve of it or otherwise without having a gentle conversation around attitudes.

Even health professionals can sometimes demonstrate that a little knowledge is a dangerous thing by assuming that somebody who looks as though they might be of sub-Saharan African origin has experienced FGM. Other examples might be assuming that someone has sickle cell anaemia when they are not remotely from the side of Africa where that is a thing. There is a lot of, “Oh, you are from this place: therefore, this must affect you and you must feel like this about it,” while on the other hand they do not unpick personal bias from the side of being a white western practitioner.

Training needs to be funded enough to allow people to unpick that bias. If it is e-learning, for example, where somebody rapidly reads it through, perhaps on their lunch break because they are so busy, it does not go in in the same way and people do not necessarily notice their own bias. Even if someone has a long history of reflective practice, there can be blind spots.

Some practitioners might be more able to attend training sessions, which is great, but other people working in the area—interpreters, for example—will not necessarily have the ability to do that on a paid basis. When issues come up locally, there can sometimes be a general sense of panic, even though we have great harmful practices protocols. I might be running around like a blue-arsed whatever doing training here and there, and there are other wonderful organisations doing the same, but people panic. They do not necessarily look at the protocols, and they sometimes push the responsibility on to third sector organisations. They might even ask those organisations to provide interpreters. Obviously, that presents a conflict of interest. The interpreter could be a family member—again, that would be a massive conflict of interest.

There may be a paid interpreter—the family may have had their right to access an interpreter explained to them, or a social worker may have organised an interpreter—but interpreters do not always have the chance to debrief after a session. They are paid sessionally, generally speaking, and they do not have the chance to attend training on a paid basis. It would really help if interpreters could be reimbursed for attending training sessions that were provided by organisations recognised as training to a gold standard, as Esther Kamonji mentioned. It should not just be anyone who provides the service; there should be some way of centralising what the training is meant to be. That goes for all the issues around violence against women and girls—VAWG issues. The training should be in line with the values of equally safe, and no one community should be stigmatised.

It would be really helpful to have something like a training bursary. I know women from practising communities with whom I have co-facilitated training, or who have helped me to create materials for training if they have not felt able to speak openly themselves. I am trying to mentor women who seem promising as trainers, and when I suggest to those women that they should go to this session or that session, we find that there is no training budget. They might be working in the area, but they are not able to access funds. They may be developing expertise, but they might not be able to put it into a wider context, because of the restrictions on working for third sector or voluntary organisations. It might help to have some kind of budget to allow people who are already experts to give training. It would also be good if there was some magical way to pressure people from the courts to access training, if they are going to be passing orders.

Fulton MacGregor: I have a further question, although I am aware of the time constraints.

There was a wee bit of discussion earlier about criminalisation, and we heard some views about that for the record, which is good. Are the members of the panel able to give their views about the penalties that have been set for breaching an FGM protection order?

The Convener: It is okay if the panel members do not have a view on that.

Alex Cole-Hamilton: This next point taps into some of the questions that we have been discussing about the application of the proposed law. I am thinking about other laws of a similar kind that the Parliament has passed. The clearest parallel can be drawn with the Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005, which created risk of sexual harm orders, or RSHOs. The order is a preventative measure that can be applied to protect potential victims from online grooming. That act came into force more than 10 years ago, but we have discovered that the number of RSHOs that have been applied by the courts can be counted on one hand. That is not to say that the problem is not happening or that children are not at risk of sexual harm, but there is a lack of guidance to the police, the judiciary and other stakeholders. What additional measures do we need to take to make the bill that we are discussing real, so that it protects people and is used, and so that it is not allowed to wither on the vine?

09:45

Esther Kamonji: It is important to have protection and support. If we just go criminal, it will not work. It would be good if we had protection and support for the person who is reporting. Remember that these things happen within the family and the community. It does not matter if the community is in Scotland, London or Africa. Today, with WhatsApp and the media, people will find out. It is important for the community or individuals to understand that they are being supported through the process.

At the moment, there are a lot of issues around protection. A child may come and say, “I am being taken away. I am going for FGM. What happens to my mother?” Remember that it is done in love but it is a crime at the same time. Does the child want their mother, their uncle or their auntie to go to prison? We must have protection and support systems in place.

I have another example. FGM has been fought, especially in Kenya, for more than 100 years. You should read “Facing Mount Kenya” by the first president, Mr Jomo Kenyatta. We need to understand why communities practise FGM. Why is the practice there? Why has fighting it legally not worked? It has worked in places where the communities have taken the lead, so that the people are supported. There are plenty of examples of that across the world. For me, the bill needs to come with protections and support.

Alex Cole-Hamilton: That was a helpful answer. Do we need to ask the Scottish Government to provide money to properly train social work, the police and the judiciary in understanding the issues around FGM, so that they can use that arrow in their quiver, rather than just applying normal child protection laws?

Esther Kamonji: Training is good and it is important to the practitioners, but where is the community in all that?

Alex Cole-Hamilton: That is a helpful question.

Esther Kamonji: The community must be there, giving its views on the way things happen. The KWISA model works from the ground up. We are just women who came together. This year, the Scottish Government gave us £25,000, which is helpful, but our way of working is about the fact that I know people back home and people here. Women from 15 countries have something back in Africa and something here. Within the bubble of their communities, there is a snowballing effect. That information is gathered together.

If we want change to happen, we should train the community members and get them involved. We should get the leadership, especially the faith leaders, involved. Faith leaders are critical in all this, because people go to churches and mosques. We should also get opinion leaders involved; not just one person, because then we get a single story, such as, “It is only cutting”, although we have four other stories.

Yes, we should train the practitioners, but we should also get the communities involved, so that we get the whole picture, people talk to each other and we know the intrigues and intricacies of the whole concept.

Alex Cole-Hamilton: Thank you. That was helpful.

Girijamba Polubothu: The training should be made mandatory for social work, police and anybody who is involved in supporting or who may come across FGM cases.

Esther Kamonji mentioned the communities. For me, it is important that we work with the survivors, irrespective of whether it is historical FGM that was done elsewhere or here. It is important to take their opinions and ideas into the training. I agree that there should be money available to train the survivors to become trainers. If a survivor has just some input into a whole day of training, that would be a good idea.

Sara McHaffie: It might also be good to have some awareness raising available to MSPs or Scottish Government policy people who speak out about it, because there has been some unhelpful language from politicians. For example, the word "barbaric" is racially loaded. I am picking up the word "traumatic" a lot. We are all obsessed with language but, if you have only a couple of column inches to put the message across, it paints a vivid picture of disgust at somebody who is a Scottish citizen. That is never appropriate. To call it inherently traumatic does not pick up on the fact that some survivors will use that word and some will not. It does not echo what we hear from women who have experienced it. When the change is implemented, the way that we put the message across is just as important as the way that support bodies and statutory organisations use it. When it comes to awareness raising, we get one shot at press releases and that kind of thing. That will put it in the news. If it is done in the right way, it will increase the need for support; if it is not, it will entrench secrecy and stigma.

Alex Cole-Hamilton: That is helpful, if mildly terrifying. To that end, if that feeling exists, I would appreciate a submission on the language that we use here, such as a glossary of terms that are racially charged or unhelpful. We do our best, but we have many different plates spinning and we might easily get that wrong. Please make a submission to guide us through the process.

I have a final question. It is only if we can reach the girls who are most at risk of FGM and impart to them the reality that FGM is not right, that they have a choice and that they can be protected, that the bill will be a success and that we will fully eradicate the practice or risk of FGM in this country. As we have discussed, a range of barriers, such as language, culture and, sometimes, family, mean that those girls are potentially further removed from society and other girls. How best can we communicate directly with those girls? How can we get them to talk to one another about what is right and about their right to protection?

Girijamba Polubothu: With any form of abuse, whether it is forced marriage, domestic abuse or FGM, we have to start talking about it in schools. It has to be part and parcel of education. It is not just about talking to the children from African communities. We want the mainstream children to know about those things, too, because they are our future citizens and they are the ones who will lead the country. We want to raise awareness with every child in the country. It is not just about the children who come from practising communities. As I said, with every form of abuse, that is what should happen.

Esther Kamonji: I agree. Looking at the way that we have worked, KWISA started working with women, then with men and women. Our most recent project, which we did with Glasgow Caledonian University, was a research project with Glasgow City Council. Unfortunately, the project ended after a year. We were working with schoolchildren. The beauty of the project was the energy that we saw in those children. Some of you came to the conference on 6 February and saw the impact of the information on those girls after we had worked with them for six weeks. Although they are African children, some of them had never heard about FGM. Nobody talks about it in school.

However, it is not just about FGM. We cannot put FGM in isolation without talking about human rights and the other issues that go with it. Traditionally, FGM is supposed to be a rite of passage. We need to have those programmes in schools but in a way that will not stigmatise the children. I agree with Girijamba that everybody needs to talk about it. The girls need to start knowing, because some of them opened up when they were asked to go and talk to their families. It is about giving them the knowledge, the confidence and the aptitude, because it is not an issue that is openly talked about. That project was for one year and it is finished now, so we have to find a way to work with it and, we hope, with you.

Alex Cole-Hamilton: Thank you. That was helpful.

The Convener: We probably need more than a glossary to properly address our inherent bias. I appreciate that issue. Feel free to challenge us if we use language that is not helpful.

Mary Fee (West Scotland) (Lab): I apologise for my voice. I have a couple of questions around guidance, which I will ask together. I also have a specific question around training.

The bill gives ministers the power to introduce statutory guidance. Do you agree that the guidance should be statutory and not advisory? What should be in the general guidance and in the specific guidance on the protection orders?

Sara McHaffie: I made a submission to the original consultation. It took me a while to think through, look at what was out there already and give a fully informed answer. I cannot do justice to the question in the five minutes that we have left, but moving towards having statutory guidance might lend credence to the fact that, as we were saying, people need to take it on board and take it seriously.

Esther Kamonji: The guidance should be statutory, but without going into the details. People need to see the seriousness, whereas if they are just advised they can decide to take it or leave it.

What was the question about training?

Mary Fee: I will come on to training in a moment. Does Girijamba Polubothu have a view on the guidance?

Girijamba Polubothu: We worked intensely on the forced marriage statutory guidance and had a lot of input into it. From our experience of that, it is necessary for the guidelines to be statutory. We can strengthen the current guidelines. Whether or not there are guidelines, it is the responsibility of every citizen in Scotland to prevent FGM and protect survivors of FGM or any other forms of domestic violence.

Mary Fee: Thank you.

My second question was around training. I will start with Sara McHaffie. Multi-agency guidance on FGM already exists. Do you use that as part of your training? Should whatever guidance is issued with the bill be suitable to use as part of a training process?

Sara McHaffie: Yes—to both questions. I highlight the laws and guidance that exist and other resources and organisations, such as the FGM aware website, KWISA, Shakti Women's Aid and Saheliya, which offer support. I use what exists and I would like to be able to say that it is statutory guidance. Even if, as we were saying before, there might be few times when somebody is the subject of an order, that would help me, just as having a law helps me when I am training. Although I can think of only one time in the north-east of Scotland when it would have been helpful, it would have been really helpful for that family. If we can say, "This law exists" or "This guidance exists", that might strengthen what we say as Scottish people about FGM being unacceptable and about how best to work with communities in which children might be at risk.

The guidance should incorporate the experience of folk who work in that area. We more often come across someone who has experienced FGM than we come across a situation of risk for a young person. We might see someone who is the subject of a lot of panic, although they have no intention of subjecting their child to FGM and would be shocked that somebody thought that they might do that, because they see FGM as trauma.

In any guidance, it would be helpful to recognise the fact that figures can be unreliable. A Scottish Government report said that around 24,000 folk

> "in Scotland were born in a country where FGM is practised".

However, a lot of people who were born in France, Italy or Scotland are from a practising community. Looking at someone's country of origin is not necessarily the most useful thing. Sometimes, it can be reassuring to have definite, black-and-white facts and figures. At other times, it is better to be open to nuance and learn more about the reality of how things play out on the ground.

10:00

Esther Kamonji: I agree. There is definitely a need to use the guidelines and all the information that we have. Above all, we need to incorporate the experiences of people on the ground. If the training is standardised in understanding the culture, the feelings and the whole concept of FGM, it will not be rejected. When people walk out of a training room, you have talked and finished and nobody else has said a word. I have come across a number of people like that. They went into training but when they left they were a little bit disappointed. We do not want that, because it means that nothing has been taught and that people go back into their own cocoons and say, "Those people were speaking to themselves."

Girijamba Polubothu: We mostly deliver training on forced marriage, but we are developing training on FGM. Like I said, we want to do a good job of it. We want to consult our survivors and get the real stories. With the forced marriage training, we talk about the legislation and the consequences of breaching it because it is important for whoever we are training to know that.

We do not do specific training on FGM although it is part of harmful practices. As Sara McHaffie said, that is how we will be training on it. We want to involve our survivors, and one of them is an active campaigner. I wanted to ask her to come today, but she is in Gambia so she could not come. She was part of the launch of the bill; she was on telly, which is good. We like to see role models.

Esther Kamonji: KWISA cannot do major training with the £20,000 that we have been given. Although we have trained outreach workers and community champions—women who are within the communities—they are constrained because they are doing that on a voluntary basis. When we think about training, we should think about resourcing the whole package, including connection to universities and colleges—the whole works.

Mary Fee: Thank you; that is helpful.

Oliver Mundell (Dumfriesshire) (Con): The bill is a slight departure from the approach that has been taken by the rest of the UK and in the Serious Crime Act 2015. Do you have any views on anonymity for victims, the offence of failure to protect and the duty to notify? Should they have been included in the bill, or are you happy with the bill as it is?

Sara McHaffie: The submission that I made in December or January talks about that in a bit more detail, and I am conscious that people have to leave. Anonymity or some way of preventing the names of victims from getting into the press one way or the other is helpful.

The Convener: I am sorry to interrupt, but could you clarify whether you mean your submission to the Scottish Government consultation?

Sara McHaffie: Yes. I do not think that I can say anything that is not already in there.

Girijamba Polubothu: We were also part of the Scottish Women's Aid submission.

When a women is suffering domestic abuse, she can be identified as the perpetrator of FGM by the abuser. We have come across that. Police, social work and such services have to look outside the box. Sometimes the woman is under so much pressure and that is part of the domestic abuse that she had gone through. She really does not want to do that to her child, but she ends up implicated in the act because of tradition.

When we come across cases of domestic abuse in which the woman is accused of being the perpetrator of FGM, we perhaps need to consider who the perpetrator is. That issue is raised by our survivors, who say that they were not the perpetrators, but that there was family pressure and everything else, and that that was the reason that they left the home.

The Convener: We have heard that from others, and the committee would acknowledge the coercion around the issue and how it can be a continuum. We would also acknowledge that risk and protection factors in such things can sometimes be muddled up a little bit. Thank you for that—it was really helpful.

Sara McHaffie: One thing that can be helpful to social workers, if they are in an area where there is a safe and together model, is just to use the training that they already have in that context. If it is part of domestic abuse, they should look at the strengths that the mother is displaying and not jump to thinking, “Oh, we can get a prosecution for failure to protect”, or something like that.

Oliver Mundell: My other question—witnesses touched on this when we talked about education—is whether there are other things that the Scottish Government should be considering to sit alongside that, or whether there are alternatives to help eradicate FGM.

Girijamba Polubothu: I think that education in schools is the best thing. I said that education should be for everybody, and one of the reasons that I said that is that an African child may disclose to a friend, who is a mainstream child, that FGM is happening. If that friend knows about FGM, they will be able to support that child. Education also means that, as we go along, we will not need to be talking about training, because people will already be trained and know about the issue from school.

As we mentioned, another thing is working with communities. At Shakti, we have a women's group, and we bring in subjects such as FGM and sexual abuse—all kinds of issues. We also bring in people to talk to the women, and not just to the African women. We want them to talk to all our women, who are of different ethnicities, because we want everybody to know about it. It is about raising awareness not just in schools but in communities and in women's groups everywhere—they can be Scottish, Irish, African or Indian women's groups. Awareness should be for everyone; it should not target just those communities in which the practice is in existence.

Esther Kamonji: We need to look again at the way in which we resource and fund various organisations, including KWISA. There are a lot of small funds, so all the community groups end up competing for resources and for the same people, and not being as organised as we should be. That also means that programmes are started but never really finish—they start, and then they are left on high. We train community outreach workers, but then we leave them to do their own thing. We work with faith leaders—we even had a big declaration that they signed to say that FGM is not part of their religious order, whether Islam or Christianity—but then we leave it on high. We work with schoolchildren, but then we leave it on high.

As such, the communities are always going through the phases of, “We are running and we are doing something” and then, “Oh no, we are deflated.” It is therefore important that we look again at the way in which organisations are funded. Of course, it is important to work with various groups and definitely with children. Whichever way we look at it, for me, resourcing and considering expertise are also important.

Oliver Mundell: Thank you—that was helpful and very interesting.

The Convener: The points that witnesses have made have also been picked up in our budget inquiry. It is useful to hear them in evidence today as well.

Sara McHaffie: There is an on-going issue with funding for voluntary and third sector organisations. It would be good to think that all bodies that ask for training would have a budget to pay for that training, so that we were not necessarily having to ask for all the money from a very small equalities budget. Equally, if that budget could be increased, that would be fantastic.

It is good to think about ways of training people who want to look at the whole manifestation of violence against women and girls. There is a real risk that people ask because they are fascinated about one particular aspect, such as FGM. I will not be able to expose someone who has experienced FGM to that environment. Thinking about what training can do—it is not a form of entertainment—is also quite important.

The Convener: Okay. Fulton MacGregor has a very brief question, and I am sure that there will be really succinct answers.

Fulton MacGregor: I just want to return to Oliver Mundell's earlier questioning on anonymity, which I think is a very interesting part of the discussion on the bill. Do you think that the courts already have powers that they could better use to provide anonymity? Are there powers already in place?

Sara McHaffie: That is not my area of expertise, so I cannot comment.

Girijamba Polubothu: Same here.

Fulton MacGregor: Okay. Thank you.

The Convener: Thank you very much for being with us this morning. Your evidence has been really helpful.

10:11

Meeting suspended.

10:16

On resuming—

The Convener: Welcome back, everybody. I will introduce our second panel. We have Vickie Davitt, gender-based violence midwife and FGM lead at NHS Lothian; Dr Rachael Wood, consultant in public health medicine in the Information Services Division of NHS National Services Scotland; Obi Amadi, lead professional officer at Unite the union; and Katie Cosgrove, organisation lead for gender-based violence at NHS Health Scotland. I thank the witnesses for being here this morning.

Do you support the Female Genital Mutilation (Protection and Guidance) (Scotland) Bill's aim to strengthen the existing legal protection? If not, why not? What is your general view of the existing legal framework in Scotland? In your answers, you might want to say a bit about your own work.

Katie Cosgrove (NHS Health Scotland): We support the bill's provisions. The work that we have been doing on FGM, as part of the gender-based violence programme, is specifically about the national action plan and its implementation. I chaired the writing group that produced the multi-agency guidance. Part of our work is about ensuring that that guidance is disseminated and implemented.

The bill's provisions undoubtedly strengthen the options that are available in the existing legal framework. The orders will create more visibility within communities, which will be fairly positive in raising awareness. We also support putting the guidance on a statutory footing.

Obi Amadi (Unite the Union): We support what is proposed, but the bill should go a bit further on providing clarity and sending a very clear message on FGM. We would like the committee to consider whether the bill could better reflect the legislation in England and Wales, so that the legislation across the UK would be more similar. That would be beneficial in providing clarity for professionals.

The Convener: We will probably get into that issue a bit more later.

Dr Rachael Wood (NHS National Services Scotland): I support the bill's aims, but I do not think that I am well placed or qualified to comment on whether the specific proposals in the bill are the best way of achieving those aims. My role is in the NHS Information Services Division, and I am the clinical and public health lead for our national data on maternal and child health. That is my area of expertise.

Vickie Davitt (NHS Lothian): I can speak only from an NHS Lothian perspective. The existing legislation needs to be strengthened. The bill is helpful in that it sends a clear message that Scotland will not tolerate FGM. However, I stress that I am speaking from an NHS Lothian perspective, because that is my job.

The Convener: How is FGM currently recorded by health services? Are there ways by which we can more accurately record it, so that we can better establish a baseline for how much FGM is happening in Scotland? A previous panel told us about how we are calculating numbers, and it would be interesting to hear this panel's perspective on that.

Vickie Davitt: I have my figures, but those are only the NHS Lothian maternity services figures. We need to find some way of recording FGM. The Royal College of Midwives has launched an e-platform that is accessible to people working on FGM at various levels, as well as people from affected communities. One of the bits on the website concerns figures. There is a list of services that are available across the UK but, when you look at the section on figures, you see that everyone falls into the sea at Berwick-upon-Tweed, because there is nothing for Scotland. You could interpret that as meaning that FGM is not an issue in Scotland, but we know that it is.

Therefore, as I said, we need to find some way of recording FGM.

Part of the problem concerns people using different systems that do not talk to each other. In Lothian, we use the TrakCare system for our electronic patient records, and we can extrapolate figures from that, but in Glasgow, they use BadgerNet.

Another issue is that as an FGM midwife, I would not be supportive of something that would create extra work for people who are working in this sphere—we are busy enough as it is without having to remember to record things on a different system. However, we need to find some way of getting figures that are as accurate as possible. I know my figures, because they represent the number of women who have been referred to me by staff from NHS Lothian maternity services. I have got figures from a colleague in Glasgow and a colleague in Aberdeen, but they are very much anecdotal. We need to be more accurate because that has implications for resourcing. I can prove that my job is needed, because of the figures that we have got, but the issue is wider than that.

The Convener: So, there are complexities around the various systems and the need to not add to people's workload.

Rachael Wood: There are two issues to consider. One is the recording at local level, in patients' full clinical notes. In 2014 and 2016, the chief medical officer issued guidance to say that, if a woman was known to have experienced FGM, that should be recorded accurately in patients' notes. Vickie Davitt is right to say that different boards use different systems to maintain those local notes.

There is then a separate question of national returns—that is, the returns that come to ISD from across the health service. It might help your understanding if I give a little bit of context. Different types of records will be generated depending on the element of care that the NHS provides to a patient. For example, when someone attends a consultant-led out-patient clinic, there is a certain return that comes to ISD; when someone is discharged from general in-patient care, there is another record; there is a specific record when a woman is discharged from an episode of maternity care; and there are also child health records, which operate a little differently—I could speak about them separately. If a patient undergoes an operative procedure during their care, whether in-patient or out-patient, a specific code from a particular coding classification—the OPCS-4—is added to that record. There is also a separate coding system for in-patient records that can be used to record the diagnosis that a patient has—that is, the reason why they came into hospital as well as any other significant medical problems that they have. The CMO's guidance is clear that, if a woman is known to have had FGM, the code indicating that should be included on those records.

It is important to understand what that means. Those are coded records. FGM or procedures to correct FGM can only be recorded once there is a code for that. The procedure codes for deinfibulation were introduced in 2014, so we have been able to count those events since then, and the diagnosis codes that indicate that a woman has had FGM were introduced in 2016, so we now have three years' worth of data in our national data sets. Before coming today, I looked at the figures. ISD holds the figures in the general data sets that we hold, and we publish general information on the number of people coming into hospital. Currently, we do not specifically publish the number of women with FGM, but we can provide those figures on request.

The number of women being recorded as undergoing a deinfibulation procedure remains very small. Looking across out-patient and in-patient records, we see that fewer than 10 women a year have been recorded as having that procedure. The number of women being recorded on national records who are being cared for by the NHS, either because of their FGM or for something else, and who are known to have a history of FGM, is now at around 100 women a year. That has increased from 2016-17, which was the first year that we could look at it. It was about 50 in that year; in the most recent year, 2018-19, about 100 women are recorded.

That shows that FGM is now being recognised in the health service and is being recorded more accurately than it could be previously.

The Convener: Do any other panel members wish to come in on that point?

Obi Amadi: I am unable to comment on the detail of the data capture that is used by the different organisations in Scotland. However, on the national data collection, I would very clearly support the need to be sure that everybody understands the categories and what it is that they are recording and reporting. We had an issue in England with confusion among professionals about recording and reporting. Being clear on that is essential. The training for professionals that needs to go along with that recording and reporting is also key, to make sure that they are addressing the issue and addressing it properly.

The Convener: Thank you. That is helpful. Katie Cosgrove, do you have anything to add?

Katie Cosgrove: The main issue is about identification of FGM in presentations—whether it is directly related to that experience or not. Quite a lot of our information is captured in recorded notes, which do not necessarily make their way on to the system. The practice for the health service in Scotland has been fairly fragmented over the past few years, but it is relatively new, so I would anticipate that there will be growing recording that the ISD will be able to capture in future. The challenge for us is to ensure that staff are aware of the requirement, that they know which codes to access and that they record accurately.

The Convener: That leads me quite nicely to my next question. Will you give the committee your reflections on whether health professionals feel supported to have discussions about FGM with women and girls whom they are caring for?

Katie Cosgrove: A lot of health professionals are covered under that umbrella. Certain aspects of the health service, particularly maternity services, probably feel more supported than others, because there is more focus on them. There has been a huge concentration of effort on ensuring that we can have sensitive conversations with women when they present to maternity services around some of the implications that FGM might have for their subsequent pregnancy. There has perhaps been less attention in other areas of the health service.

One of the issues that has dominated discussion over the past few years is child protection—the need to prevent FGM and to protect children. That has been a little bit to the neglect of the other needs of women who have experienced FGM. They are not just mothers. They have been through an experience that may have been traumatic—I bear in mind what Sara McHaffie said earlier—and the repercussions for their long-term mental and physical wellbeing need to be taken into account. I am not sure that we have given as much attention to that across the rest of the health service as we have to the need to put in place provisions to ensure that the child protection concerns are noted and acted upon.

We have a challenge in relation to ensuring that our mental health service professionals understand how to have conversations with women on the impact of those procedures if the women's mental health has been affected. Professionals in other areas of the health service must also know how to have those conversations, because there are multiple points of entry into the health service and we know the litany of subsequent emotional and physical impacts of FGM on women's health.

10:30

Alex Cole-Hamilton: I have a supplementary question about something that both Vickie Davitt and Katie Cosgrove have addressed. We heard in our initial briefing from the bill team that the bill needs to cover women as well as children because, after childbirth, a woman might be taken somewhere to have further FGM conducted on her. Are you aware of that being a practice? After childbirth, might there be further mutilation?

Vickie Davitt: Certainly, from a Lothian perspective, that is not very common, but we are aware of the possibility. We had a case where we were not concerned about the potential of FGM being carried out on the daughter who was born, but we were concerned about the mother because, when I questioned her, she could not tell me why she would want to be restitched.

It is important to us that women know that, if they have type 3 infibulation and it is opened to allow for the delivery of a baby, they will not be stitched closed. We are not allowed to do that and we would not do that. However, we knew that after that woman's first child was born, she went back to her country of origin and was restitched there. We were clear that that could not happen here, but she could not answer me when I tried to talk to her about it. That goes along with what the earlier panel said. We were fairly convinced that there was a lot of controlling behaviour from the husband, so we were more bothered about it being a problem for the woman than we were about the potential of FGM being carried out on the little girl who was born.

Alex Cole-Hamilton: What action did you take to protect that woman when you realised what had happened?

Vickie Davitt: It was really difficult, because she is over 18 and therefore, in theory, she has a choice. However, you could debate choice up, down and sideways and you might never get the answer. She would say that she is freely choosing to have that done, but it is not a free choice if she is choosing to have it done because she is worried that if she does not, her husband will take another wife. In another case that we heard of, a woman who had infibulation did not want deinfibulation because she was convinced that her husband would take another wife if she did. I am trying to think of a delicate way to say this—she was convinced that if he did not get the enjoyment that he wanted from her, he would go looking for it elsewhere. That was a real concern for her.

Alex Cole-Hamilton: Should we put something in the bill to protect those women, even though they might suggest that it is their choice?

Vickie Davitt: It would be a useful adjunct to raise awareness of that possibility. As a midwife, I have a foot in both camps—I am aware of the child protection issues surrounding FGM but I am also aware of the issues for women who have had FGM as children. It would be a useful way to bring into the light the fact that FGM is not all about children; we are dealing with some women who have been severely traumatised by events that have gone on in their lives, and that needs to be recognised. To include that point in legislation would give credence to the idea that it is a problem and that we are aware that it is a problem. Certainly, from a Lothian perspective, it is not a massive problem, but we need to be aware of it.

Alex Cole-Hamilton: Thank you.

The Convener: I will bring the discussion back to how professionals interact and talk with women about FGM. Does anyone have any reflections on that?

Vickie Davitt: Certainly, in Lothian—you are going to get bored with me saying that—I fought very hard to get my role included in maternity services. I am lucky that my boss in NHS Lothian is very supportive of me in the role. Part of it is working with women and part of it is training midwives. One of my colleagues on the team was speaking to medical students at the beginning of August. We get invited to speak to all sorts of different health professionals. It is important that health professionals are aware of the language that they use when speaking with women.

A month or so ago, I was at Glasgow airport working with the UK Border Force and Police Scotland on operation limelight and I needed to tell them about the importance of the use of language. If you ask a woman, “Do you know about FGM?”, there is a good chance that she will not know what you are talking about, and some women might be very offended by the use of the term FGM. It is about finding out what words women use—what do they understand? If I say “female cutting”, what do you understand by that? A woman to whom I was speaking yesterday calls it circumcision, so with her I called it circumcision. However, that is not a word that I would usually use, because of the links to male circumcision, which is a whole other issue—let us not get into that.

It is important to use language that women recognise. At our training, we give out a little postcard—I think that it came from the Scottish Government—with different words in different languages. I know that there are four different words in Arabic, for example, and it is a question of picking out which word is useful. When I was working in Glasgow, I managed to peel from somewhere at the back of my head the Somali word for FGM when people were speaking to a Somali woman. It is about using language that women understand. Health professionals can be good at that, but they can also be bad at it.

The Convener: I wonder whether in the sort of environment where you are caring for someone, you are not necessarily asking questions directly and using that language. Are there other routes of inquiry in terms of symptoms that people experience? With something so sensitive, even in maternity settings, just coming out with that question may be tricky.

Vickie Davitt: In Lothian, we have a policy of universal inquiry—this goes back to the possibility of racial profiling. All women are asked whether they have had any form of cutting or piercing that might cause problems in childbirth. That might include something such as a genital piercing that has gone wrong and got badly infected, which could cause a problem. If the woman gives a positive response to that inquiry, she will be referred to me and I then ask questions, because women often do not know what has been done to them. I work as a midwife and am very familiar with women’s anatomy, but a lot of women are not familiar with what a woman should look like. For example, a woman expressed surprise when I described the fact that there are three holes, because she thought that there was only one. If a woman does not know what her anatomy should look like, she does not know whether hers is normal.

A lot of my work is teasing out what problems a woman might have. She might say, “I’ve not had a lot done; it was just a little bit.” However, when I talk to her, I might realise that she has bigger symptoms than she is telling me. I have a colleague in Birmingham who would describe the same thing—women are told one thing and sometimes the opposite is true. It is about finding out how each individual is affected by her personal experience of cutting. I can tell you what type 1 or type 3 is, or whatever you want, but within those categories are women who may have been cut by a doctor or by an old woman who does not see very well and is just doing whatever she thinks. The categories are useful but only up to a point, because it is about the individual woman and what her symptoms are.

The Convener: Does Obi Amadi have any reflections from a health visiting perspective?

Obi Amadi: Unite has found that health professionals often feel uncomfortable about broaching the subject of FGM, which is why we favour a universal approach, such that everybody is included, involved and asked. Some health professionals have concerns that, when they begin to have such conversations, there will be time pressures to get everything done. We recognise that co-operation is needed for that important work to be successful.

The input in schools is very important. In their conversations, health professionals ask that work be done with boys as well as with girls. Much of the time, the focus is so much on women and girls, and people forget about men and their roles within families and communities. It is definitely of value for health professionals to speak to everybody about FGM.

Apart from work pressures, people feel uncomfortable about being viewed as racist if they raise the subject. We know that the majority of occurrences are on the African continent, but there is concern about questions being asked about people's views and whether they are racist. Clearly, those conversations should take place and are of value. Until we have a system that works, in which professionals feel trained, competent and confident to raise the issue, there will always be people with doubts. In the past, people felt the same about domestic violence—they did not want to ask questions or broach the subject. Now, professionals are much more comfortable with doing that and it is routine. We need to get to that position with FGM.

Mary Fee: Given what the witnesses have said about guidance, I take it that you all agree that there should be statutory guidance with the bill. What specific information should be included in statutory guidance to assist health professionals in dealing with women and girls who have had, or who are at risk of, FGM?

Katie Cosgrove: I am not sure that I can think of any gaps. Moving the guidance on to a statutory basis would give it more weight among professionals and ensure that it has wider reach than it has at the moment. The idea of speaking to women about abuse could be highlighted in the guidance. When we pulled our guidance together, we consulted women from various communities on the language that should be used in the guidance, and on how we should reflect how those women want to be spoken to about FGM. That was not just about whether we call it "cutting" or "circumcision"; it was more about the atmosphere and circumstances in which we ask about the subject.

From a health point of view, it is important that health information be highlighted. We should not just ask whether a woman has experienced FGM on the basis that she is African; it should be much more about asking whether FGM has had an impact on the person's health and, if so, what that impact has been. We should ask, "Has it affected your presentation here, today?", "Will it affect your pregnancy?", "Will it affect your mental health?" and we should ask what we can do to mitigate and ameliorate those circumstances.

Strengthening the guidance by giving it a statutory basis might allow more focus on areas of the health service outwith maternity care. There is a preponderance of focus on that area because most of our statistics on FGM come through maternity services. We know that affected women use all our health services, but that is not reflected in the stats, which suggests either that there is a very good clinical and health service response, so further work is not required, or that we are not having those conversations across the different domains in the health service.

Mary Fee: I will ask Vickie Davitt a specific question on that. I was struck by what you said about being at an airport with the Border Force and the different language that is used by different communities to describe and talk about FGM. Are the differences of language and the words that are used already in the multi-agency guidance? If not, should that be included in statutory guidance to help all the different agencies when they come to talk about FGM?

10:45

Vickie Davitt: We have multi-agency guidance in Lothian and there is the national guidance, which I do not know as well as I know the Lothian guidance because I was on the working group that put the Lothian guidance together. There is, at the back, a glossary of all the terms that are used in lots of different languages. It is at least one page of A4, if not more.

If I talk about female genital mutilation, female genital cutting, cutting and circumcision, I have already said four different things. However, within that, there is also, for example, labial elongation, or it could come down to something as simple as what we mean by piercing. Piercing can mean having your ear pierced, where there is a hole and you put something into it, or it can mean that a hole is made, which is, potentially, type 4 FGM.

There is a glossary in Lothian's guidance; I assume that there is one in the national guidance. It would do no harm to put one in Government guidance so that everybody would know what they are talking about.

Mary Fee: Would you use guidance in training?

Vickie Davitt: Yes. As has already been said this morning, Government guidance gives everything more weight, so that when we are training, we can say, "Look—this is the law; this is what you need to do."

When I speak to women, I always make very clear the legal position in Scotland, which is backed up with the Scottish Government leaflet. All the women are given that. Whether they know the law or express protective views, they are all told the same thing. It is the same when I am doing training; everybody is told the same thing. We have the law, and they cannot argue with it. That is how it is.

Mary Fee: That is helpful. Do other panel members have anything to add?

Katie Cosgrove: I confirm that there is an appendix in the national guidance that covers terms that are used. However, health staff are unlikely to learn multiple terms. The point of flagging them up in the guidance is to ensure that staff are aware that there is not just one term that can be used.

The other thing that has come across in the work that we have done with women is that routine inquiry of any form of abuse has to be couched in such a way that it makes sense to the person who is being asked about it. We want questions of that nature to be couched in terms of whether anything has happened to them that has caused them hurt, that might be causing them health problems or concerns, or, in the case of pregnancy, that might make it difficult for them to have a smooth and uninterrupted labour.

The way in which the topic is broached is much more important than understanding 30 or 40 different terms that are used across different communities for a particular procedure.

Rachael Wood: As I understand it, the multi-agency guidelines focus primarily on advising and guiding front-line staff on identification of risk of, or actual, FGM, and on responding to that appropriately. I am responsible for what comes after FGM has been acknowledged and recorded in someone's notes, which should be coded accurately in national records. ISD is responsible for producing national guidance for health records departments on how to code things. We produced guidance on that in response to CMO letters of 2014 and 2016. Our national terminology team produced guidance on how to code for all the health records departments in Scotland. If FGM is identified by front-line staff and appropriately recorded in the woman's notes, there is guidance on how it should then be recorded in the national returns.

That is probably separate from the multi-agency guidance that you are talking about.

Mary Fee: Thank you. Obi, do you want to add anything?

Obi Amadi: No. I agree with my colleagues.

Fulton MacGregor: I want to ask a question that I put to the previous panel. Should children's hearings be able to grant FGM prevention orders?

Rachael Wood: I do not feel qualified to comment on that.

Katie Cosgrove: I am not sure. If hearings had such a power, that might expedite matters a bit. However, I am not sure that it would necessarily change the situation greatly. Children's hearings currently have powers on compulsory supervision orders, and cases are often referred from the children's panel to the sheriff court. I do not see any huge detriment to cases of people seeking FGM prevention orders coming through the courts, but that is just my personal opinion.

Vickie Davitt: I do not have enough experience of children's hearings to comment in detail, but I agree with what Katie Cosgrove has just said.

Obi Amadi: Anything that would expedite or clarify matters should be pursued. If children's hearings having that power would be more helpful to professionals in the system, then it should be considered.

Fulton MacGregor: The committee has explored the matter previously to try to get a sense of what people think of that prospect.

I will move on. What are panel members' views on criminalisation of breaches of FGM protection orders and on the penalties that have been set for them?

Vickie Davitt: I can tell you what the women say. As I have just explained, I set out the legal position to all the women whom I see. More often than not, when I mention the length of custodial sentence that is possible, many of them say that it is not long enough.

Rachael Wood: I am not qualified to comment on that.

Obi Amadi: I cannot comment, either.

Fulton MacGregor: I will go back to Vickie Davitt's answer. Do the women whom you speak to feel that the penalties should be increased?

Vickie Davitt: That is very much the opinion of women who are survivors of FGM. They want the practice to stop and they think that one way that that could happen is much tougher sentencing.

There is a difficulty in that there has been only one conviction in the UK. Until we have more evidence on how courts treat cases, it will be hard to say that penalties should be increased, because we do not have evidence to support that view. In that one case, the woman who was convicted went to jail for 12 years, so it was taken very seriously. However, we do not know whether that would happen in all cases until more cases are decided. That would send the right message—that Scotland takes FGM very seriously—and it would show what will happen to people who are caught practising it. Yesterday, I was speaking to a lady who said, "Well, I know that if I did it I would go to jail", so the message is already out there that it is taken very seriously in this country, which is important.

Fulton MacGregor: It is interesting to hear about your direct experience of working with women. The panels that we heard from last week expressed the fear that the tougher the sentencing, the more the criminalisation process could force the practice underground. It sounds as though a balancing act between those two aspects is needed. Do panel members acknowledge that?

Vickie Davitt: I definitely agree with that. On the one hand, women are saying that sentences are not long enough, but we also know that they are already quite vocal about FGM being wrong and about the need for it to be stopped. However, there is, among families and communities that still practise FGM, the potential for it to go underground. Just because I say to women that it is illegal in Scotland, that does not mean that it is not happening. We know that murder is illegal, but it still happens.

A delicate balancing act is required. There is difficulty getting the right intelligence from within the communities, because women are told that they should not talk about FGM. If it is not talked about, how can we find out whether it is being done? It is a difficult issue.

Obi Amadi: The anecdotal information that we have is that women want there to be custodial sentences, but I cannot support or advise the use of a particular sentence term. The existence of custodial sentences sends a clear message to perpetrators that FGM is a crime.

In respect of the fear that that would drive the practice underground, I say that it is already underground. If there were a shop that people could go to for FGM, we would know that it was not underground, but that is not the case.

We need to work with communities and professionals. It is an issue on which we cannot work in isolation. A much wider approach in terms of educating and supporting people is needed. If we do that, there will be fewer opportunities for an underground system or practice to thrive.

We need to think about the matter in terms of all of the stuff that is going on behind the scenes and we need to think about how we can work with communities. The leaders in the communities are the key to reducing the occurrence of FGM. As my colleague said, other things that are criminal offences continue. In order to make a big impact, we need to ensure that other people are involved in the right way.

The Convener: Earlier, you talked about the fact that there are slightly different systems in England and Scotland. I will ask Obi Amadi to answer the question first, then others can come in. What lessons can be learned from the approach that is taken south of the border? Are there things that are working well there that are not proposed in the bill, or are there things that we have missed?

Obi Amadi: One of the most difficult issues is mandatory reporting, which has been controversial and, perhaps, unpopular in England. However, some of us view it as having been quite successful, because it has enabled the professions to be clear about FGM. We had a situation in which some health professionals felt that when someone said that they had had FGM, they needed to examine them, but that is completely inappropriate. Examination must be left to professionals who have specialist knowledge. Mandatory reporting has led to an increase in people who have specialist roles around FGM. There were always some midwives who specialised in the area, but the number has increased, and other professional groups are starting to have people who have such knowledge. Identification and confirmation of FGM are specialised.

The Convener: One of the opinions that was given to us—either by a witness in a committee meeting or someone on one of our visits—was that mandatory reporting could be harmful to the relationship between a GP and their patient. It was accepted that there would not be collusion in the practice, but the possibility was raised of harm being caused in relation to communication. How would you address that?

Obi Amadi: I do not agree with that. In England, a lot of general practitioners were concerned about what might happen to their relationships with patients when mandatory reporting was introduced. The things that happen in a GP practice are quite important; the practice nurse or the GP will see people who come repeatedly with backache or urinary tract infections, but might not always think that those are symptoms of something that they need to have another conversation about. That is why universal provisions are much better.

Much of the success around issues such as FGM is the result of good relationships. Deterioration of the relationship is much less likely in an open and honest relationship in which people trust each other. As is the case in child protection and safeguarding situations, if people are honest and clear about why they are doing and saying something, there is less chance of deterioration.

11:00

The Convener: Do other members of the panel have a view on mandatory reporting?

Rachael Wood: We need to be clear about what type of mandatory reporting we are talking about, because health professionals in England are under two separate duties in that regard. First, they have a duty to report any cases of FGM involving children to the police. Secondly, they have a duty to report identifiable information to NHS Digital, which is ISD's rough equivalent.

I think that, today, you are talking about mandatory reporting in the health service. I must respectfully disagree with Obi Amadi and say that ISD is clear that we would not support that in Scotland. There are established mechanisms in England to mandate returns to NHS Digital, because the secretary of state works under different legal powers. In Scotland, we do not have those mechanisms. Obviously, some health events are subject to statutory reporting, but they are subject to specific laws in and of themselves. For example, terminations of pregnancy are reported to the chief medical officer and notifiable infectious diseases are reported under public health legislation. However, currently, there is no mechanism for ISD to mandate an identifiable return on FGM. There are practical issues why we would not support such reporting.

My personal preference, and the preference of my organisation, would be to support the accurate recording of FGM as it is identified in the routine records that we already receive. As I have already said, I think that that process is strengthening, and we are already starting to see that coming through as a result of the guidance that is available.

There are wider professional issues to do with mandating reporting. I have concerns about how it influences the relationship between health professionals and their patients. It potentially puts doctors in conflict with their professional duties from the General Medical Council, as the duty of an individual patient’s care must always be our primary concern. If a doctor is under separate mandatory duties that take away their clinical judgment about what that person’s best interests are, that can put them in an uncomfortable professional position.

Katie Cosgrove: I echo what Rachael Wood has said. When we were developing the guidance, we considered some of the issues to do with mandatory reporting that they have in England. We were very much concerned with the need to have a proportionate response. We were also concerned about the need to ensure that we can support health staff to identify and respond sympathetically to women presenting with FGM, and ensure that that confidentiality was maintained.

When we consulted, women were concerned about the fact that they would not have any control over the information. They were not sure what would be done with it and they did not necessarily make the distinction between what was being done with it internally in the health service and externally with the police. Part of the concern was about the impact that that would have on their relationship with their practitioner.

There is clear guidance on how we share information across the health service. At times, sharing information is obviously very important. However, the concerns that were raised by women—and by practitioners, because there has been concern about the nature of that reporting among some practitioners in England—certainly shaped our thinking when we decided not to support mandatory reporting in the bill.

Rachael Wood: There are a number of articles that I could point you to in which health professionals express serious disquiet about the mandatory reporting requirements. Ironically, mandatory reporting does not necessarily lead to good information. You can mandate it, but, actually, NHS Digital continues to publish its statistics as experimental, and there are concerns about the quality of the information that is being generated.

The Convener: It is always helpful for the committee to hear differing perspectives.

Vickie Davitt: What would we be trying to achieve with mandatory reporting? The current system would not cope with its introduction. You risk criminalising women who have had something done to them. Who are we trying to get to here? Are we trying to give a woman who was subjected to FGM as a five-year-old child a criminal record? When I talk to midwives about mandatory reporting and I say that it includes the reporting of tattoos, there is general hilarity, because we have all seen 17-year-olds with tattoos; legally, they should not have them, but they do. Are we going to give those girls a criminal record because they have chosen to get a tattoo? That is completely different from a 17-year-old who was subjected to FGM when she was five. The two things are not the same. I respectfully disagree with my colleague. Mandatory reporting is not the way to go.

Rachael Wood: I think that Vickie Davitt’s question about what we are trying to achieve through mandatory reporting is really important. I assume that we are trying to achieve better visibility of the prevalence of FGM in the Scottish population, so that we can plan to meet the needs of those women appropriately. As I said, I think that there are better ways that we can do that through routine NHS records, but it would also be interesting for the Scottish Government to consider commissioning research on the prevalence of FGM, because there is none for the Scottish population. That is a positive thing that could be done.

Alex Cole-Hamilton: Vickie Davitt’s point about the mandatory reporting of tattoos is well made. My interpretation is that mandatory reporting is more about issuing protection orders than it is about giving someone a criminal record. For example, Vickie Davitt talked about the woman she assisted who had given birth, who had talked about getting restitched or whatever it was. If there was legislation that could be leaned on, so that a protection order could be imposed on her—for example, that woman could have her passport removed until she felt that she was no longer at risk—she would not be able to fly back to a country where that restitching could take place. That would not be about giving her a criminal record; it would be about protecting her. How do you feel about that scenario and having the obligation to report such a concern?

Vickie Davitt: The two examples are not necessarily the same. It is very difficult. If you take away a passport from somebody, when do you decide that the risk is no longer there? My colleagues and I in the al-nisa service in Lothian work on a continuum of risk. The risk never goes away. It is always there, but it just changes over time. At what point would you give that woman her passport back? Are you really going to prevent her from going back home to visit her family when she may or may not be at risk?

If the woman is over 18, this is, again, about choice. For a lot of the women whom I see, their body works how their body works and that is how they like it. I have seen one woman who has had two pregnancies so she has been through my system twice, but I have also had discussions with her twice outwith pregnancy. Therefore, I have had four interactions with her to talk about deinfibulation. She does not want to have deinfibulation because her body works how her body has always worked. It is her husband who is trying to persuade her to have it done, which is a bit different. She is just not interested. She would say, “My body is fine, thank you very much. I don’t want to change how it works.”

For women over 18, when do we decide that somebody is being coerced into having something done or whether they just want their bodies back to how it was? That is what all women want after they have had a baby, but it just depends on what the meaning of that is.

Alex Cole-Hamilton: That is the challenge before us.

Obi Amadi: I did say that the issue is controversial.

On what my colleagues said about doctors finding it difficult, doctors are the same as all other health professionals and it is no different for them than it is for other people. If they have the information and are clear about it, there is no issue with deteriorating relationships. We do not believe that and have not seen it.

Another thing to remember is that many survivors, when we have conversations with them, want to speak, tell, be asked and share, because they do not want it to happen to other women or, in particular, to girls.

On criminalisation, we are talking about mandatory reporting when it comes to children, but the reporting is more along the lines of recording when it comes to adults.

The Convener: Thank you all for coming along this morning. Your evidence has been very helpful.

At our next meeting, we will take evidence from third sector member organisations, regulators, inspectors and third sector equality organisations as part of our scrutiny of the Scottish Government’s budget for 2020-21.

11:11

Meeting continued in private until 11:26.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba