Equal Opportunities Committee

2nd Report, 2005 (Session 2)

Stage 1 Report on the Prohibition of Female Genital Mutilation (Scotland) Bill
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Equal Opportunities Committee

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ANNEX A: EXTRACTS FROM THE MINUTES

16 November 2004, (17th Meeting, Session 2 (2004))
30 November 2004, (18th Meeting, Session 2 (2004))
11 January 2005, (1st Meeting, Session 2 (2005))
18 January 2005, (2nd Meeting, Session 2 (2005))
1 February 2005, (3rd Meeting, Session 2 (2005))

ANNEX B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

30 November 2004, (18th Meeting, Session 2 (2004))

Oral Evidence
Scottish Executive


Written Evidence
Somali Women Action Group
Oral Evidence
AMINA
FORWARD
Somali Women Action Group

11 January 2005, (1st Meeting, Session 2 (2005))
Written Evidence
   Glasgow City Council
Oral Evidence
   Glasgow City Council

18 January 2005, (2nd Meeting, Session 2 (2005))
Written Evidence
   Amnesty International Scotland
   Save the Children Scotland
Oral Evidence
   Amnesty International Scotland
   Save the Children Scotland
   Scottish Refugee Council
   World Health Organisation (WHO)
   Royal College of Midwives
   Royal College of Obstetricians and Gynaecologists

1 February 2005, (3rd Meeting, Session 2 (2005))
Written Evidence
   Scottish Executive
Oral Evidence
   Hugh Henry MSP, Deputy Minister for Justice

ANNEX C: OTHER WRITTEN EVIDENCE

Association of Chief Police Officers in Scotland (ACPOS)
Association of Directors of Social Work (ADSW)
British Medical Association (BMA)
Commissioner for Children and Young People in Scotland
Equal Opportunities Commission
Dr Mary Hepburn
Mr John Telfer
Dr Pamela Buck
Gender Reporter’s Note of Meeting with the Somali Women Action Group, 28 Jan 2005

The following documentation was also received, which is not reproduced here-

Scottish Executive consultation response from Scottish Refugee Council
Background information from Royal College of Midwives
Background information from Royal College of Obstetricians and Gynaecologists
World Health Organisation (WHO); Entre Nous – The European Magazine for Sexual and Reproductive Health No 55 – 2003
World Health Organisation (WHO); European Regional Strategy on Sexual and Reproductive Health
Save the Children; Rights of Passage – Harmful cultural practices and children’s rights
World Health Organisation (WHO); World report on violence and health

Copies are available on request from the Clerk.
Equal Opportunities Committee

Remit and membership

Remit:

The remit of the Equal Opportunities Committee is to consider and report on matters relating to equal opportunities and upon the observance of equal opportunities within the Parliament.

Membership:

Cathy Peattie (Convener)
Shiona Baird
Frances Curran
Phil Gallie
Marilyn Glen
Marilyn Livingstone
Nora Radcliffe (Deputy Convener)
Elaine Smith
Ms Sandra White

Committee Clerking Team:

Clerk to the Committee
Steve Farrell

Senior Assistant Clerk
Zoé Tough

Assistant Clerk
Roy McMahon
Equal Opportunities Committee

2nd Report, 2005 (Session 2)

Stage 1 Report on the Prohibition of Female Genital Mutilation (Scotland) Bill

The Committee reports to the Parliament as follows—

Introduction

1. The Prohibition of Female Genital Mutilation (Scotland) Bill (SP Bill 29) was introduced in the Parliament on 29 October 2004 by the Minister for Justice, Cathy Jamieson MSP. The Bill is accompanied by Explanatory Notes (SP Bill 29-EN), a Financial Memorandum, and a Policy Memorandum (SP Bill 29-PM) as required by Standing Orders. The Parliament referred the Bill to the Equal Opportunities Committee as lead committee on 2 November 2004. Under Rule 9.6 of Standing Orders it is for the lead committee to report to the Parliament on the general principles of the Bill.

Background

2. Female genital mutilation (FGM) has been a specific criminal offence in the UK since the passage of the Prohibition of Female Circumcision Act 1985. The Female Genital Mutilation Act 2003 repealed and re-enacted the provisions of the 1985 Act in England, Wales and Northern Ireland, giving them extraterritorial effect and increasing the maximum penalty for FGM from 5 to 14 years imprisonment.

3. The Policy Memorandum of the Bill notes that the policy intention is to “ensure that equal legal protection is afforded in Scotland as in the rest of the UK.”

Consultation

4. The Scottish Executive circulated the draft Bill on 20 July 2004 with responses requested by 31 August 2004. A report on the 59 written responses received was made available to the Committee along with copies of the responses.

Evidence Taken by the Committee

5. The Committee took oral evidence over the course of five meetings starting with the Scottish Executive Bill Team on 30 November 2004 and concluding...
with evidence from the Deputy Minister for Justice on 1 February 2005. At its meeting on 14 December 2004, the Committee heard from AMINA - the Muslim Women’s Resource Centre, the Foundation for Women’s Health, Research and Development (FORWARD) and the Somali Women Action Group. On 11 January 2005, the Committee took evidence from Glasgow City Council and, on 18 January 2005, from Amnesty International Scotland, Save the Children Scotland, the Scottish Refugee Council, the World Health Organisation (WHO), the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.

6. The Committee issued an open call for written evidence and received several written submissions in addition to those provided by the organisations giving oral evidence. The Gender Reporter to the Committee held two meetings with the Somali Women Action Group to discuss the legislation and reports of these meetings are attached at Annexes B and C. The Committee would like to record its thanks to all of those who provided written or oral evidence.

Summary of Recommendations

Consultation Process

7. The Committee recommends that the Executive must take the necessary steps in future consultation exercises to ensure that it complies with its own consultation guidance, and that the 12 week response period identified in the guidance is regarded as a minimum requirement.

8. The Committee recommends that where the Executive considers that there are very exceptional circumstances which justify reducing the consultation period, it should make these circumstances clear in the documentation issued with the consultation and with the Bill.

9. The Committee recommends that in future the Executive should be proactive in identifying, contacting and consulting with any specific groups that are likely to be affected by its policy and legislative proposals.

10. The Committee recommends that the Executive should be proactive in identifying and implementing the most effective methods and means of communication and consultation with such groups to ensure that they are given the opportunity to participate effectively in the consultation process.

11. The Committee recommends that where suggestions for change are identified in a consultation report the Executive should, as well as giving a clear indication as to whether it intends to accept proposed changes, provide an explanation of its response to the points raised.

Specification of Relevant Procedures

12. The Committee recommends that the World Health Organisation classification system of FGM in its entirety (currently types I to IV) is used in the Bill as a reference point to specify procedures which are unlawful under the legislation.
13. The Committee recommends that the Executive should specifically exclude from the provisions of the Bill those elective cosmetic surgical procedures, such as reduction labioplasty, which are increasingly commonly carried out in the UK.

14. The Committee recommends that, in the interest of clarity, the Executive, in addition to referencing the WHO classification of FGM, should specify in the Bill the particular procedures which it wishes to remain outwith the scope of the Bill, such as, for example, decorative piercing, tattooing and specified cosmetic procedures.

15. The Committee recommends that there should be no age limit in the Bill.

16. The Committee recommends that re-infibulation is defined and mentioned specifically on the face of the Bill as an unlawful procedure.

17. The Committee recommends that the offences of attempted FGM and incitement to commit FGM be referred to specifically in guidance issued in respect of the Bill to communities likely to be affected by FGM.

Exceptions
18. The Committee is of the view that it is important that the legislation should ensure that the procedures for permitting surgery which may be considered to be FGM on the basis of either the physical or mental health exceptions should be robust enough to ensure that they are not open to abuse. It considers that there is merit in the Royal College of Physicians in Edinburgh’s suggestion that a second specialist medical opinion would go some way towards achieving this. The Committee therefore recommends that the Scottish Executive should bring forward proposals to amend the Bill accordingly at Stage 2.

Extra-territorial Provision
19. The Committee seeks further clarification from the Minister as to what steps might be taken to extend the provisions of the Bill to provide further protection for asylum seeker children from FGM should they be removed from Scotland.

Penalties for Offences
20. The Committee recommends that the relevant penalties should be given some prominence in information and guidance material circulated to the communities likely to be affected.

Prosecutions
21. The Committee recommends that the Executive take forward its promised discussions with the Crown Office and Procurator Fiscal Service regarding vulnerable witnesses as soon as is practicable and would welcome a report on any subsequent efforts taken to ensure that measures are available which assist those reporting FGM to stay within their communities whilst providing them with adequate support and protection.
Guidance, Education and Training

22. The Committee urges the Scottish Executive to carry out an immediate review of the guidance, education and training currently available for the full range of professionals who are likely to have to deal with instances of FGM and its consequences, assess its effectiveness and develop a plan to ensure the availability and effective implementation of suitable, updated and appropriate material.

23. The Committee further recommends that the Executive should take cognisance of such guidance, education and training material which is already available elsewhere in the UK and worldwide.

24. The Committee seeks an assurance from the Executive that a process will be put in place to ensure that an integrated approach is taken across the Executive and invites a response from the Executive in due course providing information on how this will be achieved.

25. The Committee notes the reference in the Executive’s recently published sexual health strategy to FGM\(^1\) and looks forward to receiving notification from the Executive that the guidance referred to has been produced and implemented. However, the Committee urges the Executive to ensure that any guidance is only one action undertaken as part of a wider, co-ordinated and strategic approach encompassing all of the services likely to deal with FGM.

26. The Committee recognises that education, awareness raising and confidence building in communities will entail a range of different actions by various organisations and agencies as well as the effective deployment of suitable resources. The Committee seeks clarification from the Executive regarding its plans to develop and support these activities in the relevant communities.

27. The Committee seeks clarification from the Executive as to the costs it expects the range of required initiatives to incur and how it expects them to be funded.

Research and Information

28. The Committee recommends that the Executive take steps to develop methods of collecting baseline data on the prevalence of FGM, whether as part of a UK-wide process, or specifically targeted at the prevalence of FGM in Scotland.

Conclusion

29. The Committee recommends that the general principles of the Bill be agreed to.

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\(^1\) Scottish Executive, Respect and Responsibility; Strategy and Action Plan for Improving Sexual Health, Edinburgh 2005, page 20
Consultation Process

30. The Scottish Executive consultation period on the draft Bill ran from 20 July to 31 August 2004. The Committee was concerned that this period was limited and asked witnesses at Stage 1 for their views on the adequacy of the consultation period. In evidence to the Committee, Jean Murphy of Glasgow City Council noted:

“The timescale was tight for us, particularly as the consultation ran during a holiday period and many of the people who we felt might have had something to say that we could include in our response were not around. It was also during the council recess, so there was no time to prepare a report to go through the committee structure, which was problematic for us.”  

31. Fariha Thomas of AMINA – The Muslim Women’s Resource Centre said:

“If we had had more time, we would have been able to talk to more people and consult more widely. … A longer and more targeted consultation process might have reached more people.”

32. The Scottish Executive Consultation Good Practice Guidance (June 2004) states that:

“In order to meet existing SE consultation commitments you must:

- allow consultees at least 12 weeks to respond, except in very exceptional circumstances”

33. When asked why the consultation period had been so short, the Deputy Minister for Justice gave the Committee a number of reasons including:

“We were unable to act when the Female Genital Mutilation Bill was going through the UK Parliament, because that coincided with our parliamentary elections, which meant that there was a gap. Although a relatively small number of people are affected, we did not want too long a delay, in case anyone was affected who could otherwise have been protected. We wanted to act quickly. Extending the consultation period would have had the unfortunate consequence of causing other parliamentary delays; we had to manage a fairly heavy parliamentary agenda, with other bills going through, but managed to procure a slot.”

and

“We thought that we would be able to get views in a relatively short space of time. We realised that there was not a huge geographical spread of interest and that that interest was concentrated among specific groups. We thought

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2 Equal Opportunities Committee, Official Report, 11 January 2005, col 743
3 Equal Opportunities Committee, Official Report, 14 December 2004, col 713
4 Scottish Executive: Consultation Good Practice Guidance (June 2004), page 5
that we would be able to cope with the consultation in a relatively short period.\textsuperscript{5}

34. In the Committee’s view, however, none of the reasons given qualify as ‘very exceptional circumstances’ – to paraphrase the Executive’s own good practice guidelines - which would justify such a short consultation timescale, particularly during a holiday period. It is of particular concern to the Committee that the local authority most likely to have to deal with issues related to FGM did not have enough time to produce a response which complied with its normal internal procedures.

35. The Committee acknowledges that the Executive was keen to move quickly to bring forward its proposals to ensure that the protection already provided elsewhere in the UK was made available in Scotland. However, it considers that, regardless of the pressures of the Executive’s parliamentary agenda or other political factors such as the timing of Scottish Parliament or other elections, there is an expectation that consultation on legislative proposals should be carried out in an appropriate and reasonable manner.

36. The Committee therefore recommends that the Executive must take the necessary steps in future consultation exercises to ensure that it complies with its own consultation guidance, and that the 12 week response period identified in the guidance is regarded as a minimum requirement.

37. It further recommends that where the Executive considers that there are very exceptional circumstances which justify reducing the consultation period, it should make these circumstances clear in the documentation issued with the consultation and with the Bill.

38. Concern was also expressed in evidence to the Committee in relation to the format of the consultation material. For example, Susan Elsley of Save the Children Scotland noted:

“… I am concerned about whether there was sufficient opportunity for information to get out to communities that may be particularly affected by the bill and whether that information was presented to them in an appropriate form and in appropriate languages.”\textsuperscript{6}

39. Efua Dorkenoo from FORWARD highlighted the issue of providing information in relevant formats:

“… there is a need to ascertain whether the people who should read the material are literate. There is a tendency to translate material quickly into local languages, but members of the community, particularly women, might not be able to read the documents; it might be better to put the information on tape.”\textsuperscript{7}

\textsuperscript{5} Equal Opportunities Committee, Official Report, 1 February 2005, col 826
\textsuperscript{6} Equal Opportunities Committee, Official Report, 18 January 2005, col 772
\textsuperscript{7} Equal Opportunities Committee, Official Report, 24 December 2004, col 714
40. Witnesses from the Somali Women Action Group agreed in evidence to the Committee that various alternative formats, such as tape, images and translation, would have been useful particularly for members of the Somali community in Scotland.

41. Councillor Graham of Glasgow City Council pointed out in evidence:

“We all – whether the Executive or the councils – have to think about other forms in which to make such sensitive information available. For example, a well-placed key worker working with the communities often provides a good route in.”

42. A report from the International Centre for Reproductive Health at Ghent University which carried out a study of legislation on FGM advises:

“In the event that specific legislation is developed, or that there are amendments to be made to existing legislation, the government must ensure that members of the community and NGOs are fully consulted, and that they are adequately resourced to advocate.”

43. It is of concern to the Committee that it appears from evidence that it was only a matter of luck that the Somali Women Action Group were included in the consultation process. Jean Murphy of Glasgow City Council said:

“It was sheer chance that I had been invited along to the group’s inaugural meeting a week before I received the consultation document. At that meeting, the group had stated that one of its objectives was to tackle FGM, so I knew that it would have something to say on the issue, which is why I encouraged it to respond to the consultation.”

44. The Minister indicated in evidence that the Executive was “not aware of the Somali women’s action group”, but that it “offered to have a range of meetings in case people preferred to discuss the issues with officials rather than providing written evidence”. Whilst this may have been the case, the Committee is disappointed that not enough effort appears to have been made by the Executive to identify and contact the appropriate representatives of the relatively small range of community groups which were most likely to be potentially affected to make them aware of its proposals.

45. The Committee therefore recommends that in future the Executive should be proactive in identifying, contacting and consulting with any specific groups that are likely to be affected by its policy and legislative proposals.

46. The Committee further recommends that the Executive should also be proactive in identifying and implementing the most effective methods and means of communication and consultation with such groups to ensure

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8 Equal Opportunities Committee, Official Report, 11 January 2005 col 744
9 Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK, Els Leye and Jessika Deblonde (coord.), International Centre for Reproductive Health, Ghent University, April 2004, page 47, paragraph 2.
10 Equal Opportunities Committee, Official Report, 11 January 2005, col 744
that they are given the opportunity to participate effectively in the consultation process.

47. The report on the responses to the consultation makes it clear that three changes had been suggested by the respondents. The Policy Memorandum notes that “No changes were made to the draft Bill as a result of the consultation.” The Scottish Executive, however, provides no explanation for its decision not to act on these suggestions.

48. The Committee recommends that where suggestions for change are identified in a consultation report the Executive should, as well as giving a clear indication as to whether it intends to accept proposed changes, provide an explanation of its response to the points raised.

Specification of Relevant Procedures

49. The procedures which qualify as female genital mutilation are specified in section 1(1) of the Bill as excising, infibulating or otherwise mutilating the whole or any part of the labia majora, labia minora or clitoris. According to the World Health Organisation, FGM comprises:

“… all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.”

50. WHO notes that there are different types of FGM practised, which can be categorised as follows:

- Type I – excision of the prepuce, with or without excision of part or all of the clitoris;
- Type II – excision of the clitoris with partial or total excision of the labia minora;
- Type III – excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- Type IV – pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue;
  - scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts);
  - introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

51. The Committee notes the concerns raised in evidence regarding the clarity of specification of procedures which qualify as unlawful under the provisions of the Bill.

52. Efua Dorkenoo of FORWARD, for example, said in evidence to the Committee:

“The Scottish Parliament could consider the definition in the bill. The English law talks about excising or mutilating, but that creates a tendency for people to think that other forms of genital mutilation are okay, as long as they are not the radical form. … It is important to use the WHO terminology to spell out what is allowed and what is not allowed. The English act is not very clear.”

53. When asked if a reference to the different types should be on the face of the Bill, she responded:

“Yes. All the different types should be noted. Perhaps a footnote could state that female genital mutilation means any of the WHO classifications – types I, II, III and IV.”

54. The Deputy Minister for Justice in his evidence to the Committee accepts that WHO classification Type IV FGM is not included in the provisions of the Bill:

“I know that type IV female genital mutilation encompasses a range of procedures, some of which involve injury to the vagina rather than to the labia and will not, therefore, be covered by the bill.”

55. Whilst accepting that some of these procedures “involve injury to the vagina”, the Deputy Minister’s justification for this exclusion appears to be threefold:

“… we need to be sure that we do not catch other procedures, such as tightening procedures on women who have had a number of children. … we do not have evidence that type IV female genital mutilation is necessarily prevalent in Scotland. … It is right to have a degree of consistency across the UK.”

56. With regard to the lack of evidence of prevalence of Type IV FGM in Scotland, the Committee notes that the Bill contains an extra-territorial provision and should, therefore, relate to procedures which are likely to be carried out in other countries. FORWARD’s evidence also suggests that practitioners of FGM might change the procedures they carry out in order to remain within the law.

57. Following evidence received from both Dr Pamela Buck of the Royal College of Obstetricians and Gynaecologists and John Telfer, Consultant Plastic Surgeon, the Committee is content that vaginal tightening procedures on women who have had a number of children are routinely performed procedures which would fall under the health exception of the Bill (section 1(2)(a)).
58. In relation to the question of the need for consistency across the UK, the Committee considers that clear and effective legislative provision is more important than consistency. **The Committee therefore recommends that the WHO classification system in its entirety (currently types I to IV) is used in the Bill as a reference point to specify procedures which are unlawful under the legislation.**

59. The Committee notes the Deputy Minister’s comments in relation to the WHO classification:

“... the WHO is rethinking and reformulating the definition of female genital mutilation and I would be worried that a more specific definition in the bill could miss some of the forms of FGM that the WHO might describe.”\(^{17}\)

60. However, as Dr Baumgarten of the WHO noted in evidence to the Committee:

“The WHO definition is internationally recognised as the standard definition of what we mean if we talk about female genital mutilation, female genital cutting or female circumcision. Usually, the countries that have legislation refer to that definition, although some countries make exceptions in respect of piercing in the area of the vagina, for example.”\(^{18}\)

61. The Committee is not suggesting that the Bill lists exhaustively the specific procedures to be made unlawful, but rather refers to the WHO classification as the internationally recognised definition of FGM and **specifically identifies any procedures to be excluded in terms of the legislation in Scotland.**

62. The Committee welcomes the Deputy Minister’s assurance that he will reflect on the use of the WHO classification in the Bill.\(^{19}\)

**Elective cosmetic vaginal surgery**

63. It has been brought to the attention of the Committee in evidence that there are certain elective cosmetic procedures, such as reduction in the size of the labia minora, which fall within the scope of the procedures identified as unlawful in the Bill.

64. Consultant Plastic Surgeon, John Telfer, explains in his written submission to the Committee that, in relation to the procedure known as *reduction labioplasty*:

“... there are a group of patients, who do not have physical problems or significant, clinically apparent, psychological concerns, who request such surgery. Currently, under these circumstances, such surgery, if the letter of the law is to be applied, would be illegal.”

65. He comments on the frequency of such cosmetic surgical procedures:

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\(^{17}\) Equal Opportunities Committee, Official Report, 1 February 2005, col 829

\(^{18}\) Equal Opportunities Committee, Official Report, 18 January 2005, col 775

\(^{19}\) Equal Opportunities Committee, Official Report, 1 February 2005, col 829
“It was recognised at the meeting of the British Society of Sexual Medicine in London, in January 2004, that the request for cosmetic procedures to the female genitalia was rising.” He concludes;

“It would … seem inappropriate to outlaw such procedures specifically or by including such surgery under the terms of the Prohibition of Female Genital Mutilation (Scotland) Bill and yet allow other forms of cosmetic surgery.”

66. Comfort Momoh from the Royal College of Midwives confirmed that:

“Cosmetic procedures are common in London. I know that people go to Harley Street to have their labia reduced.”  

67. A report from the International Centre for Reproductive Health in Ghent supports the need for clarity:

“In case specific law provisions exist, these should be very clear about the forms of FGM that are prohibited, especially with regard to the emerging practice of piercing/tattooing of the genitals and cosmetic vaginal surgery vis-à-vis FGM.”

68. The Committee assumes that this type of surgery is not the intended target of this legislation. It considers therefore that it would be inappropriate to outlaw such elective cosmetic procedures which are commonly and increasingly carried out throughout the UK - and which could not be considered to be FGM - as a consequence of the Bill.

69. The Committee recommends that the Executive specifically exclude from the provisions of the Bill those elective cosmetic surgical procedures, such as reduction labioplasty, which are increasingly commonly carried out in the UK.

70. The Committee therefore recommends that, in the interest of clarity, the Executive, in addition to referencing the WHO classification of FGM (see paragraph 58 above) should specify in the Bill the particular procedures which it wishes to remain outwith the scope of the Bill, such as, for example, decorative piercing, tattooing and specified cosmetic procedures.

71. The Committee welcomes the Deputy Minister’s assurances that the Executive will continue to discuss matters in relation to cosmetic surgery  and that he will reconsider the definitions to see if there could be some unintended consequence.

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20 Equal Opportunities Committee, Official Report, 18 January 2005, col 800
21 Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK, Els Leye and Jessika Deblonde (coord.), International Centre for Reproductive Health, Ghent University, April 2004, page 47, paragraph 2.
22 Equal Opportunities Committee, Official Report, 1 February 2005, col 831
23 Equal Opportunities Committee, Official Report, 1 February 2005, col 832
Age limit/consent

72. In view of the fact that some countries which have laws against FGM have an age limit of 18 years of age, allowing for consenting adults to have relevant elective cosmetic surgical procedures carried out, the Committee considered whether Scotland should make similar provision in its legislation. This proposition did not, however, find favour with any of the witnesses who gave evidence.

73. Efua Dorkenoo mentions in evidence, for example, the following issues in relation to age and consent:

“FGM is usually done up to the age of puberty, but it is also done to 18-year-olds and it is forced on older women by their families.” 24

and:

“... the reality is that gross pressure is brought to bear on African women and it is more likely for women to be conditioned — the push factor is strong.

You must also consider the pressure that the extended family might put on a woman over the age of 18 — she might not even be from the community. Years ago, I worked with a white woman in Manchester who married a Sudanese man and was pressured by the women in the community to undergo infibulation. She underwent the procedure to be accepted within the group.” 25

74. The Somali Women Action Group in a meeting with the Committee’s Gender Reporter strongly expressed the view that FGM procedures should be made unlawful irrespective of age. 26 The Committee is persuaded by the evidence that it has heard that this would not be a helpful addition to the Bill. The Committee, therefore, recommends that there should be no age limit in the Bill.

Re-infibulation

75. Concern was expressed in evidence to the Committee regarding the clarity of the legislation in relation to the status of re-infibulation — restitching after childbirth to return a woman who had previously undergone stage III FGM (infibulation) to the condition she was in before childbirth.

76. Dr Mary Hepburn, Consultant Obstetrician, notes in her written submission that the legislation does not clearly state that re-infibulation following childbirth is unlawful:

“... health care workers in maternity services who have to make incisions to enlarge the introitus for delivery are often put under pressure to repair this incision to restore the genitalia to the condition before pregnancy/delivery. At present this is clearly illegal. However, I am concerned that the wording of

24 Equal Opportunities Committee, Official Report, 14 December 2004, col 726
26 Gender Reporter’s Meeting with the Somali Women Action Group (SWAG) 28 January 2005, Annex
the proposed legislation does not make that explicit. … I think it is important that the legislation leaves no room for ambiguity.”

77. The report from the International Centre for Reproductive Health also supports this view and highlights the need to differentiate clearly between re-suturing an episiotomy and re-infibulation:

“To avoid confusion, re-infibulation needs to be defined and specific law provisions should be very clear about re-infibulation.”

78. The Committee is concerned that there should be no confusion between the common and necessary practice of re-suturing after an episiotomy and the unnecessary and mutilating practice of re-infibulation. The Committee, therefore, recommends that re-infibulation is defined and mentioned specifically on the face of the Bill as an unlawful procedure.

Additional Offences

79. In its written submission to the Committee, Amnesty International Scotland suggested that the Bill should include two additional offences — attempted FGM and incitement to FGM. Rosemary Burnett of Amnesty International Scotland pointed out in evidence:

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

80. The Committee questioned the Deputy Minister on the possibility of including these additional offences in the Bill and he indicated that incitement to commit a crime and attempted crime are already offences in Scots law:

"Section 294 of the Criminal Procedure (Scotland) Act 1995 states:

"Attempt to commit any indictable crime is itself an indictable crime."; and

"… conspiracy and incitement to commit crimes are offences under Scots common law.";

81. The Committee is content with the reassurance given by the Deputy Minister that attempted FGM and incitement to commit FGM will become offences in Scots law should the Bill be passed and that there is, therefore, no need to add these specifically to the Bill.

27 Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK, Els Leye and Jessika Deblonde (coord.), International Centre for Reproductive Health, Ghent University, April 2004, page 47, paragraph 2.
28 Equal Opportunities Committee, Official Report, 18 January 2005, col 778
29 Equal Opportunities Committee, Official Report, 1 February 2005, col 848
82. The Committee recommends that these offences be referred to specifically in guidance issued in respect of the Bill to communities likely to be affected by FGM.

Exceptions

Mental health exception

83. Section 1(2)(a) of the Bill provides that no offence is committed when an approved person performs “a surgical operation on another person which is necessary for that other person’s physical or mental health.” However, concerns have been raised in evidence that the mental health exception in the Bill might provide a loophole which could be open to abuse. Glasgow City Council, for example, notes in evidence:

“We are a wee bit concerned that the bill says that it would not be illegal for someone to perform the procedure if it was for the good of a person's mental health. We think that could be used as a loophole; that is what worries us.”

84. Councillor Irene Graham from Glasgow City Council expands on this concern:

“We know that women in the communities in which FGM takes place and is long established are under severe cultural pressure from everybody in the those communities. … a coherent and cogent argument might be made for FGM being good for a woman’s or child’s mental health. For that reason, we are against the provision in the bill as it stands.”

85. This concern is echoed by the Royal College of Physicians of Edinburgh (RCPE) in its consultation response to the Scottish Executive, where it states:

“Perhaps it would be stronger if the person’s physical need for the operation must be agreed by two consultant obstetricians/gynaecologists with a certificate of completion of specialist training (or equivalent) and registered with the UK General Medical Council. The same clause could also be added for the mental health requirement with two psychiatrists, again with a certificate of completion of specialist training (or equivalent) and registered with the UK General Medical Council.”

86. The Committee raised the issue of the potential loophole with the Deputy Minister and asked if he would consider including in the Bill a provision for two competent people to decide whether a proposed procedure is acceptable under the exemption.

87. The Deputy Minister noted that he did not think that there was a loophole and that the requirement for two medical practitioners to agree on a procedure would:

“... introduce unnecessary complications, and it could introduce unnecessary delays.”32

88. The Committee is of the view that it is important that the legislation should ensure that the procedures for permitting surgery which may be considered to be FGM on the basis of either the physical or mental health exceptions should be robust enough to ensure that they are not open to abuse. It considers that there is merit in the RCPE’s suggestion that a second specialist medical opinion would go some way towards achieving this.

89. The Committee therefore recommends that the Scottish Executive should bring forward proposals to amend the Bill accordingly at Stage 2. It welcomes the assurances of the Deputy Minister that he will reconsider this matter.33

Extra-territorial Provision

90. The Bill creates extra-territorial offences that prevent UK nationals or permanent UK residents being taken abroad to have FGM performed on them. In addition, the Bill prevents UK nationals or permanent UK residents performing FGM abroad. The provisions in this Bill go further than the 1985 Act in relation to where the offence of performing FGM can take place and the provisions in the Bill would bring Scotland in line with the 2003 Act’s provisions.

91. The Committee welcomes this proposed extension to the current legislation but notes that there are remaining concerns about the level of protection afforded to asylum seekers.

92. The Committee was assured in evidence from Executive officials that the proposals would protect asylum seekers whilst they were in the UK. A member of the Scottish Executive Bill Team said:

“I want to make it absolutely clear that while asylum seekers are in Scotland — or, for that matter, the rest of the UK — they are covered by the terms of the bill.”34

93. However concern was expressed by a number of witnesses that asylum-seeker children would not be covered by the Bill if they were taken abroad to have FGM performed on them. In evidence, Simon Hodgson from the Scottish Refugee Council said:

“... the Bill will still not protect children who are seeking asylum.”35

94. Councillor Irene Graham from Glasgow City Council said:

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32 Equal Opportunities Committee, Official Report, 1 February 2005, col 842
33 Equal Opportunities Committee, Official Report, 1 February 2005, col 842
34 Equal Opportunities Committee, Official Report, 30 November 2004, col 689
35 Equal Opportunities Committee, Official Report, 18 January 2005, col 776
“... we cannot assume that children will never be taken out of the country by other family or community members. We are concerned that the bill should contain additional protection.”

95. The Deputy Minister, when asked by the Committee to clarify the position in relation to children of asylum seekers, confirmed that if an asylum seeker child was taken abroad by a foreign national to have FGM performed, there would be no offence, because:

“... the law does not cover individuals who have no rights here. The act would take place in a country over which we had no jurisdiction and would be carried out by someone who would not be subject to UK law.”

96. Kathleen Marshall, the Commissioner for Children and Young People in Scotland, expressed in evidence concern that some children would be excluded from the Bill’s protection “in a way that appears discriminatory in terms of article 2 of the [United Nations] Convention on the Rights of the Child.” (UNCRC)

97. The Committee raised this concern with the Deputy Minister in evidence and he stated:

“That is one interpretation. I repeat my earlier point that when children come to this country they are protected against any such acts that are carried out within this country. However, there are limits in international law to how wide we can extend our extraterritorial powers. International law requires a tangible link to Scotland.”

98. On considering the evidence received the Committee is satisfied that the Bill is not in breach of the UK’s obligations under the UNCRC. Article 2 of the UNCRC states that:

“States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.”

99. The Committee understands that because the Bill provides that FGM against any child in Scotland is an offence, the Bill will not be discriminatory for the purposes of article 2.

100. In addition, the Deputy Minister said:

“It would be highly unusual in international law for us to take jurisdiction over acts committed abroad by people who are not UK residents.... International law requires a tangible link to Scotland. Establishing a link becomes more
difficult if someone is temporarily here without any legal rights and then goes abroad, where something happens."  

101. The Scottish Refugee Council also expressed concern that a situation could potentially arise whereby a UK national or permanent UK resident could arrange for FGM to be carried out abroad on an asylum seeker child. However, it is the Committee’s understanding that if a UK national or permanent UK resident were to become involved in such activity, they would not be guilty of an offence under this Bill. The Deputy Minister confirmed that this was the case for the following reason:

“… the UK resident would be committing an act in relation to someone who had no tangible link to Scotland.”

102. The Committee notes, however, that the Deputy Minister suggests that there might be scope for considering how further protection might be offered to asylum seeker children. In evidence the Deputy Minister stated:

“There is a technical issue about the competence of the Parliament and the scope of the bill. Presumably, something could be done, but there could be ramifications in relation to international responsibilities and obligations, and we are unsure of the net result.”

and

“...We are consulting the Home Office on difficulties and the matter has not been concluded. We want to resolve some of the ambiguities and difficulties.”

103. The Committee seeks further clarification from the Minister as to what steps might be taken to extend the provisions of the Bill to provide further protection for asylum seeker children from FGM should they be removed from Scotland.

Penalties for Offences

104. Section 4 of the Bill increases the maximum penalty from 5 to 14 years imprisonment. This proposal was welcomed by the majority of those who gave evidence to the Committee. As Rosemary Burnett of Amnesty International Scotland notes in evidence:

“It is important to send out a signal that the practice is wrong. We need to be clear that the practice constitutes torture and that it will not be countenanced in Scotland. The Bill sends out that signal.”

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40 Equal Opportunities Committee, Official Report, 18 January 2005, col 843
41 Equal Opportunities Committee, Official Report, 18 January 2005, col 846
42 Equal Opportunities Committee, Official Report, 18 January 2005, col 842
43 Equal Opportunities Committee, Official Report, 1 February 2005, col 844
44 Equal Opportunities Committee, Official Report, 18 January 2005, col 780
105. The Committee welcomes the increase in the maximum custodial sentence for those found guilty of carrying out offences under the proposed legislation. It is of the view that this provides a clear indication of the seriousness with which the offences laid down in the legislation are viewed in Scotland. The Committee recommends that the relevant penalties should be given some prominence in information and guidance material circulated to the communities likely to be affected.

Prosecutions

106. The Executive notes in the Financial Memorandum which accompanies the Bill that:

“Given the lack of FGM investigations and prosecutions under the 1985 Act, few, if any, prosecutions are anticipated under this Bill …”

107. However, the Committee has heard evidence which suggests that this might not be the case. Efua Dorkenoo of FORWARD stated in evidence to the Committee:

“We must not … underestimate the possibility of prosecution. Right now, we have second-generation British girls asking us to pursue legislation because they want to take their parents to court. In France, about two years ago, a 22-year-old woman of Malian parentage not only identified the woman who mutilated her - the communities were bringing traditional practitioners into France to do it - but was able to get hold of about 22 other girls who had undergone genital mutilation. … We should not say that prosecution is not going to happen, because it is a process. At the moment, even though we do not want to alienate girls from their families, some girls feel very angry about what has happened to them and may move in the direction of prosecution.”

108. The Committee notes that prosecutions may be more likely as cultural changes take place due to the introduction and acceptance of legislation such as that proposed together with awareness-raising work in the target communities. However, the Committee is also aware of the need for support to be available for members of affected communities.

109. FORWARD noted, for example, in relation to work done in England:

“… we have found that older siblings have acted to protect their younger siblings. They know that there are places where they can call for help and where help will be given.”

110. The Committee asked the Deputy Minister whether sufficient support mechanisms were in place for those members of relevant communities who report cases of FGM and heard that:

“ … we have been improving the services that we give to those people who report crime … who are vulnerable witnesses.”

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45 Equal Opportunities Committee, Official Report, 14 December 2004, col 723
46 Equal Opportunities Committee, Official Report, 14 December 2004, col 721
111. The Committee is concerned that existing measures to protect vulnerable witnesses may not be wholly appropriate given that it is likely that those who report FGM would wish to remain within their communities. The Committee welcomes the Deputy Minister’s undertaking that:

“We will discuss with the Crown Office and Procurator Fiscal Service how some of the substantial training that it is carrying out on how vulnerable witnesses should be treated is applied to people who give evidence in cases that arise under the bill.”

112. *The Committee recommends that the Executive take forward these discussions as soon as is practicable and would welcome a report on any subsequent efforts taken to ensure that measures are available which assist those reporting FGM to stay within their communities whilst providing them with adequate support and protection.*

**Guidance, Education and Training**

113. Much of the evidence provided to the Committee highlights the importance of supporting the legislation through the provision of guidance, education and training for professionals as well as awareness-raising and support for members of affected communities.

114. Dr Baumgarten of the World Health Organisation notes in evidence:

“In Europe, we have become aware through consultative meetings with technical experts in the health field that health care providers in many countries — whether doctors, midwives, nurses, paediatric nurses or others — still have insufficient knowledge. They do not know what to do if they are confronted with FGM — they are embarrassed and afraid to take action that might result in their being labelled as having a racist attitude and they might not know how to deal with problems.”

115. Comfort Momoh of the Royal College of Midwives echoes this concern when she states:

“From my experience of running conferences and seminar, I am sad to say that only about 70% of professionals in the UK are aware of FGM even if they are not aware of the law.”

116. More worryingly, in the Committee’s opinion, a health report notes:

“A study among professionals in health, education, social services and police in three major UK cities found nearly four-fifths felt ill-equipped to deal with cases.”

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47 Equal Opportunities Committee, Official Report, 1 February 2005, col 849
48 Equal Opportunities Committee, Official Report, 1 February 2005, col 850
49 Equal Opportunities Committee, Official Report, 18 January 2005, col 774
50 Equal Opportunities Committee, Official Report, 18 January 2005, col 792
51 Lawrence A, Assessing training needs of UK professionals on female genital mutilation (FGM). London: FORWARD 2001
117. Efua Dorkenoo of FORWARD pointed out in evidence:

"Professionals need to be given protocols and guidelines. ... Once a local authority has developed policies, professionals will require a lot of training to help them to work with the subject."\(^{53}\)

118. The Committee is concerned that, although FGM has been unlawful in the UK since 1985 under the provisions of the Prohibition of Female Circumcision Act 1985, the evidence the Committee has received shows that there is still a lack of understanding and expertise amongst the professionals who are likely to be confronted with FGM and its consequences. This is despite the fact, as has been made clear to the Committee in evidence from FORWARD, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, that guidance and information is currently available.

119. The Committee recognises that the issue of FGM cuts across the remits of a number of departments of the Executive and considers that effective implementation of the policy objectives of the proposed legislation can only be achieved through a co-ordinated and integrated, strategic approach.

120. Rosemary Burnett of Amnesty International Scotland stated in relation to the legislation:

"... it should be part of an integrated strategy to protect girls and women from harmful cultural practices. It will not work in isolation but will be part of an integrated approach by the Scottish Executive."\(^{54}\)

121. The Committee, therefore, welcomes the recognition on the part of the Deputy Minister that:

"Across the Executive — perhaps more so for my colleagues who deal with health and social work issues — there is a need to work together with a range of agencies to ensure that further guidance is integrated with existing relevant work on child protection, domestic abuse, sexual health and maternal health issues. ... as is integrated and co-operative work across departments of the Executive and agencies, which we need to ensure are working towards the same purpose."\(^{55}\)

122. The Committee notes the reference in the Executive's recently published sexual health strategy to the production of a form of guidance on FGM\(^{56}\) and looks forward to receiving notification from the Executive that the guidance referred to has been produced and implemented.

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\(^{52}\) R.A. Powell et al./Health policy 70 (2004) 151-162: Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda, page 156
\(^{53}\) Equal Opportunities Committee, Official Report, 14 December 2004, col 719
\(^{54}\) Equal Opportunities Committee, Official Report, 18 January 2005, col 784
\(^{55}\) Equal Opportunities Committee, Official Report, 1 February 2005, col 835
\(^{56}\) Scottish Executive, Respect and Responsibility; Strategy and Action Plan for Improving Sexual Health, Edinburgh 2005, page 20
123. The Committee, nevertheless, urges the Scottish Executive to carry out an immediate review of the guidance, education and training currently available for the full range of professionals who are likely to have to deal with instances of FGM and its consequences, assess its effectiveness and develop a plan to ensure the availability and effective implementation of suitable, updated and appropriate material.

124. The Committee heard in evidence and received examples of a range of guidance materials produced by organisations such as FORWARD, the Royal College of Midwives and the World Health Organisation. The Committee, therefore, further recommends that the Executive should take cognisance of such material which is already available.

125. The Committee seeks an assurance from the Executive that a process will be put in place to ensure that an integrated approach is taken across the Executive and invites a response from the Executive providing information on how this will be achieved.

126. Evidence has highlighted the need, in addition to introducing the legislation and providing guidance and training for relevant professionals, to work effectively with the target communities to raise their awareness about FGM, the legislation and the services which are available to them. Efua Dorkenoo of FORWARD, for example, notes in evidence:

"The other angle relates to providing support, resources and empowerment to communities to enable them to start to address the issue. … Work must be done with the professionals at the same time as the message is being sent out to the communities."\(^57\)

127. The Somali Women Action Group in Glasgow pointed out in evidence:

"We know that it is illegal, but our group does not understand what is legal or illegal. People do not understand if we say that it is illegal. They say that they do not want to change their culture. Our group needs more education."\(^58\)

128. Comfort Momoh of the Royal College of Midwives underlines one of the issues in relation to working with the target communities:

"The mistake that was made in respect of the Prohibition of Female Circumcision Act was that the communities were not aware of it because it had not been translated into different languages."\(^59\)

129. The Committee, therefore, welcomes the Deputy Minister's assurance that:

"It is incumbent on us to approach this matter with sensitivity and to consider education, awareness raising and confidence building in the communities."\(^60\)

\(^{57}\) Equal Opportunities Committee, Official Report, 14 December 2004, col 719
\(^{58}\) Equal Opportunities Committee, Official Report, 14 December 2004, col 732
\(^{59}\) Equal Opportunities Committee, Official Report, 18 January 2005, col 795
130. The Committee recognises that this will entail a range of different actions by various organisations and agencies as well as the effective deployment of suitable resources. **The Committee seeks clarification from the Executive regarding its plans to develop and support these activities in the relevant communities.**

131. The Committee considers that the effective provision of guidance, education and training to support the Bill is likely to involve costs which have not been identified in the Financial Memorandum. Dr Inge Baumgarten of the World Health Organisation, for example, noted in evidence to the Committee:

"It is unrealistic to assume that we will be able to do what needs to be done without any additional funding. For example, if we want to know more about the prevalence of the practice in Scotland, we will need to carry out research, which will require money. If we want to train people, we will need money. An integrated approach that brings together representatives from the various sectors will need time and resources to be allocated to it to ensure that people can attend meetings, for example. Producing materials will also require funding."^[61]

132. The Committee recognises the Deputy Minister's view that:

"I do not think that the bill is the place for us to resolve issues around providing support mechanisms, education and training and raising awareness in a range of communities."^[62]

133. However, as the Committee has heard, such measures must accompany the law to make it effective in the long run. This being the case, and as the Deputy Minister recognised in evidence such a need, **the Committee seeks clarification from the Executive as to the costs it expects the range of required initiatives to incur and how it expects them to be funded.**

**Research and Information**

134. It has become clear from the evidence the Committee has heard that there is insufficient reliable information about the prevalence of FGM. Although FGM has been unlawful in the UK since 1985 and the law in England, Wales and Northern Ireland was extended by means of the Female Genital Mutilation Act 2003, Efua Dorkenoo from FORWARD reports:

"… if you were to ask us about the prevalence of FGM in England, we do not have data; the evidence is all anecdotal. At the moment, we are designing a study of prevalence by examining a number of maternity hospitals and asking them what they are seeing. We will set those data as our baseline so that we can check in the next generation whether there has been a change. We need such data, but we also need to do attitudinal studies within communities. Such studies would inform the educational strategy, tell us

^[60] Equal Opportunities Committee, Official Report, 1 February 2005, col 835
where we should target information and tell us whether the critical issue is the religious angle or something else."63

135. In the absence of such baseline data, it will be difficult to monitor the impact of the Bill and any other initiatives put in place to support the Bill. The Committee recommends that the Executive take steps to develop methods of collecting such data, whether as part of a UK-wide process, or specifically targeted at the prevalence of FGM in Scotland.

Conclusion

136. Subject to the recommendations and comments contained within this report, the Committee welcomes the introduction of the Prohibition of Female Genital Mutilation (Scotland) Bill as a means of restating and strengthening the protection currently afforded under the Prohibition of Female Circumcision Act 1985.

137. The Committee therefore recommends that the general principles of the Bill be agreed to.

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63 Equal Opportunities Committee, Official Report, 14 December 2004, col 726
ANNEX A: EXTRACTS FROM THE MINUTES

EQUAL OPPORTUNITIES COMMITTEE

EXTRACT FROM MINUTES

17th Meeting, 2004 (Session 2)

Tuesday 16 November 2004

Present:

Shiona Baird
Marlyn Glen
Cathy Peattie (Convener)
Elaine Smith

Frances Curran
Mrs Nanette Milne
Nora Radcliffe
Ms Sandra White

Apologies: Marilyn Livingstone

Items in private: The Committee agreed to take items 4 and 5 in private.

Prohibition of Female Genital Mutilation (Scotland) Bill (in private): The Committee agreed its approach to consideration of the Bill at Stage 1.

EQUAL OPPORTUNITIES COMMITTEE

EXTRACT FROM MINUTES

18th Meeting, 2004 (Session 2)

Tuesday 30 November 2004

Present:

Shiona Baird
Shona Baird

Marlyn Glen
Mrs Nanette Milne
Nora Radcliffe
Elaine Smith

Cathy Peattie (Convener)

Hugh Dignon, Bill Team Leader, Scottish Executive Justice Department;
Susie Gledhill, Bill Team, Scottish Executive Justice Department;
Paul Johnston, Senior Principal Legal Officer, Office of the Solicitor to the Scottish Executive (OSSE); and
Valerie Montgomery, Principal Legal Officer, OSSE.

Apologies: Frances Curran, Marilyn Livingstone

Prohibition of Female Genital Mutilation (Scotland) Bill: The Committee heard evidence at Stage 1 from—

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Present:

Shiona Baird  Marlyn Glen
Marilyn Livingstone  Mrs Nanette Milne
Cathy Peattie (Convener)  Nora Radcliffe
Elaine Smith  Sandra White

Apologies: Frances Curran

Prohibition of Female Genital Mutilation (Scotland) Bill: The Committee heard evidence at Stage 1 from—

Panel 1
Fariha Thomas, AMINA – The Muslim Women’s Resource Centre
Efua Dorkenoo OBE, FORWARD (Foundation for Women’s Health, Research and Development)

Panel 2
Representatives from the Somali Women Action Group.

Prohibition of Female Genital Mutilation (Scotland) Bill – witness expenses: The Committee agreed to delegate authority to the Convener to authorise, under Rule 12.4.3, payment of witness expenses which arise during the Committee’s consideration of the Bill.

EQUAL OPPORTUNITIES COMMITTEE

EXTRACT FROM MINUTES

1st Meeting, 2005 (Session 2)

Tuesday 11 January 2005

Present:

Shiona Baird  Frances Curran
Marilyn Glen  Marilyn Livingstone
Mrs Nanette Milne  Cathy Peattie (Convener)
Nora Radcliffe  Elaine Smith

Apologies: Sandra White

Prohibition of Female Genital Mutilation (Scotland) Bill: The Committee heard evidence at Stage 1 from—

Councillor Irene Graham, Moira McKinnon and Jean Murphy, Glasgow City Council.

EQUAL OPPORTUNITIES COMMITTEE

EXTRACT FROM MINUTES

2nd Meeting, 2005 (Session 2)

Tuesday 18 January 2005

Present:
Shiona Baird  Marlyn Glen
Marilyn Livingstone  Mrs Nanette Milne
Cathy Peattie (Convener)  Ms Sandra White

Apologies: Frances Curran, Nora Radcliffe, Elaine Smith

Prohibition of Female Genital Mutilation (Scotland) Bill: The Committee heard evidence at Stage 1 from—

Panel 1
Rosemary Burnett, Amnesty International Scotland
Susan Elsley, Save the Children Scotland
Simon Hodgson, Scottish Refugee Council
Dr Inge Baumgarten, World Health Organisation (WHO)

Panel 2
Comfort Momoh, Royal College of Midwives
Dr Pamela Buck, Royal College of Obstetricians and Gynaecologists.

EQUAL OPPORTUNITIES COMMITTEE
EXTRACT FROM MINUTES
3rd Meeting, 2005 (Session 2)
Tuesday 1 February 2005

Present:
Shiona Baird  Frances Curran
Marlyn Glen  Marilyn Livingstone
Mrs Nanette Milne  Cathy Peattie (Convener)
Nora Radcliffe  Elaine Smith
Ms Sandra White

Items in private: The Committee agreed to take item 3 in private and to take items at future meetings on its draft report on the Prohibition of Female Genital Mutilation (Scotland) Bill at Stage 1 in private.

Prohibition of Female Genital Mutilation (Scotland) Bill: The Committee heard evidence at Stage 1 from—

Hugh Henry MSP, Deputy Minister for Justice.

Prohibition of Female Genital Mutilation (Scotland) Bill (in private): The Committee considered the evidence heard and agreed its approach to the Bill at Stage 1.

EQUAL OPPORTUNITIES COMMITTEE
EXTRACT FROM MINUTES
4th Meeting, 2005 (Session 2)
Tuesday 22 February 2005
Present:

Shiona Baird
Marilyn Livingstone
Nora Radcliffe
Ms Sandra White

Marilyn Glen
Cathy Peattie (Convener)
Elaine Smith

Apologies: Phil Gallie

**Prohibition of Female Genital Mutilation (Scotland) Bill (in private):** The Committee considered a Stage 1 report and agreed to finalise its terms by correspondence.
Scottish Parliament
Equal Opportunities Committee
Tuesday 30 November 2004

[THE CONVENER opened the meeting at 10:31]

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

The Convener (Cathy Peattie): Good morning and welcome to the 18th meeting in 2004 of the Equal Opportunities Committee. As we are meeting on St Andrew’s day, it only fitting that the committee recognises that St Andrew’s day is the day on which people officially campaign against racism in Scotland. We need to record that.

Our first and only agenda item is to take evidence on the Prohibition of Female Genital Mutilation (Scotland) Bill. I welcome our witnesses. Hugh Dignon and Susie Gledhill are from the bill team and Paul Johnston and Valerie Montgomery are from the office of the solicitor to the Scottish Executive. The committee will consider a number of issues. If we ask questions that the witnesses feel that it would be more appropriate for a minister to answer, they should feel free to indicate that. We will have the opportunity to question one of the justice ministers as part of the stage 1 process.

I will begin the questioning. Will you explain the reasons behind the change in the name of the offence from female circumcision, which formed part of the name of the relevant legislation—the Prohibition of Female Circumcision Act 1985—to female genital mutilation?

Susie Gledhill (Scottish Executive Justice Department): There were a number of reasons for that. First, circumcision falsely implies an analogy with male circumcision. Given that a significantly different degree of injury is involved, we did not want anyone to think that the two procedures were in any way similar. The word “mutilation” more accurately describes the degree of harm that is involved. FGM is the term that is most commonly used for such procedures throughout the United Kingdom and its use was recommended at the Westminster all-party parliamentary group hearings in 2000.

Elaine Smith (Coatbridge and Chryston) (Lab): Has the consultation revealed any problems with the terminology? Is there any sensitivity to the proposed change in the terminology?

Susie Gledhill: From my recollection of the consultation, no one was unhappy about the use of the term “FGM”.

The Convener: Although the explanatory notes to the bill make it clear what practices the bill is targeting, the use of the phrase “or otherwise mutilates” in section 1 leaves some scope for interpretation. That could include practices such as piercing and elective surgical procedures. Will it be left to the courts to decide what constitutes mutilation?

Susie Gledhill: Yes, it will be for the courts to decide what constitutes mutilation. That will depend on the individual circumstances of the case, but the definition in the bill, which sets out what is illegal, will be taken into account.

Valerie Montgomery (Scottish Executive Legal and Parliamentary Services): The prosecutor would have to take into account the circumstances in which the act was carried out before the matter even got to court, so they would have to have a reasonable belief that the act fell within the offence of mutilation as defined in section 1 of the bill before they would consider a prosecution. Ultimately, it would be for the court to decide what constituted mutilation.

The Convener: Is there a danger that the increasing prevalence of elective cosmetic procedures could lead to prosecutions, or do you believe that decisions on such matters would be taken before they got anywhere near a court?

Valerie Montgomery: That would depend on the circumstances of the cosmetic procedures that had been carried out and on who had carried them out but, ultimately, those issues would be taken into account before a prosecution was brought—if, indeed, the matter was ever referred to the prosecutor.

Elaine Smith: The bill is obviously about providing legal protection and strengthening the existing protection but, in my view, part of it is about raising awareness that FGM is an unacceptable practice that constitutes violence against women and children. The policy memorandum states:

“The Scottish Executive is committed to doing what it can to ensure that this cruel and unnecessary practice is eradicated.”

Given that there have been no prosecutions in Scotland or the UK under the existing legislation, I suspect that we are not expecting a large number of prosecutions to be brought once the bill is passed. Is the Executive planning activities that are additional to the bill that would assist with the eradication of FGM once the bill is enacted, such as the provision of guidance to local authorities
and health professionals on services that they can offer to victims of FGM?

Susie Gledhill: Many different areas are involved, such as health, teaching and social work. The Executive is using the bill as an opportunity to raise awareness among our colleagues and to explain to them what needs to be done.

In addition, a lot of work is being done outside the Executive. On Friday, I visited the Somali women's action group, which is working with the Glasgow violence against women partnership, and it was mentioned that you had been to speak to its members. They did a play to raise awareness of FGM, which they wanted to put on for doctors and other people who work with them. A lot of awareness-raising work is going on out with the Executive.

Elaine Smith: If health service professionals do not understand the nature of FGM, problems can arise, especially if a woman is pregnant. I heard about some of those problems when I spoke to the Somali women's action group. Awareness raising is important. Without other initiatives, would the bill on its own be able to eradicate FGM?

Hugh Dignon (Scottish Executive Justice Department): No. The bill by itself is not expected to do that; its purpose is to strengthen the legal framework surrounding FGM. I do not think that the Executive is under any illusion that the bill by itself will eradicate FGM, but it will strengthen the legal framework by increasing the penalties and by addressing the issue of extraterritorial jurisdiction, which we will no doubt come on to discuss. That will deal with situations in which it is suspected that girls are being taken abroad to evade the law. That is what the bill is about. As Susie Gledhill has said, it also represents an opportunity for us to raise awareness of the dangers of FGM throughout the medical and education communities.

Elaine Smith: The bill is sending a strong message, but given that we are not expecting many prosecutions to be brought, the whole idea of it is to help to raise awareness of the unacceptability of the practice and, we hope, to eradicate it through such action. In that context, how do you envisage the bill being publicised among the communities in Scotland to which it might be most relevant? Are you considering publicisation in particular languages and formats, which is a suggestion that was made when I met the Somali women's action group? The people who deliver training could also be helpful in that regard. From what I heard, it would be better to do such work within communities so that you are not seen to be dictating to them about FGM.

Susie Gledhill: We do not yet have a fixed plan in place for how we will publicise the bill. Our plan is very much to take the lead from the community and to listen to what it thinks will be most effective. It would be pointless for us to say that we will run television advertisements if it would be much better to work with the targeted community.

Elaine Smith: I do not know whether this is an appropriate question, but do you think that resources will be available for doing that?

Hugh Dignon: I cannot speak about resources that will be available through the Health Department or the Education Department. The proposals are part of the sexual health strategy and it would be reasonable to conclude from that that resources will be available to raise awareness and deal with issues as they arise. However, we are from the Justice Department and our focus is on justice issues. I would not feel comfortable saying what resources might be available in other parts of the Executive.

The Convener: We will want to ask the minister that question.

Nora Radcliffe (Gordon) (LD): Are copies of the bill available in a language that is accessible to the community that is affected?

Susie Gledhill: No. However, I want to pursue the point. We are talking about primary legislation and the letter of the law, if you like, and it is not only women who might want to access the bill—the whole community might want to do so. The proposals might carry more weight with community leaders if they thought that they were getting the substantive bill in a language that they understand.

Hugh Dignon: A minister will ultimately decide what will and will not be done, but my guess is that we would probably look favourably on any request to provide the bill in any community language that would help people. We would not want to think that the bill is targeted at one particular community and that we should therefore issue it only in a particular language, but we would certainly be receptive to any requests that came to us.

The Convener: The bill also has guidance notes and so on for explanation.

Hugh Dignon: I mean all the accompanying documents as well as the bill.

Mrs Nanette Milne (North East Scotland) (Con): We have been talking about communities. The policy memorandum states:
“There is no evidence that this practice is widespread within communities in Scotland”.

However, it also recognises the often private nature of the practice. Has any work been done, or is any work being done, to establish the current or expected scale of the problem in Scotland?

Susie Gledhill: No research is currently being done to try to establish that. The only group that came to our knowledge through the consultation was the Somali group, which is almost all in Glasgow.

Mrs Milne: I wondered about that. I know that everyone speaks about the Somali group, but have you heard of any other communities or groups in Scotland that might be affected by the practice?

Susie Gledhill: No. We have not heard of anyone and no one in the consultation said that they thought that another group was affected.

Mrs Milne: Given that there was no separate Scottish legislation previously, are there differences between the Scottish bill and the UK Female Genital Mutilation Act 2003? If not, why was having a separate Scottish bill considered necessary?

Hugh Dignon: The issue is within the devolved competence of the Scottish Parliament, so the default position is that the Scottish Parliament will legislate. Whether the issue would be suitable for a Sewel motion was considered, but I think that there were issues to do with the timing of the Scottish parliamentary elections. I think that the UK bill was going through some time in spring 2003, so the processes would not have worked well in that context. It was therefore decided to have Scottish legislation.

The only substantive policy difference between our bill and the UK act is that our bill applies in a gender-neutral way—you will have noticed that the language used is gender neutral—whereas the UK act applies specifically to women only. The bill and the act are different in various details, but the policy intention is the same. The differences in detail reflect the different construction of the bill by Scottish parliamentary draftsmen to make it fit in better with Scots law.

10:45

Mrs Milne: Is there a reason for making the bill gender neutral, given that female genital mutilation is the really concerning issue?

Hugh Dignon: As you know, it is the policy preference of the Parliament that legislation be drafted in gender-neutral language. We thought long and hard about how that would apply in this case. It is conceivable that there are circumstances—albeit rare—in which a person might have the relevant genitalia but not be a legal female. The bill will provide protection for those persons in the same way as it will provide protection for legal females.

Susie Gledhill: The Equality Network in its consultation response welcomed the fact that the bill was drafted in gender-neutral terms to cover people in those admittedly rare circumstances.

Mrs Milne: There is obviously an increasing prevalence of elective cosmetic surgical procedures, which might not be recognised as constituting FGM. Is it likely that those could lead to prosecutions, beyond what is intended in the bill?

Susie Gledhill: Section 1 of the bill sets out the specific procedures that are unlawful. If a procedure were carried out that met that definition and was not required for medical reasons it would constitute an offence. As Valerie Montgomery said earlier, it would be for the prosecutor to decide whether to prosecute on the basis of the facts of the case.

Mrs Milne: So the bill sets out specifically what would be an offence.

Elaine Smith: I just want to ask a quick supplementary on the previous point. Some of the research that we have seen reports that FGM is practised in 28 African countries. I do not imagine that it is practised only among the Somali community. The bill might help to bring that out as we proceed through stage 1. Obviously, the issue is a private and sensitive one for people to talk about.

Can we differ in Scotland? We are not legislating through a Sewel motion for the various reasons that Hugh Dignon outlined. Given that we are considering legislation for Scotland, I presume that if we wish to make it slightly different from the UK legislation, we can do so.

Hugh Dignon: Absolutely, as long as any changes that are made are within the Parliament’s competence. There is no reason for the bill to follow the UK model. However, it is always helpful to have a consistent regime north and south of the border on such issues so there is not a differential whereby people moving north or south can do different things or find that different things are criminal. Nevertheless, that is not a determining reason why one should not make changes, if they are thought necessary, to make the legislation different in some way, as long as it is within the competence of the Parliament to make such changes.

Elaine Smith: I want to pursue the competence issue, about which I know questions were asked previously, because that does not cover asylum seekers. Although we have separate Scots law
and we are a separate legislature, I understand that we cannot change the law if it impacts on a reserved issue. Is it technically possible for us to consider covering people who are in this country seeking asylum, who could be here for a number of years while that process is on-going? I am not saying that we would want to do that but, if we did, would it be competent?

Hugh Dignon: My legal colleagues will correct me if I get any of the details wrong. Essentially, the main issue for the bill is the need for a link to Scotland. In other words, we need to ensure that the bill does not attempt to change the law on matters where there is no such link, which means that the main consideration is the need for a degree of residence in or connection to the country. If that condition is met, I see no reason why asylum seekers, for example, should not be included in the bill’s provisions. I should point out that section 29(2) of the Scotland Act 1998 states that the law must be changed with respect to functions that are “exercisable … in or as regards Scotland”.

Paul Johnston (Scottish Executive Legal and Parliamentary Services): I agree with everything that has been said. However, on the question of reserved and devolved matters, we would need to be clear that any change would alter devolved criminal law, not asylum and immigration law. Moreover, under international law, there needs to be a tangible link between the person over whom jurisdiction is being exercised and the state that is seeking to exercise that jurisdiction. The question that members should examine at this stage and at stage 2 is whether any changes would maintain that tangible link between the person and Scotland.

Elaine Smith: Before we move on with our stage 1 consideration, we should perhaps receive a briefing note or some clarification on the issue. After all, we might not want to do what has been suggested, but we should still find out whether it can be done.

The Convener: It would be helpful if we could get a briefing note on the implications of such a decision.

Susie Gledhill: I want to make it absolutely clear that while asylum seekers are in Scotland—or, for that matter, the rest of the UK—they are covered by the terms of the bill. Some of the consultation responses confused the bill’s overall powers with extraterritorial powers. Asylum seekers will not be covered by the bill if they leave the UK. However, we expect that they will be in the UK most of the time because, if they leave, their asylum appeals will be thrown out.

Elaine Smith: I am sorry to push the matter, but I feel that I need to. We are talking generally about girls between five and seven years old. What would happen if, for example, their grandparents, other relatives or friends took them abroad while their parents stayed to seek asylum in the country? Would the bill make such an action illegal?

Susie Gledhill: I do not know the immigration laws in detail and would have to check whether children between five and seven must have asylum claims in their own right or whether they can form part of a family claim.

The Convener: We would welcome some clarity on that matter.

Marlyn Glen (North East Scotland) (Lab): The bill will increase the penalty on indictment from five to 14 years’ imprisonment. On what basis was that increase decided? For example, was the offence assessed in relation to comparable offences?

Hugh Dignon: As I said earlier, one of the bill’s purposes was to seek to restate the law and to strengthen the legal framework and, by increasing the penalty to 14 years, we were signalling that the offence was regarded as being particularly serious. We chose that sentence primarily to ensure consistency with UK legislation, which had already set the penalty at 14 years. We are also perfectly happy that it is consistent with penalties for other offences under Scots law.

Marlyn Glen: Is it possible that the proposed penalties will prevent women from coming forward for fear of the risk to members of their families?

Hugh Dignon: I accept that there is always a risk that that sort of thing might take place, but we need to strike a balance. We see the balance being struck in favour of sending out the message that FGM is a serious offence and will be dealt with appropriately. There is clearly a risk, however, that some people might be deterred. We hope that that will be addressed through the support and education programmes that Susie Gledhill referred to.

The Convener: The courts sentence retrospectively. If a young woman came forward at the age of 25 and her parents were responsible for the act being carried out, would the courts consider prosecuting? Are we talking about acts now or acts that happened in the past?

Valerie Montgomery: The bill will apply only to acts committed after the bill is passed, but anyone who has committed an act that is an offence under the previous legislation could still be prosecuted under that legislation, even though that legislation is repealed in the bill. That is due to provisions in the interpretation order that applies to the interpretation of all acts of the Scottish Parliament.

Nora Radcliffe: The committee would appreciate some clarification of who the bill aims
specifically to protect and of what evidence there is, if any, that those people will be protected.

Susie Gledhill: The bill aims to protect all women who are at risk of being mutilated. As we have made clear, we do not have specific figures on prevalence. The practice is very private, so it would not be possible to get that kind of data.

Nora Radcliffe: So it will be difficult to measure the effectiveness of the bill.

The bill provides for an exception to the offence in the case of
“a surgical operation ... which is necessary for that other person's physical or mental health”,
but it does not really define what that means. Is there a reason why the bill is not more specific about what is meant by that exception?

Hugh Dignon: On whether it would be sensible to be more specific about exceptions, it was decided that there might be a number of circumstances that could not be foreseen and we had no wish to attempt at this stage to prejudge the sort of issues that might arise. The preferred approach was to set down what the offence was and what the medical exceptions were and to allow a court to decide, if necessary, whether any procedures that had been carried out fell within those exceptions. I guess that a number of possible circumstances could arise, sometimes at relatively short notice, when decisions need to be taken by medical practitioners. We would not want to have people attempting to decide whether or not those procedures fell within some precise definition; we would leave that to medical judgment at the time.

Nora Radcliffe: Do you see any merit in some sort of caveat, such as there having to be two medical opinions, or is it safer just to leave the matter open and leave it to the courts to create precedents if any are needed?

Hugh Dignon: We considered that as a potential way forward, but we are happy with the structure of the provision at present. It allows for a medical practitioner to take a decision on the basis of the facts as he or she sees them at the time. It is conceivable, as I said, that a medical practitioner may need to make a decision quickly on whether a procedure should be carried out. In the unlikely event of that leading to a prosecution, it would be for the court to decide whether the medical practitioner had acted appropriately. We are perfectly content with that construction.

Paul Johnston: The term “physical or mental health” is used elsewhere in the statute book and the courts are well versed in considering it.

Nora Radcliffe: That is useful clarification.

11:00

Shiona Baird (North East Scotland) (Green):
One of the key changes that the bill proposes is the extraterritorial provision. Given that there have been no prosecutions under the existing legislation and that normally children are sent abroad for the procedure, is it likely that there will be more prosecutions once the bill is enacted?

Hugh Dignon: I would not like to speculate on whether there will be more prosecutions. I imagine that it is unlikely that there will ever be a large number of prosecutions. It is possible that under the bill there will be more prosecutions than there have been in the past. The intention in introducing the bill is not to seek to prosecute large numbers of people, but to send a clear message and to make it clear that Scots law applies when a child is taken abroad, as well as to procedures that are carried out in this country.

Shiona Baird: Can you clarify exactly how the extraterritorial provision will work in practice?

Susie Gledhill: If we want to get a witness or evidence from abroad, we can apply to other countries for mutual legal assistance—we can get more detailed information in writing from the Crown Office, if members wish. We can ask another country to issue a warrant to get evidence or a witness. Witnesses are able to give evidence from other countries through closed-circuit television links and so on. We are able to gather evidence from abroad for use in Scottish courts.

Shiona Baird: Would there have to be a legal link? I have forgotten the correct phrase.

Nora Radcliffe: Do you mean reciprocal arrangements?

Shiona Baird: Yes, but there is another phrase for it.

Hugh Dignon: Do you mean dual criminality?

Shiona Baird: It is something simpler than that. It will come to me as soon as I walk out the door. Would the procedure be based on some sort of reciprocal arrangement with the other countries involved?

Susie Gledhill: There are specific arrangements with some countries. I can check with the Crown Office and come back to the committee on this point, but I understand that Scotland may ask any country whether it is willing to help to gather evidence for us. It is for the Government concerned to decide whether to accept our request.

Shiona Baird: Elaine Smith has raised some of the issues that I wanted to discuss. Reference is made to the consultation with the Scottish Refugee Council. From what you have said, it is clear that there is some concern about the
implications of the strict definition of who will be held to account—the term "United Kingdom national". The Scottish Refugee Council stated:

“This means that children seeking asylum in Scotland will not be covered or protected by this legislation, unless, or until they are given leave to remain.”

What is your reaction to that comment?

The Somali women's action group expressed similar concerns. It said:

“We cannot believe that what you deem a criminal offence against a 'UK national or a permanent UK resident' is not a criminal offence if committed against asylum seeker women and children. We are distraught. Some Somali girls will have been granted refugee status owing to their well founded fear of FGM. Why will the Scottish Parliament not protect us?”

How can you address those concerns?

Susie Gledhill: That comes back to the extraterritorial issues that we discussed earlier. It is clear that, while people are in Scotland, they are covered. However, an issue arises if people leave the UK to have FGM performed in another country. Those who do not have indefinite leave to remain do not have the same strong link back to the UK as people who have been given indefinite leave to remain, such as refugees. That is the justification for the way in which the line has been drawn. We must perform a careful balancing act between trying to protect as many people as we can and staying within the bounds of international law. Paul Johnston spoke earlier of the need for people to have a direct connection to Scotland.

Shiona Baird: We will need to investigate that issue further.

The Convener: You may want to ask the minister about it when you have the opportunity to do so. Does Elaine Smith want to pursue the issue?

Elaine Smith: Shiona Baird says that there are not many prosecutions. I have heard that people are not practising FGM in Scotland because of the fear of prosecution, although the General Medical Council has found a few doctors guilty of it in the past. I would not subscribe to this view, but I imagine that, rather than sending their children abroad, where dirty knives or bits of glass are used, people may seek out medically qualified people thinking that they are doing the right thing for their children—whatever we think, that is the tradition. Although the evidence suggests that the practice is not being carried out in Scotland at the moment, I presume that parents might be sending girls abroad for that purpose and perhaps the bill can help to stop that.

Can the Executive, as part of the awareness-raising process, ask the immigration authorities to consider the possibility of recognising FGM as a good reason for granting asylum? There has been press coverage of the fact that women who have been refused asylum have been anxious about returning to their country because that would mean putting their daughters in danger of FGM. Can the Executive also point out somewhere—perhaps in guidance—that, although women will be reluctant to volunteer such information, they will provide it if they are asked the question directly? Is there any scope for the Executive to take that kind of action in raising awareness of the bill?

Susie Gledhill: I will ask Hugh Dignon to talk about whether we can feed into the immigration process, which is a reserved matter. My understanding is that FGM is a reason for which refugee status can be claimed in specific circumstances, but I will have to check that.

Elaine Smith: The problem is that women would have to volunteer the information. Are they asked for it? That makes a big difference. Perhaps the Executive can pursue that question.

The Convener: Do you want to comment, Hugh?

Hugh Dignon: I do not have a lot to add. As Susie Gledhill says, immigration policy is reserved under the Scotland Act 1998. However, there is no reason why we would not be able to suggest to the Home Office that it might be helpful if immigration officials were to ask that question. They would be under no obligation to take that on board, but it might be a helpful suggestion. I see no reason why we should not do that.

Marlyn Glen: I presume that, in the absence of any provision for consent, it will remain an offence to carry out certain elective cosmetic surgical procedures that, as was discussed earlier, are becoming more common. Would it not have been possible to include a provision for consents in the bill, which would have ensured protection for those who needed the protection while allowing adults the freedom to undergo procedures that they wished to undergo for cosmetic reasons?

Susie Gledhill: Again, we considered that and it is mentioned in the policy memorandum. There were several reasons why we decided to go down the route that we did. First, allowing adults to consent would undermine the strong message that we are trying to send out that FGM is extremely harmful and unjustifiable—it could undermine the bill's deterrent effect.

Secondly, the purpose of the bill is to strengthen the protection that is already offered against FGM. If we introduced a consent provision, it would weaken that protection, as FGM would no longer be illegal in some circumstances in which it was illegal before.

Thirdly, concerns have been expressed by some of the pressure groups and non-governmental
organisations that work on FGM, which feel that in some cases meaningful consent to FGM is impossible. They say that, because women are financially bound into their communities and emotionally tied into them, it would be difficult to establish meaningful consent.

We are not alone in taking that route. Of the countries that have banned FGM, only Tanzania, Canada and America have consent clauses. All the other countries say that the practice is illegal regardless of age and consent.

Marilyn Glen: Thank you. That is helpful.

Nora Radcliffe: I have some questions about the consultation process. The Scottish Executive good practice guidance says that consultations should take at least 12 weeks. However, the policy memorandum indicates that the consultation period for the draft bill was 20 July to 31 August. Was there a reason for that? Was there also a reason why the consultation was carried out during a holiday period?

Hugh Dignon: I do not think that there was any reason for making the consultation period particularly short. The bill was proposed because we were anxious to offer the protection that had been offered to girls and women in other parts of the UK as soon as possible.

There was also a feeling that the issue is of fairly limited range and interest. In other words, a limited number and range of people would be interested in the legislation and it would be reasonably easy for the Executive to focus and make sure that those people were addressed and consulted over a relatively short period of time. We therefore felt reasonably comfortable with a relatively short consultation period, especially given the perceived need to get a move on and to get the legislation on to the statute book as soon as possible.

Nora Radcliffe: How many consultation papers were issued? What targeting was carried out? I want to know a wee bit more about the process and how it was undertaken.

Susie Gledhill: I do not have the number with me at the moment. The consultation papers were sent to the national health service boards, local authorities, ethnic minority groups, women's groups and domestic abuse groups.

Hugh Dignon: We thought that the groups that Susie Gledhill mentioned would have a targeted interest in the subject, which is fairly specialised. In addition, we went to the usual people whom we consult on justice issues, such as the police, prosecutors and the Law Society of Scotland. As Susie Gledhill mentioned, the people who will come up against the issue are representatives of ethnic minorities, the various women’s groups and health professionals. Those are the people whom we were able to target during the consultation.

Nora Radcliffe: Was the consultation in English alone or was a range of languages used?

Susie Gledhill: The consultation was in English. I cannot remember whether translations were offered.

Hugh Dignon: I would have to check on the details of that. Certainly we were not under the impression that there was a call for translations from anyone. I am sure that we would be perfectly happy to provide information in any community language on the Executive’s position in relation to the bill and its accompanying documents.

Nora Radcliffe: The policy memorandum notes that most respondents welcomed the bill and that no changes were made as a result of the consultation. Were any changes suggested by respondents?

Susie Gledhill: There were no changes. Virtually everyone strongly welcomed the principles of the bill. The committee clerks have a short report on the consultation, although we are waiting for the final confidentiality statements to come in before that report can be made public. Three themes ran through the responses, which were comments rather than calls for changes. They were, first, to consider the exemptions on physical and mental health, which we have discussed; secondly, to consider the extraterritorial powers, particularly in relation to protection for asylum seekers; and, thirdly, to clarify whether piercing and so on would be unlawful. Those were the main issues that were raised.

Nora Radcliffe: That will all come out in the full report.

Susie Gledhill: Yes. The Scottish Parliament information centre researcher and your clerks have draft copies of it. Once we get clearance for the quotations in it, it will be on the website.

Nora Radcliffe: It will all be in the public domain. That is fine.

Elaine Smith: Susie Gledhill said that, if prosecutions take place, it will be possible to link up with other countries and perhaps take evidence by video link. Did you consult countries where FGM is prevalent and where girls are likely to be sent? If you did not, would it have been useful to consult them via embassies?

11:15

Susie Gledhill: We did not specifically target any other countries. We targeted minority groups that were already in Scotland to see what issues they had come up with.
Elaine Smith: Might it be helpful for the committee to take evidence on the bill from countries where girls might be sent, which will become illegal under the bill?

Hugh Dignon: Any evidence is useful in considering how the bill might best be taken forward, but we would not rely on the attitude of or approach taken in other countries in exercising the extraterritorial jurisdiction. Prosecutions under the extraterritorial jurisdiction could take place in Scotland where the person who committed the offence returned to Scotland and where the evidence was also to be found in Scotland. The fact that the offence had taken place abroad would not necessarily mean that we would seek much co-operation from other countries.

Clearly, the judicial co-operation and extradition routes that Susie Gledhill talked about are well established; they are followed for a variety of offences and we would be happy to use them in relation to the bill. However, they are not strictly necessary. I think that in the unlikely event that the issue comes up, we may be able to prosecute under extraterritorial jurisdiction without recourse to anything like extradition or mutual legal assistance arrangements.

Elaine Smith: I am speaking more about awareness than legality. If we find out more from people who are based in countries where FGM is common practice and not illegal and where the girls are sent, that might help in determining how to pitch any guidance or awareness campaigns. This has to be the stage at which that is done, whether by the Executive through consultation or by this committee at stage 1. The evidence that can be drawn out now can inform you on the guidance at a later date.

Susie Gledhill: As was said, any evidence is going to be useful. I have received the general impression that there can be changes in attitudes when immigrants are faced with a new set of cultural pressures. If you want to gather evidence from elsewhere, you might want to consider places with large immigrant populations that have faced the problems for longer than Scotland has, such as London or some of the Scandinavian countries.

Elaine Smith: I am sorry to go on, but I am saying that we know the reasons for FGM—the main one is that the girl is not marriageable if it is not done. That is a huge cultural and traditional issue and you can imagine that trying to overcome it is difficult. However, in countries where FGM is performed on practically 100 per cent of women, we may find that there are other issues that would inform the drawing up of guidance and the determination of what training to give. We can sit here in Scotland and say, “Okay, the reasons for doing this are cultural and traditional. The issue is about whether someone is marriageable or not.” However, we might not be able to see the other issues that are involved.

Hugh Dignon: We need to be clear that the bill is saying that, in the eyes of the law, traditional and cultural reasons are not sufficient for FGM to be carried out. The Executive does not see its primary role as researching the reasons why the procedure might be carried out in other countries. The primary concern of the Justice Department is to ensure that the legal framework in Scotland is sufficiently strong for us to be able to send out the clear message that I gave in the earlier part of my answer.

Colleagues in other parts of the Executive might feel the need to have more information on the cultural and background issues, because the information might help them in putting together guidance and training material for professionals. If that is the case, I guess that they would be prepared to consider doing that work.

The Convener: A fair amount of work has been done in London on the subject. We may well want to look at that and draw from the experiences on all sides. The SPICe briefing has highlighted some of the written evidence from other countries and we might want to look at that as well.

Elaine Smith: I am a wee bit disturbed about the last point that Hugh Dignon made. Surely the intention behind the bill is to provide protection. I know that huge numbers of prosecutions are not expected—there have been none under the 1985 act—and the practice is illegal in this country. However, I thought that a major part of the bill was awareness raising, training, education and that kind of thing. If the Executive is going to inform that process, it will surely have to look a bit further afield than Scotland.

Shiona Baird: Following on from that point, one of the things that came out of the consultation document was the fact that people who live in African countries are putting pressure on people who live in Scotland to have FGM carried out on their children. If we want to eliminate the practice, we need to look at what is happening in those countries.

My final question concerned costing, but we have addressed that already. Although charges that the bill will incur extra costs are being dismissed, the significant fact is that—ultimately and hopefully—it will prevent FGM. We need to ensure that sufficient funds are made available to raise awareness and fund the social work departments that will work in this area. That brings me full circle to the issue that Elaine Smith raised about the amount of work that is being done globally to raise awareness of and eradicate the practice, which in turn brings me to the World Health Organisation’s listing of the different types...
of FGM. As far as I can see, type IV FGM is not included in the bill. Why have we included some, but not all elements of the practice? If we deem the practice to be bad because it damages young women, why are we not including all the WHO definitions?

Susie Gledhill: As we heard earlier, there has been no change in the definition from that which is given in the 1985 act. We understand that the prevalence of type IV FGM is marginal in Scotland—indeed, we know of no community in Scotland that practises type IV. The main community we know about is the Somali community, which practises type III infibulation.

We have taken note of evidence that was given at the time that the English and Welsh bill went through. The Royal College of Gynaecologists and Obstetricians was asked about type IV FGM because it has a wide definition that catches many different kinds of procedures, from inserting corrosive substances into the vagina to cuts and so on. The Royal College said that it would be complicated and difficult to come up with a legal definition that encompassed all type IV procedures and yet did not infringe on other medical procedures.

Shiona Baird: Perhaps that is another matter that we need to examine further. Type IV FGM can cause as much suffering as any other type and I do not understand why we cannot use different wording. The approach seems negative.

Valerie Montgomery: I do not think that type IV procedures would not be covered in any circumstances. The offence in section 1 relates to excising, infibulating or otherwise mutilating. The phrase “otherwise mutilates” represents a broader category than excision or infibulation. Mutilation suggests an element of violence. In some circumstances, the bill may cover a type IV procedure. It is hard to give examples of what would and would not be covered, because that depends on the individual circumstances and severity of the case.

Shiona Baird: The meaning of mutilation depends on interpretation, but it implies incision. The introduction of a corrosive substance can have a devastating effect without being mutilating.

The Convener: I take that still to be mutilation, but that is my assumption.

Shiona Baird: That is okay.

Susie Gledhill: The dictionary definition of “mutilate” includes to maim and to damage or spoil beyond recognition. That would probably cover the practice that Shiona Baird described.

Shiona Baird: That is fair enough.

The Convener: That is my understanding.

Elaine Smith: I want the position to be clear, because we are dealing with what will be legislation. I have sympathy with what Shiona Baird says, but I approach the matter from a different angle. Type IV procedures include cutting the vagina. Could that be mixed up with procedures that occur during labour, when cutting and stitching may take place? In some cases, if that went wrong, some mutilation might occur, but women might have to have incisions and stitching during labour.

Susie Gledhill: Section 1(2)(b) contains a clear exception for that.

Elaine Smith: So it is clear that such a procedure would be acceptable.

Susie Gledhill: The exception relates to “a surgical operation on another person who is in any stage of labour or has just given birth, for purposes connected with the labour or birth.”

Elaine Smith: Does that create a loophole for any kind of FGM?

Susie Gledhill: No. The type of FGM that is commonly associated with birth is the request for reinfibulation afterwards. The British Medical Association guidance tells doctors clearly not to infibulate a woman beyond what enables her to have sexual intercourse or beyond what is normal and natural. If a woman was infibulated before, doctors are not allowed to sew her back up as before, but only to what would be natural or would allow her to have sexual intercourse.

Elaine Smith: Do we have clear guidance about what is normal in those circumstances?

Susie Gledhill: That is in the British Medical Association guidance. I am not a doctor. The guidance sets out clearly what doctors are allowed to do.

Elaine Smith: You are happy that the bill is clear.

The Convener: We will take evidence from practitioners later, so we may be able to pursue those questions.

Shiona Baird: I do not how relevant the French situation is. The SPICe briefing says that to counter the practice in France

“a legal duty was placed on doctors to report any incidences of child abuse to the police or a prosecutor. Further, ‘Doctors are not subjected to the professional code of secrecy when it comes to child abuse. Doctors now speak more openly to the families. Because of the trials, the taboo has been lifted.’”

I do not understand all the codes that doctors are bound by but, when I read that, I thought that it seemed to imply that we have a different code in
Britain and that doctors are subject to a stronger code of secrecy that would mean that they would not comment if they felt that a child was being abused. Can anyone clarify what seems to be a major inconsistency?

11:30

Susie Gledhill: I cannot compare the situation with the French situation in great detail because I do not know enough about the specifics of the French situation, other than what is written in the SPICe briefing. Our understanding is that FGM would be treated as a form of child abuse and that the cases would be dealt with under the same child protection procedures that are in place for any form of child abuse.

There is an issue of patient confidentiality but the child protection guidance to health professionals states that, if doctors feel that a child is at risk, they have to have a discussion with the family about legal and health issues and can override the parents’ right to control information about a child in order to protect the child from serious harm. Further, the BMA guidance sets out various issues that doctors need to consider. However, we would have to check with colleagues in the Education Department who deal specifically with child protection to answer your question fully.

The “It’s everyone’s job to make sure I’m alright” report goes for a multi-agency approach and encourages doctors to share information. I would have to check whether they have a specific duty in that regard, but I suspect that, if they think that the child is at risk of serious harm, there are steps that they have to take.

The Convener: It is my understanding that everyone who is involved in child protection should speak out if they think that a child has been abused in any sense.

Elaine Smith: The issue that we are discussing relates to empowering women, changing traditions and educating men to understand that FGM represents unacceptable control of women’s bodies. I hope that we can eradicate the practice. Obviously, the bill will not be retrospective, but I am worried that, if the legislation comes into force next year, it might be that, in 10 years’ time, a woman who had been a victim of FGM after the act had come into force might be scared to seek medical assistance if, for example, she were pregnant. Would pressure be put on that woman under the guidance that Shiona Baird was just talking about to tell doctors where and when this was done in an attempt to discover, for example, whether the mutilation had been carried out in this country or abroad? That might have an impact on women’s health in the future.

Susie Gledhill: Again, we would have to check the medical guidance, but my understanding is that, particularly with adults, the patient-doctor relationship is confidential. I do not think that doctors would be able to break that confidentiality, but I would have to check. The requirement for confidentiality is clear, precisely because of the issues that you are talking about, which can arise not only in relation to FGM but also in relation to, for example, rape and domestic abuse. It is felt to be important to ensure that women can get the medical help that they need without being scared of the consequences if they do not want to press charges.

Nora Radcliffe: Another legal issue occurs to me. If a doctor treats a woman who has undergone FGM and is aware that the woman has children, what do they do about raising concerns if they worry that the children might also be subjected to FGM?

Susie Gledhill: Again, that would come down to the child protection procedures and would depend on the facts of the individual case. If, when talking to the doctor, the woman said what a terrible time she had had because of FGM and that she would never want to put her daughters through that, the doctor would come to the conclusion that those children were not at risk. If a different sort of conversation were had, the doctor might come to the conclusion that the female children were at risk and would follow the normal child protection procedures, alerting social services or whoever was most appropriate.

The Convener: I thank our witnesses. Your information has been helpful. I know that this is not a particularly easy subject to talk about. I think that we shall become more aware of that as we continue to discuss this legislation.

I record apologies from Frances Curran and Marilyn Livingstone.

Meeting closed at 11:35.
Note of Meeting between the Gender Reporter and the Somali Women Action Group

Introduction
The Equal Opportunities Committee’s Gender Reporter, Elaine Smith MSP, met with representatives of the Somali Women’s Action Group in Glasgow on Tuesday 23 November to discuss issues related to the Prohibition of Female Genital Mutilation (Scotland) Bill. Ruth Cooper, Senior Assistant Clerk, was also in attendance. This note records the key issues which were discussed.

Extended provisions to prosecute in relation to children and women being sent abroad
There is intensive pressure within the Somali community to carry out this procedure on girls. One of the group explained that in the minds of every female there is the thought that they are required to arrange this procedure for their daughter.

The Group believed that FGM did not happen in Scotland because of fear of prosecution. However, the Group confirmed that it can happen that children are sent abroad to have the procedure carried out.

Culture
The Group made it clear that they understood FGM to be a cultural and not a religious practice. When asked about changing this culture, the women answered that their Group wished to see the practice abolished. However, they did explain that some people within the community (mostly older people) were holding onto the practice, as they consider that it is something that they should do.

Education
The Group emphasised how important it was to raise awareness within the Somali community and give women full knowledge of the risks associated with the practice of FGM.

The Group emphasised the need for seminars on this subject, run by the community itself to educate women and promote understanding of the horrific nature of the procedure. They also wanted to reach the whole of their society with this message and they emphasised the importance of issues that are sensitive to the community being dealt with by someone within the community. They felt that women should be given training in running seminars to support this aim.

The need to educate men in their community was also raised as it was felt that currently the majority of Somali men support FGM. The links to marriage were explained, the traditional view being that a woman cannot get married unless she has undergone this procedure. It was indicated that men instructed their wives to ensure that this procedure was carried out on their daughters.

The Group felt that there should be translated reports and pamphlets to be part of an education programme for women and men.

When asked by the Reporter about the possible impact on the community in Somalia of the proposed legislative changes in Scotland, the Group felt that although it may take time, this would have an impact on wider society.

Language
The women believed that the word circumcision should not be used in relation to this practice as it is the wrong definition for what is actually performed. They explained, however, that there is a core of people who still support the practice who would continue to use the word circumcision as the term mutilation does not sit well with their beliefs.
**FGM and Health Risks**

Girls are most commonly aged 5-7 when this practice is carried out. The group explained how there are mental health issues and problems related to FGM. Children worry about the stories they hear about the procedure before it happens to them and they worry about the pain. They ask their female relatives about the procedure and it creates an atmosphere of fear for them. The fear for children was felt to be very important and was stressed during the meeting.

The women explained that when the procedure is carried out it is extremely painful, there is no anaesthetic and can be fatal. The women pointed out that it is not carried out by health professionals but by older women in the community. There is no sterilisation of whatever implements are used, no gloves are worn and there is no cleaning of the wound.

The women described the extreme pain and bleeding associated with the procedure; that girls can die from the bleeding; that FGM can also cause lots of infection and that girls can be hospitalised. Once the procedure is carried out, the child cannot drink for 3-7 days afterwards as it is so painful to urinate.

The women explained how it is sometimes necessary to repeat the procedure more than once e.g. when there are problems with stitching. A member of the group explained that sometimes a woman needs to be opened up again to sort out problems. However, if this is done, it is believed that no-one will marry the woman.

**Health treatment in the UK**

The women talked of their experiences in Scotland where medical practitioners did not understand FGM and found it very strange. One woman in the group explained that she had to have a caesarean section to avoid complications because of her FGM. The Group thought it would be very helpful to raise awareness with health professionals about FGM and they explained that 3 or 4 other women in Scotland had experienced similar problems when they accessed health and antenatal services. It was felt that there was more understanding in England where they can deal with associated problems more effectively because of the experience they have built up with the Somali Community.

**Issues around Asylum**

The Reporter questioned the Group in relation to why it was that they believed that asylum seekers should also be protected by the legislation, when in fact it was the case that if asylum seekers left the country their asylum application would fall in any case.

The women explained the pressure from family for them to have this procedure conducted on their children and to return them to Somalia to have it carried out. They felt that the message had to reach the whole society and they strongly stated their view that this legislation should also cover women and children who are seeking asylum.

The Reporter also explored the issues around people seeking asylum in order to prevent FGM.

**Evidence taking**

The Group gave a positive response to the proposed witnesses for evidence taking at Stage 1 of the Bill. The only addition to the proposals was the idea of taking evidence from English nurses and midwives who have built up expertise in this area.

The Reporter also discussed with the Group the possibility of their giving formal evidence to the Committee and it was agreed that the Clerks should liaise with them to set out proposals for this to be taken forward.

**The Somali Women’s Action Group**

The women asked the Reporter what the Committee could do to support the work of the Group and she agreed to visit with them again. They also pointed out the need for translation of a number of documents to support the work of the women’s group. They explained their lack of resources and their hope that they could do positive work in the coming months and years.
Scottish Parliament
Equal Opportunities Committee
Tuesday 14 December 2004

[THE CONVENER opened the meeting at 10:21]

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

The Convener (Cathy Peattie): Good morning and welcome to the Equal Opportunities Committee’s 19th, and last, meeting in 2004. I have received apologies from Frances Curran.

Agenda item 1 is to take evidence on the Prohibition of Female Genital Mutilation (Scotland) Bill. I give a warm welcome to our first two witnesses, who are Fariha Thomas of Amina – The Muslim Women’s Resource Centre, and Efua Dorkenoo from FORWARD—the Foundation for Women’s Health, Research and Development. I thank them for coming. It is important for us to talk to the witnesses to ensure that the information that we have is accurate. The committee has a number of questions, but the witnesses may want to start with a short statement.

Efua Dorkenoo (Foundation for Women’s Health, Research and Development): I am a public health specialist with FORWARD, but I was also a founder of the organisation about 20 years ago. The organisation is one of the leading groups in the world that promotes action against female genital mutilation. Between 1995 and 2001, I was the World Health Organisation’s expert on female genital mutilation and helped the organisation to put female genital mutilation on the agenda of the ministries of health of countries where it is practised.

Fariha Thomas (Amina – The Muslim Women’s Resource Centre): I am the co-ordinator of Amina – The Muslim Women’s Resource Centre, which is a project that is based in Glasgow but which has a Scotland-wide helpline for Muslim women that is funded by the Scottish Executive—I thought that I had better say that. We sent a response to the committee and were asked to come along. As I told the clerk, I am not an expert on female genital mutilation, but I bring information, primarily from the west of Scotland, but also from Scotland as a whole, on what women are saying or not saying about the practice.

Our project deals primarily with Muslim women, although other women come to us. People do not generally come to us about female genital mutilation, but about a broad range of other issues. We deal with people from a range of communities. The biggest Muslim community in Scotland is the Pakistani community, in which FGM does not take place. Indeed, the majority of people were shocked to hear about it because they did not know that it existed. It is not commonly felt to be something that Muslims do. However, people from other backgrounds—Malaysian and African—also use our services. FGM of different kinds takes place in those communities.

The Convener: Can you describe briefly for the committee how FGM can affect girls and women on whom the procedure is carried out?

Efua Dorkenoo: The term FGM covers a range of procedures. As defined by the World Health Organisation, it includes partial or total removal of external female genitalia and injury to external female genitalia for non-therapeutic reasons. The WHO has carried out a systematic review of the health complications of genital mutilation that have been found to date. Those include immediate complications such as acute pain, infections, bleeding and, occasionally, death. However, few studies have been done on those issues.

There are also long-term complications. The information that we have relates largely to the most radical form of genital mutilation, which involves almost total removal of external female genitalia, stitching together and leaving an opening that is often the size of the head of a matchstick for the passage of urine and menstrual blood, until the girl child is ready to get married. At that point, the opening must be widened for the consummation of the marriage. The health complications of this procedure that have been observed include obstetric difficulties—difficulties in labour and delivery. There may also be gynaecological problems, including menstrual problems. Young girls who have undergone this form of genital mutilation may have difficulties with menstruation and the passage of urine.

There are psychosexual problems, because the core of the procedure is often removal of the clitoris, and issues of psychological morbidity. FORWARD’s work with women in England indicates that girls who grow up here are more likely to have problems relating to psychosexual and psychological health. In particular, they may have psychological problems, because they may not relate very strongly to the cultural reasoning for FGM that is given to them and may grow up with the feeling that they are not complete. They may feel that their parents have deceived them. Such issues and lack of sexual response are the main problems that FORWARD has encountered when working with women in this country.

Fariha Thomas: Primarily because of where they have been located, the majority of asylum
seekers in Glasgow tend to go to the new Princess Royal maternity hospital, which is attached to the royal infirmary. Women who have been subjected to FGM have experienced obstetric problems when giving birth at the hospital. I refer especially to women from the Somali community, which is increasing in size in Glasgow.

I have also spoken to some Malaysian sisters about this issue. In Malaysia, FGM is a very small operation—only a small part of the hood of the clitoris is removed. Those women say that the operation is performed on small babies and because babies often do not cry when it is done, they cannot be experiencing much pain. They believe that the operation does not have much effect and that it does not affect enjoyment of marriage or sex. It is important to remember that we are talking about a broad spectrum of procedures, the effects of which will vary.

Efua Dorkenoo: When we discuss the complications of FGM, we should not focus solely on the health consequences. We should also consider the human rights dimension. Female genital mutilation is carried out mainly to suppress the sexuality of girl children. In itself, it is a gross violation of the rights of girl children.

Fariha Thomas: It sounds as if I am defending the practice in Malaysia, but I am not; I am just reflecting what people have said to me. Such suppression is not necessarily the intention in Malaysia—it may or may not be the intention in certain circumstances. Like male circumcision, FGM is viewed more from the point of view of cleanliness. That is how the Malaysian situation has been explained to me by a couple of Malaysian sisters to whom I spoke. FGM is done for different reasons. Even though it is not an Islamic practice, it is often done in the name of Islam. I will discuss that further.

10:30

The Convener: We will try to cover as much of that as possible. Our gender reporter Elaine Smith will pick up some of the issues that we do not deal with. That takes us to my next question.

Paragraph 4 of the policy memorandum that accompanies the bill notes:

“No religion requires female genital mutilation, and the practice is not limited to any religious group.”

However, religion is still given as a reason for carrying out FGM. Do you believe that the proposed new law will make any difference in that respect? How do you think that we should tackle the misunderstanding?

Fariha Thomas: Primarily, education is what is needed. The existing legislation and the bill send out a message but, on their own, they will not get us very far. Some people might consider legislation on FGM to be an imposition on their cultural views. It is an issue that relates to local cultures; it is not about a religion.

I remember reading an article about FGM many years ago—I think that it was in The Sunday Times—which talked about two tribes in a similar area of Sudan. One of the tribes was Christian and the other was Muslim. The Christian tribe thought that it said in the Bible that the practice was necessary and the Muslim tribe thought that it said in the Qur’an that it was necessary. Although FGM is mentioned in neither of those books, that is what the members of those tribes genuinely believed, because that is what they had been taught. They were not literate; they had been taught by word of mouth.

Some well-respected Islamic scholars have made pronouncements on the subject, but the majority of scholars who have studied the issue say that FGM is not part of Islam and that the practice should not be required. Although some schools of Islam seem to be more in favour of it, everyone says that the major forms of it are not correct and that, indeed, they are opposite to what Islam preaches, because they involve God’s creation being damaged. God has not created us in a certain way so that we can mutilate women.

Efua Dorkenoo: FGM predates most of the major religions, including Islam and Christianity. In the countries where it takes place, it is practised by non-believers and believers alike and its practice by believers is not specific to Muslims—it is practised by Christians such as Copts, Protestants and Catholics, as well as animists.

FGM is not in the Qur’an, but there is something about it in the Hadith, which contains the sayings of the Prophet Mohammed. It states that when the Prophet saw a midwife performing genital mutilation, he directed her not to cut too deep. In some communities, religious leaders have used such sayings to promote the practice, but I repeat that FGM is not in the Qur’an.

In the context of Islamic jurisprudence, whenever there is discord in the interpretation of the sayings of the Prophet in the Hadith, the subject of the disputed interpretation is not an obligation. That is the situation. Unfortunately, four communities that use Islam as the reason for practising FGM have religious leaders that promote the practice on the basis of what is said in the Hadith.

Fariha Thomas: Although some Hadith are cited, they are recognised as being weak—that means that the chain of narration and the validity that can be given to them are considered weak. That does not stop some people from choosing to use them for their own reasons, but most Muslims
would not recognise those Hadith as supporting the use to which they are sometimes put.

When undertaking education in the Muslim community or in relation to other religions, it is important to use religious idioms and religious leaders. Most religious leaders would say, "This is not on." Muslim leaders in this country are strongly aware that FGM is not part of the religion. One way to make progress is to get leaders on board, to use them in education campaigns and to have information read out in mosques. Having information read out in any religious institutions or put in newsletters and magazines that people read in their communities will reach people in a way that legislation will not.

However, legislation is useful. FGM is already banned in this country and the bill will tighten that. Legislation sends the message that the practice is not on and is unacceptable here. That at least tells people who do not want to be convinced that they cannot undertake the practice here. Legislation is welcome in that way, but legislation on its own is not adequate.

The Convener: In your experience, where does the pressure to undertake FGM come from? Does it come from the communities in which it takes place or from any group in or section of a community? If so, how should we deal that? How do we contact communities? You said that what is required is not only education of women, but encouragement to wider communities to consider the issue. If the pressure is not religious, is it from communities?

Efua Dorkenoo: I agree that legislation is one tool to deal with the issue. From my experience in England, a legislative framework—particularly when that is applied to child protection services—is crucial. A multipronged approach is needed. The legislation is implemented by child protection services, which means that all the professionals who work on the front line with families—such as health visitors and other professionals in health, social work and education—incorporate the legislation into their normal work.

England has experienced much success in using the law for prevention. Local authorities have undertaken many child protection interventions. That has protected children who were at risk of genital mutilation. In some cases, parents tried to take their children out of the country and local authorities stepped in to prevent that.

Involving child protection services obliges local authorities to identify communities that practise genital mutilation. Those communities are quite wide. Local authorities have also to promote education through support for community groups to undertake education activities, on which we have worked with mosques and religious leaders. We are planning with police child protection services a seminar in Finsbury Park mosque to highlight the fact that genital mutilation is not a religious practice.

The law can be used as a major tool to assist parents who feel under pressure. That pressure comes from different angles. The communities that practise genital mutilation live in extended family structures, so they are not like families in the United Kingdom in which a marriage is a one-to-one situation. A wider extended family is involved, which includes a mother-in-law.

The older people in the family tend to put pressure on younger women to submit their daughters to the practice of female genital mutilation. Because of the nature of the patriarchal family, younger women or couples often do not have a lot of control over that. Sometimes, they have been able to use legislation as a tool to enable them to say, "I would have done it but I couldn't because there is legislation against it."

In England and other countries where work is being done, we would like there to be a multipronged approach involving, on one hand, the authorities working on an educational level and using child protection services to step in when there is an increased risk of a child undergoing genital mutilation and, on the other hand, communities and women's organisations—resourced and empowered by the authorities—working with people in the community.

A third group that we tend to miss are the women and girls in this country who have already undergone genital mutilation. Those who have the extreme forms of it have problems in accessing health care and we need to consider how best to promote such access. In London, we have six clinics that facilitate antenatal care for women who have undergone the most radical forms of genital mutilation, and gynaecological care for girls and young women who are closed and want to be opened up very quickly. They can walk into the clinics and have that done within 24 hours.

Fariha Thomas: On the issue of pressure, one of the reasons why people will submit their daughters, granddaughters, nieces or whoever to genital mutilation is because of the fear that, if they do not, the girl will not be marriageable. Marriage is extremely important in those communities and the fear is that, without genital mutilation, the daughter will have no honour and will not be marriageable and her life will be blighted. There is a feeling that, with genital mutilation she has a limited life but that, without it, she has no life and that, therefore, it is the best option for her.
I was reading some material that someone found for me on the internet. In Africa, people are working with villages to try to change the culture. That is crucial. There must be a cultural change to ensure that people do not think that a woman cannot be married or will be a loose woman unless she has undergone genital mutilation. A lot of work needs to be done in that regard both back home—for those who still see another country as being back home—and here as well.

Having said that, my Malaysian contacts were saying that they felt that genital mutilation in their country—where a much less severe form of genital mutilation is practised—is decreasing. Of course, that might be because there it is seen as being more to do with cleanliness than honour. A lot of work is being done around the world to change cultural assumptions, but it is important to remember that many people who might not want to take part in the practice do so because of cultural pressure.

Efua Dorkenoo: I must add that most of the young men growing up in this country who are likely to marry these young girls are not interested in genital mutilation. There is a kind of lag between parents thinking that this is what the young men want and the facts. I should also add that, in England, there is a lot of discussion and work on forced marriages. One of the reasons why FGM persists is that girl children are put through forced marriages. That is also important in Asian communities.

Two weeks ago, I was with the Women's National Commission, which appears to be moving towards the view that there should be a law against forced marriage as well. When the girl children are allowed to choose who they want to marry, they would rather marry somebody who respects them as a human being, as opposed to someone who will look at their genitals to see whether they have undergone genital mutilation. That is what we have found with the girls with whom we have worked.

10:45

Elaine Smith (Coatbridge and Chryston) (Lab): I would like to explore further some of the issues that have been raised because it is important that we get to the roots of what we are up against and what we are trying to tackle. Clearly, there are two approaches. One relates to what legislation can be put in place to try to stop the practice happening. The other, which is as important, is about quite radical change in deeply rooted cultures and traditions. Women in the Somali women's action group told me that there was intense pressure on women to have the procedure carried out on their daughters, for some of the reasons that you have outlined.

Efua Dorkenoo made the point that genital mutilation predates the current religions and teachings. Is the issue primarily about chastity, virginity and a wish to ensure that girls keep themselves for their husbands? Is genital mutilation an extreme and horrendous form of chastity belt? There are issues to do with cleanliness as well, but is that the main crux of the matter?

Efua Dorkenoo: Different groups give different reasons for it. However, the core of it relates to control of women's sexuality. Some people say that there is a lot of concern around psychosexual aspects such as the wish to attenuate the sexual desire of the female. That thread runs through all the groups that have the practice. Some of the groups say that it is a religious thing but, if you work with groups and go further into the issue that way, you find that it comes back to the attenuation of the sexuality of the girl child. In some countries, the ritual is also inserted into puberty rites and is made the core of rituals relating to puberty. You need to go further to discover the extent to which genital mutilation is to do with promoting what society says about womanhood and ensuring that girls conform to specific roles. Again, that comes back to control of sexuality.

The extreme forms of genital mutilation—type III or infibulation—is the creation of a flesh chastity belt. The removal of the clitoris is to do with the attenuation of sexual desire. I come from a community that practises that form of genital mutilation and know that, if you asked them, they would tell you that the practice is to do with cleanliness, maintaining virginity and toning down the female's sexual desire. That is why we come to the conclusion that, if you analyse the practice further within the context of the patriarchal family, the basic purpose is to control the sexuality of the female.

Elaine Smith: It is sometimes put to me that it is women who carry out the procedure on girls, but I see it as part of the continuum of men's violence against women and children and as having to do with the patriarchal control of women's bodies. What do you say to the argument that it is women who do this to other women?

Efua Dorkenoo: The issue is mainly to do with women's powerlessness. In a traditional, standard family system, control of a woman's sexuality occurs during the period of reproduction—from roughly the age of 15 until the menopause. During that time, females' reproductive and sexuality are very controlled. After the menopause, women of my age group gain a lot of power. They are given many privileges within the patriarchal family and it becomes their responsibility to ensure that younger women fall into the mould.
Mainly because of women’s powerlessness in society—at least in Africa, where FGM is most widespread—they do not have access to the resources to ensure their survival. In an agrarian economy, they do not have access to land for farming; in a pastoral economy, they do not have access to animals. They get access to land through marriage or through male members of their family. In that context, FGM is linked to marriage—it is the gateway. Only after a woman has undergone genital mutilation can she get married and gain access to resources. Therefore, FGM has come to be understood as a female ritual. According to older women’s perception of reality, they think that they are protecting the younger women by ensuring that they can access resources.

However, things are changing very fast. In Africa, where FGM is widespread, there is a strong movement to stop FGM and all forms of violence against women. Female genital mutilation is classified by the United Nations as a form of gender-based violence. What is being done here in Scotland is in tune with Scotland’s status as part of the United Nations, which is moving towards addressing all forms of violence against women, including forced marriages and the battering of women in the home.

It is easy to forget about FGM or to think of it as a part of African culture; however, the violation of women’s human rights in the home happens throughout the world. It is condoned by the family and by the culture, so it can be difficult for people to see that it is an imposition on women. If we are to move forward in what we are doing to encourage girls to do the best that they can and to fulfil their potential, we cannot have any of that imposition on them. The issue is not just about the physical mutilation; it is about the message that it gives out and the context in which it happens, and it is critical that we address those.

Elaine Smith: From what you say, it seems that FGM is being done not out of a desire to harm the child but as the lesser of two evils within a cultural situation. You talked about young men in this country being less interested in FGM as a prerequisite for marriage, which perhaps answers my question. Given the fact that the issue is a cultural one and is a deeply rooted traditional practice, do you think that it is more difficult to deal with FGM in communities in the UK, which might be under pressure to hold on to their cultural traditions and practices, or is the culture in this country, where FGM is not a common practice, having some influence?

Efua Dorkenoo: In this country, as in all western countries to which people have moved from the traditional communities, FGM takes a much different form. It becomes a strong weapon with which to control girls in communities. Most of the African communities in this country that practise FGM come from a traditional society and might see a more liberal society, in which there is freedom for young girls, as polluting and sexually promiscuous. Therefore, female genital mutilation is often done to keep girls within the community—it is an added weapon or control mechanism.

It is not necessarily boys who want the female genital mutilation to take place, but families as a whole. We live in networks of communities in which it is not just the man and the wife who make decisions, but the broader community. We have very strong extended family systems, which still operate when we are outside those communities, and many families feel that female genital mutilation prevents girls from going beyond their own communities and marrying outside them, because it is like a mark that is put on the girl child.

In our project, we try to find a space for younger women to express some of their concerns, such as feeling robbed of their natural sexuality. Many young, second-generation girls who underwent genital mutilation feel very angry and express issues around sexual responsiveness. The problem is such that they cannot discuss it with their families or community groups because they would be frowned upon for moving away from the culture or the religion.

Fariha Thomas: Because of religious and cultural change, female genital mutilation is new for us in Scotland. There must have been a few people around for a time who experienced it, but until quite recently, the majority of new Scots came from the Indian sub-continent and China, which are not areas where female genital mutilation regularly takes place. As I said, Pakistani Muslims are horrified at the concept. The majority of those to whom I spoke had never heard of it before. The more educated ones, who read things, were aware of it, but they were all horrified by it.

We have not faced female genital mutilation before, but there is an analogous situation. Many in the older generation have a myth that everybody in the west is incredibly promiscuous and that, if they do not keep strict control of their daughters, girls will be corrupted as soon as they step out the door, so some of them have tried to enforce restrictions. However, many of the younger people who are growing up here in the Muslim community and, I think, in the Sikh community—it might apply to other communities as well—have access to education that their parents’ generation often did not have and are learning more about their religions. Many young Muslim girls and not-so-young Muslim girls—adults—think of themselves as Scottish Muslims...
rather than as Pakistanis. They know what their religion says and does not say about women’s rights, and it says many things about women’s rights that their parental generation was not aware of and did not disclose to women. Because they have been empowered by that knowledge, they are able to stand up and argue with some of the things that their parents feel are a part of the religion but which they have learned are not.

In some ways, female genital mutilation will become less of an issue because, as younger women grow up, they will be able to realise that their religion does not tell them that it has to be done. If it is done to them, they will realise, at least as they become mothers, that although it was done in the name of religion, it is about culture. There is a tendency to hang on to traditions; some traditions will be hung on to, but some of the more negative ones, such as female genital mutilation, will go, because the religious justification for them will disappear as people become more able to access information about their religion through education.

**Shiona Baird (North East Scotland) (Green):** My question is about the consultation that the Scottish Executive carried out, so it is probably more for Farida Thomas than it is for Efua Dorkenoo, but if Efua wants to comment, that is fair enough.

The consultation period was very short. Did the Muslim Women’s Resource Centre have enough time to respond to the consultation? If it had had more time, would it have responded differently?

**Fariha Thomas:** I was aware that the consultation period was very short. If we had had more time, we would have been able to talk to more people and consult more widely. I do not know whether our final response would have been different, but it would have been better if the response time had been longer.

The committee might consider this later, but I was not aware that the documentation was available in other languages. It would have been useful if there had been translations, particularly into the languages of the communities in which the practice is most common. We are not necessarily in contact with such communities. My initial thought when the committee contacted us was that you should speak to the Somali women’s action group rather than to us, because it is probably the biggest group—certainly in Glasgow—that represents women who have been subjected to the practice, but I was told that the committee had already contacted the group. A longer and more targeted consultation process might have reached more people.

**Shiona Baird:** I was going to ask about translations. What you said about that is worrying.

**Fariha Thomas:** I was not aware that the material had been translated, although translations might have been available.

**Shiona Baird:** How can we ensure that the relevant people realise that the documents are available in their own languages?

**Efua Dorkenoo:** First, it is important to identify all the communities that you want to reach. We tend to focus on Somali communities because they are very visible, but there might also be Sudanese or Egyptian communities here or women who have come here from west African communities in which FGM might not be strongly linked to the Islamic religion. Secondly, there is a need to ascertain whether the people who should read the material are literate. There is a tendency to translate material quickly into local languages, but members of the community, particularly women, might not be able to read the documents; it might be better to put the information on tape.

I would have thought that the best approach would be to identify the communities in Scotland who are from countries in which FGM is a traditional practice, because our experience is that people from such places continue the practice when they come here. You could then meet those communities, who could tell you about the networks that exist within the communities and how to disseminate information.

**Fariha Thomas:** Our basic information leaflet is not translated into Somali, but our next priority is to get it translated, because many sisters have asked us for a Somali translation. Although not everybody is literate in Somali—I understand that the written language is quite new—quite a lot of people are asking for the leaflet. People also request Arabic and Swahili translations. Most of the people from Malaysia who are here are overseas students or the wives of overseas students and English is their second language, so they can read the documents in English.

I understand from anecdotal evidence that some people who are here on work permits or as overseas students, particularly from Egypt, have sent their daughters back for the procedure. Such people are not permanent residents in this country, so I understand that the bill would not affect them, but they might at least be reached by education campaigns. My information is second hand, but I understand that several families have sent their daughters back for the procedure and brought them back to this country afterwards—that can happen in the school summer holidays when people are visiting their families.

**Ms Sandra White (Glasgow) (SNP):** Good morning and thank you for coming to the meeting.
There has been a debate about the change in terminology; we now talk about mutilation rather than circumcision. Is the change important and will it affect the communities in which FGM is practised?

Efua Dorkenoo: At FORWARD we consider that matter on two levels. At policy level, we use the WHO and UN terminology “genital mutilation” to describe what is really happening. On the ground, there is a lot of confusion between female genital mutilation and male circumcision. We realise that at programme level—at grass-roots level—many women feel uncomfortable with the terminology “female genital mutilation”, because it has become a normative practice in some communities, so confronting it as “mutilation” is difficult for women, especially initially, because they must question what their parents did to them. They have been told that it was a good thing and that it made them a good woman, clean and so on.

We work on two levels. At policy level, we should agree exactly what is being done and there should be no fighting about it; however, on the ground, in our work with communities, we use the terminology with which people feel comfortable. For example, if they call the practice “circumcision”, it is important for us to call it circumcision, but it is also important to highlight the differences between male circumcision and female circumcision. In our outreach work, we tend to pick up on the terminology that communities use. Some Somali communities call it qudnini. If we are doing outreach work there, we will call it that. Gradually, we bring in the human rights dimension until people use the term “female genital mutilation” without problem, as do many people in Africa. In western countries, because of issues with race relations, people feel uncomfortable, but as we work with them, we can highlight the degree of severity. That is how we have been operating.

Fariha Thomas: I agree. That is really helpful. Many people feel uncomfortable with “female genital mutilation” as a concept. If it has been done, they think, “I’m mutilated,” which does not make them feel positive about themselves. Many people even find it difficult to use the word “genital”, and it is important to remember that when we are dealing with people.

It will be important for education campaigns to consider which terminology is used. There is a bit of a feeling that the term “female genital mutilation” reflects a bit of an imperialistic attitude: “We know better than those primitive people.” Some of the literature that I have read says that, until the 1950s, the practice was still being carried out as therapy for women who were not behaving the way men wanted them to behave. There is a history of it in the west; it is not something that only ethnic minorities—whatever that means—have done.

It is important to use different words in different contexts. I was not 100 per cent comfortable with the wording in the bill, but I think that it is all right to label something as long as in education campaigns we are aware that we need to be sensitive about the language that we use.

Ms White: I agree with everything that you have said. There is concern that “mutilation” rather than “circumcision” is a western word. Would it be helpful if, when we produce leaflets or tapes, or speak to women, we used their own language? That way we would be taking a twin-track approach: the wording in the bill would make the west aware that we are talking about mutilation and that the issue is nothing to do with cleanliness, because it concerns violence against women; but when we are talking to communities and handing out leaflets to men and families, rather than just to women who have been circumcised for example, we would emphasise the word “circumcision” rather than “mutilation”.

Efua Dorkenoo: That would depend. The idea is to change the mindset that FGM is good. As long as communities feel that there is nothing wrong with it and that it is only a little bit of circumcision, it will continue. We are going through a process—we have to get people to see how serious female genital mutilation is and then they might change. If information comes from an authority such as the Scottish Parliament, the practice must be spelled out, although in brackets we could say that it is commonly called circumcision, cutting or something else. If a leaflet is prepared in the Somali language, it might use the word “gudniin” or another term. However, in some places, it is called tahara, which is not helpful because that word is linked to purification. When the World Health Organisation discussed the issue in 1995, most of the experts who came from the countries that are directly concerned said that we should move away from terminologies that give a false impression of the practice. Another such term is “sunna”—many of the Muslim populations that practise FGM use that term, which has a religious meaning.

Fariha Thomas: In that sense, it is related to the Prophet, so it is a good thing.

Efua Dorkenoo: In Africa in 1990, the women’s movement that is called the Inter-African Committee on Harmful Traditional Practices, which has chapters in more than 28 countries, came to a resolution in Addis Ababa to use the term “female genital mutilation”, because it is the clinical terminology to describe removing a normal, functioning organ. That was important because people who work in the field have a lot of difficulty trying to clarify for communities what the
difference is between female genital mutilation and male circumcision. We need to give the direction of the campaign but perhaps accommodate in brackets other commonly used terminology, otherwise we will never get communities to realise the seriousness of the issue.

FGM has been a controversial issue in the past, but it is now on everybody's agenda. Work is just starting in Scotland, but in England and other countries a lot of work has been done by communities. In England, we have more than 30 local organisations working on the issue, but 20 years ago, when we started, we could not get anybody to work with us. I see our work as a process. Government must give the ideal situation that everyone should follow.

Fariha Thomas: It is logical for Scotland to follow the English legislation, the Female Genital Mutilation Act 2003, which uses the term “female genital mutilation”. If we used a different term, that would be confusing and might give out a message that Scotland thinks that FGM is not as bad as England thinks it is. We can be different on other issues—we lead the way on many issues—but, on this one, it is important to have consistency.

Efua Dorkenoo: The Scottish Parliament could consider the definition in the bill. The English law talks about excising or mutilating, but that creates a tendency for people to think that other forms of genital mutilation are okay, as long as they are not the radical form. The WHO classifies FGM into types I, II, III and IV. It is important to ensure that people understand that all forms of female genital mutilation are illegal. People who do the most radical forms, such as type III—which involves closing up—often stop doing so and instead carry out partial clitoridectomy, which they say is okay, although it is not. The committee might want to consider including the WHO classifications in the bill.

In the Netherlands, there was a lot of discussion about whether clinics should bring in little girls and put pin-pricks into the clitoris to release blood, just to satisfy the community. The thinking was that it might be okay if it was just a pin-prick. People say, “Oh, we do it on the baby and we just take a little bit of tissue at the top.” However, as a health person, I know that, with babies, it is impossible to take out the hood. Many experts in the field agree that such procedures involve damage to the glans of the clitoris, even though people say, “We just took a little bit off.”

It is important to use the WHO terminology to spell out what is allowed and what is not allowed. The English act is not very clear.

11:15

Elaine Smith: Should a reference to types I, II, III and IV be on the face of the bill rather than in guidance? Is that your suggestion?

Efua Dorkenoo: Yes. All the different types should be noted. Perhaps a footnote could state that female genital mutilation means any of the WHO classifications—types I, II, III and IV.

Elaine Smith: So the types should be noted in the definition of female genital mutilation, which should be on the face of the bill.

Efua Dorkenoo: Yes.

Elaine Smith: The representatives from the Somali women’s action group thought that the word “circumcision” should not be used because it does not properly define the practice. However, they also said that a core of people support the continued use of that term because the term “mutilation” does not sit well with their beliefs. In educating people and providing leaflets about the issue, is it important that we employ people from within those communities, who will presumably be more sensitive about the terms that should be used?

Secondly, given that the bill is not just about legalities but about raising awareness, should we concentrate on training doctors and health staff to be sensitive about the terms that they use? For example, if a woman has come for help or to give birth, we would not want to upset her by making references to “female genital mutilation” if she would not be comfortable with that term.

Efua Dorkenoo: So far, the whole world is moving towards an holistic approach that brings the issue into the main stream. That means that local authorities need to develop local policies and protocols on how to integrate the issue into the health agenda. Health visitors and midwives can be more useful than general practitioners, but GPs need to be aware of the issue.

Another angle is that health visitors who work with children—I do not know whether you have those under the Scottish set-up—and midwives can start the education process during ante-natal care. That is the ideal situation, as it also helps later on, when women come to request restitching. Health visitors and midwives need to incorporate education into what they are doing. The ideal is that the education and awareness-raising process goes on in the clinics that women attend with their babies, especially baby girls.

In English schools, we are now trying to integrate the issue into the aspects of social education that deal with abuse and about what people can and cannot touch. We have education materials on FGM for the police and for child protection professionals, because once you start an education campaign, you will get casework. A sibling might tell you, “My sister is going to be done.” Some years ago, when one teacher
discussed with her class what they would do during the holidays, one six-year-old girl told her that she was going to Kenya or somewhere like that where, her mum said, a doctor would give her an injection in her bottom. The teacher was able to pick up very quickly that the girl was going to undergo genital mutilation.

Professionals need to be given protocols and guidelines. To incorporate the issue into child protection, it needs to be massaged a bit so that it is likely that the interventions will be much more preventive. Once a local authority has developed policies, professionals will require a lot of training to help them to work with the subject.

The other angle relates to providing support, resources and empowerment to communities to enable them to start to address the issue. There must be workshops to help to do that and work alongside that on women’s health and women’s bodies. Work can be done in the wider context of sexual and reproductive health and so on. Communities should be able to come up with the appropriate terminologies and ways of working with groups. For example, at the moment, we are working through hairdressers, where many women meet.

There is an holistic angle. Work must be done with the professionals at the same time as the message is being sent out to the communities.

Elaine Smith: Efua Dorkenoo mentioned restitching. Do we know whether it is illegal for a woman to request restitching?

The Convener: I am not sure.

Efua Dorkenoo: Can you clarify what you are asking?

Elaine Smith: Obviously, female genital mutilation is illegal in this country at the moment. However, you talked about a woman requesting restitching, presumably after having given birth. Is that illegal?

Efua Dorkenoo: That is illegal under British law. The Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Nursing have given guidelines to health workers in that regard.

Normally, Somali women do not restitch. Sudanese women, however, would probably request that doctors restitch them to the state that they were in when they arrived for antenatal care. If you conducted a survey of obstetricians, you might find that some of them are already doing that and that some of them avoid the issue by doing caesarean sections.

In England, we have a lot of specialists, such as Mr Harry Gordon, who have spread good practice in how to deliver such women’s babies and how to open them up to the point at which the baby can be born but which does not interfere with intercourse afterwards.

The Convener: At a later date, we will have a chance to speak to people such as medical practitioners, who will be able to tell us about that sort of issue from a Scottish perspective.

Fariha Thomas: I agree with what Efua Dorkenoo said about the need for two levels. There is a danger, if professionals are not educated appropriately, that stereotypes can be created. Yesterday, I was talking to someone who works in a women’s project in the east end of Glasgow, who told me that she had the previous day been talking to a number of professionals who had come out with appalling statements such as, “All Muslim women are oppressed,” and so on.

The same thing happens with discussions about forced marriage. Forced marriage must be ended, but it is not widespread in Scotland: as far as we can tell, it is more widespread in England and in Scotland takes place more in Edinburgh than it does in Glasgow. However, people latch on to the idea and assume that everyone in a community does it, which leads to racist stereotyping. When we go about educating professionals, it will be important that we do not reinforce myths.

Efua Dorkenoo: That is why FGM can be addressed through training. Twenty years ago, people said that nobody should even touch the subject. The experience in England was that communities were told that they should get on with it, but we found that that did not work. As we worked more in communities, we found that girls who were growing up in the UK were being taken back to their mother’s or parents’ home country for FGM. Those young people were not the offspring of ethnic minority or illegal immigrant families, but of second-generation families.

In a case from one of the cities in the north of the country, a 16-year-old wrote to tell us that this practice was going to be done to her while she was on holiday. She also said how nice her parents were and so on. We referred her case to social services but they did nothing; they simply said that the issue was a community issue. Given the framework of abuse, there is a limit to the educational work that community groups can do.

When it comes to interventions on child protection grounds, the statutory agencies must intervene. FGM must be dealt with through policy and protocols at local authority level. In that way, front-line health workers can be given guidelines and training on how they should deal with the issue.

At the moment, we have just finished a training pack for Westminster Primary Care Trust. Many Sudanese people live in that area and the pack is
aimed at professional and community groups including obstetricians, gynaecologists and midwives. It sets out how they should deliver policies and work with their clients. We also set out how health visitors should work with families. That sort of material needs to be produced as a package.

The Convener: I will bring in Nanette Milne in a moment. The issue is not only about awareness in communities but awareness among professionals that they should not make generalised statements. It is important that health professionals, teachers and other professionals who work with children know the right protocols and practice. The bill can do that because the protocols are written into the bill, and it can raise awareness on the issue.

Mrs Nanette Milne (North East Scotland) (Con): You have dealt fairly comprehensively with a number of matters that I was going to raise. It is clear that a change in the law is required. It is also clear that everything that goes with the bill, including education and culture, will have to be changed. Will the new law provide greater protection to young women than the existing law does?

Efua Dorkenoo: It will, as long as it does not remain just paperwork. For example, the experience in England is that parents were circumventing the law by taking their girl children outside the country—they would go on holiday and have the practice done elsewhere. Parents would even take their children to other European countries, so we have had to work at European level to get a resolution through the European Parliament. A number of countries have introduced legislation or issued clarification on FGM and have made it clear that they treat the issue as a child protection issue.

The bill will close a loophole that allows parents to take their girl children outside the UK, have the practice done and bring them back into the country. The loophole in the current law means that nothing can be done about that practice.

Mrs Milne: Given that families have FGM done privately by taking their children outside the country, will it be easy to police the new law and to uphold the law abroad?

Efua Dorkenoo: Most of the families want to come back to the UK. The education process has involved members of the younger generation and we have found that older siblings have acted to protect their younger siblings. They know that there are places where they can call for help and where help will be given. As with any other child abuse issue, we cannot guarantee that FGM will not happen. There is a lot of child abuse out there, but if we do not know about it there is nothing we can do. If we get to know about it, we can do something about it. Also, professionals and families are becoming more aware of levels of risk and they can be guided on what to do.

11:30

Fariha Thomas: It is unlikely that there will be many prosecutions. The point is that the bill will prevent people from practising FGM because of the risk of their being found out, but we are concerned that if there is a prosecution the daughter or whoever has blown the whistle will be blamed and guilt will be put on them by the extended family and perhaps by the community. We need to consider what support mechanisms can be put in place in such cases.

It is particularly unlikely that there will be many prosecutions in Scotland because there is only a small relevant community here. I hope that more asylum seekers who ought to get refugee status will get it, but I know that that is not for the Scottish Parliament to decide. As more people from different communities get refugee status, more people will fall under Parliament’s remit, but at the moment many people who are at risk in Scotland are overseas students or people who have work permits of various kinds. In the future, there will be more such people because of the initiatives to recruit people from elsewhere—including asylum seekers—but they will not be covered by the legislation. It is true that asylum seekers who go back to their country of origin will not get back into Scotland, but the bill does not cover any visitors from overseas.

I am not sure why it would not be possible to make it illegal for a UK citizen to assist with female genital mutilation. I understand that we cannot prosecute people who are not UK citizens and who do not live here for what they do abroad but if, for example, my organisation assisted someone in organising female genital mutilation—we would never do that—we should be in breach of the law. However, my reading of the bill is that we would not be in breach of the law if the person was not a UK citizen. I am still not sure why the bill could not make that illegal. That said, we would never hear that advice because we would never be involved in that way.

The Convener: We will put that question to the minister.

Fariha Thomas: I received a partial response on that question, which was that the reason is that such provision is not within the jurisdiction of the UK. However, I would have thought that it would be in the UK’s jurisdiction in the case of a UK citizen’s giving advice on FGM.

The Convener: I think that the legislation may cover that, but the committee will put the matter to the minister—it is a wee bit ambiguous.
Fariha Thomas: There will still be people who will not be covered, which is inevitable because of the way the law operates. However, they will still benefit from the educational aspects.

Efua Dorkenoo: I want to add that we should not see legislation purely from the punitive angle. Legislation has many purposes and, for us, the area in which it has really worked is child protection, which is more about preventive measures.

Mrs Milne: I think that we agree that there will not be many prosecutions under the legislation. There were not many prosecutions under the Prohibition of Female Circumcision Act 1985 and it is unlikely that there will be many in future. I have a fair idea of the answer to my question, but what do you think prevents people from coming forward in the first place? What would make prosecutions more likely?

Fariha Thomas: Family and societal pressures continue to make it difficult for people to come forward. People risk putting themselves outside their families and their communities, which is why people who have had FGM done to them do not come forward. However, the legislation will give people strength to resist it being done to them or to people they know.

Efua Dorkenoo: The answer depends on the age at which genital mutilation is done. In the groups that we work with in England, it is being done between the ages of five and eight. In France, for example, there is a large catchment of communities from Senegal and Mali, among whom FGM is being done on babies. Some hospitals have recorded cases of babies dying because of it, and there have been many prosecutions.

We must not, however, underestimate the possibility of prosecution. Right now, we have second-generation British girls asking us to pursue legislation because they want to take their parents to court. It is a process. In France, about two years ago, a 22-year-old woman of Malian parentage not only identified the woman who mutilated her—the communities were bringing traditional practitioners into France to do it—but was able to get hold of about 22 other girls who had undergone genital mutilation. Those who were responsible could be prosecuted retrospectively. We should not say that that prosecution is not going to happen, because it is a process. At the moment, even though we do not want to alienate girls from their families, some girls feel very angry about what has happened to them and may move in the direction of prosecution.

In one Somali community that we work with, in West Hampstead, the community leader has said to the members of that community, “If I hear that anybody wants to practise genital mutilation, I will report them to the social services.” We should not put the community outside what is happening in the main stream; the more aware people are of what is happening, the more they will feel that there is support for them if they want to report female genital mutilation.

On the guidelines on intervention in FGM, our focus has been very much on prevention. When it is reported, there is a case conference, just as there would be for any child abuse case. There is a discussion about who should intervene in the family, and that intervention is to do with cautioning them. The legislation can be used if the girls are put through FGM. Thereafter, there is a follow-up plan of counselling and support for the family, which includes integration. I know of one girl who threatened her parents. She had undergone FGM and said that she would, if it was done to her little sisters, commit suicide. The work plan for the family involved integrating the child back into the community. It is possible to come up with good practice on how to work with families to resolve the issues.

Ms White: I think that my question has been covered. The first question asked about changing the terminology to help to educate communities. It is a cultural matter, so we really have to educate the communities. You have explained exactly how we should go forward. However, do you think that we have enough people in Scotland who could carry out the work of educating communities and professionals? We could gain from the work that you have been doing in England, so are there groups there that we could contact? Would that be the best way forward?

Efua Dorkenoo: FORWARD would be happy to facilitate getting that training on to your agenda. It is a very specialised area, and local authorities need to develop policy on it. Professionals require training and community groups need their capacity built to enable them to undertake education. So far, we have worked with local authorities and primary care trusts, but we have been called on by other countries, too; for example, we have helped Sweden and the Netherlands to put together their programmes and have been consulted by Australia on matters of health care policy. We would be happy to assist in the whole process and to build the capacity here for groups and professionals to work with communities on FGM.

Fariha Thomas: On some aspects of FGM, it would be useful to bring up the experience in England, where it has been an issue for a lot longer than it has in Scotland. A lot more work has been done there on reaching people, on building capacity in the communities and on supporting local women’s groups that want to work on the issue, such as the Somali women’s action group and other community groups that are already in
the networks. Research has shown that most black and ethnic minority community groups in Scotland are under-resourced and struggling, and it can be difficult for them to take on another big issue. Capacity needs to be built in the communities.

There are also people around, such as those who work on forced marriage—in respect of which there are some analogous issues—who could combine inputs with those from organisations such as FORWARD, which would be useful. There should be a mixture of approaches and we should not sell ourselves short; there are a lot of skills in Scotland but there is expertise elsewhere that we need. I hate bringing up from England experts who do not understand Scotland, but on this issue we need some of that expertise. We have some knowledge in Scotland, although it is not so much about the issue as it is about how our systems operate and how we can work through them.

The Convener: That is the sense that the committee has. Normally we would look within Scotland, but the experience to which you have access is important for us. We need to work on educating the professionals as much as the communities.

Marilyn Livingstone (Kirkcaldy) (Lab): I have some specific questions about training, although it has been indicated to me that I have to keep my questions brief. I would like to see examples of the training materials and best practice that have been used, particularly by FORWARD, because they would be helpful to us. It would certainly cut down on some of the questions that I was going to ask. I would like insight into best practice and how things should work.

Efua Dorkenoo: We have a lot of education materials. FORWARD gets co-funding from the Department of Health and has developed a lot of materials that could be used.

Marilyn Livingstone: We have talked a lot about collecting information and finding out how many young women are affected by FGM in our communities. What is the best way for the Executive to collect that information?

Efua Dorkenoo: A baseline of where we are now needs to be set so that in five years we can evaluate whether there has been change. We never did best practice in England because we did not have the resources and the Department of Health had not highlighted the issue. We have found that we are getting to the point where everyone is asking what changes there have been. There have been some small qualitative studies in the community and we have seen the change in attitude and the shift from infibulation to type III FGM.

However, if you were to ask us about the prevalence of FGM in England, we do not have data; the evidence is all anecdotal. At the moment, we are designing a study of prevalence by examining a number of maternity hospitals and asking what they are seeing. We will set those data as our baseline so that we can check in the next generation whether there has been a change. We need such data, but we also need to do attitudinal studies within communities. Such studies would inform the education strategy, tell us where we should target information and tell us whether the critical issue is the religious angle or something else. We want to know what inter-generational changes have been happening. We need to do those two types of study; I should think that some of the universities would be very happy to do them.

Marlyn Glen (North East Scotland) (Lab): Section 1 of the bill provides for an exception to the offence of FGM in the case of a surgical operation that it is necessary for a person’s physical or mental health. However, the bill does not make specific provision for when such an operation would be necessary or how that would be decided. Do you think that the exception is reasonable?

11:45

Efua Dorkenoo: That is a complex issue and I think that we need a broader discussion of it within the women’s movement. Technically, FORWARD would regard FGM—for example, trimming the vulva—as being necessary only for the therapeutic reasons that the WHO defines; we regard sexual reassignment as necessary in that sense. However, we have problems with the idea of cosmetic surgery on the vagina. As my colleague Fariha Thomas said, people in some countries may say that they do FGM for aesthetic reasons, but they have a similar mindset to those who say that they do it for cosmetic reasons. Other people argue that African or ethnic minority FGM is separate and traditional and that it is racist to regard it as cosmetic surgery. However, 90 per cent of traditional FGM is done on children, which is unacceptable. FGM is usually done up to the age of puberty, but it is also done to 18-year-olds and it is forced on older women by their families.

I hesitate to say what our position is. However, basically, we believe that doing FGM for cosmetic reasons is the same as doing it for aesthetic reasons. We believe that a woman who says that her labia minora is too long and that she must trim it is saying the same thing as an African woman who says that she would look much better aesthetically if her labia minora were removed. We are uncomfortable about separating those attitudes. Our campaign position is that FGM is
unacceptable for children, but we also disagree that cosmetic surgery is necessary, because it is about how women perceive themselves. Some women feel that, for cosmetic reasons, they must have something cut from their natural vagina. For example, an African woman might want her vagina reconstructed and tightened.

FGM that is done for reasons other than therapeutic ones presents a complex problem for which I do not have an answer at the moment. However, the factors in the traditional set-up that push women to have FGM done on themselves or their daughters may be much stronger than the factors in more modern societies that push individual women to seek cosmetic surgery on their vaginas.

Fariha Thomas: There are problems in respect of, for example, women who have been taught to believe that they are not women if they do not get restitching and whose mental health could be affected if they do not get it. However, there is a big difference between doing FGM for that reason and doing it for cosmetic reasons. As Efua Dorkenoo asked, where do we draw the line between somebody who wants restitching because it is part of something that was done to them when they were younger and a western woman who wants cosmetic surgery?

I saw an appalling programme recently. It was one of those late-night programmes on Channel 4 or Channel 5 in which people have all sorts of plastic surgery. They were doing vaginal reconstruction for a woman who felt that, having had two children, her vagina was too slack. The surgery was done on camera, but I could not watch—it was appalling. I turned off the television because I could not stand to watch. What pushed that woman to feel that such a procedure was necessary? She might have had other physical problems and been pushed into having it.

There can be similar pressures on women to change their bodies, regardless of where they come from. Cosmetic surgery is somewhat dodgy anyway and is forbidden in Islam; we are not meant to change what we have unless we do so for a medical reason, which is a good argument against everything that we are talking about. How we define medical reasons is difficult and perhaps some of that can be left to doctors. However, we might then leave a loophole in which a doctor could say, “We are doing this to preserve the patient’s mental health, because she thinks that she will suffer mentally unless she has the procedure.”

Marilyn Glen: I realise how complex the matter is. Some countries have laws about FGM that include an age limit of 18 years, to allow consenting adults to undergo the procedure. Should the bill include such an age limit?

Efua Dorkenoo: That would be difficult for FORWARD. Technically, if there is no age limit, you are treating the African woman as a child—I stress the word “technically”. However, the reality is that gross pressure is brought to bear on African women and it is more likely for women to be conditioned—the push factor is strong.

You must also consider the pressure that the extended family might put on a woman over the age of 18—she might not even be from the community. Years ago, I worked with a white woman in Manchester who married a Sudanese man and was pressured by the women in the community to undergo infibulation. She underwent the procedure to be accepted within the group.

In places in Kenya, if a woman from an ethnic group that does not practise FGM marries into an ethnic group that practises FGM, the older women in her husband’s family might stop her when she is out walking one day, pin her down and mutilate her. If the bill were to include a cut-off point of 18 years, there would be no protection for a great many women and the pressure would continue. However, technically, the women from practising communities would be considered as non-adults, so the issue is complex.

We have tended to consider the priorities for women who are affected. Some 100 million to 140 million girls and women have undergone some form of FGM in our countries and the prevalence of the practice is extremely high in certain groups. We must consider where we should place the emphasis and we have tended to agree that the law should cover adults as well as younger women. We are being pragmatic, because we understand that technically that is not ideal.

The Convener: If Fariha Thomas does not want to add to that, Nora Radcliffe may finally ask her questions.

Nora Radcliffe (Gordon) (LD): Good morning—it is still the morning. Is it realistic to expect that the bill will prevent people from sending their children abroad? Also, the bill would increase the maximum penalty from five years’ imprisonment to 14 years’ imprisonment. Will you comment on that?

Efua Dorkenoo: We can consider the bill as an education tool. If the message about sending their kids abroad gets through to the communities concerned, parents will sit up and think about what they are doing and the bill will offer some protection to the girls who are in that situation. Again from the education angle, the increase in the penalty would spell out the seriousness of the matter.

Fariha Thomas: I agree with that. The bill may stop people sending their kids abroad. I hope that it will. It also shows that the issue is serious.
Nora Radcliffe: I would like to return to an earlier discussion about what should be in the bill. I wonder whether having four degrees of mutilation sends a signal that one is less bad than another. I shall read what is in the bill at the moment and you can tell me whether you think that it is better because it is complete. At present, the bill states:

“A person who excises, infibulates or otherwise mutilates the whole or any part of the labia majora, labia minora or clitoris of another person is guilty of an offence.”

Do you think that that is stronger than having four degrees of mutilation and saying that each is unacceptable?

Fariha Thomas: I think that the bill is fine the way it is, because it is comprehensive. If it started going into the different degrees of mutilation, that would get too complicated. You are right to say that people might think that one form is not as bad as the next. However, as I said at the outset, I am not really an expert in that field. It may be that people elsewhere have found that putting in the details of the World Health Organisation categories has been helpful.

Efua Dorkenoo: We must ensure that we do not get into a situation in which—as some anthropologists might suggest—units could be created in the clinics where pins could be put into the clitoris to release some blood, so that the parents would be happy.

Nora Radcliffe: In a symbolic way.

Efua Dorkenoo: That is right. The WHO included type IV as an unclassified area that includes all kinds of things that people might want to include in one law. For example, some communities do not cut, but they pull to stretch the clitoris; they do that to little girls. Large numbers of women, in order to please their men, put all kinds of things inside the vagina to tighten it, which can lead to complications when they are delivering or for other gynaecological health reasons. However, you may not want the bill to cover everything—I shall leave that to you.

Nora Radcliffe: That is helpful.

Fariha Thomas: When I read the bill, I wondered whether body piercing might be covered. I believe that it is quite trendy to put rings and things into all sorts of parts of one’s anatomy, including some of those organs. I wonder whether that issue has been considered.

The Convener: That issue has been thought about. We have also been educated about it, although we might have thought, “Oh no, surely not.” We have looked at that and taken it into consideration in the context of the bill.

Thank you for your evidence and for coming to see us this morning—particularly for coming north of the border to tell us about your experiences. It has been very helpful.

Efua Dorkenoo: It was a pleasure.

11:58
Meeting suspended.

12:09

On resuming—

The Convener: I welcome representatives of the Somali women’s action group and their interpreter. If committee members ask questions too quickly and you need more time to interpret what has been said, or if you are not absolutely clear about the question, please tell us. Sometimes we get so involved in an issue that we want 10 questions to be answered at the same time. If that happens, tell us to wait a minute.

Thank you for coming along this morning. Your evidence on the Prohibition of Female Genital Mutilation (Scotland) Bill is very important for us. I will put my questions first. If I get things wrong, other members will tease me. Can you describe briefly for the committee how FGM can affect the girls and women on whom the procedure is carried out?

Witness A (Somali Women’s Action Group) spoke in Somali.

Witness C (Interpreter): She says that a girl may suffer from bleeding and heavy periods.

Witness A: It is a big operation and is done without anaesthesia or other help, so a girl may have a lot of pain. She may have bleeding and infection. Many girls have died of tetanus, because sometimes thorns from trees are used, without having been washed. A girl may die from haemorrhage or a tetanus infection. The cycle goes on after the procedure, as the girl may have painful periods. When she gives birth to a child, she has to be cut. There is no end to it.

The Convener: Paragraph 4 of the policy memorandum that accompanies the bill states:

“No religion requires female genital mutilation, and the practice is not limited to any religious group.”

However, religion is still given as a reason for carrying out FGM. Do you believe that the new law will make any difference in that respect? How do you think that we should tackle the misunderstanding that FGM is a religious instruction, rather than a tradition?

Witnesses spoke in Somali.

Witness A: Could you repeat the question?

The Convener: In some communities, it is understood that female genital mutilation is a
religious instruction. Others say that there is no religious requirement to have it done. There is a misunderstanding about whether it is done because of religion or because of a tradition. How do we deal with that misunderstanding?

Witnesses spoke in Somali.

Witness C: She says that it is not a religious practice, but a cultural practice.

The Convener: Do people understand that?

Witness A: Yes. They do it because it is part of their culture.

The Convener: It has been around for a long time.

Witness A: Yes, but it has nothing to do with religion.

The Convener: In your experience, from where in communities does the cultural pressure to carry out FGM come? Does it come from particular groups or sections of the community? How can we challenge the tradition?

Witnesses spoke in Somali.

12:15

Witness A: It comes from older people, because they are trying to keep their culture. They want to stick to their culture and they do not want to change. They think that it is a shame if it is not done. They do not feel good about that. Younger people are more educated and understand the complications and dangers. The older people are mostly not educated and do not read or write. They just stick to the culture.

The Convener: Do they want to protect the practice because they see it as part of their culture?

Witness A: Yes. They do not want to lose it.

Elaine Smith: When I met you before, you talked about the intense pressure in the Somali community to carry out the procedure on girls. You say that it is seen as a good thing for girls. Can you confirm that in the Somali community the main purpose of FGM is to ensure chastity and purity prior to marriage and thereafter?

Witness A: Yes.

Elaine Smith: Given that the law is not just about punishment, but about raising awareness and changing deeply rooted cultural attitudes and traditions, do you think that education is the way forward? I will give you an example of programmes that other Governments have funded. In Kenya, there is an initiation ceremony of circumcision through words, which serves as a rite of passage into adulthood for young women. It is about sex education and raising awareness through words, rather than the practice of FGM. Might that be helpful in your community?

Witness C: It would be, if it were tried.

Witnesses spoke in Somali.

Witness B (Somali Women’s Action Group): We know that it is illegal, but our group does not understand what is legal or illegal. People do not understand if we say that it is illegal. They say that they do not want to change their culture. Our group needs more education.

Elaine Smith: Do you think that, because FGM is a cultural issue and is deeply rooted, it is more difficult to deal with it in communities that are living in the UK, which may feel under pressure to hold on to cultural traditions?

Witness B: It is difficult to tell someone that the practice is illegal and that we can no longer carry it out because it is a very bad practice that is dangerous for our daughters. Our group is only three months old. We hold meetings to talk about the issues and tell our group that, although the practice is part of our culture, it is not good for our children. It is not good for their health or education.

The Convener: So it is more important to tell people that the practice is not healthy and is not good for the children. The issue is about protecting the children and trying to change the culture, rather than saying, “FGM is illegal. You can’t do it.”

Witness B: Yes, we try to do that.

Witnesses spoke in Somali.

Witness C: They say that that would be much better.

Shiona Baird: My questions are about the consultation that the Scottish Executive carried out. It was carried out over a very short period. Did you have long enough to respond and would you have responded differently if you had had more time?

Witnesses spoke in Somali.

Witness B: Yes, we had enough time.

Shiona Baird: You were happy with the consultation.

Witnesses spoke in Somali.

Witness C: They agree.

Shiona Baird: My other question concerns language. Were you aware that information on the bill was available in a language other than English and did you know that you could ask for a translation of the material?

Witnesses spoke in Somali.
Witness B: Translation is better, because our people understand the Somali language better. We are new in Scotland and most of our people do not understand English, so a Somali translation would be better.

Shiona Baird: It would be important to have a Somali translation, then.

Witness A: Yes.

Nora Radcliffe: I will take that a stage further. We spoke earlier to a lady from London, who said that it is fine to get materials translated into Somali, for example, but if people do not read the language, it is probably as well to have the materials on tape so that they can hear it rather than have to read it. Do you think that that is important?

Witness C: Yes, that or images and people who can explain them.

Witness A: Any way that people can understand more.

The Convener: So translation, tapes and different kinds of publicity and information are important.

Witness C: Yes, they are very important.

Ms White: I welcome the witnesses. Thank you for coming along.

There has been some debate about the terminology that is used—“circumcision” or “female genital mutilation”. A member of the media just asked us whether we had a different word, because they were uncomfortable with using the word “mutilation”: Is it important to make the change from using the word “circumcision” to the phrase “female genital mutilation”? How will that affect the communities that we are trying to reach?

Witness A: What they do is more than circumcision, so I agree with using “female genital mutilation”. They remove so many parts.

The Convener: It is much more than circumcision. That is a good answer.

Ms White: I am pleased that the witness said that. We have heard from witnesses previously that, if we used the word “mutilation” in the communities, the women who had gone through it would feel bad, so it might be better to use “mutilation” in the bill but mention that what is considered to be circumcision in the local communities is also covered by the word “mutilation”: Do you think that we should go straight for saying that we are dealing with female genital mutilation, without using softening words?

Witness B: Our group uses the word “circumcision”. When we translate our language, we use the word “circumcision”. Perhaps it is better to use that word.

Ms White: That is the point that I am trying to clarify. Perhaps some groups are uncomfortable with the word “mutilation”. However, when the chap from the media said that he was uncomfortable with using the word “mutilation”, we were shocked, because I believe that we have to get across the message that we are talking about mutilation.

Witness C: The bill should say “mutilation”, because that is what happens. It is not circumcision, because that word refers to one thing, whereas lots of things are being done.

Ms White: So we should be using the word “mutilation”.

Witness C: Yes.

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

Witnesses spoke in Somali.

Witness C: The new law will help the people who live in the UK or Scotland. What about those who live abroad?

Mrs Milne: So far there have been no prosecutions under the existing law. It is unlikely that there will be many prosecutions under the new law. Do you have an opinion about the lack of prosecution? Why will people not come forward to seek prosecutions? Can anything be done to make prosecutions more likely?

Witnesses spoke in Somali.

Witness B: We do not understand. Can you ask again, please?

Mrs Milne: People have not been prosecuted for carrying out FGM. Cases are not usually reported to the authorities. Why is that? Can steps be taken to encourage people to come forward and report it so it can be prosecuted?

Witnesses spoke in Somali.

Witness C: They say that people help each other, because no one wants to go against the Somali community; everyone wants to stay in that community. People cannot go to the police and report it, because they will end up out of the community. People help each other, even if they are against it.

Witness A: If someone reports something today and it happens tomorrow, they have the same problem.

Mrs Milne: Do you think that education will gradually change things?

Witness A: I think so.
Mrs Milne: People will be less afraid.

Witness A: Yes. People have to be aware of what is going on, the complications and the danger that their children are in. From childhood women are frightened. They are waiting for the day. They are not comfortable at all. They are always asking questions. They need to understand more.

Mrs Milne: So it is not just about the law. It is a long process.

Witness A: Yes, to make it clear what is going to happen.

The Convener: Do you think that the discussion around FGM and the publicity that comes with it will help to give people information and ammunition to stop their children having FGM in the future, or that they will help to change cultures? At the start, it was clearly said that female genital mutilation can be dangerous and unpleasant. Can we consider ways of trying to change people's attitudes? Obviously, people are not going to talk to their mother or grandmother or tell the police that their grandmother or whoever was involved, but are the law and the information that people have important?

12:30

Witness A: Yes. People must then uphold the law and think about what will happen to them if they do not. They need both.

The Convener: So information is important.

Mrs Milne: Will more publicity and education make it less likely that children will be taken abroad?

Witness C: They will be taken abroad, but GPs should examine girls in the country before they go abroad to find out whether they have had it done. They must also be checked when they come back.

The Convener: We want to stop people taking their children abroad for FGM.

Elaine Smith: Would the practice make people reluctant to take children to a GP if they were ill?

Witness C: Yes, it would.

Elaine Smith: The midwife from England said in the previous session that a difference had been made in a Somali community in England because the community leaders—the most respected and more senior members of the community—had made it clear that FGM was unacceptable. Is that a way forward? Would influential people in the community spelling out such a message be a good way of changing attitudes, cultures and traditions?

Witnesses spoke in Somali.

Witness B: Yes. Our group respects old women, so if an old woman says that we have to do a practice, we do it. So, first we need to talk to the old women and tell them that the practice cannot be done.

Elaine Smith: What about the men? When I met you, we talked about the attitudes of men.

Witness A: They are also important.

Ms White: I was thinking about getting into communities to educate people. We have talked about education in communities. Are there any activities apart from those that have already been mentioned that we could undertake with communities, groups and educators in your communities to raise awareness of, and work towards the eradication of, female mutilation? Is there anything that we can do immediately or in the long term in your communities?

Witnesses spoke in Somali.

Witness C: We need a lot of meetings. There are also a lot of things to be done.

Ms White: Would it be relatively easy for committee members or individual MSPs to go and speak to the relevant members of your community? Would those people be willing to listen and to take on board educational materials?

Witnesses spoke in Somali.

Witness C: Witness A says that you can go there but, to be educated, those people need a Somalian person to be able to talk to them. The FORWARD people can be there and observe.

Witness A: People think that, if a foreigner is talking to them, that means that they are trying to change their culture or influencing them to do something. It is better if it comes from their own people.

Ms White: So it would be better if someone from the Somali community were appointed to speak to the elders and to distribute the material that is produced by the Scottish Executive. Would that be the best way to go about it?

Witnesses: Yes.

The Convener: It is always important for women within a community to be active. Perhaps it is about women in the community being aware of information and being able to spread that information, rather than having people coming into the community to tell women what they have to do. I would object to people coming into my community to tell me how to live. I am sure that it would be the same with you. It is about trying to spread information and get discussion going, with organisations providing the necessary support for that work.
Witness C: Yes.

Ms White: I agree entirely with that. I wanted your views on how easy it would be for someone in the community not to feel ostracised by carrying out such work. I am sure that, as you have mentioned, there will be women in the community who can do that work.

You mentioned that people should be aware of situations in which children are taken out of the country and have the operation. How can we reach members of the medical professions, social workers and child care professionals? They need to be educated about what is happening to children in the communities. What would be the best way of approaching those professionals?

Witnesses spoke in Somali.

Witness C: That includes people providing medical care, too.

Witness A: People do not know how to reach them when it comes to—

Ms White: Medical professionals, even—

Witness C: Yes, medical professionals.

Ms White: When a woman is having a baby, or when it comes to treating adolescents, people need to be able to recognise that someone has had FGM done to them. We are pushing for such expertise. We spoke to the people from England—FORWARD—who have had 20 years’ experience. Are there enough experienced people in Scotland to handle the type of investigation or education that is required? Should we be bringing up people from FORWARD or other organisations in England, where people have more expertise, to give us a hand?

Witness C: Yes, I think that you should get the people from London to help. They have more experience than people in Scotland.

The Convener: They have experience and practice.

Witness C: Yes.

Elaine Smith: I want to talk about the care that is required when a woman is pregnant. If a woman has undergone FGM and goes into hospital to have a baby, is it common for her to want to be stitched up again afterwards? Would that be a common request?

Witness B: Yes. That would be very common. I remember that, two months ago, one of my friends was pregnant. She had had female genital mutilation. When the doctor saw that, he was surprised. He did two operations.

Witnesses spoke in Somali.

Witness C: Could you repeat the question, please?

Elaine Smith: Yes. I will phrase it differently. I am concerned that women would elect or ask to have—

Witness C: After a baby is born?

Elaine Smith: No—before the baby is born. I am concerned that women might ask to have a caesarean section because it would be illegal for them to be stitched up again after the baby is born. I am concerned that, because of that, a lot of women will undergo an intense surgical procedure. Another aspect is that caesareans might be performed routinely because the health staff do not know how to deal with the issue of FGM. Have you had any experience of those issues?

Witness C: As an interpreter, I have been to a lot of births, but I have never seen a Somali lady who asked to be stitched after her baby was born.

Witnesses spoke in Somali.

Marilyn Livingstone: Thanks very much for coming to the meeting. Are you aware of any other communities in Scotland where FGM is practised? If so, do you have any communication with them?

Witness B: We have met some people from different countries like Egypt and Sudan. We have met those people to discuss the issues. We know more people, but we do not know exactly about other communities.

Marilyn Livingstone: The policy memorandum to the bill states that there is no evidence that the practice is widespread in communities in Scotland, but it also recognises the private nature of the practice. It is not easy for the Scottish Executive to collect statistical information on the number of women and young children who have been affected. How would you advise us to try to collect the information and keep it up to date?

Witnesses spoke in Somali.

Witness C: Go door to door to ask everyone if they have done it. The survey should be anonymous. It should not ask for the person’s name, but the age and whether she has had it done.

Witness A: If we say that we will write down the name, nobody will tell us anything.

Marilyn Livingstone: Yes. The information that is collected should be confidential, statistical information.

Witness C: Yes.

Marilyn Livingstone: We heard from witnesses earlier that a lot of information, in particular health information, is available in different formats. What
access do you have to that information? Would it be helpful to have more such information?

Witnesses spoke in Somali.

Witness C: They say that they have a meeting every two months on the health problems and that they will do whatever it takes to inform those people.

The Convener: So, more information is important—

Witness C: More information, yes.

12:45

The Convener: How aware of FGM issues are the health professionals who work in the communities? We are finding that often the health professionals, as much as communities, need awareness training and education on particular issues. How much information do they have? Do you think that you need lots of information and support?

Witness A spoke in Somali.

Witness C: A lot, she says. The health board does not have that much information.

Marlyn Glen: Some countries that have laws against FGM set an age limit of 18 years, which allows consenting adults to have the procedures carried out. Do you think that the law here should include an age limit?

Witnesses spoke in Somali.

Witness C: Yes. When they are 18 years old, a person should be able to decide what is done with their body.

Marlyn Glen: So, once a woman is 18, she should be able to give consent?

Witnesses indicated agreement.

Marlyn Glen: That is not in the bill at the moment. Were you aware of that?

Witnesses indicated agreement.

Witness C: Yes. If she is 18, she can decide what will happen to her body.

Marlyn Glen: Do you think that she would be able to make that decision without pressure from anyone else?

Witness A spoke in Somali.

Witness C: If she lived in the UK, no one could pressure her.

Marlyn Glen: So, if she lived in the UK, it would be okay to have an age limit.

Witness A: Yes. She would be under no pressure.

Nora Radcliffe: The new law will increase the possible term of imprisonment—from five years to 14 years—for anyone who carries out FGM or who arranges for it to be carried out either here or abroad. Do you have any views about that change in the length of sentence?

Witnesses spoke in Somali.

Witness C: They do not have anything against that, but people should be taught that the law is coming and that they are going to be sent to prison for 14 years. They should be made aware of that.

Nora Radcliffe: Do you think that the threat of a much longer sentence will have more influence?

Witnesses spoke in Somali.

Witness C: Yes.

Nora Radcliffe: If the bill makes it illegal to have girls sent abroad to have FGM, do you think that will help to stop the practice?

Witness A: If there is a possibility that the Government knows what someone intends to do, they will not do it. The Government should be able to find out whether it has been done.

Nora Radcliffe: You are saying that it is all very well to have the law, but that it must be enforced and the Government must take steps to ensure that people are found out.

Witness A: Yes. If that is the case, people will think twice before they act.

Nora Radcliffe: We hope so.

Elaine Smith: I want to pick up on a couple of points. When I met you before, you did not think that FGM was being carried out in Scotland. You felt that the fact that it was illegal meant that there was a deterrent. However, I presume that girls might still be being sent abroad. Is that correct?

Witness C: Yes.

Elaine Smith: The new law should help to stop that happening, but I am concerned that FGM might be being carried out in other communities in Scotland. Although FGM is illegal in Tanzania, it is still being performed underground. Are you sure that it is not being done in Scotland?

Witness A: I do not think that it is being done in Scotland.

Elaine Smith: It is important to pass the bill, because the problem at the moment is children being sent abroad.

Witness A: If children are forced to have it done abroad, they will report that—they will not keep quiet.
Elaine Smith: When I spoke to you before, you felt strongly that asylum seekers, too, should be covered by the bill. The reason for their not being included seems to be that if people who seek asylum leave the country, their asylum application falls. However, is it possible that the daughters of asylum seekers could be taken abroad by other members of the community who were not asylum seekers because they had already been granted residency? If the bill does not deal with asylum-seeking families, those girls might not be covered by it. Is that an issue? Could that happen to girls in that position?

Witnesses spoke in Somali.

Witness C: I do not think that that would happen in the Somali community.

Elaine Smith: Why does the group think that asylum seekers should be covered by the bill?

Witness C: Asylum seekers are not all Somali people. There are many asylum seekers from other countries, whose children could be sent abroad to have it done.

Elaine Smith: So you think that, in other communities, children of asylum seekers might be taken abroad by someone else.

Witness C: Yes.

Witness A: If asylum seekers are not given asylum, they will be sent back to Africa, where such oppression will be carried out.

Elaine Smith: That takes us on to a slightly different issue—the reasons for granting asylum. I think that the immigration authorities should consider the threat of FGM as a good reason for granting asylum. You said that although it might be difficult for women to volunteer that information, if they were asked a specific question, they would answer it. Is that correct?

Witness A: Yes.

Witnesses spoke in Somali.

Elaine Smith: Do you think that the upcoming generation of men in your community have a different attitude to FGM? Would they wish their wives or the women that they want to marry to have FGM undertaken? Have attitudes among younger men changed?

Witness C: It depends.

Elaine Smith: On what?

Witness C: Most of them believe that, but some guys do not. It depends on the individual.

Elaine Smith: Is that the result of their being influenced by the different culture or would they have felt that way anyway?
11 January 2005, (1st Meeting, Session 2 (2005))

Submission from Glasgow City Council

Female Genital Mutilation – Draft Bill

Glasgow City Council welcomes the opportunity to comment on the draft Female Genital Mutilation (Scotland) Bill which will close the current gap in Scots Law and align the legal position in Scotland with that of England and Wales. More women in Glasgow are affected by this issue than anywhere else in Scotland and therefore it is appropriate that Glasgow's views are taken into account. However, due to the tight timescale, there has not been time to consider the document through the Council's committee structure. Therefore this response has been prepared by officers on behalf of the Council in consultation with the Council’s Equalities convener.

We endorse the position of the Executive in subscribing to the United Nations General Assembly definition of Violence Against Women which places Female Genital Mutilation (FGM) on a continuum of gender based violence which causes physical, sexual and/or psychological harm to girls and young women. The World Health Organisation estimates that every year two million women undergo some form of genital mutilation. FGM is a violation of women's and girls' human rights and its effects can last for the rest of their lives. The practice can lead to severe pain, infection, excessive scar tissue, problems with childbirth and even death. Additionally, women report feelings of anxiety, terror, humiliation and betrayal.

The Council is committed to tackling all forms of violence against women and we would agree that the current law in Scotland in relation to FGM requires to be strengthened. African women living in Glasgow report pressure on them from families in Africa to send their daughters abroad for FGM to countries where the practice is legal. Widening the law to make it an offence to take a girl or woman abroad for the purposes of FGM would close this loophole and help to eradicate this dangerous tradition.

Whilst supporting the draft Bill, we would wish to comment on the following points:

Section 1(a) identifies the circumstances where no offence is committed by an approved person who performs “a surgical operation on another person which is necessary for that other person’s physical or mental health”. It is assumed the mental health aspect of this section is to ensure there is no difficulty for women who wish to undergo sex reassignment surgery. Perhaps this should be mentioned specifically to close a loophole where the legislation may be open to abuse.

The addition of the phrase “for the purpose of determining whether an operation is necessary for the mental health of a person, it is immaterial whether that or any other person believes that the operation is required as a matter of custom or ritual” is a helpful inclusion in the Bill although it is potentially difficult to enforce. This safeguard within the legislation will require close scrutiny and rigorous application. Whilst the World Health Organisation condemns the practice of FGM there is some evidence to suggest that in some countries, the practice is being medicalised and therefore legitimised.

Section 3(a) and Section 6 define those who would be protected under the Bill as a United Kingdom national or permanent United Kingdom resident. It would therefore appear that the provisions of the Bill will not apply to women and girls who are seeking asylum or those who have been granted Indefinite Leave to Remain/Humanitarian Protection. Many of these women and children are likely to come from countries where Female Genital Mutilation is commonly carried out and could be in a position of significant risk but will not be afforded legal protection on an equitable basis. This position would be extremely concerning for Glasgow and we would urge the Executive to ensure that the legal framework explicitly recognises the needs of and ensures the protection of all women and girls under Immigration Control.

As part of the African Caribbean Network in the City, the Somali Women’s Association has expressed its desire to work with the Council and other partners to raise awareness of this issue and its devastating impact on girls and young women. The Council will continue to support the group and views the introduction of this Bill as an essential tool to provide girls and women with additional protection and as a route to increase education and awareness raising.

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We are also aware that the group has met with the First Minister to discuss FGM and other support needs for girls and women. Resources to appropriately empower these vulnerable women and increase their capacity to collectively work in partnership with others on this agenda will now be required.

George Black  
Chief Executive  
Glasgow City Council  
August 2004
Scottish Parliament
Equal Opportunities Committee
Tuesday 11 January 2005

[THE CONVENER opened the meeting at 10:04]

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

The Convener (Cathy Peattie): Good morning. I welcome everyone to the first meeting of the Equal Opportunities Committee in 2005 and wish everyone a happy new year. We have apologies from Sandra White this morning.

Agenda item 1 is consideration of the Prohibition of Female Genital Mutilation (Scotland) Bill. I give a warm welcome to Councillor Irene Graham, Moira McKinnon and Jean Murphy from Glasgow City Council. I understand that Ann Marie Mullaney is unable to attend.

I thank the witnesses for their interest in the bill. It is important that local authorities have been considering the issue that it addresses. I invite Irene Graham to make an opening statement.

Councillor Irene Graham (Glasgow City Council): I will not make a long statement. Glasgow City Council considers female genital mutilation to be part of the continuum of violence against women. In Glasgow, our approach to violence against women covers the whole range of violence, which includes prostitution—many of the committee members know our stance on that. That is the context in which Glasgow City Council is making its response.

The Convener: Do you have any views on the consultation process that the Scottish Executive carried out? The consultation period was short, as you said in your response to the consultation. Did you have enough time to respond? Would you have responded differently had there been more time?

Jean Murphy (Glasgow City Council): The timescale was tight for us, particularly as the consultation ran during a holiday period and many of the people who we felt might have had something to say that we could include in our response were not around. It was also during the council recess, so there was no time to prepare a report to go through the committee structure, which was problematic for us. However, I am not sure whether the response would have been any different had there been any more time. We might have been able to include other organisations’ responses in ours, but we cannot be clear on that, although we were able to include the Somali women’s action group. That group did not know about the consultation, but it was a new group, so it would probably not have known about the consultation anyway.

The Convener: I was interested that the Somali women’s action group had been involved. Was it your community workers or other links that you have with the group that enabled you to encourage its participation?

Jean Murphy: It was sheer chance that I had been invited along to the group’s inaugural meeting a week before I received the consultation document. At that meeting, the group had stated that one of its objectives was to tackle FGM, so I knew that it would have something to say on the issue, which is why I encouraged it to respond to the consultation.

The Convener: Were you aware whether information on the bill was available in a language other than English or whether there was a process for asking for a translation? If not, should the information be made available in other languages? Should there be another approach to ensure wider access and participation in commenting on such a bill?

Jean Murphy: Yes, there should. The information was available in other languages, but that was not clear from the introductory letter. There was a line at the end of the letter to say that information was available in other languages, but it might have been better if the information had been available from the beginning in the most obvious community languages and other formats, such as on tape or in Braille.

Councillor Graham: The council has a lot of experience of producing documents in more than one language, but we are aware that even when we do that, it does not always meet the need, because many people in the communities are not literate. That is especially the case with women. We all—whether the Executive or the councils—have to think about other forms in which to make such sensitive information available. For example, a well-placed key worker working with the communities often provides a good route in. In Glasgow, an African-Caribbean development officer, Khadija Coll, has been recruited. She works through the Taleem Trust and is working with at least 12 established groups from African communities plus two new groups. We must all consider supporting such contacts to take the message into the communities by word of mouth.

The Convener: You are right. It is not enough for the information to be available in different languages, because if people do not know that it is available, it does not matter what language it is in. We need to have contact with the communities and other ways of working with them. That is an important point.
Moira McKinnon (Glasgow City Council): I will comment from a child protection point of view. I do not know how the consultation relates to the current three-year reform programme for child protection. If we had had a bit more time, we might have been able to create a debate on the child protection implications among child protection professionals, who are probably struggling with FGM as well and have limited knowledge of the issues.

Elaine Smith (Coatbridge and Chryston) (Lab): I will ask about terminology, but before I do so, I will pick up on something that Councillor Graham said. She said that she saw FGM as part of the continuum of violence against women. She did not say “male violence” against women, but I presume that the greatest violence against women and children is male violence. Therefore, how would you answer the comment that some folk have made to me—perhaps not on the record—that FGM is carried out on women and children by women? Why is FGM performed in that way?

Councillor Graham: First of all, I clarify that I meant male violence against women. To answer the question where this procedure fits in, given that many of the practitioners who perform it are women, one has to look at the cultural norms and the intention of female genital mutilation. From my understanding of the situation and having looked at submissions to the committee from experts, I think that it is clear that FGM comes from society. Given that men dominate society, and that African societies in particular are very patriarchal, men in society are attempting to control women’s sexuality. Although women might be the practitioners of FGM, they conduct the practice in that cultural context, which is about controlling women’s sexuality.

Elaine Smith: I hope that you did not mind my asking you that, because it is important to make such points on the record.

We have had some discussion about the word “circumcision”, which is often used to describe FGM. What are your views on using that word rather than “mutilation”? Is it important that we talk about “female genital mutilation”? Is that terminology likely to impact on the communities that practise FGM? Some people in those communities still speak about circumcision rather than mutilation.

Councillor Graham: We are in favour of using the term “female genital mutilation”. My personal reason is that when we hear the word “circumcision”, we think that it is an acceptable practice that happens legitimately with no outcry. We tend to think of male circumcision, which is an established practice in many faith communities and for which there are often good medical reasons. However, what happens to women is not in any sense the same as male circumcision. The danger of using the word “circumcision” is that it diminishes what happens to women because we tend to think that the practice on men is accepted throughout the world. If we consider the range of mutilations that go on under the so-called acceptable term “circumcision”, in all conscience, I think that what happens to women is nothing like circumcision.

Evidence that was given to the committee said that some of the practices that are carried out on women are done for reasons to do with cleanliness. I do not see the medical evidence for that and think that such claims confuse the issue and give female genital mutilation a legitimacy that it does not have.

Elaine Smith: Do you think that despite the number of people who might feel offended by the term “mutilation”, the purpose of using it is to call a spade a spade and to raise awareness of what the matter is really about?

Councillor Graham: We have to tap into how the different communities use their own terminology if we are to make a difference and a change. However, we should be clear that we are talking about the World Health Organisation definition of female genital mutilation. Although we have to work with the communities and perhaps access their understanding by using whichever words they use to describe the practice, we have to go beyond that. If we just accept their terminology, we will not be giving people the tools with which to mount a challenge in their communities.

Marilyn Glen (North East Scotland) (Lab): My questions are about policy objectives. Do you believe that the new law will protect girls and women from FGM and that it will provide more protection than the existing law?

10:15

Moira McKinnon: The new law is welcome. At the moment, young people and adults are protected. However, the difficulty concerns what happens in practice. Although a law exists to protect children and vulnerable women, from a child protection perspective, we know little about any children in our community to whom FGM is happening. We hear that it is happening, but it is not coming to our attention. In Glasgow, we are not working with children in families in which we know that the practice is happening and we are not working to protect children. Although I cannot speak about the national context, I think that that situation will be replicated throughout Scotland.

The law is welcome because it gives us a legal status and a position from which we hope to be able to protect children in the future. However,
how we implement the law and how we begin to work with families and to get into communities to identify the problem that is happening are a different issue. We still face many difficulties in communities.

Councillor Graham: The law will give us a framework that will let us set out our stall and our intentions. However, the law on its own will not be sufficient and has to be backed up by a range of measures. First, there has to be clear political leadership, which the law will provide, but how we deal with that thereafter will be crucial. A range of training and awareness raising needs to be provided alongside the law and that must be aimed at many different professionals. Awareness must be raised in communities and education must be provided in schools. We also need to look at what support we can provide in communities. If we raise awareness of FGM in schools, we have to consider what support we give to young people who might disclose either that it has happened to them or that they suspect that it will happen to them or to a younger or older sister.

Marilyn Glen: Moira McKinnon said that you are not working with families at the moment, but that you hear that such practices go on. The policy memorandum notes that there is anecdotal evidence of FGM in the Somali community in Glasgow. Are you aware of any other groups or communities where it is likely that the practice is carried out?

Councillor Graham: No. We considered that question and we do not have anecdotal evidence from any other communities, although that might change as the issue is brought out more into the public domain and we have more confidence about speaking about it.

Marilyn Glen: So the bill is helpful in that way. The explanatory notes to the bill explain that there have been no prosecutions under the existing law and that the Scottish Executive does not expect there to be many prosecutions under the new law. What are your views on the lack of prosecutions under the existing legislation?

Councillor Graham: In looking at why there have been no prosecutions, we have to understand the context in which FGM happens and the fear, shame and stigma that would be attached to communities if someone were to push for such a prosecution. Typically, the sense of family is much stronger in those communities and community pressures on people are much stronger, so it is not unusual that there have been few prosecutions at this stage.

We can draw a parallel with the number of prosecutions for and reports of domestic violence and abuse in this country. It is not the case that there is a much higher incidence now than there was 20 or 30 years ago; it is just that the political climate has changed and women are now able to come forward. However, it has taken a long time for that confidence to come out in women and as we know, many women still find it very difficult to come forward. One can translate that experience to those much newer communities in Scotland, in whose culture the sense of family is strong. I am not surprised that there are few prosecutions, because there is very little reporting.

Marilyn Glen: That is a helpful analysis.

Elaine Smith: On that point, when I met the Somali women’s action group, its members thought that there were no prosecutions under the existing law because it acted as a deterrent and people knew that it was illegal to carry out the practice in this country.

We know that girls are being sent abroad, even if the evidence is only anecdotal. I hope that the bill will prevent that by making it illegal. I will take up the family issue that Irene Graham raised. The worry is that when the bill kicks in to make sending girls abroad illegal, that might have an impact on whether families seek medical help or help in the community, for example, because people might be concerned about having to give evidence against their family, who had arranged for the procedure to be undertaken abroad. Could that be an issue?

Councillor Graham: Yes. In the hypothetical scenario that a young girl who was taken abroad for one of the forms of female genital mutilation developed an infection on her return, her family might be unwilling to take her for medical assistance, for the reasons that you gave. That could also apply much later. The issue might arise not when the practice is undertaken, but when a young woman becomes pregnant and goes to gynaecological services. The issue could suddenly arise then.

Perhaps there are parallels with child sexual abuse, much of which is not disclosed until girls and boys become adults. The impact that you described could occur. We must send the message that women and girls are valuable and are valued and equal members of society. We must break through the old patriarchal traditions that still apply in many African communities. From speaking to some people who work with African communities, I know that women are often not allowed to attend meetings—those are the words that are used. The stakeholders and gatekeepers for consultation are often men. Therefore, we must go beyond that or try to work with leaders. If they take the lead, some taboos will begin to be broken down.

Marilyn Glen: You talked about the need for leadership, training and awareness raising and I will develop that. In the absence of initiatives to
support it, will the bill assist in working towards eradicating FGM? If so, how?

**Councillor Graham:** I am sorry—did you say, “In the absence of”?

**Marilyn Glen:** Yes. I mean the bill on its own.

**Councillor Graham:** If the bill is passed and no campaign or process is put in place to back it up and to make people aware of it, the danger is that it could be just a well-intentioned bit of paper. I hope that that will not be the case. The scrutiny of the bill and the consultation that is taking place suggest that the bill will not stand alone. People already have to discuss and consider it.

The issues that the council must deal with are not easy. That is why we are pleased that Moira McKinnon is here today to deal with child protection issues. In a sense, those have not been tested, so we are not sure what can happen. The bill is forcing us to consider potential scenarios. We have discussed how the council would respond if it was given information and notice, given that it has not done that before.

**Moira McKinnon:** There is a considerable need for professionals who work in child protection to debate the issue, of which we as a group have had no significant discussion or understanding. For the bill to have an effect and for the legal changes to mean something, we need to educate workers in those communities who come into contact with families.

That applies not only to the new communities that we are talking about, but to our own communities in social work services. Social workers need to be aware of FGM and the fact that it could happen to a child with whom they are working. They need to begin to identify signs and what they should be looking for, just as we did 20 years ago with sexual abuse, when we told social workers about aspects to look out for and questions that they had to think about when engaging with a family. The same process will be followed. FGM is another form of child sexual abuse and will be dealt with as abuse would normally be dealt with under our tried and tested child protection procedures and processes, which are well established. Each agency understands fully its roles and responsibilities in relation to those procedures and processes.

As Councillor Graham said, we have not yet sat down in a case conference to debate the implications for a specific child and how we keep that child safe. We have not debated what steps we would take to prevent a child from going somewhere if somebody in the community told us that they believed that that child would go next week for the practice. Could we use child protection measures, such as child protection orders, to prevent a child from going? We talked about a child’s return. What support will such a child need? What support will a family need in the context of their community? We have not tested that. We need to think through how we manage such issues.

The child protection process is no different. When we understand a child to be at risk of female genital mutilation, we will take the same steps and use our processes in the same way as we would if a child was being sexually or physically abused. Our processes are robust enough for us to do that. However, we have not debated that. We need to open that up in a wider context with a group of key professionals who work in communities.

**Marilyn Livingstone (Kirkcaldy) (Lab):** I will take that slightly further. One of my tasks in the Parliament is to chair the cross-party group on survivors of childhood sexual abuse. I have seen how long it has taken us to reach the current position in which we discuss the subject openly. We know that child sexual abuse happens in society. Support for victims is not perfect, but we have a group of professionals in child protection, and many voluntary sector groups work with victims of abuse.

I am concerned about one issue that Irene Graham raised. She said that the people involved might present years down the line. I believe that some women in the new communities that the witnesses talked about will need help when they are pregnant or at other times. That raises two questions, one of which you have partly answered. We need to start having the debate now, because we do not want to play catch-up, which we might have to do because of the types of community that are involved and because FGM could present in very young children—as with sexual abuse—or in women. As you have said, we have seen that.

I have three questions, which I will ask all at once, because they are related. How do we start the process of ensuring that we have support? How do we ensure that communities know that support exists? How do we first create a forum in which people consider how to put that support together? My comment was quite long, but the questions are interrelated.

**Councillor Graham:** Moira McKinnon mentioned the child protection review that is taking place. We need to consider whether dealing with FGM is part of that discussion. If it is not, we need to insist that it is. That would help.

Your first question was about how we start the process of support. I think that the process has started. It is clear that Somali women’s organisations and other women in Scotland have raised the issue. Simply having the discussion has started the process. We need to look beyond that and ask women in the affected communities what
support they need. We cannot assume that we have the answers to that. You asked how we can ensure that the community knows that the support is there. That implies that there would be a set, standard response.

10:30

Marilyn Livingstone: That is not what I meant. People often know by word of mouth where they can go for support in relation to sexual abuse. Sometimes people go to a voluntary agency first, because child protection committees and the council are seen as authority bodies. Moira McKinnon is nodding; I think that she understands the point that I am making. Given the complexities of the issue, how can we make people aware of the agencies that are available to them?

Moira McKinnon: I do not know. I would have thought that one of the key places for debates should be child protection committees, which have responsibility in their area for key issues around child protection, the key debates that have to be had and the key decisions that must be made on a multi-agency basis. Most of the committees will have senior managers sitting around the table debating, discussing and agreeing to take forward their priorities.

That takes us back to the reform programme, which is taking a significant overview of what is happening in child protection in Scotland. We need to ensure that the reform programme sees FGM as a priority and begins to communicate that to child protection committees. The committees are the catalysts for taking forward the agenda that the reform team is driving.

Much multi-agency training is taking place in child protection committee areas. In Glasgow, we have a modular training programme that runs for nine months of the year. There are a range of modules covering sexual abuse and a number of other things. We are considering how we can raise professional awareness as well as awareness within communities, which Councillor Graham talked about. We need to ensure that that is part of the training agenda so that people can consider on a multi-agency basis the implications of female genital mutilation, what it means for the agencies, what their response would be and whether they understand their roles and responsibilities.

As Marilyn Livingstone said, in cases of sexual abuse, families and children will often go not to social work services but to other people for initial support, because sometimes they are frightened to approach social work services. For many people the same will apply in relation to FGM; they will go to their community leaders. We have to ensure that we work alongside community leaders, because we need them to take the issue seriously and to refer cases on to the appropriate persons.

Marilyn Livingstone: Thanks very much.

Councillor Graham: We are not talking about operating in a vacuum. The Scottish Executive has a national training strategy on male violence against women, on which a document is available. We need to consider whether we need to put the issue of FGM on to that agenda, if it is not already included. We also need to learn from what we know works in the broad spectrum of male violence against women. Glasgow City Council and other local authorities produce a comprehensive booklet that gives a range of information about who women can contact, whether in relation to child sexual abuse, rape, sexual assault or domestic abuse. That leaflet lists voluntary organisations as well as council services. The Glasgow violence against women partnership plays a key role in co-ordinating the production of such leaflets.

We know that, on their own, such leaflets are not enough. Many Women’s Aid organisations and other organisations have produced credit card-sized information cards that women who are trying to deal with domestic abuse can keep safely in their purse. We can learn from the information systems that we know work; we also need to consider how we can go beyond that for the specific communities that we are talking about.

I mentioned the Somali women’s organisation. Khadija Coll is working on developing an African-Caribbean network for Glasgow. We need to link in with her work, which she is doing across a range of communities. I know that she has taken up the issue of FGM over a number of years since she has been in Scotland.

We need to consider the key access points as well as what kind of information we provide. If women who experience female genital mutilation can understand that it is part of a range of abuse against women, that might help to allay some of their fears about breaking with their traditional cultures.

Jean Murphy: I want to add to what Councillor Graham said about the leaflet that is distributed in Glasgow on where women can go for advice and support, which has been on the go for many years and lists all the different organisations that can help women. The Glasgow violence against women partnership recently produced a version that is aimed specifically at asylum-seeking women and refugees and lists the agencies that can support them. It has been translated into all the languages that we know will reach the targeted communities.

Shiona Baird (North East Scotland) (Green): I want to expand on the point about the expertise...
that is available in Scotland. One or two people have been mentioned, but are there enough people in Scotland with the relevant experience? Some of our other witnesses have suggested that we should look outside Scotland to gain more information, help and advice to help further our expertise.

**Councillor Graham:** When the council considered lap dancing and prostitution, we considered the best practice and best models and considered whether they were transferable to Scotland or whether they needed to be modified. Rape and sexual assault centres are one of the proposals for which we hope to get funding for a pilot—fingers crossed. We did extensive research in England and elsewhere to find out what makes a good rape and sexual assault centre and what provides the best support for women. We have come up with what we think would be the most appropriate solution for Scotland. I note the evidence given by the woman from the Foundation for Women’s Health, Research and Development. Can we learn from the expertise that she has built up? Is her experience transferable to Scotland? If so, we should do so. If not, we need to consider where we can build up the expertise in this country.

**Shiona Baird:** You mentioned in your submission the need to raise awareness in the wider community and you have talked about training and awareness issues and education in schools. Can you suggest other activities that the Scottish Executive should undertake to raise awareness?

**Councillor Graham:** I mentioned leadership. We need someone to lead on the issue politically so that, when the bill is passed, there is publicity about it. We should have a champion, which is a word that Cathy Peattie has heard me use many times. We need someone who is clearly identifiable as being associated with the issue and who is prepared to be outspoken about it and to promote the bill. One of the good things that the Scottish Parliament has done is to take a strong lead on male violence against women. We have a strategy for that and a roll-out programme. We need to ensure that FGM becomes part of that agenda so that it does not operate in a vacuum and is not seen as separate. That would bring the issue within the training strategy that I mentioned. We need someone who is prepared to be outspoken about it and to promote the bill. One of the good things that the Scottish Parliament has done is to take a strong lead on male violence against women. We have a strategy for that and a roll-out programme. We need to ensure that FGM becomes part of that agenda so that it does not operate in a vacuum and is not seen as separate. That would bring the issue within the training strategy that I mentioned. Given the funding that the Scottish Executive has made available to deal with a range of male violence against women, perhaps a project could be supported to give FGM additional prominence.

**Shiona Baird:** I have a final question on information gathering. The nature of the practice is such that people are secretive about it. Have you any suggestions for how we should gather statistical evidence and information about how widespread the practice is?

**Councillor Graham:** Previous evidence has noted the lack of baseline data. If we really want to get the data, there are ways of doing so. One of the research exercises that has been conducted in Glasgow focuses on male violence against women in minority ethnic communities, which is a sensitive area. The research has taken a bit longer than we expected it would, but we have had to adjust the normal ways of conducting research to gain specific access.

That is one example of our going out with the normal research methodology to bring in people who are sensitive to the cultural issues. We brought in a lot of women researchers on that project. If we really wanted to, we could embark on a research exercise and work with organisations such as the Somali women’s organisation and the African network to determine how the research should be conducted. Unless such research is carried out, we will not know whether we have had much impact.

**The Convener:** I will allow Elaine Smith to ask a question if we have time, but we are really struggling for time. Marilyn Livingstone has a question on penalties.

**Marilyn Livingstone:** I will be brief. The new law will increase the possible term of imprisonment from five years to 14 years. Do you have any views on the change in the penalty?

**Councillor Graham:** We welcome it.

**Nora Radcliffe (Gordon) (LD):** I want to go back to some of the things that have been said and tap into the witnesses’ experience of working with communities on such sensitive issues. I wonder whether it would be helpful for the committee to take evidence from male leaders of the communities. Would that be helpful or would it be counterproductive? Given their experience in the field, it would be valuable for us to know whether the panel members feel that that would be helpful.

**Councillor Graham:** I immediately think of the parallel with how we have dealt with domestic abuse in some of our minority ethnic communities. Some years ago, when we held a number of seminars in Glasgow to raise awareness of that issue, there was a bit of a backlash from some male members of the communities. They wondered why we were raising such an issue and denied that it existed; however, that proved not to be the case. We know that domestic abuse exists in every community. I cannot say that you should not take the evidence that you suggest, but you would have to understand that they would not present the same view as some of the women’s organisations would.
Nora Radcliffe: We would get a different perspective. From the point of view of raising awareness in the communities and for our inquiry, would it be helpful for us to get male community leaders’ perspective on the issue? Might that facilitate changing their stance?

Councillor Graham: In some communities in England, faith community leaders have taken a clear stance against FGM. They have spoken out against it in the mosques, for example, and have said that it is not a religious practice and that it should not be encouraged. If we could move to that, that would be ideal. Whether the way to do that is to invite people along to a committee such as this, I do not know.

Nora Radcliffe: It is useful to have the benefit of your experience. I thank you for that.

In your submission, you express concerns about the fact that the bill makes an exception in law in relation to FGM for reasons of physical or mental health. Will you expand a little on that?

Jean Murphy: We are a wee bit concerned that the bill says that it would not be illegal for someone to perform the procedure if it was for the good of a person’s mental health. We think that that could be used as a loophole; that is what worries us. The bill should expand on that a wee bit and say exactly what is meant by mental health. If sex reassignment surgery is what is meant—if the bill is trying to ensure that that can still happen without the procedure being illegal—perhaps that should be mentioned somewhere in the bill, otherwise the provision will be open to abuse.

10:45

Nora Radcliffe: And interpretation. Indeed.

Some countries that have laws against FGM have an age limit of 18 years, which allows consenting adults to undergo elective cosmetic surgical procedures. Should the law here include an age limit?

The Convener: Irene Graham wanted to add something to what Jean Murphy said on the question of physical and mental health.

Councillor Graham: We know that women in the communities in which FGM takes place and is long established are under severe cultural pressure from everybody in those communities. Therefore, an argument could be made that, if FGM were not conducted, the women would be more mentally unstable, which would badly affect their mental health, and they would perhaps be rejected by their society or experience difficulty in getting a marriage within that society. Therefore, a coherent and cogent argument might be made for FGM being good for a woman’s or child’s mental health. For that reason, we are against the provision in the bill as it stands.

On the age limit, we feel that part of what you are trying to do is to achieve consistency with the legislation in England. For that reason alone, it would be useful not to have an age limit. We should recognise that, although FGM sometimes happens to very young children, it also happens to women over the age of 18. Whether women have free choice even at the age of 18 or into their early 20s and beyond is a moot point. Such are the pressures and such is women’s position within these communities that the reality is that women may not have any power at any stage in their life until they achieve elder status.

Mrs Nanette Milne (North East Scotland) (Con): It is suggested that the existing law has created a situation in which people are likely to send their children abroad to have FGM carried out because it is illegal in this country. In your submission, you note specifically that pressure is placed on certain families to have their daughters sent abroad. Realistically, do you think that the proposed new law will prevent that?

Councillor Graham: It has the potential to prevent it, which is why the bill has been introduced, but how can we know whether it will do that? We are making the strong statement that it is illegal to perform FGM. If we back that up with awareness raising and the training of professionals, we will put the whole issue in a very different light.

When FGM was discussed by the council about four years ago, it was quite shocking to talk about it. We have moved well away from that. I hesitate to say that we are comfortable with talking about it, but we now have little hesitation in saying that FGM is an abuse of women. The fact that legislation on the issue has been drafted gives a strong message. If the bill is widely promoted and the information gets to the communities in which FGM happens, that will send a big signal to those communities that if they do it, they will be breaking the law and there will be serious consequences. The bill has potential, but unless we promote it, tell people about it and make it clear that we are serious about FGM, the danger is that it will be just a well-intentioned piece of legislation.

Mrs Milne: So, you think that it could have a significant effect on the communities that are resident in Scotland.

Councillor Graham: Yes, if we back it up with awareness raising, education and support.

Elaine Smith: I hope that you do not mind if I pick up on a few bits and pieces, convener.

The Convener: Please be brief, as Councillor Graham needs to leave soon.
Councillor Graham: I have rescheduled my later meeting, just in case.

Elaine Smith: It is important that we explore the issues while we have the chance.

Let us return to an issue that was touched on in response to Shiona Baird's question. Councillor Graham mentioned the fact that the bill is part of the agenda to address male violence against women and children, which is right. Do you also see FGM as being an issue that runs across the Executive's departments? I am thinking in particular of its sexual health strategy. When the strategy was presented to the Parliament in 2003, I noticed that it contained a brief mention of FGM. A Tanzanian member of Parliament was shadowing me at the time and I took the opportunity of asking a question on the subject. Is it important not only that the Development Department, with its responsibility for communities, picks up on the issue but that other departments also do so?

Councillor Graham: Again, the committee might want to draw on our experience of the wide range of issues in respect of male violence against women, which is that such issues do not fit neatly into one category. For example, it is clear that a centre such as the rape and sexual assault centre that we are trying to set up as a pilot in the city crosses three main Executive departments: it falls within the remit of the Justice Department in terms of the criminal side of things; of the Health Department; and of the Development Department, because of its responsibility for communities. The challenge for the Executive—as for councils—is for departments to cross-cut effectively, so that a corporate approach can be taken to issues that do not fit into neat categories.

The procedure could have consequences for health, including the mental health problems that we have discussed. There is also a long-term issue of women having to fit into communities. The same issues arise for women who experience FGM as for those who experience sexual abuse, domestic abuse or rape and sexual assault. We need to see FGM not as something that is out there and different that must somehow be treated differently, but as part of the wider issue of violence against women. If we do that, we can consider how women who have experienced other forms of male violence cope and the range of services and agencies that have to come into play to make women's lives better. That is the parallel that I would draw.

Elaine Smith: That leads me neatly into a question about the cost implications of the bill. The assumption is that any additional workload will be absorbed into the everyday work of social work departments; the bill anticipates no additional costs for the local authority social work system. What is your comment on that? I know that the Somali women's action group receives assistance from Glasgow's social work department, for example.

You said earlier that the bill could become a well-intentioned bit of paper. What systems need to be put in place to ensure that that is not the case? If the bill is enacted, there will be a need for education and guidance on not only child protection measures but other areas. Do you envisage costs to local authorities? I will let you answer that question before I put a question on an issue you raised in your submission.

Moira McKinnon: I will answer by returning to what Councillor Graham said about responsibilities. A parallel can be drawn with the fact that child protection is not the responsibility of one agency. That is a key issue for us, given that we need to ensure that every agency and community is aware of its responsibility in respect of child protection. The issue of FGM is no different, as our response to it takes us across a range of agencies, community groups and individuals, all of whom need to understand their roles and responsibilities in the wider context of the protection of children, of which FGM is one aspect.

Child protection is a priority area for social work services. If a child is at risk, the stops are pulled out and workers are taken off other duties so that they can follow up a case. If an issue such as FGM arose through our child protection work, it would be dealt with immediately. The case would receive an immediate response. We would try to ensure that the agencies that are working together collaboratively put together a programme and package to try to ensure the safety of the child. That said, our work with and support of communities have cost implications; we have to come up with the cost of training and awareness raising.

We sit with the child protection committees, which have the task of ensuring that they have an overview of the child protection measures within their committee area. Although they develop that understanding, they have no budget to do so, as no money is assigned to the child protection committees. The action that they take is based on the good will of the agencies that sit around the table. That is a difficult position in which to place committees. We must consider their funding and how to give them additional funding that will allow them to take forward the programmes that they want to develop.

Elaine Smith: In your submission, you say: “Resources to appropriately empower these vulnerable women and increase their capacity to collectively work in partnership with others on this agenda will now be required.”
Who will require them? Will the resources come from local or central Government?

Councillor Graham: More than one set of costs is involved, but let us deal with the cost of the resources. Typically, new groups that form around an issue look to a range of funding sources of which local authorities are one, as is the lottery in all its forms. The Home Office has made some money available, for example to the development worker who works with our African communities. Although that work is not specifically focused on FGM, we know that the issue has arisen as a result of her work with women’s groups. Having met the worker, we know that she feels a bit overwhelmed because of the numbers involved. She has identified around 7,000 women and 12 to 14 separate groups. Although not all of those groups are working on FGM, it is an issue for many of the women with whom she works.

The question is how that work can be resourced. As the committee knows, local authority budgets are set, so it is not always easy to fit a new issue into existing budgets. Although we will do what we can, partnership funding with the Scottish Executive is a useful way forward. That is how we are funding our work with faith communities. In my role as the equalities spokesperson for the council, I chair the equalities sub-committee. The council is entering into a joint venture with the Executive to fund a faith liaison officer for Glasgow, again on a pilot basis.

We should not expect local authorities to be the only source of funding. If we consider the key community planning players, we see that many of them—such as the health boards—have huge budgets. We should consider whether the health boards can have a role in funding work. An element of work around women's confidence and training could also be met by Scottish Enterprise funding, even indirectly.

The kind of community support to which I have referred will need support, as will issues around training. As a result of a multi-agency domestic abuse pilot in the east end of the city, we know that the huge resources that are required for training cannot be met from existing budgets. One of the issues is how to release staff who deliver a service to allow them to receive training. Often, the people who offer services are in the voluntary sector, as that is where the expertise lies. How can the voluntary sector be resourced? Community development support and training are two key areas that we have not tackled yet and our budgets for them are already stretched.

Elaine Smith: That is an issue that we will want to put to the Executive.

I have a final question on asylum.

The Convener: Right, but you may have one question only.

Elaine Smith: The Glasgow City Council submission states:

“the provisions of the Bill will not apply to women and girls who are seeking asylum or those who have been granted Indefinite Leave to Remain/Humanitarian Protection.”

Obviously, that issue is of concern. I understand that the Westminster bill does not cover those areas. Although our bill will not be hugely different, it is good that we did not legislate under the Sewel procedure and that we are having this robust scrutiny of the bill.

What are the panel's views on whether the bill should offer the same protection to those who are seeking asylum or who have been granted indefinite leave to remain? One of the reasons for the bill not offering protection to those groups is that if someone who is seeking asylum goes abroad, their asylum application would fall. Whether that would apply to children who are sent abroad with someone else is a different issue.

11:00

Councillor Graham: In front of me I have the response that rejects the point about asylum seekers leaving the country and their applications becoming invalid. Other members of the community taking children out of the country is another issue. There have been various reports of children arriving in the country with their aunts, or whomever, and some of those cases have had very tragic consequences as we know. Just because the legislation is in place, we cannot assume that children will never be taken out of the country by other family or community members. We are concerned that the bill should contain additional protection.

We have been trying to get a bit more information about those who have indefinite leave to remain. The committee might be better placed to get that. I understand that anyone who has indefinite leave to remain will be covered by the legislation. Is that right?

Elaine Smith: I do not know.

Councillor Graham: The question should be asked and, if they are not covered by the bill, those people should be protected. If the bill covers them, we will not need to do any more.

The Convener: We are waiting for further information from the Executive. When the minister comes before the committee, we will ask those questions, because members are concerned. We will pursue the issue.
Marlyn Glen: I will understand if panel members feel that the answer to this question is not within their remit but I take the opportunity to ask it. It goes back to exceptions and age limits. Do you envisage any difficulty with adult women being caught up in the legislation when they elect to have cosmetic surgery? I accept that the point might be outwith your remit, but I would value your comments if you have any.

Councillor Graham: We anticipated that question through our discussions with the committee clerks. When I first came across the question, I did not really understand what it was about. However, I have read the other evidence and it is quite clear that there are occasions when people choose to do that. It is so outwith my experience that I cannot comment.

Marlyn Glen: I just wondered about the issue in the context of the council’s extended remit on violence against women. I take it that it has not come up so far.

Councillor Graham: Not so far.

The Convener: I thank the witnesses for their evidence this morning. It has been really helpful.

11:03

Meeting suspended.
Amnesty international comments on the proposed legislation on FGM:
The Bill covers (1) a person who commits FGM whether in the UK or overseas, (2) a person who aids, abets, counsels or procures a person who is not a UK national or PR to commit FGM outside the UK and (3) a person who aids, abets, counsels or procures another person to commit FGM on that other person’s own body.

However, there may be situations where a person (parent, guardian, relative) takes his/her daughter abroad (say on holiday) and allows a relative or other person overseas to commit or arrange commission of FGM. In this instance, the relevant person has not directly aided, abetted, counselled or procured the perpetrator of the FGM. It is open to such a person to argue that he/she was helpless or unable to prevent the FGM from taking place even though this is unlikely to have been the case.

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

An attempt of offences is not covered. There may be a situation where a person tries to arrange for FGM to take place and either the plan fails or is not completed. It is advisable for attempted FGM or complicity thereof to be incorporated so as to provide a complete protection against the practice. The message has to be made clear that FGM is not acceptable.

The ‘mental health’ provision in Clause 1(2)(a) needs to be tightened, as it remains open to interpretation. Whilst wording that ensures traditional cultural arguments cannot be used to justify the need for surgery is welcomed, FGM could still be performed on girls and women citing mental health concerns other than custom and ritual. The issue of FGM potentially being performed under the guise of ‘cosmetic surgery’ is an issue that needs to be carefully thought through. Moreover, what exactly constitutes mental health might be interpreted subjectively. A woman may desire FGM through fear of being ostracized by her community if she does not have it. It may be argued that not having FGM would adversely affect her mental health.

The Bill should protect

- girls and women who are UK nationals/residents irrespective of whether the FGM is carried out in the UK or abroad
- girls and women who are not UK nationals or residents with less certain or limited immigration (ie those with limited or uncertain immigration status such as asylum seekers, students, workers, those with exceptional leave to remain or who have been granted humanitarian protection and the dependants of all the above categories) irrespective of whether the FGM is carried out in the UK or abroad.

The Bill should include as an offence the situation where a person “incites” FGM. Propagation of the practice should be discouraged as it serves to adversely condition peoples’ minds.

Consent from the woman or girl should not be a permitted defence under the Bill. Often, women are pressured into consent emotionally and psychologically or even physically.

Amnesty International Scotland
January 2005

Submission from Save the Children

The following evidence was forwarded to the Executive on 11th August 2004. The purpose of this letter is to reiterate our position, we hope you find it useful.
Save the Children welcomes the restatement and amendment to the law relating to female genital mutilation; and for connected purposes. We are committed to working to ensure that the needs of all children are adequately addressed, as outlined in the UN Convention of the Rights of the Child (UNCRC).

Save the Children, however, believe that there are improvements that could be made to strengthen the Act further, particularly with regards to monitoring, awareness raising and the provision of guidance.

In terms of monitoring the impact, SCUK would like to see recommendations made and supported to ensure that migrant and refugee communities likely to practice FGM are informed about new legislation and that all newcomers to Scotland are fully informed about this law. We recognise that addressing FGM with these communities is complex and should be tackled sensitively. Actions could include setting up sexual health programmes, sex education classes and working with community groups to raise awareness of harmful traditional practices.

Save the Children highly recommends that the statutory sector provides training and information for midwives, health visitors, doctors and teachers to raise awareness and provide guidance on how to be well prepared to respond positively and sensitively to actual suspected cases of FGM.

To conclude, we would like to highlight 2 important articles within the United Nations Convention on the Rights of the Child, which the UK Government ratified in 1991. The UNCRC includes all children and young people aged 18 and under. We would ask the Scottish Executive to take these points into consideration when restating and amending the Bill:

Article 12 of the UNCRC states that it is a child’s right to express an opinion in matters affecting the child and to have that opinion heard. Provision of appropriate information and education is essential.

Article 24(3) of the UNCRC states that State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

Susan Elsley
Head of Policy and Research
January 2005
Prohibition of Female Genital Mutilation (Scotland) Bill: Stage 1

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

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

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

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

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

The Convener: We will pursue the matter in questioning.

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

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

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

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

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

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

10:15

Dr Baumgartner: The World Health Organisation was made aware of and invited to take part in this process only last week. That is very short notice and did not give us sufficient time to prepare and consult member states.
I notice that some important information is missing from the reading list that has been supplied to the committee by the Scottish Parliament information centre and in supporting materials. I highlight the fact that there has been a study of legislation in Europe regarding female genital mutilation and the implementation of the law in Belgium, France, Spain, Sweden and the United Kingdom. The study was produced by the international centre for reproductive health in Ghent. I offer that information so that the committee can include it in its further deliberations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mrs Milne: Thank you. That is helpful.

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

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

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

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

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

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

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

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

Mrs Milne: That is something to consider.

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

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

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

10:30

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rosemary Burnett: All the evidence shows that refugee flows come from areas in which there have been wars and disasters. The present situation in Sudan means that it is probably reasonable to assume that in the future there could be a refugee flow from Sudan, where FGM is practised.

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

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

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

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

Simon Hodgson: Yes.

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

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

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

Rosemary Burnett: It is important to send out a signal that the practice is wrong. We need to be clear that the practice constitutes torture and that it will not be countenanced in Scotland. The bill sends out that signal. Although the difficulty of bringing a prosecution under the bill is a factor, the most important factor is the deterrent effect that the bill will have.
Dr Baumgartner: From the material on the bill that I downloaded from the internet, I can see that the intention is not to increase the number of court cases but to protect girls from being victimised. I agree with Rosemary Burnett that the bill sends out an important signal. It should act as the basis for further action and activity by women’s groups, public health authorities and so on.

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

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

Mrs Milne: Thank you; that is helpful.

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

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

10:45

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

Simon Hodgson: I spoke to one of our community development workers yesterday on the subject. We have a network of groups across Glasgow, including women’s groups, groups from different nationalities and local area groups, some of which come together already. Therefore, we can access the networks that exist through us and others who work with groups in Glasgow. For example, Glasgow City Council also knows where the asylum seekers are and which countries they come from.

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

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

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

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

The WHO has collaborating centres in the field of women’s health and gender mainstreaming, one of which is at the University of Glasgow. If required, the centre could support any further work that the committee might undertake on identifying
appropriate measures. The committee is about to hear evidence from Comfort Momoh that will include information on the African well woman clinic in London. She can tell the committee about her experience of good practice in reaching ethnic minority women and girls.

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

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

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

The Convener: There is lots of community pressure.

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

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

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

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

Dr Baumgartner: The WHO has produced three brochures that are aimed specifically at midwives and nurses. One is a teacher training manual, the second is a student manual and the third contains policy guidelines for nurses and midwives and information on international human rights instruments relating particularly to the right to health. Those three important manuals, which can be downloaded, have been produced in consultation with people in African and European countries. The WHO is more than happy to support you in educating medical students, midwives and nurses and in providing on-going in-service training and support.

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

Susan Elsley: In relation to article 12?

Shiona Baird: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

11:00

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

Rosemary Burnett: I do not know that I am qualified to say what the penalties should be. We are merely trying to point out that it would be possible to put in place an offence of incitement and that such an offence should be included in the bill. The bill should say not only that it is wrong to practise FGM, but that it is wrong to encourage and incite others to practise it. I remember that the committee received information from some Somali women who said that they believed that the practice of FGM was tied up with their religion, and you can imagine that there might encouragement by religious leaders to continue the practice. If it were an offence to incite the practice, we might not reach the stage at which prosecution was necessary. The possibility of prosecution might act as a disincentive to any incitement.
Ms White: I understand your point, which is that although you would like a law against incitement, you would rather speak to people and try to stop the incitement or encouragement of FGM and its practice without parents’ knowledge. You mentioned religious issues, which leads me on to the exemption for mental health reasons and the age of consent. I have read what the panels’ written submissions, including Amnesty’s, say on exemptions. Do you think that the proposed exemption for reasons of physical or mental health is reasonable?

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

Dr Baumgartner: I do not have a legal background, so I am not sure that I understand the bill perfectly. However, I have a couple of concerns about it. The first relates to section 1(2), which states that “an approved person who performs ... a surgical operation on another person who is in any stage of labour or has just given birth, for purposes connected with the labour or birth” should be excluded from punishment. It is likely that the clitoris is included in that provision, but I am not aware of any surgical operation in relation to labour and delivery that would justify the excision of the clitoris.

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

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

Section 3(2) of the bill states: “No offence under section 1 is committed by a person who ... in relation to the operation, provides services corresponding to those of an approved person.” Irrespective of the definition of “approved person”, somebody from an African country could say that a medical doctor conducted the operation. However, from our international point of view, FGM would still be a human rights violation even if a doctor conducted it. Those are my concerns about the bill, not only as a public health person but, from the legal point of view, as a lay person.

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

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

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

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

Ms White: My final question is on the age limit. In most countries that have laws against FGM, the age limit is 18, but you have questioned whether that will suffice. An issue arises in relation to
consenting adults having cosmetic surgery. Should the law in Scotland contain an age limit in relation to female genital mutilation? Should cosmetic surgical procedures be regarded as a separate issue? When we first looked at the bill, we talked about the distinction between cosmetic surgery and female genital mutilation, which is entirely different. There are two questions. Should there be a cut-off point at 18 years of age? Also, where should we go on the cosmetic surgery issue, which could be used as an excuse for FGM?

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

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

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

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

11:15

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

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

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

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

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

I suspend the meeting for five minutes.

11:17

Meeting suspended.
11:24

On resuming—

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

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

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

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

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

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

The Convener: I will start by asking about terminology. What is your view on the change of terminology in the law, from the use of “circumcision” to “mutilation”? Is it important to make that change? How is it likely to affect communities that practise FGM?

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

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

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

11:30

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

I agree that when we are talking to communities and individual patients, we need to be a little bit more sensitive. The majority of the patients that I
see are Somali and they call it “cutting”. In the group that I meet, we ask, “Have you been cut?” and they know exactly what is meant.

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

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

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

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

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

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

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

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

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

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

Dr Buck: I believe that it is happening.

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

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

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

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

The Convener: That is interesting.

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

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

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

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

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

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

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

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

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

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

11:45

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

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

**Ms White:** The policy memorandum says:

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

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

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

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

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

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

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

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

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

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

**Comfort Momoh:** Pregnancy can bring flashbacks and memories, which can cause anxiety for the expectant mother. It is important that professionals are aware of the issue. Some women need a lot of support. Their pregnancy may be the first time that anyone has raised the issue of FGM. In most cases, given that the
women had it done when they were aged five or six and that the subject is taboo, nobody has talked to them about it. Some of the women are extremely anxious during their pregnancy and labour.

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

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

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

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

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

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

Dr Buck: The only potential argument for the exception for mental health reasons is that, if a young woman has been denied FGM, she might be ostracised in her community; she might not be deemed marriageable should she go back home—although I do not think that that would be the case in Scotland or England—and would therefore be socially outcast and suffer emotional and mental trauma. However, the physical and mental disadvantages of FGM greatly outweigh that. It is rather perverse, but I have heard it argued that FGM has to be carried out because otherwise the girl in question will not be deemed marriageable and will be socially outcast in her village or town.

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

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

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

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

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

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

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

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

12:00

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

Dr Buck: That is right.

I have problems with some procedures to reduce the labia. I do some such procedures on the national health service—usually on girls who are in their teens or early twenties, who have gross elongation of the labia. Their labia are so big that they catch on clothes and they dare not wear a bathing suit. However, I get requests from people who merely perceive that their labia are big. If I think that the labia look normal, I will not
carry out the procedure. Some of those people may go to the private sector; as I do not practise in the private sector at all, I do not know whether that is the case.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Dr Buck:** The impact of costs could be minimised. FGM education should be carried out in the context of reproductive health education. With such a package, it would be a question of introducing or strengthening the FGM component within the teaching material, perhaps when it is being reprinted, so that you do not need to scrap all your educational material and start again. That could be phased in, but somebody will have to write the material, somebody will have to translate it and somebody will have to devise and deliver the module on FGM in other health education packages. From colleagues, I have gained some idea of the community gynaecology services in Glasgow, which seem pretty well geared up to deliver.
Comfort Momoh: You can also tap into other resources that are already available, instead of reinventing them, such as the WHO, us at Guy’s and St Thomas’, and other organisations. I am happy to come back to provide educational support to professionals or to raise awareness at any time. Feel free to call me.

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

12:09

Meeting suspended.
Submission from the Scottish Executive

Please find enclosed two briefing papers, as requested by the Committee when we gave evidence on the Prohibition of Female Genital Mutilation (Scotland) Bill on 30 November, 2004.

The first briefing paper explains the degree to which asylum seekers are covered by the provisions of the Bill. It contains advice from the Home Office as to the effect on an asylum claim of an asylum seeker leaving the UK, and information about seeking asylum on the basis of a threat of FGM.

The second briefing paper is from the Crown Office and Procurator Fiscal Service, and sets out the procedures for seeking evidence or witnesses from abroad. I would be happy to pass on the relevant contacts in the Crown Office if you require further information on this subject.

The Committee also enquired as to when the consultation responses and consultation report would be available. If a respondent is content for their response to be public, that response has been available since the permission was granted. Copies of these responses were sent to your clerks and researchers as permissions were received. The consultation report has been available since 6 December, 2004. Both the responses and report are available from the Scottish Executive’s library and are also available on the Scottish Executive’s website at:

http://www.scotland.gov.uk/Topics/Justice/criminal/17543/FemaleGenitalMutilation/Introduction

I hope that this information assists the Committee in its consideration of the Bill.

Justice Department
Scottish Executive
January 2005

Female Genital Mutilation and Asylum Seekers

Immigration policy, including asylum and the status and capacity of persons in the United Kingdom who are not British citizens, is a reserved issue. The Scottish Executive has sought advice from the Home Office and that advice is included in this briefing note.

Who is covered by the Bill

The Bill makes it unlawful in Scots Law:

For any person, regardless of nationality or status, to carry out or to aid and abet an FGM procedure carried out in Scotland.

For UK nationals and permanent UK residents* to carry out FGM in any other country, regardless of whether or not it is lawful in the country concerned.

For any person in Scotland or for UK nationals and permanent UK residents in any other country to aid and abet an FGM procedure carried out in any other country if the procedure is:

Performed upon a UK national or a permanent UK resident; or
Performed by a UK national or a permanent UK resident,
Regardless of whether or not it is lawful in the country concerned.

For any person in Scotland or for UK nationals and permanent UK residents in any other country to aid and abet another person to mutilate themselves, regardless of whether or not it is lawful in the country concerned.

*A permanent UK resident is a person who is settled in the UK, that is a person with indefinite leave to enter/remain (or ILE/R), provided they have not been outside the UK for more than 2 years. It
Does the Bill protect daughters of asylum seekers?
The Bill would protect daughters of asylum seekers whilst they are in Scotland.
If the daughter of an asylum seeker were taken to another country, the Bill would offer her protection if a UK national or a permanent UK resident performed FGM upon her; however it would not be unlawful under Scots law for any other person to perform FGM upon her.

Impact of leaving UK on asylum claims
If the principal asylum applicant leaves the UK whilst his or her asylum claim is still outstanding, that claim lapses. However, if he/she re-enters the UK, there is nothing to stop them from making another asylum application. If there are other dependants remaining in the UK when the head of the family and the daughter leave, they would be expected to make a claim (either asylum or other leave to remain application) in their own right as they cannot be a dependant on someone who is not in the UK.

If a dependant daughter were taken overseas and returned to the UK before a decision on the main applicant’s claim was made, then she would be able to rejoin the family’s asylum application. If she were taken overseas by another dependant on the family asylum application that dependant would also be able to rejoin the family’s asylum application. If they return after an initial decision has been taken, and the main applicant was granted asylum and indefinite leave to remain, humanitarian protection or discretionary leave, their applications to be treated as dependants would be fall to be considered under the asylum family reunion policy. However in such cases the Home Office may ask the main applicant why the dependents went away and returned, and where they went. This could affect credibility of the asylum claim, depending on the reasons given. If they returned to their country of origin, it could affect their credibility because if they are claiming asylum then they are asserting that they are being persecuted in their country of origin.

Is threat of FGM grounds for asylum to be awarded?
It depends on the individual circumstances of the case. Under the terms of the 1951 UN Convention relating to the Status of Refugees, asylum is granted to claimants who can demonstrate that they have a well founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion. The Home Office recognises that FGM is serious enough to constitute ‘persecution’, but asylum can only be granted when the persecution is for a Convention reason.

Women threatened by FGM most commonly lodge asylum claims on the grounds that their fear is based on their membership of a particular social group (i.e. women/women who have not already undergone FGM). Of course other Convention grounds may also be appropriate depending on the individual circumstances of the case. The Home Office Asylum Policy Instruction on Gender Issues in the Asylum Claims states that:

"women who may be subject to FGM have been found by the Immigration Appeals Tribunal to constitute a particular social group (PSG) for the purposes of the 1951 Convention in some circumstances. Whether a PSG exists will depend on the conditions in the society from which the applicant came. If there is a well-founded fear, which includes evidence that FGM is knowingly tolerated by the authorities or they are unable to offer effective protection, and there is no possibility of an internal flight option, an applicant who claims that she would on return to her home country suffer FGM may qualify for refugee status”.

Claimants who do not qualify for asylum under the terms of the Convention, but who can show there is a real risk they will be subjected to FGM if they are returned to their home country, may be eligible for a grant of temporary leave in accordance with the Home Office policy on Humanitarian Protection. Broadly speaking, Humanitarian Protection is granted when the claimant's return to her home country would breach her human rights under Article 3 of the European Convention on Human Rights (ECHR): “no one shall be subjected to torture or to inhuman or degrading treatment or punishment”. Humanitarian Protection is usually granted for three years in the first instance, but it can be extended if the reasons for granting it in the first place persist.
The Home Office does not collect figures on the number of people who have been granted asylum or temporary leave on the basis of a fear of FGM.


Can a child claim asylum?

UK immigration rules state that a person of any age may qualify for refugee status under the Convention. A child may lodge an asylum claim at any time during his/her stay in the UK, including after the principal applicant's asylum claim has been considered and refused. An application for asylum can be made on behalf of the child. An asylum application made on behalf of a child should not be refused solely because the child is too young to understand the situation or to have formed a well-founded fear of persecution. (This also applies to unaccompanied asylum seeking children). When considering asylum applications from children, whether accompanied or not, close attention is given to the welfare of the child at all times.

Under UK policy, adults cannot be dependants on a minor's claim because they are not "dependent" as such and do not fall within the definition. However if the child establishes a claim under the 1951 Refugee Convention, or a protection need under Article 3 ECHR (on the basis of FGM), and is granted some form of leave in the UK, then the parent may also have a claim under Article 8 ECHR (right to family life), even where the parent has no claim under the Refugee Convention or Article 3 ECHR. Each case will be considered on its individual merits.

Criminal Justice Division
Scottish Executive
19 January 2005

Recovering evidence from abroad

The primary legislation for the recovery of evidence which is believed to be abroad is contained within Section 7 Crime (International Co-operation) Act 2003. That Act is a UK Act.

In Scotland a judge of the High Court or a Sheriff or the Lord Advocate or a Procurator Fiscal may request a foreign judicial authority to provide assistance in the recovery of evidence in that State if they are satisfied that an offence has been committed or that there are reasonable grounds for suspectsing that such an offence has been committed and, in addition, that proceedings in respect of the offence have been instituted or that the offence is being investigated.

In practice these provisions allow for a wide variety of circumstances where the recovery of evidence from abroad would be required. The Act allows for the prosecutor who has received a report from the police or is involved in the investigation of an allegation of criminal activity to issue a Letter of Request to a foreign judicial authority seeking assistance for recovery of evidence which is believed to be found in that foreign jurisdiction.

Section 7 also allows for both the prosecution and the defence to make an application to the court and invite the court to issue a Letter of Request seeking the recovery of evidence which is believed to be held in a foreign jurisdiction. In this way the rights of the accused are protected by the use of mutual legal assistance legislation.

There are separate provisions for the recovery of evidence on a police to police basis. However, for the evidence to be admissible before a court, it has to be obtained on a judicial authority to judicial authority basis as provided for in the Crime (International Co-operation) Act 2003. Section
9 of that Act allows evidence recovered from a foreign jurisdiction to be admissible before a Scottish court as if it had been recovered under normal domestic arrangements.

The Letter of Request will outline the evidence which it is believed is in the foreign jurisdiction. It will also outline the nature of that evidence and its role in the case. However, it is a matter for the foreign judicial authority as to how they execute the Letter of Request. Therefore, while there is recognition of the respective laws of the jurisdictions it is open to the foreign judicial authority to exercise its own domestic law as to how it recovers that evidence. The Letter of Request will, however, ask that evidence is prepared in such a way that it would be admissible before a Scottish court. To that end, Letters of Request from the Scottish jurisdiction for the recovery of evidence will request that the principal physical evidence is recovered and that a witness provides a statement as to the recovery of that evidence together with its significance. The foreign judicial authority will also be asked to confirm with the witness or witnesses whether they are prepared to return to the Scottish jurisdiction to provide evidence.

Therefore, the Crime (International Co-operation) Act 2003 allows evidence to be received in evidence without being sworn to by witnesses so far as that may be done without unfairness to either party. However, ordinarily the prosecution would seek to lead oral evidence from witnesses either to the recovery of physical evidence or their own evidence.

 Normally the Scottish courts require the attendance of witnesses in person to provide oral evidence. However, Section 29 Crime (International Co-operation) Act 2003 allows for evidence to be obtained from witnesses resident in a foreign jurisdiction to provide evidence in Scottish court proceedings by way of a live television link. This has occurred on a number of occasions and links have recently been utilised between Scotland and Australia and Spain. The witnesses in those jurisdictions gave evidence in criminal trials before the High Court. The legal basis for this is Section 273 Criminal Procedure (Scotland) Act 1995 as read with the Act of Adjournal (Criminal Procedure Rules (Amendment) (Miscellaneous) 2004/195 for operating the provisions of Section 29 Crime (International Co-operation) Act 2003.

International Co-operation Unit
Crown Office
14 January 2005
Prohibition of Female Genital Mutilation (Scotland) Bill: Stage 1

10:02

The Convener: Under item 2, we continue our evidence taking on the Prohibition of Female Genital Mutilation (Scotland) Bill. I give a warm welcome—sunshine and everything—to Hugh Henry, the Deputy Minister for Justice, who is accompanied by Scottish Executive officials Paul Johnston, Susie Gledhill and Valerie Montgomery. I invite the minister to make an introductory statement before we move to questions from the committee.

The Deputy Minister for Justice (Hugh Henry): Thank you, convener. I know that the committee has been taking evidence about how horrific female genital mutilation is. Like the committee, the Executive is committed to doing what we can to stop women and girls having to suffer in this way.

Female genital mutilation has been unlawful in the United Kingdom since 1985. The Westminster all-party parliamentary group on population, development and reproductive health raised concerns that people might be evading the law by taking their daughters out of the country on a so-called “holiday” in order to have FGM performed on them. In 2003, following the group’s work, the UK Government legislated to increase the protection for women and girls in England, Wales and Northern Ireland.

The bill that is currently before the Scottish Parliament will offer the same level of protection in Scotland as that which is provided in the rest of the UK. It does three things. First, it increases the protection against being taken abroad for FGM. It will be unlawful to take or send a UK national or permanent UK resident abroad for FGM. It will also be unlawful for a UK national or permanent UK resident to perform FGM abroad. There is pressure on communities in Scotland to send girls overseas for FGM. Equally important, the bill will provide support for grass-roots movements against FGM within those communities.

Secondly, the bill increases the maximum penalty for FGM from five to 14 years. As that is the highest sentence that a court can impose, short of life imprisonment, it will show how serious an offence FGM is. We hope that it will deter those who may be considering having a girl cut. The increase in the penalty also sends out a strong signal to professionals that FGM is viewed as a serious offence in the eyes of the law and that appropriate steps should be taken to protect girls who are at risk.
Finally, the bill changes the terminology used from “female circumcision” to the more appropriate term “female genital mutilation”. I believe that “mutilation” is the right word to describe the harm and suffering that the procedures cause. We cannot shy away from the realities of what happens to the women involved.

We consulted on the draft bill in July and August 2004 and received 59 responses, the vast majority of which welcomed the bill. I believe that my officials have sent a copy of the consultation report to the committee. We heard about the harrowing personal experience of members of the Somali women’s action group and I put on record my thanks to them for talking about such a difficult and sensitive issue, which could not have been easy.

To eradicate FGM, action will have to be taken in a number of areas, such as health, social work, education and policing. The sexual health strategy, which has just been published, tackles FGM, as does the guidance on responding to domestic abuse. My colleagues are considering how work in their portfolios can help to protect girls and assist those who are suffering because of FGM. We hope to learn from the excellent work that you have heard about in London and other parts of England.

The bill is an important tool to protect girls and women from female genital mutilation. The parliamentary process that has taken place has provided an invaluable service in helping to raise awareness in communities that might practise FGM and among the professionals who work with those communities. The bill will have a direct effect by supporting community movements against FGM and it sets the framework for wider measures to tackle it. I believe that it shows that female genital mutilation is unacceptable in Scotland and that we want to protect girls and women in Scotland from that horrific practice.

The Convener: Thank you. I have a few questions on consultation. Why was such a short consultation period held during what was in effect a holiday period? Concerns have been raised about the time given for the consultation.

Hugh Henry: I understand that. One of the difficulties that we had was that the rest of the UK had been covered in 2003. We were unable to act when the Female Genital Mutilation Bill was going through the UK Parliament, because that coincided with our parliamentary elections, which meant that there was a gap. Although a relatively small number of people are affected, we did not want too long a delay, in case anyone was affected who could otherwise have been protected. We wanted to act quickly. Extending the consultation period would have had the unfortunate consequence of causing other parliamentary delays; we had to manage a fairly heavy parliamentary agenda, with other bills going through, but managed to procure a slot.

Hindsight is a wonderful thing, but we thought that, because a limited number of people would be affected, a limited number of organisations would be interested directly. We thought that we would be able to get views in a relatively short space of time. We realised that there was not a huge geographical spread of interest and that that interest was concentrated among specific groups. We thought that we would be able to cope with the consultation in a relatively short period.

The Convener: On the nature of the consultation, did the process consist only of a published call for written responses or did the Executive hold consultation discussions with particular groups and, if so, with which groups? Given that a small, specific group of people in Scotland is likely to be affected by FGM, what efforts did the Executive make to contact the relevant communities, including the Somali community?

Hugh Henry: We offered to have a range of meetings in case people preferred to discuss the issues with officials rather than providing written evidence. To the best of my knowledge, we received a response about having a meeting only from someone from the African-Caribbean network. Meetings were on offer to anyone else who wished to take part. It was right to make that offer, because such a sensitive and traumatic issue could well cause personal problems for people who might want to participate in the process.

We recognised that there could have been language or educational difficulties with putting things down in writing. Furthermore, people might have hesitated to put down on paper details of what could be a very personal experience, which might have some cultural ramifications in their community. We made the offer to meet but, for whatever reason, there was only the one response. We were not aware of the Somali women’s action group, which I believe was created only at the end of last July.

The Convener: Was information available in alternative formats and languages? Concern has been expressed to the committee about how the consultation has taken place. We received some good evidence from Glasgow City Council, which felt that the number of people involved was not enough to warrant producing papers and that it would be better to go out and work at a local level. The council’s work and its community links seem to have given rise to some really good evidence. Would the Executive consider using such links to reach people? People in excluded groups can often experience difficulty in getting information or even in finding out that information is available.
Hugh Henry: There are two issues. One is the need to move quickly and effectively to give legal protection. However, the much more fundamental issue is about continuing work, educational awareness and support. I take the point that you and Glasgow City Council have made about the need to get into the communities concerned with people who understand them and the issues involved. I suggest that the bill is merely one part of the work that is required. It is one thing for us to set the legal framework, but we know that we are up against a lot of cultural resistance.

The bill is unusual in that it does not just give protection to people here; it also tries to extend protection to those who have a base here but who travel abroad. We believe that it is right for us to play our part, with other countries throughout the world, in trying to eradicate what is a totally unacceptable practice.

The Convener: The consultation report on the draft bill suggested three areas for change. However, the policy memorandum notes:

“No changes were made to the draft Bill as a result of the consultation.”

Can you explain why, or indeed how, it was decided not to make any changes as a result of the issues raised by respondents?

Hugh Henry: We considered some of the issues raised. The issue of extraterritorial powers is complicated. We were keen to ensure consistency throughout the UK. We did not want people from certain communities who had come to this country to seek refugee status as asylum seekers to feel that some of their cultural views could be better protected by coming to Scotland because the law in the rest of the UK prevents FGM and sending people abroad for that purpose; we wanted to ensure a degree of consistency. However, that consistency also applies to trying to form a unified view on international obligations and responsibilities. We considered some of those issues around the extraterritorial powers.

As I said, we need to do further work to ensure that the subject is properly integrated into the relevant work on child protection, domestic abuse, sexual health and maternal health. On Friday, we announced under the sexual health strategy that the sexual health and well-being learning network will develop guidance on FGM. Therefore, we have taken steps to recognise that further matters need to be addressed.

10:15

Elaine Smith (Coatbridge and Chryston) (Lab): The submission from Kathleen Marshall highlights the lack of consultation with children and young people—perhaps the committee should also address that point—although she mentions that the sensitivity of the issue might make such consultation difficult. On the other hand, the majority of girls who might be affected by the bill are between five and seven years of age when the procedure happens to them. I can understand the need to be sensitive in talking to children about female genital mutilation but, if it is happening to them, it might have been wise to talk to them about it. The submission from the commissioner for children and young people goes on to say that it is important that young people’s views are taken into account in shaping whatever educational and other measures flow from the implementation of the bill. How does the minister respond to that?

Hugh Henry: There are two separate issues. Elaine Smith is right to highlight the measures that will come from the bill, such as the educational work that will need to be done.

I think that Kathleen Marshall’s wider point about the need to consult young people probably pertains to all pieces of Scottish Parliament legislation that affect young people. However, I am not sure that our approach to seeking the views of children and young people should be different for this bill just because it particularly affects them. In this instance, I think that the necessity to protect children probably overrides the requirement to consult children. I would not have been comfortable about delaying the bill simply to ascertain the views of some of the girls who might have been affected between the ages of five and seven. In addition, there would have been difficulties in taking evidence on a very horrific procedure from such young children and there are cultural and language issues. In this instance, the need to provide legislative protection probably takes precedence over the general desire to consult young people on Scottish Parliament legislation.

Elaine Smith: Convener, perhaps the committee can pick up the commissioner’s point about how we engage with young people across the board. We could seek the commissioner’s assistance on how to do that. I raise the point merely because it has been raised in evidence to us.

Shiona Baird (North East Scotland) (Green): The need for clarity over what procedures will be covered by the bill was raised several times in evidence. Will the minister explain why the bill does not include procedures that are listed under the World Health Organisation classification type IV?

Hugh Henry: I know that type IV female genital mutilation encompasses a range of procedures, some of which involve injury to the vagina rather than to the labia and will not, therefore, be covered by the bill. The bill covers procedures that involve mutilation of the clitoris or labia. I recognise the
sensitivities and difficulties involved, but we need to be sure that we do not catch other procedures, such as tightening procedures on women who have had a number of children. I know that the committee has taken evidence on that. Notwithstanding that, we do not have evidence that type IV female genital mutilation is necessarily prevalent in Scotland.

We think that the bill strikes the right balance. It is right to have a degree of consistency across the UK. We also think it right not to include inadvertently other procedures within the scope of the bill, as that might have unfortunate consequences on women.

Shiona Baird: With type IV, are you concerned that you will exclude piercing, which is a fashion procedure in the west? Might it be better to have better definitions, so that the bill is absolutely clear?

Hugh Henry: There are already procedures that are unlawful under the Prohibition of Female Circumcision Act 1985 and we do not propose to change them. Equally, as I explained, we do not want unintentionally to catch other procedures. If any of the measures that Shiona Baird describes are currently lawful, they will not be affected. If they are unlawful, they will remain unlawful.

Shiona Baird: Based on the evidence that we have received, there is concern about clarity. Would you be willing to take on board that evidence and employ the four World Health Organisation classifications somewhere in the bill, to make it absolutely clear what we are and are not talking about?

Hugh Henry: There is a slight difficulty. It is right to put on record that our policy intention is not to criminalise genital piercing. I do not think that that would come within the scope of the offence, because the procedures envisaged appear to be far more severe. However, we also need to examine our legal procedures. We cannot define every action in the legislation. Even where legislation has been framed, there is still a requirement for an offence to be committed, for it to be reported, for the procurator fiscal to make a determination and for the courts to take a decision.

If we felt that clarification would be helpful, we would consider it, but I am not at this stage persuaded that having detailed, strict interpretations in the bill is the way forward. In addition, it is right to point out that the WHO is rethinking and reformulating the definition of female genital mutilation and I would be worried that a more specific definition in the bill could miss some of the forms of FGM that the WHO might describe. On balance, we have taken a reasonable approach, but I will reflect on Shiona Baird’s question.

Ms Sandra White (Glasgow) (SNP): That issue has given us cause for concern. We heard evidence from the World Health Organisation last week, which did not indicate that anything was changing. I am sure that the convener will consider your comments.

Hugh Henry: That is the advice that I have been given. I would be happy for my officials to liaise with the committee clerks.

The Convener: As Sandra White said, we had a WHO representative here last week and she seemed clear about what should and should not be included in the definitions. I do not know whether you have that information, but we will want to discuss it in more detail in our report.

Ms White: The definition of type IV refers to inserting herbs and corrosive substances into the vagina to cause bleeding and tightening. Women can also get tattoos in the area of their vagina. In Scotland, people under 18 cannot get a tattoo on their arm, because that is illegal. However, the concern is that, if the type IV practices are not classified, they will be legal. I want to raise the anomalies and the difficulties that we will have if type IV is not included in the bill, so that you can look into the matter.

Hugh Henry: That is a reasonable point and we will reflect on it. We do not believe that there is a problem, but we will look at the matter again.

Elaine Smith: I have some understanding of the issue, having taken a member’s bill through the Parliament. I had to clarify exactly what “child” meant in that bill. It seems that it would make for good legislation and clarity if the definition of type IV mutilation were contained in the bill. However, if it is not going to be in the bill and you do not think that it needs to be, will it be spelled out in guidance?

Hugh Henry: There will be guidance on a number of the issues, and we will reflect further on that specific matter.

Ms White: The question has been raised in evidence to us whether infibulation after childbirth is included in the provisions of the bill. There are concerns that that matter needs to be made explicit in the bill. Do you agree that, in the interests of clarity, the bill should state that re-infibulation following childbirth is an offence, just as infibulation is considered an offence?

Hugh Henry: I appreciate that point, but we do not think it necessary to make explicit provision for that practice, as it is already an offence under the bill. Guidance for professionals is available from the British Medical Association and the Royal College of Obstetricians and Gynaecologists, which states that

“it is illegal to repair the labia intentionally in such a way that intercourse is difficult or impossible.”
We think that that is sufficient.

Elaine Smith: I have had a couple of meetings with the Somali women’s action group outwith the committee’s meeting with that group and I have two related questions. First, could there be an issue with the re-suturing that is required after an episiotomy or a tear? Secondly, given the fact that FGM is illegal, is there a danger that medical practitioners or surgeons could carry out caesarean sections rather than risk getting into such problems? Do you foresee women electing to have caesarean sections, with all the problems that are involved in such a major operation? Have you considered those issues?

Hugh Henry: It is difficult for me to say whether I foresee women electing to have that procedure. To be honest, that would be entirely speculative. I could not give any objective answer or an answer that could be validated. If a procedure is necessary for a woman’s physical health, it would not be an offence under the bill.

Elaine Smith: Given what I have heard about the issues surrounding caesarean sections, the minister’s colleagues in the Health Department might want to look into that.

Hugh Henry: We will certainly refer the matter to our colleagues in the Health Department, to make them aware of the concerns that have been expressed.

Ms White: We have heard evidence that there is pressure on doctors and midwives to carry out the procedure because of the culture that the women come from. Doctors have said that they elect to give caesareans rather than go through the procedure. Have you approached any representative bodies of surgeons, plastic surgeons, and so on to investigate the prevalence of the procedure?

Hugh Henry: We have spoken to them generally, but not specifically about caesarean operations. Following today’s meeting, we can contact them about that.

Ms White: I have a follow-up question on cosmetic surgery, although I think that you answered it when you answered Shiona Baird’s question. Have you spoken to surgeons specifically about the consequences of cosmetic surgery and about the prevalence of type IV FGM?

Hugh Henry: There have been some general discussions and we are aware of the comments by some surgeons about cosmetic surgery. We do not want the bill to create an inconsistency within the UK such that we become an attractive destination for people who could get cosmetic surgery in Scotland that would not be available in the rest of the UK. That is not the type of tourist traffic that we want to encourage. There are sensitivities and I realise that there are also significant issues. We have had some discussions and we will continue to discuss matters, but consistency throughout the UK is important.

10:30

Ms White: The minister has answered most of my questions, but I am sure he will agree that the opposite of what he suggests could happen. We would not want people to be able to elect to have such cosmetic surgery here, but it could go that way depending on how definitions in the bill are interpreted. I am just picking up on the minister’s point about consistency and what he said about not wanting to see cosmetic surgery being prevalent here.

Hugh Henry: Sandra White has the advantage of me, convener. We have attempted to use the same definitions. I am not aware of the potential for that to happen, but I will certainly reconsider the definitions to see whether there could be some unintended consequence. I am not aware that that is the case, but we will certainly examine the issue again.

The Convener: We have received evidence that cosmetic surgery—legal or otherwise—is happening in Scotland and London. We need to be clear about what the bill means for cosmetic surgery. Will it outlaw it altogether?

Hugh Henry: The bill will ensure that the law is the same throughout the UK, so if there is a problem here, it will exist elsewhere and vice versa. However, as far as the legislation goes, we should also remember that procurators fiscal will still have discretion; it would not automatically be the case that every act of cosmetic surgery would be an offence. The procurator fiscal would have to consider the circumstances. However, it is important to put on the record that we are not making changes to the law in relation to cosmetic surgery.

The Convener: Even if the law is not working in the rest of the UK, we have an opportunity to ensure that our legislation is up to date. We have a responsibility to ensure that our legislation is viable.

Hugh Henry: If there is wider concern that the law on cosmetic surgery is not working, that is a different issue that will probably require a different consultation process that we would have to discuss with our colleagues in the Health Department and the rest of the UK. Again, convener, you have the advantage of me; the matter is not in my portfolio and I am not entirely familiar with it. However, if there is a problem, we will have to examine it.
Marlyn Glen (North East Scotland) (Lab): Despite all the evidence that we have heard and all the reading that I have done, I am still not clear. I am aware that there will be a UK-wide consultation on cosmetic surgery, but I am not reassured that we will be consistent with the UK legislation. If the UK law is being flouted at the moment, our legislation will be, too. I am not reassured that the bill differentiates clearly between FGM and elective vaginal cosmetic surgery.

We have read a lot of evidence and many people have talked to us about the bill. If the bill were passed in its present form, does the minister envisage that there would be prosecutions of cosmetic surgeons who were found to have carried out illegal procedures? It seems to me that the bill would make certain cosmetic procedures illegal.

Hugh Henry: Again, even if I agreed that Marlyn Glen's interpretation was correct, it would not be for me to determine whether there would be prosecutions. Procurators fiscal would have a distinct role in that. It would be wrong for a Government minister to try to second-guess or influence their decisions.

I repeat that we are not making changes to the law. If certain cosmetic surgery procedures fell within the scope of the offences that are set out in the bill, they would be unlawful. However, a procurator fiscal would have discretion as to whether to bring a prosecution in any case. Therefore, even if Marlyn Glen is correct that the bill would make certain cosmetic surgery procedures unlawful, that would not automatically mean that a prosecution would result from such surgery. That would be a matter for a procurator fiscal.

Marlyn Glen: I understand that, but that is where our concern about the exact definition comes from. We want clarity about what would and would not be unlawful and whether there would be exceptions. If there are to be exceptions, perhaps they should be included in the bill to ensure that the law is as clear as possible.

What is the minister's view of the inclusion of an age limit in the bill, which would allow specified procedures to be carried out on consenting adults with the agreement of suitably recognised medical personnel?

Hugh Henry: We wanted to ensure that protection against FGM was as strong as possible. We were a bit worried that to allow FGM by consent would weaken the current legal position, which does not provide for consent. We are aware that, because of cultural and family pressures, FGM could remain an issue for adults in certain communities. We hesitate to say, for example, that it would be right to carry out FGM on someone over the age of 18 who freely gave consent. Such a position would fly in the face of everything that we seek to achieve.

Marlyn Glen: It could, however, be argued that a western woman who elects to have cosmetic surgery is responding to cultural and family pressures in the same way. There is a fine line. For example, we have talked previously about genital piercing. We might want to allow that for an adult and say that it is an exception. However, genital piercing is included in the type IV definition in relation to babies.

Hugh Henry: Again, we are not proposing to change the 1985 act. To repeat my earlier point, we are not making changes to the law in relation to cosmetic surgery. A fundamental difference is involved in respect of the bill. If there is a need—as the convener and members have suggested—to take a wider look at cosmetic surgery, that is a different matter. The bill deals with a specific issue in relation to a practice that has been illegal since 1985; we seek to extend the protection that has been available since then. To seek to do more would mean that we would stray into areas beyond the scope of the bill. It is valid to raise the broader concerns about cosmetic surgery in its widest sense.

Marlyn Glen: I realise that matters have moved on hugely. As you said in your opening remarks, the practice itself used to be called "female circumcision". However, the difficulty is that, according to evidence that we received, we do not know how prevalent the practice is. A comparison could be made with child protection issues; we did not think that child abuse was so prevalent, but as people have become more confident and have reported incidences of such abuse, its prevalence was uncovered.

Hugh Henry: We have moved on. However, I have to say that we do not believe that the practice is prevalent in Scotland. The problem is that it has been very difficult to get information from some of the communities in question. Members should bear it in mind that we are not introducing a new offence; although the 1985 act referred to "female circumcision", the procedure that was outlawed in that legislation is still the same. We are simply attempting to extend the protection that is available. In any case, it does not matter whether the practice is prevalent. To be frank, I think that one such act is one too many.

Marilyn Livingstone (Kirkcaldy) (Lab): Although the witnesses from whom we took evidence are pleased with the bill and feel that it will make a difference, they said that it is only one part of a bigger picture. Many of them raised issues such as training, education and support for communities; I want to focus on those areas. In
your opening remarks, you talked about reaching out to communities. What is the Executive doing to support professionals and to give them guidance on, and training in, dealing with someone who is unfortunately suffering from the effects of something that happened to them as a child?

**Hugh Henry:** Although that is not strictly an issue for the bill, it is a fundamental concern. I know that professional bodies such as the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the British Medical Association all issue guidance and training to their members, which is to be welcomed. As I said, guidance on FGM is included in guidance to health care workers on domestic abuse. Moreover, as part of our sexual health strategy, we have announced that the sexual health and well-being learning network will develop guidance on the matter for practitioners.

Across the Executive—perhaps more so for my colleagues who deal with health and social work issues—there is a need to work together with a range of agencies to ensure that further guidance is integrated with existing relevant work on child protection, domestic abuse, sexual health and maternal health issues. We also want to learn from best practice elsewhere. After all, some communities in the UK have greater direct experience of the matter, so we would seek to learn from them how best to address some of the critical issues that Marilyn Livingstone identified.

**Marilyn Livingstone:** I am really pleased by that last comment. According to evidence that we have received, expertise exists in other parts of the UK, so I am glad that we will tap into that.

There are clearly at-risk groups, as you have defined them, in the community. What steps will be taken to raise awareness among those groups with regard to preventing FGM and dealing with its consequences?

10:45

**Hugh Henry:** The guidance to which I referred earlier is critical, as is integrated and co-operative work across departments of the Executive and agencies, which we need to ensure are working towards the same purpose. The training of staff and professionals who engage with the communities is important because they should know what to do when they come across cases of FGM. The last thing we want to introduce to those communities is a legislative hammer—this is not simply about taking a punitive approach. We want to punish people who engage consciously in a horrific act, but we have to consider the wider context of the trauma that many people have experienced prior to our arriving at this point.

It is incumbent on us to approach the matter with sensitivity and to consider education, awareness raising and confidence building in the communities. The most effective way of eradicating FGM from any communities in Scotland that still practice it is not just to say that it is against the law to do it here or to send a child abroad to have it done; it is about persuading people that it is wrong and that it has no place, for either religious or social reasons, in their culture within this country. I hope that, given the links that people in those communities have with the counties they come from, they could start to influence what is happening to friends and relatives there. Whatever little we can do in this country to stop FGM happening anywhere in the world is justified.

**Elaine Smith:** You said that the bill is not simply about punitive measures, but it seems from our scrutiny that it is. You said that the relevant communities are best placed to effect change. That is right—we heard from Somali women that persuasion to change is best done by people within their community. You said at the beginning that we need to provide support for grass-roots movements. How do we do that, given that from a justice point of view the bill is about punitive measures?

**Hugh Henry:** Again, there are two issues. One is about the legislation that we require to state that in this country FGM is not just unacceptable but illegal and that it is unacceptable for someone in this country to have it done elsewhere. That is what the bill is about and that is what I have responsibility for from a justice perspective. Beyond that, we get into the wider areas of supporting women and children and providing advice and assistance for refugees and asylum seekers, which cuts across a wider range of portfolios and agencies. I do not think that the bill is the place for us to resolve issues around providing support mechanisms, education and training and raising awareness in a range of communities.

The work needs to be done. I have referred to the guidance that we think a range of organisations need to put in place. That said, to be fair, many organisations provide such guidance at present. A lot of work requires to be done by our local authorities, which are the key players in local delivery of services. Clearly, they have partnerships, as we do, with some important voluntary organisations.

The bill is not the place in which to resolve some of the wider issues. As I said, the bill should not be seen in isolation from the responsibility that a range of organisations and partners have to address the issue.

**Elaine Smith:** The reason why Marilyn Livingstone raised the issue is the lack of support, education and so forth at the moment. Certainly,
the impression that I gained from the evidence is that there is not much of those. As the minister said, the provisions in the bill will simply extend the provisions of the 1985 act. That is a problem because those provisions have been in place in Scotland since 1985. Where is the grass-roots support and education?

Hugh Henry: We are starting to stray into the more complex issue of what the Scottish Executive should be responsible for and what local authorities should be responsible for. I agree that the Executive is responsible for supporting national frameworks and national organisations. However, what we do, we do nationally—as I have said in recent months in discussions that I have had with a range of organisations on family mediation and other support work, for example.

Because of the frustrations that organisations have at local level, they say that the Executive should make decisions about what should happen at local level, including decisions about who should get what in terms of finance. That is a much bigger issue, however, and it is one that poses questions about subsidiarity and about who should be responsible for allocation of money and resources to a range of organisations at local level.

The considered view of Parliament may be that Parliament and the Executive should determine what each and every group is given at local level. However, if we did that, it would change fundamentally the Executive’s relationship with local government. We need to strike a balance between the Executive’s setting national frameworks and introducing legislation, and its persuading and encouraging our partners at local level to do what they should do. It is a bit like our work on domestic abuse and child protection; we set the legislative framework and the guidance, but implementation and practice are done locally.

Elaine Smith: I understand what the minister is saying, but it does not explain fully why medical assistance is not in place; for example, it does not explain why midwives who are familiar with FGM are not already in communities.

Hugh Henry: The point to which I return is that it is not the bill’s responsibility to address those problems. Clearly, Elaine Smith should address such issues to her local health board. Indeed, given that she is also talking about social work support services, she should raise them with the appropriate social work agencies. We are starting to move beyond the bill into the wider responsibilities of Parliament and what local providers make available. Those are different matters altogether, although they are legitimate.

The Convener: There is a view that we have to change things, which means that people will need to work at local level to do that. Based on the evidence that we have heard, Elaine Smith is absolutely right to question how that is to be taken forward.

Marilyn Livingstone: The evidence that we have heard has been quite strong. Although people welcome the bill, it is acknowledged that support for communities and professionals needs to run alongside it. We have heard about best practice in other parts of the United Kingdom.

When we took evidence from the Scottish Refugee Council, we heard that its network of contacts could assist in making contact with relevant groups. Have you had discussions with organisations such as the Scottish Refugee Council on the issue?

Hugh Henry: I am advised that we have had a general discussion about identifying how many people may have endured female genital mutilation, but we have not yet entered into discussions about developing support and awareness work. However, such discussions will take place.

Marilyn Livingstone: On support and contacting groups that have knowledge, I wanted to say before Elaine Smith came in that we have been told in evidence that the way to make change is to get respected leaders in communities to come out publicly against FGM. Perhaps work on that needs to be considered. You are right—even if all the proposals were implemented, we would need huge support from communities to identify who the key people are in them who could help and support the work. Discussions not only with people in the Scottish Refugee Council but with others who have been mentioned today would be a way of taking things forward.

Hugh Henry: That is a perfectly valid point. Leaders in communities have a key role to play. I return to a point that I made earlier: it is not simply a matter of passing a law and hoping that it will have the desired effect; it is clear that there are more profound and fundamental issues in some communities that must be addressed. We are talking about changing habits that have existed for many years and about changing a practice that is—unfortunately—embedded in certain communities. Things cannot simply be changed overnight by passing a law. We must encourage leaders; we must make them confident and ensure that those who are responsible for supporting groups and people are aware of the need to develop leaders in the community.

I repeat what I said earlier: it would be an advantage if, in attempting to achieve the bill’s aims, we gave confidence, courage and awareness to people so that they can start to change and influence practices in communities
elsewhere in the world. However, that takes us from the specifics of the bill into broader issues of community development and awareness raising, which are needed but will not be addressed specifically through the bill.

Marilyn Livingstone: Evidence has clearly highlighted the need for guidance and training, but the bill’s financial memorandum does not recognise the costs that will be involved in those. We have been asked for clarification of how the costs that will inevitably arise will be met.

Hugh Henry: The financial memorandum deals only with any new costs that will be directly caused by the bill. I hope that we have identified realistic financial costs.

On the broader issues, I return to our previous discussion. The financial memorandum does not address additional measures that should be put in place whether or not the bill is used to extend protection. It should be remembered that the bill will not fundamentally change the law on female genital mutilation. The points that Marilyn Livingstone is driving at should be addressed in any case. I am aware of and accept that there is a need for awareness raising not only of the current situation, but of how there might be an extension of protection, so that people who have UK residency are aware that they may leave themselves liable to prosecution if they attempt to send someone abroad for female genital mutilation. Part of the awareness training will have to address that.

There is also a continuing need for training, awareness, counselling and support generally in relation to this horrific practice. We think that we have realistically addressed what will be needed as a result of the bill, but we accept that more needs to be done in relation to the wider issue.

11:00

Nora Radcliffe (Gordon) (LD): Let us return to the specifics of the bill. You suggest that the scope of the bill is quite narrow and that it is just about extending protection so that there is extraterritorial effect. However, the stated aim of the bill is “to restate and amend the law ... and to provide for extraterritorial effect”.

The scope is perhaps a wee bit wider than you are saying. There is scope for the bill to do more than just extend protection so that there is extraterritorial effect.

Hugh Henry: That is right. Apart from changing the terminology from “female circumcision” to “female genital mutilation”, the bill increases the penalty significantly from five years’ to 14 years’ imprisonment. However, I am not sure that, apart from that, we are significantly changing the scope of the existing legislation beyond addressing the extraterritorial matters to which you refer.

Nora Radcliffe: I want to address the concerns that have been raised with us and with the Executive, through its consultation, about the mental health exception, which is seen as a potential loophole. Have you considered making the wording of the provision more explicit, so that the bill is clear and unambiguous on the issue?

Hugh Henry: No. The bill states that it is “immaterial” whether any person believes that female genital mutilation is required as a matter of custom or ritual. We think that the phrase “physical or mental health” is well understood by the courts. It is used in other legislation. We recognise the fact that certain operations—for example, operations for sex reassignment and for the shortening of grossly elongated labia—are required for mental health reasons, and that has been properly addressed elsewhere. I do not think that there is any reason for us to change the stance that we have taken in relation to mental health. It is reasonable and allows us to consider individual circumstances in deciding whether an operation is necessary. The framework is robust and the definitions and terminology are well understood by the courts, so I do not think that there is any need for us to look at that again.

Nora Radcliffe: Would you consider taking a belt-and-braces approach in specifying, for example, that two competent people should decide whether what is proposed is acceptable under the exemption, as happens for the termination of a pregnancy and other procedures?

Hugh Henry: It is a difficult area. There could be circumstances in which a medical practitioner would need to make a swift decision, and whether time would allow for another practitioner to be consulted in order to provide certification is a matter for debate. Also, we would not wish to interfere with medical judgment at the time. I am, therefore, not persuaded to make the change that you suggest.

In the unlikely event that a course of action could lead to prosecution, it would be a matter for the court to decide whether the medical practitioner had acted appropriately. Indeed, that is the situation in relation to a number of procedures now, and not just in medical terms. If people make a certain judgment, it is ultimately a matter for the courts to decide whether their action is legal or illegal. I am satisfied that what we are suggesting does not prejudice the protection that is offered by the bill, nor does it unnecessarily endanger medical practitioners.

Nora Radcliffe: Are you not worried about the strong evidence that exists that people see the mental health exception as a potential loophole?
Hugh Henry: We will certainly reflect on the evidence, but we think that, in any dispute, it is best left to the courts to decide on the individual circumstances. Having said that female genital mutilation is unacceptable, I would hesitate to say that a provision whereby two doctors could automatically decide that someone can undergo female genital mutilation would be an acceptable change to the bill.

Nora Radcliffe: I can envisage a scenario in which somebody, perhaps somebody medically qualified from one of the communities in which the practice is accepted, uses the exemption as an excuse or defence. You say that the courts will decide, but who would prosecute if the scenario arises within the community? There seems to be a danger of the mental health exception forming a potential loophole. If there are ways to make such a loophole less likely to be used, we should seek them.

Hugh Henry: I recognise the valid concerns that have been expressed by Nora Radcliffe, but we do not think that that loophole would exist in practice. Section 1(4) states:

“For the purposes of determining whether an operation is necessary for the mental health of a person, it is immaterial whether that or any other person believes that the operation is required as a matter of custom or ritual.”

We think that—

Nora Radcliffe: But the mental health exemption says that, if the person is under severe mental pressure because of the consequences of doing or not doing the procedure, which is the loophole—

Hugh Henry: We will know, because subsection (4) says that it does not matter—that it is “immaterial”.

Nora Radcliffe: People are not proceeding on the basis that FGM is a “matter of custom or ritual.”

They are proceeding on the basis that not to do so would impose a mental strain on the person because they were being excluded from the community.

Hugh Henry: But we then get back to the wider discussion about mental health. There are very clear definitions of mental health. The courts understand what the definitions of physical and mental health are, and I think that medical practitioners generally understand the parameters within which they must operate in relation to that definition.

Nora Radcliffe: I return to the analogy with termination of pregnancy, to which we could apply all the same arguments. In determining whether a termination is acceptable for reasons of mental health, we require two medical practitioners to agree. I cannot see why you are so set against having the same degree of protection for this equally radical procedure.

Hugh Henry: It would introduce unnecessary complications, and it could introduce unnecessary delays. We think that the courts would be able to interpret the mental health exemption appropriately in individual circumstances. We will certainly reflect on the comments of Nora Radcliffe and others on the matter. However, as things stand, we do not think that there is a loophole, nor do we think that there is sufficient justification for change. However, we will look at the matter again.

Nora Radcliffe: You mentioned delay. To me, a comparison of a delay in gender reassignment, labia shortening or whatever with a delay in the termination of a pregnancy just does not stack up. I do not think that the delay argument is valid.

Hugh Henry: I can only repeat that I am not persuaded that there is a loophole.

Nora Radcliffe: We will continue to try to persuade you, minister.

Hugh Henry: We will look at the matter again.

Mrs Nanette Milne (North East Scotland) (Con): My question follows on from the comment by the Scottish Refugee Council in evidence that “the bill still will not protect children who are seeking asylum.”—[Official Report, Equal Opportunities Committee, 18 January 2005; c 776.]

Several witnesses have expressed concern at the lack of protection that is available to girls and women who are not UK residents, such as children who are seeking asylum, who might be taken abroad for the procedure to be carried out. Has any consideration been given to how protection might be extended to such people?

Hugh Henry: That is a difficult problem, which exercised our colleagues at Westminster when they considered their legislation. There is a technical issue about the competence of the Parliament and the scope of the bill. Presumably, something could be done, but there could be ramifications in relation to international responsibilities and obligations, and we are unsure of the net result.

We would be attempting to impose penalties on someone who in a sense has no rights, or for whom we have no responsibility within the UK, but who sends someone beyond the UK for action to be taken. Let me be clear: if they attempt to do something that is illegal within the UK, an offence will be committed, so children are protected. In addition, the minute that someone gets refugee status, they will automatically receive protection in relation to the extraterritorial powers.
With the bill, we are already seeking to introduce unusually wide jurisdiction, in that there is no requirement for dual criminality, so we are already pushing at the bounds of legislative competence. It would be highly unusual in international law for us to take jurisdiction over acts committed abroad by people who are not UK residents. We and our colleagues at Westminster have struggled with that, because we know that there is a potential problem in relation to people in some of the communities who do not currently have refugee status. I am not sure that there is an easy answer to some of those broader questions.

Elaine Smith: Children who seek asylum and come from communities where FGM is extremely common do not have the advantage—if you want to call it that—that people from such communities who have been living in Scotland have in knowing that FGM is illegal under our law. It could be argued that those children will be the group that is most in need of the bill’s protection. I argue that we might be more in line with international obligations if we were to close the loophole.

I refer again to Kathleen Marshall, the commissioner for children and young people, who states in her evidence:

“Some children are excluded from its protection”— referring to the bill—

“in a way that appears discriminatory in terms of article 2 of the Convention on the Rights of the Child—in particular, the children of those seeking asylum in the UK, and others whose ‘leave to remain’ is temporary, who are possibly at greatest risk of mutilation”.

Perhaps in closing the loophole, we would be more in line with international obligations.

Hugh Henry: That is one interpretation. I repeat my earlier point that when children come to this country they are protected against any such acts that are carried out within this country. However, there are limits in international law to how wide we can extend our extraterritorial powers. International law requires a tangible link to Scotland. Establishing a link becomes more difficult if someone is temporarily here without any legal rights and then goes abroad, where something happens.

There is no way that I will define international law at this meeting—it would not be competent for me to do so. Our advice is that we have already stretched in what we are attempting to do. We are not convinced that we have the legislative competence to go beyond that. The problem was examined when the legislation was changed in 2003 at Westminster.

11:15

Elaine Smith: I hope that the issue will be reconsidered in terms of the United Nations Convention on the Rights of the Child, because children carry those rights wherever they go.

Hugh Henry: I understand what Elaine Smith says. We should put the matter in the context of the wider circumstances that bring people here. I am sure that an exception to the rule will always exist, but let me give an example. A woman with children flees Somalia—which has been referred to several times—to avoid persecution and is in Britain as an asylum seeker but has not been given refugee status. Would that woman for cultural reasons want to send her children to Somalia to have FGM carried out and then have them brought back to the United Kingdom? A reasonable view might be that, having fled persecution and oppression, that woman would not want voluntarily to return to Somalia and then come back to this country. An exception could always exist to that—God forbid that it should ever happen.

We have considered the matter as broadly as we could. We think that we are straying at the margins of legislative competence, notwithstanding what Elaine Smith says. We are consulting the Home Office on difficulties and the matter has not been concluded. We want to resolve some of the ambiguities and difficulties. The issue is not easy to resolve.

Ms White: After seeing the evidence, which you and the clerks have also seen, I think that a woman who fled persecution in the form of female genital mutilation and who brought her children here—people sometimes arrive in families—would at times experience pressure from the community in which she lived and from the men in that community. That pressure would usually result in her husband or another relative—but not the woman—taking her children outwith the United Kingdom, back to their homeland or somewhere else to have the horrific procedure performed and then bringing the children back.

We open our doors to asylum seekers and they come here. We encounter female genital mutilation in this country because people are being sent back for the procedure. We are talking about children from as young as three months old up to seven and eight-year-olds.

Women’s groups have given evidence that they abhor the practice, but that we must not criminalise the women on whom the practice has been carried out. We must be much more sensitive to the issue, which is unfortunately prevalent in Scotland and in the United Kingdom. Of course we want matching legislation across the board. Everyone here has accepted the bill in good faith and we have spent weeks on gathering evidence.

The act that was passed at Westminster might not be good. Perhaps the position can be
improved here. I am not making a political point. We have examined the bill in good faith and I think that the bill could be improved. I ask the minister to realise what is happening in communities and to asylum-seeker children. We should examine that. If the bill were changed in the way that I think that you want continuity and that it does not matter what we say and do here today, or what we have done in the past weeks, as things will not change because the Westminster legislation has gone through. I would really like an honest answer.

Hugh Henry: I thought that I had explained the position. The Westminster legislation caused some difficulty when it was being considered. Members there sought advice on some of the issues of extraterritorial competence. I explained earlier that we are continuing to discuss those issues with our colleagues at Westminster. We will continue to do so because we acknowledge that some difficulties may have been caused.

I am not seeking consistency simply because Westminster has enacted legislation but because there could be legislative implications if the Scottish Parliament exceeds its competence. Sometimes that can be tested in a court of law only once it has been done; that is true of a number of things. The nub of the issue is about what it is competent for us to do within international law, notwithstanding the view of the commissioner for children and young people. That is only one view, and other views say that it might not be possible for us to follow the commissioner’s analysis.

We have to reflect carefully on our international obligations and what international law says; that is why we are consulting carefully. We have not automatically discarded the provisions just because they are in the English bill; we have considered them very carefully.

Sandra White makes other points, and I think that they show that we need to be careful in our use of language. Sandra White said that the practice is prevalent in Scotland. Using the strict definition of the word “prevalent”, I suggest that the practice is not prevalent. FGM in Scotland is illegal for asylum seekers, refugees or anyone else. Is it prevalent? If it is, it would be useful for us to be able to identify that prevalence.

However, if we are talking specifically about extraterritorial issues and people sending their children back, is that prevalent? We have seen no evidence that people who come to this country are sending substantial numbers of their children back to countries such as Somalia for the procedure to be carried out, and then bringing them back to Scotland. Let us remember the difficulty that those people have had in getting out of their home country in the first place, so it would not be easy for them to send their children back and then have them returned to Scotland.

Sandra White makes a point about women being under pressure from the communities and from men, but the evidence from the Somali community is that the vast majority—I am trying to remember the percentage; it could be 60 to 70 per cent—of the family units of Somali origin in Scotland are headed by a woman. There are very few Somali men here. If that minority of men—who have also fled Somalia to avoid oppression—are putting pressure on those families to send their children back for cultural reasons, that introduces a level of complication of which I was unaware. If that is happening, it would certainly re-emphasise the need for education in those communities.

As far as those who are seeking asylum are concerned—we are talking about a small number who are not afforded protection—we need to stop saying that the practice is prevalent and get some more evidence on how many asylum seekers are sending their children back to those countries to have the procedure done. I would not use the word “prevalent”. I hesitate to say that the practice never happens but, if it does, I would like to see the evidence.

Mrs Milne: My understanding is that it is not the men in the Somali community who are putting on the pressure; the pressure tends to be exerted by the senior women.

Hugh Henry: Exactly. Nanette Milne is right about that.

Mrs Milne: Another concern arises from the Executive’s briefing, which says that if a UK resident were to organise for a non-UK resident to carry out FGM on an asylum seeker or any other non-UK resident outwith the UK, that UK resident would not be committing an offence under the bill. Is that the case and, if it is, will you clarify why that is so?

Hugh Henry: Yes, that is correct.

Mrs Milne: Why is that the case?

Hugh Henry: In such a situation, the UK resident would be committing an act in relation to someone who had no tangible link to Scotland. That takes us back to the legal status of such individuals.

The issue is who would carry out the FGM. If it was carried out abroad on someone who had no tangible link to Scotland, no offence in law would be committed, because the law does not cover individuals who have no rights here. The act would take place in a country over which we had no
jurisdiction and would be carried out by someone who would not be subject to UK law. If the FGM was performed by a UK doctor or a UK resident, they would be covered by the law, but that is a separate matter.

Mrs Milne: I understand that, but there seems to be a loophole. I would have thought that a UK resident who instigated the committing of the crime of FGM, wherever it was carried out, would bear some responsibility for it.

Hugh Henry: For a crime to have been committed, we need to define in law who the victim of the crime is. We have sought to consider the position of asylum seekers who do not have legal status here. If we cannot define their status in law, how can we control an act that is committed on them in another country by someone who is a resident of another country? At that point, we reach the limits of international law. The victim and the resident would have to have a direct and substantial link to Scotland. If the victim had no tangible link to Scotland, the constraints of international law mean that we would have problems.

Mrs Milne: Could anything be done under common law—under the offence of assault, for example?

Hugh Henry: The assault would not be happening here. If the assault happened here, we would be talking about a crime, but if it took place in another country and was committed by someone who was not a UK resident, it would be hard for us to take action. We are already pushing at the limits. If there was an easy way of tackling the issue, we would adopt it.

Frances Curran (West of Scotland) (SSP): According to a report from the centre for reproductive health at Ghent University, of the six European countries that have implemented anti-FGM legislation, Britain is the only one that has not included the offence of attempted FGM. Why has such an offence not been included in the bill? Will you consider creating such an offence?

Hugh Henry: That is possibly to do with the difference between the legal systems in the other countries and that in Scotland. Here, any attempt to commit an offence would be an offence in and of itself.

Frances Curran: If we followed the example of those other countries by making specific provision on attempted FGM, would that not strengthen the bill?

Hugh Henry: I suppose that I could turn that round and ask what would be different about female genital mutilation that would make the attempt to commit that offence different from attempts to commit any other offence. Why would we not put an attempt to commit any other offence into Scots law and make specific provision for that? Section 294 of the Criminal Procedure (Scotland) Act 1995 states:

“Attempt to commit any indictable crime is itself an indictable crime.”

That is very clear.

11:30

Frances Curran: I would like to ask you another question. Amnesty International Scotland’s evidence said that it wanted to go even further than attempted FGM; it also raised the question of incitement. Are you saying that that would be taken under the general law rather than specifically in the bill? Would you argue that Amnesty has got what it wanted in its evidence because incitement would be covered under the general law in Scotland instead of specifically under the bill on FGM?

Hugh Henry: Yes, because conspiracy and incitement to commit crimes are offences under Scots common law.

Marilyn Glen: I return to the question of the prevalence of the practice. Basically, it is the absence of baseline data that is the problem, so it will be difficult to monitor the impact of the bill and of any other initiatives that are put in place to support it. What efforts are being made towards the systematic collection of baseline data of relevance to the provisions of the bill?

Hugh Henry: There are a number of offences that will clearly be recorded if we can identify them. As Marilyn Livingstone said, there is ongoing work to be done with the communities with regard to education and awareness. Local agencies need to work directly with those communities to ensure that there is awareness of the law and of the requirement to operate within the law, and to try to change some of the cultural attitudes. Any offence would be recorded in the normal way. Under the child protection guidance, any professional who has reasonable concern that a child may be at risk should take steps to protect that child. Our normal child protection procedures should also cover the recording of incidents.

Marilyn Glen: It seems that people in England are trying to deal with the idea that all the evidence is anecdotal by examining maternity hospitals and asking what they are seeing, and using that as baseline data. They also see a need for more informal attitudinal studies. Does the Scottish Executive currently have any plans to monitor the impact of the legislation?

Hugh Henry: Marilyn Glen raises reasonable issues. She also identifies a weakness, in that the methodologies are not precise and are not as well
developed on this subject as they are on others. I recognise that any research would not be straightforward. We need to reflect on some of the evidence that the committee has taken on these matters and we need to consider whether we need to do any further research into prevalence. We also need to balance that by asking ourselves what level of research would be required, how much it would cost, whether it could be justified given our other demands for work and whether the cost would be disproportionate. We must examine all those issues and it is a matter that we need to think through carefully.

**Marilyn Glen:** That would be helpful.

**Elaine Smith:** I turn to some of the evidence that we have heard about prosecutions. We have heard that there might well be prosecutions under the legislation once the affected communities become more aware of the legal system and gain an understanding of the protection that it provides. That might be true not only of the bill but of existing legislation. There are difficulties in communities, and the culture that we are dealing with is such that people actually think that FGM is a good thing for their daughters’ future opportunities and even their future health. Are there sufficient support mechanisms in place to support those members of communities who might blow the whistle on FGM?

**Hugh Henry:** First, I refer the committee to my earlier comments on the need for support mechanisms at a local level and the role of councils and voluntary agencies.

On the second aspect of the issue that Elaine Smith raised, we have been improving the services that we give to those people who report crime— whistleblowing is a fairly crude term—who are vulnerable witnesses. We have attempted to improve that support in sensitive cases in which identities need to be changed and in serious cases in which people need to be moved.

In cases that arise under the bill, a balanced judgment might need to be made about whether— notwithstanding some of the other work that needs to be done in a community—someone requires help to remain within their community. In that case, the police and social work agencies might be involved. However, in some circumstances, people might well need to be helped to move out of the community. Again, police, social work and housing agencies would need to be involved in that.

We have structures in place to support people who give evidence, but I accept that those structures could always be improved and that we might need to reflect on whether specific issues that arise from the bill will need to be dealt with in guidance. However, one thing that we will want to avoid is moving those who take a stand against female genital mutilation. As I discussed earlier in response to the questions of Marilyn Livingstone and others, we need to develop and enhance the support for community leaders.

**Elaine Smith:** Will the Executive consider taking steps to ensure that an understanding of the support mechanisms is communicated to the relevant communities in a way that they can understand? Will that not need to come from the centre? I understand your comments about the difference between what is dealt with by the centre and what is dealt with by local authorities, but do you accept that the Executive also has a role in that?

**Hugh Henry:** On a range of issues under the bill, we will need to consider what guidance is appropriate for local authorities, voluntary organisations, police and others. I hope that that will be as comprehensive as is needed. We will also ensure that the issue is referred to the Local Advocate and the Solicitor General. We will discuss with the Crown Office and Procurator Fiscal Service how some of the substantial training that it is carrying out on how vulnerable witnesses should be treated is applied to people who give evidence in cases that arise under the bill.

**Elaine Smith:** On a slightly different subject, I want to pick up on Sandra White’s earlier question, which I am not sure received a proper answer—my asking it shows that it was definitely not party political. Throughout your evidence, you have said that you will reflect on various issues and we welcome that commitment. However, you also said that the bill was unable to coincide with legislation at Westminster because of the Scottish Parliament elections in 2003. That implies that the issue would otherwise have been Seweled. Moreover, you have constantly referred to the need for consistency across the UK. That worries me slightly, because it seems that you want the bill to be identical to the one that was passed at Westminster. If that is the case, it will seem a waste of time to the consultees to have put in so much work in giving evidence to the committee. However, I would say that that work has been a useful way of raising awareness of the issue.

We have a chance to improve the 2003 act. Given that you have talked about consistency, are you minded to resist any differences because you want an identical bill or are you open-minded about going back and examining the issues that you said that you would reflect on and having a Scottish act if the committee is able to persuade you that there are areas of the bill that could be improved?

**Hugh Henry:** We have departed from the 2003 act where we believe that doing so is helpful. We have made our bill gender neutral, which is
different from the 2003 act. We would consider doing anything that would enhance Scots law and our ability to effect legislation.

I know that this is not the time to have a debate on the wider issue of Sewel motions, but they, too, provide committees with an opportunity to take evidence and enable the Executive to include certain issues relating to Scots law that we believe require to be dealt with differently from how they are dealt with in the rest of the United Kingdom. We have done that and we will continue to do that. In that kind of principled way, there would be no difference.

If you look at the situation objectively, you can see that there are not huge differences between this bill and the 2003 act. The debate at the time would have been to do with whether the differences would have warranted there being a stand-alone bill compared to other bits of legislation that we were considering. That would be a matter of political judgment by the parties and the Parliament. In fact, as others do, you could apply the same argument to every Sewel motion. However, the reality is that we could not have dealt with every matter that has been dealt with by a Sewel motion through stand-alone legislation because the Parliament would not have had the time to cope with that. Sometimes, we decide that it is appropriate to take the Sewel motion route because, by using a UK bill, we can make the changes that Scotland requires or because we think that the UK bill is entirely consistent with our intention. With regard to the matter that we are discussing, the consistencies are such that I believe that the matter could have been dealt with through the Sewel procedure. However, for various reasons, that route was not taken and the matter has come before us in a different way.

We believed that we had to take action. We could have stuck with the provisions of the 1985 act, but we thought that, as action had been taken in the rest of the UK, there was a political imperative to ensure that there was consistency across the UK. We did not want women and children in Scotland to have less protection than was available elsewhere in the UK. That is why we have introduced the bill and have taken the opportunity to change the legislation. If there is anything further that can be done, we will do it, if it is consistent with our obligations to this Parliament and our international obligations.

Clearly, we want to avoid an imbalance. We do not want women in this country to have less protection than those in England and Wales and, equally, we want to avoid a situation in which people could come to this country to have acts carried out that could not be carried out elsewhere in the UK.

Elaine Smith: I wanted to clarify that point because I did not think that the position was clear in your answer to Sandra White. However, the response that you have given now is welcome and reassuring.

The Convener: I echo that and thank the witnesses for their attendance.

We will now move into private session to discuss further our approach at stage 1 to the Prevention of Female Genital Mutilation (Scotland) Bill.

11:44

Meeting continued in private until 12:39.
ANNEX C: OTHER WRITTEN EVIDENCE

Submission from Association of Chief Police Officers in Scotland (ACPOS)

Prohibition of Female Genital Mutilation (Scotland) Bill
Current legislation exists via the Prohibition of Female Circumcision Act 1985 making female genital mutilation unlawful in Scotland. Whilst no prosecutions under this legislation have been made in Scotland, anecdotal evidence appears to exist that such practices do occur, performed both within and outwith our country.

The Association of Chief Police Officers in Scotland (ACPOS) is supportive of the existing legislation and welcomes this new Bill, recognising the need to deter persons from sending adults or children to countries where such procedure is lawful.

The primary purpose of this legislation should be the protection of individuals from such mutilation. The increase in sentencing powers to 14 years imprisonment sends out a clear message of intent, but requires to be supported by education in order for the legislation to be preventative rather than solely punitive.

William Rae QPM
Chief Constable
ACPOS
January 2005

Submission from Association of Directors of Social Work

Prohibition of Female Genital Mutilation (Scotland) Bill
We are supportive of the above Bill and only have a couple of comments regarding it’s successful implementation.

Female genital mutilation is a form of child abuse. We could find no evidence of any social work department having to handle a case of FGM but that is not to say that it is not a problem and that it does not happen. It is a hidden form of abuse that needs both the law and the actions of relevant agencies to work together to eradicate it.

In the light of the introduction of this Bill and the nature of our ever-changing multi-cultural communities, many councils and child protection committees are updating or considering rewriting their child protection procedures to specifically include a section on FGM. A useful starting point for some councils has been the section on FGM for London Child Protection Procedures (in use since early 2004) written by FORWARD (Foundation for Women’s Health, Research and Development). 64

Like many of the agencies who responded to the initial consultation last summer, we believe that there is some work to be done to communicate the implications of the new legislation to relevant communities. Specifically targeted information should also be made available to young girls at risk and offer them advice as to who they should contact for help.

The need for awareness raising and training amongst professional groups who will encounter cases of FGM is vital. FGM, unlike most types of abuse, is a devastating one off and is carried out by parents who genuinely believe it is in the best interests of their daughter. Additionally, before (and even after) this abuse, the child may be happy in a supportive and loving family. The focus of all awareness raising and training must therefore be on prevention. These staff need appropriate

and specific cultural awareness training to be able to understand the issues surrounding FGM and be able to identify a girl who may be heading towards the time where it may be carried out. ADSW believe that Child Protection Committees are well placed to deal with the co-ordination of awareness raising and training for professionals.

I hope these comments are useful.

Shona Main  
ADSW Policy and Parliamentary Officer  
January 2005

Submission from BMA Scotland

Introduction

The BMA welcomes the opportunity to provide written evidence to the Equal Opportunities Committee for its considerations of the Prohibition of Female Genital Mutilation (Scotland) Bill. The BMA supports the effective enforcement of the Female Genital Mutilation Act 2003 which outlaws female genital mutilation (FGM) in England and Wales. We therefore support the general principles of this Bill which will bring Scotland into line with legislation in the rest of the UK.

FGM is already illegal in Scotland under the Prohibition of Female Circumcision Act 1985, however, we welcome proposals outlined in the Scottish Bill to ensure that patients cannot be taken abroad for genital mutilation.

The BMA's Ethics Committee has published guidance on FGM. This can be accessed at our website (Female genital mutilation: caring for patients and child protection).

In addition to the introduction of more comprehensive legislation, it is also the view of the BMA that there is a pressing need to raise awareness about the health and legal issues about the services and sources of information that are available to communities that practice FGM. All medical personnel should be trained in cultural sensitivity and how to meet the needs of women who have undergone FGM.

Some of the more relevant points of the BMA’s guidance are outlined below:

Health Risks

Mutilation has immediate health risks, including severe pain, haemorrhage, tetanus and other infections, septicaemia or even death. These consequences are worsened when traditional ‘circumcisers’, who may be brought by immigrants to the UK from their home country, work in unsterile conditions without anaesthesia.

In the longer term, women experience problems with their sexual, reproductive and general health. These may leave women infertile and others who do conceive are likely to experience difficulties with childbirth. FGM doubles the risk of the mother’s death in childbirth, and increases the risk of the child being stillborn by three or four times.

Medicalisation

It is sometimes argued that, as it would minimise some of the health risks, FGM should be done by doctors, in sterile conditions with anaesthesia. This argument cannot be easily dismissed in the light of accounts of the alternative being mutilation by elderly women using crude tools such as knives, scissors, scalpels, pieces of glass or razor blades, in poor light and septic conditions. Nevertheless, most international organisations and national medical associations, including the BMA, agree that health professionals should not carry out FGM and that the practice constitutes a clear breach of human rights. The World Health Organisation considers that “the medicalisation of the procedure does not eliminate this harm and is inappropriate for two major reasons: genital mutilation runs against basic ethics of health care whereby unnecessary bodily mutilation cannot be condoned by health providers; and, its medicalisation seems to legitimise the harmful practice.”
Distribution and prevalence
In Britain, FGM is seen in some ethnic groups that have immigrated to this country, often as refugees. Dispersal of asylum seekers across the UK makes increasing numbers of doctors likely to come into contact with women who have been mutilated and girls who might be. In Britain the most common age for a girl to be mutilated is between 7 and 9 years.

In November 2000, the All Party Parliamentary Group on Population, Development and Reproductive Health (Westminster) acknowledged that there was a severe shortage of data about prevalence in the UK. One estimate says that 10,000 girls and young women are at risk of FGM[1]. Another estimate shows that there are 3,000 to 4,000 new cases each year in this country[2].

Regulation
A person found guilty of an offence under this Bill would, in line with legislation in the rest of the UK, be imprisoned for up to 14 years. The BMA is unaware of any prosecutions since the implementation of the Female Genital Mutilation Act 2003.

Two doctors have been found guilty of serious professional misconduct before the General Medical Council, however. The first of these, in 1993, involved a doctor who had performed FGM while knowing it was illegal. The doctor was struck off the medical register but the police refused to prosecute. In 2000, another doctor was struck off for offering to carry out FGM.

Asylum seekers
UNICEF and other agencies of the United Nations have stated that refugee and asylum status should be granted to women and girls fleeing their country to escape genital mutilation. The BMA supports this position.

Worldwide, only a small number of women have been granted refugee status on the grounds that they would be at risk of FGM if they returned to their country. No statistics are available for the UK, but the Home Office reports that there have been successful asylum claims in the UK based on the threat of FGM, where removing the applicant could be contrary to Article 3 of the European Convention on Human Rights that protects the right to be free from torture, inhuman or degrading treatment.

Conclusion
The BMA supports the principles of the Prohibition of Female Genital Mutilation (Scotland) Bill which will close the existing gap between legislation in Scotland and the rest of the UK. This legislation should be complemented by a programme to raise awareness about the health and legal issues, and about the services and sources of information that are available to communities that practise FGM.

Risk of FGM should be recognised as legitimate grounds for refugee and asylum status.

Gail Grant
Senior Public Affairs Officer
BMA
January 2005

Submission from Kathleen Marshall, Commissioner for Children and Young People in Scotland

The Role of the Commissioner
The office of the Commissioner was established by the Commissioner for Children and Young People (Scotland) Act 2003. The general function of the Commissioner is to “promote and safeguard the rights of children and young people.” In particular, the Commissioner must review law, policy and practice relating to the rights of children and young people with a view to assessing their adequacy and effectiveness. Specific regard must be had to any relevant provisions of the United Nations Convention on the Rights of the Child, especially those requiring that the best interests of the child
be a primary consideration in decision-making, and that due account be taken of the views of affected children and young people.

The Commissioner must exercise this responsibility towards all children and young people in Scotland who are under 18 years of age, or under 21 if they have at any time been looked after by a local authority or in their care.65

Summary of Comments
As Commissioner, it is my opinion that the Prohibition of Female Genital Mutilation (Scotland) Bill is to be welcomed as a measure that promotes the rights of children and young people in terms of Scottish and international law. However:

Some children are excluded from its protection in a way that appears discriminatory in terms of article 2 of the Convention on the Rights of the Child – in particular, the children of those seeking asylum in the UK, and others whose “leave to remain” is temporary, who are possibly at greatest risk of mutilation;

Consideration should be given to the definition of female genital mutilation to ensure that it encompasses all of its forms; and

I draw attention to some child protection considerations that might benefit from further exploration.

Convention on the Rights of the Child
When the UK ratified the United Nations Convention on the Rights of the Child, it made promises to the children and young people in this country that it would make life better for them by respecting and promoting the standards set out in the Convention. The promises relevant to the question of female genital mutilation are:

- The rights in the Convention would be respected, no matter what the race, colour, sex, ethnic origin, or status of the child or the child’s legal guardians (article 2);
- The best interests of the child would be a primary consideration in decisions made by legislative bodies or administrative authorities (article 3.1);
- The state would take whatever legal or administrative steps were necessary to ensure the care and protection of the child (article 3.2);
- The state would take whatever legal, administrative or other measures were necessary to implement the rights in the Convention (article 4);
- The state would ensure, to the maximum extent possible, the survival and development of the child (article 6);
- The views of the child concerned would be given due weight in all matters affecting the child (article 12);
- The state would take all appropriate steps to protect the child from physical or mental injury by parents or other carers (article 19);
- Children seeking refugee status would receive appropriate protection and humanitarian assistance to enjoy the rights set out in the Convention (article 22)66;
- The state would take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children (article 24.3);
- The state would take all appropriate measures to help a child recover from any form of torture or cruel, inhuman or degrading treatment (article 39).

65 It should be noted that these general functions under sections 4 and 5 of the Act contain no exceptions in relation to matters reserved to the Westminster parliament. This exception is specified in section 7, which allows the Commissioner to carry out formal investigations with associated legal powers.
66 The UK Government entered a reservation to article 22, but this was designed to preserve its right to control entry to the country. The articles at which it was directed were articles 9 (separation from parents) and 10 (family reunification) rather than article 22. Therefore, the Convention is applicable to refugee children and those seeking refugee status. Further information on this can be provided if requested.
When the UN Committee on the Rights of the Child considered the UK’s Second Report on implementation of the Convention, it expressed concern “at the persistence of female genital mutilation despite its illegality”, and recommended that the UK take all appropriate measures “to enforce, through educational and other measures, the prohibition of female genital mutilation.”  

European Convention on Human Rights

The Parliamentary Assembly of the Council of Europe has made it clear that female genital mutilation “should be regarded as inhuman and degrading treatment within the meaning of Article 3 of the European Convention on Human Rights, even if carried out under hygienic conditions by competent personnel.” It calls on states to ban the practice by legislation and to prosecute perpetrators and their accomplices, including family members and health personnel, including cases where the mutilation is committed abroad.

Article 14 of the Convention also prohibits discrimination on the basis of sex, race, colour, national origin or other status.

Consultation with Children and Young People

Children and young people do not appear to have been consulted on this Bill. It may be that the sensitivity of the issue would have made this difficult. However, it is important that young people’s views are taken into account in shaping the educational and other implementation measures that should follow it.

Application to Non-permanent residents, etc.

Summary of the Bill

The Bill protects every person in the UK from female genital mutilation perpetrated within the UK. The Bill says that female genital mutilation perpetrated abroad at the instigation of any person in Scotland can be prosecuted in Scotland, but only where the victim is a UK national or permanent UK resident. This means that refugees would be protected from mutilation abroad, where that was arranged in Scotland, but asylum seekers, foreign students and foreign visitors would not. Neither, it is understood, would those with temporary leave to remain be protected; those whose leave is categorised as “exceptional”, “humanitarian” or “discretionary.”

The reasons for not extending this protection to those who are not permanently resident are:

- The connection with the UK is not “substantial” enough to provide the basis for a prosecution; and
- As far as asylum seekers are concerned, they are unlikely to leave the country to have the mutilation carried out abroad because their asylum claim would fall.

These arguments may have some validity where they focus on those adults who have at least some freedom to determine their own movements and place of residence. However, as will be explained, the situation looks different from a child’s perspective.

If the Bill is passed in its current form, the children of refugees would be protected, while the children of asylum seekers, and others with more temporary leave would not. This means that their adult relatives would be able to take or send them out of the UK for mutilation without fear of reprisal.

In the rest of this paper, UK nationals and permanent UK residents will be referred to as “UK persons” and non-nationals and non-permanent residents as “non-UK persons.”

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68 Resolution 1247 (2001), adopted by the Standing Committee on behalf of the Assembly, on 22 May, 2001. The resolution also called on member states “to adopt more flexible measures for granting the right of asylum to mothers and their children who fear being subjected to such practices.”
69 This is a paraphrase of the points made in paragraph 10 of the Policy Memorandum.
“Substantial connection”
The issue in point 1 above about the need for a “substantial connection” with the UK has two dimensions:

- The connection between the UK and the offender; and
- The connection between the UK and the victim.

Sometimes these appear to be confused in the debates.

The offender
Where the offence focuses on a person within Scotland who arranges for mutilation to be carried out abroad, the offender’s connection with the UK is irrelevant. (But the victim’s “connection” is still relevant. See below.) It will be an offence whether or not the person arranging the mutilation or the person carrying it out is a UK person. (Clause 2(1) and its extension in Clause 3(1))

Where the offence focuses on what happens abroad, then the offender’s “connection” with the UK becomes relevant. Thus, a UK person who carried out mutilation abroad, or one who “aided” it etc., while abroad, would be liable to prosecution on return to Scotland, whereas a non-UK person would not. This means that a non-UK person could (a) legally go abroad and arrange for mutilation to be carried out there; or (b) visit the UK without fear of prosecution for having carried out mutilation abroad. (Clause 1(1) and 2 and their extension in Clause 3(1))

The victim
Clause 2(2) says that mutilation carried out abroad is an offence only if it is “done to” a UK person. The equivalent Westminster provision was explained by the Bill’s promoter (Ann Clwyd) as follows:

“… the offence applies only when the victim is a UK national or permanent UK resident. Restricting the clause to victims who are UK nationals or permanent UK residents increases the connection to the UK. Without such a restriction, we would be making it an offence to assist an FGM operation carried out abroad by a person who has no connection to the UK on a victim who has no connection to the UK. It is right that all children should be protected from FGM, whatever their nationality or residency, but it does not necessarily fall to, nor is it possible for, the UK to legislate to protect all victims outside our own jurisdiction.”

The kind of scenario that seems to be envisaged here is where a temporarily UK-based foreign student, for example, goes abroad to arrange for their foreign child to be mutilated there. On this view, there would be insufficient “connection” with the UK to justify a prosecution.

This statement presumes that the non-UK victims have “no connection” to the UK, whereas they could, in fact, be children who have spent a large part of their life here. It also refers to a perceived lack of responsibility for “victims outside our own jurisdiction.” This seems a strange statement to make, given the clear statements of the United Nations and other international bodies that rest upon a perception of our common responsibility as a human family for our most innocent and vulnerable members.

Whereas the law may need to be read narrowly where the purpose is punishment, it should be interpreted generously where the purpose is the protection of innocent and vulnerable children. It

70 “FGM” is a common abbreviation for “female genital mutilation.”
71 House of Commons Standing Committee C (pt 2), 25 June 2003, Col 009.
72 Convention on the Rights of the Child Preamble: “Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.” International commitment has been reaffirmed in a number of statements, including Resolution S-27/2, “A world fit for children” adopted by the UN General Assembly on 10 May, 2002, which starts, “Eleven years ago, at the World Summit for Children, world leaders made a joint commitment and issued an urgent, universal appeal to give every child a better future.”
must be possible to exclude the possibilities of prosecution of persons whose link with the UK is deemed too insubstantial, while at the same time retaining protection for non-UK victims.

The focus within this debate on the offender at the expense of the victim is carried through into the debates on the second point listed above about asylum seekers.

Asylum Seekers
It is argued that asylum seekers are unlikely to leave the country to have the mutilation carried out abroad because their asylum claim would fall if they left the UK. Firstly, it should be clear that the perceived likelihood of an event should not be the criterion for deciding whether basic human rights standards should apply.

Secondly, it should be noted that children are not generally the applicants for asylum status – their parents are. Therefore the child of an asylum seeker could be sent out of the country while the parents remained, without the asylum claim falling. The Scottish Refugee Council has observed that:

“While many people in this category may not be in a position to arrange for their children to leave the country, there are people seeking safe haven who do have considerable resources. Provided people have travel documents there is nothing to stop them leaving the country, or arranging for an agent to take their child to a country where genital mutilation could be performed.”

In this circumstance, the fact that the parents remained in the country should surely provide sufficient “connection” to justify a prosecution. However, this situation would not be criminalised by the Bill.

Conclusion
Children’s rights to freedom from mutilation require that the protective measures be extended to all children and young people in Scotland, without discrimination.

If clause 2(2)(a) were deleted (and a few minor adjustments made):

- It would be an offence for anyone in Scotland to aid or abet female genital mutilation outside the UK, whether or not the victim was a UK person.
- A UK person could be prosecuted in Scotland for carrying out female genital mutilation, or aiding or abetting it, anywhere by anyone upon anyone.
- A non-UK person would not be liable to prosecution in Scotland for carrying out female genital mutilation, or aiding or abetting it abroad; although, where that person was temporarily resident in the UK, a question might arise about the extent to which the mutilation was “procured” while that person was in Scotland.

Type IV FGM
The World Health Organisation identifies four “types” of female genital mutilation:

- **Type I** Excision of the prepuce with or without excision of part or all of the clitoris.
- **Type II** Excision of the prepuce and clitoris together with partial or total excision of the labia minora.
- **Type III** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- **Type IV** Unclassified: includes pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the definition of FGM given above.

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73 Quoted in SPICe Briefing, page 19.

The definition in the Bill is more generally phrased and some have doubted whether it covers Type IV.\textsuperscript{75} In Committee, it has been argued that it would be for the courts to determine whether any particular practice fell within the “otherwise mutilates” part of the clause 1 definition.\textsuperscript{76}

If there is any doubt, then it would be more consistent with the rights of the child were the definition to be amended to make it more specific. Otherwise, it would be strange contradiction that, while the tattooing of young people under 18 is an offence\textsuperscript{77}, the practices described in Type IV would not be.

It would be possible for guidance to make clear the breadth of the prohibited mutilations. However, there may be some merit in considering whether the Bill should require regard to be had to a definition of female genital mutilation set out in secondary legislation. This could encompass the definition used by the World Health Organisation, which could be amended in accordance with developments in thinking. The general phrase “otherwise mutilates” could be retained.

Child Protection
This part of the response draws attention to some child protection issues, which might benefit from exploration with local authorities and the Scottish Children’s Reporter Administration (if this has not already been done) to ensure that comprehensive protection for children and young people is achieved.

The Legal Framework
It is important to take account of the different child protection systems throughout the UK and not to assume that protective mechanisms available in other parts of the UK would also be available in Scotland (and vice-versa). For example, in the debates associated with the equivalent Westminster Bill, and the guidance issued thereafter, much reference has been made to the availability of the “prohibited steps order” as a mechanism for protecting girls by prohibiting their removal from the country. Here it is important to note that, while local authorities in England and Wales can apply for these orders under Section 8 of the Children Act 1989, local authorities in Scotland cannot apply for the equivalent “interdict” in terms of section 11 of the Children (Scotland) Act 1995. Section 11(5) of that Act excludes local authorities from the category of persons entitled to apply for section 11 orders. Other interested individuals and agencies such as health and police would be able to apply, although this is possibly not widely known. The reason for this is that the view was taken in Scotland that local authorities should use the “public law” child protection measures in Part II of the Act rather than the “private”, basically family law, measures in Part I. This means that there is more hanging on our child protection law in Scotland than there is in the rest of the UK. It would be possible for a local authority in Scotland to apply for a child protection order under section 57 of the 1995 Act where plans for removal for mutilation were suspected. However, the effect of this lasts for a maximum of 8 days, after which it may be taken into the children’s hearing system. It may be possible for a children’s hearing supervision requirement to prohibit removal if it is worded very carefully, but this perhaps needs to be confirmed and its adequacy assessed. It may also be helpful to consider whether “port stops” such as those available to prevent international child abduction could be made available to protect these girls.

Child protection law takes special note of what are called “Schedule 1 offences.” These are listed in Schedule 1 to the Criminal Procedure (Scotland) Act 1995. The list includes some specified offences, but also refers to “Any other offence involving bodily injury to a child under the age of 17 years.” The planned creation of new offences by the Bill would make it clearer that female genital mutilation was a Schedule 1 offence falling within the general part of the definition. It is likely that this would be sufficient to ensure the protection of children, although specific inclusion of the practice in Schedule 1 might extend awareness.

\textsuperscript{75} As detailed in the SPICe Briefing, page 14.
\textsuperscript{76} Equal Opportunities Committee, 30 November, 2004.
\textsuperscript{77} Tattooing of Minors Act 1969.
Guidance
Consideration should also be given to making more specific reference to female genital mutilation in guidance on child protection. It might also be specifically included in the category of physical abuse.

It was noted above that article 39 of the Convention on the Rights of the Child requires states to take all appropriate measures to help a child recover from any form of torture or cruel, inhuman or degrading treatment. It may be appropriate to draw the attention of local authorities to these children who should fall within the definition of those “in need” in terms of section 22 of the Children (Scotland) Act 1995.

Education and Awareness-raising
As Commissioner, I would add my voice to the calls for more public and professional education about female genital mutilation. I am also considering the contribution my office might make to this task.

Kathleen Marshall
Commissioner for Children and Young People in Scotland
January 2005

Submission from Equal Opportunities Commission

Introduction
The Equal Opportunities Commission (EOC) was set up by the Sex Discrimination Act 1975 (the SDA). Its duties are to work towards the elimination of discrimination between women and men, to promote equality of opportunity between women and men generally, and to keep under review the workings of the Sex Discrimination and Equal Pay Acts. The Equal Opportunities Commission (EOC) is a non-departmental public body, funded through grant-in-aid. Our sponsor department is the Women and Equality Unit at the Department for Trade and Industry. The Equal Opportunities Commission is the leading agency working to eliminate sex discrimination in 21st Century Britain.

The EOC’s statutory responsibility relates specifically to gender equality, and that is where the Commission’s main expertise is. However, issues of gender equality are integral to all other equality groups, including those areas regulated by statute and those identified in Schedule 5 of The Scotland Act.

EOC Scotland welcomes the proposed Bill to restate and amend the law relating to female genital mutilation. It will ensure that equal legal protection is afforded in Scotland as in the rest of the UK and sends an important signal that practices such as female genital mutilation are not acceptable in Scotland.

While this issue is outside our statutory responsibilities, we view this both as an issue of human rights and of women’s health. We are convinced by the evidence in respect of women’s health outlined by Martha Nussbaum. In making the case about the need to judge other cultures, Nussbaum cites UN and other evidence in respect of the impact of female genital mutilation on women and also underlines issues around consent and the denial of human rights. She contends that the practice is:

- Carried out by force on girls and women
- Is linked to extensive and sometimes life-long health problems
- Is irreversible
- Is usually carried out on girls far too young to give their consent even were consent solicited

Rona Fitzgerald,
Director of Policy and Parliamentary Affairs,
Equal Opportunities Commission
**Submission from Dr Mary Hepburn**

Thank you for including me in the discussion about this work. From what I've seen of the proposed legislation I have 2 concerns.

Firstly there is confusion about the anatomical origin of the clitoris and it is the view of the local anatomists with whom I discussed this that it does not clearly fall into classification as part of either the labia majora or labia minora. Consequently to ensure that there is no confusion that any form or degree of mutilation of the clitoris is illegal it should be separately mentioned. I am pleased to hear that this has in fact now been included.

Secondly, health care workers in maternity services who have to make incisions to enlarge the introitus for delivery are often put under pressure to repair this incision to restore the genitalia to the condition before pregnancy / delivery. At present this is clearly illegal. However I am concerned that the wording of the proposed legislation does not make that explicit. I think it could be argued that there is a clear distinction between the initial infibulation and re-infibulation since the former involves excision of tissue while the latter simply involves repairing an incision made to allow delivery. This might be interpreted as comparable to repair of an episiotomy. This is particularly true if the incision to allow delivery is made during labour / delivery. There would be less scope for misinterpretation where the incision reversing infibulation is made during pregnancy and well before the onset of labour. In that situation restoration to the pre-pregnancy state would involve additional incising then suturing so would be more analogous to re-infibulation but I think it would still be a bit of a grey area. I think it is important that the legislation leaves no room for ambiguity.

Mary Hepburn  
Consultant Obstetrician  
Princess Royal Maternity Hospital, Glasgow  
January 2005

**Submission from John Telfer**

*Regarding: Reduction Labioplasty with Respect to Prohibition of Female Genital Mutilation (Scotland) Bill*

It is recognised that there has been an increase in the demand for and provision of Cosmetic Surgery across the board, particularly in the United States, but also in the United Kingdom. The exact cause of this is not clear, but it is probably multifactoral. There is certainly a greater awareness amongst the general public of the accessibility of Cosmetic Surgery, through the media and advertising. Our society is more affluent, medical loans are readily available and such procedures have achieved greater acceptability. There has also been a realisation that some procedures previously regarded as purely cosmetic, may address very real physical problems, as well as promoting psychological well being, in appropriate cases. There are quality of life studies to support this.

It is perhaps not surprising therefore, that a greater awareness of the possibility of Female Genital Cosmetic Surgery has developed and demand has increased. The most common requests are for Reduction Labioplasty, Vaginal Tightening post childbirth and Augmentation of the Labia Majora.

Reduction Labioplasty may address functional problems, in particular prolapse of the Labia Minora into the vagina during intercourse, which is uncomfortable, or friction against under garments during exercise. There may be real or perceived concerns that the Labia Minora are excessively large, leading to psychological distress and this may be relieved by surgery. My understanding is that surgery would be acceptable under current Legislation in either of these circumstances.

However there are a group of patients, who do not have physical problems or significant, clinically apparent, psychological concerns, who request such surgery. Currently under these circumstances, such surgery, if the letter of the law is to be applied, would be illegal. It is difficult to accurately assess the number of patients in this category seeking such surgery. A simple search for Labioplasty on the Internet throws up a multitude of websites that offer or indeed claim to
specialise in such surgery. It was recognised at the meeting of the British Society of Sexual Medicine in London, in January 2004, that the request for cosmetic procedures to the female genitalia was rising. It was speculated that the readily available array of images of the female genitalia that can be accessed online may be a factor, provoking comparison between the individual or partners’ own genitalia and what is felt to be normal or desirable.

Whilst the idea of cosmetic surgery to the female genitalia may not interest everyone and indeed may cause abhorrence to many, to some the quest to improve their body image will lead to requests for such surgery. By and large such surgery is relatively simple and straightforward and should carry a low complication rate. If carried out in appropriate settings, by suitably qualified personnel, after obtaining informed consent, the procedure may relieve physical symptoms and may engender a feeling of psychological well being in the patients.

I would contrast this directly with Female Genital Mutilation. These procedures, of which there are several variants, are usually undertaken in minors, usually against their will and for which there can be little practical or psychological benefit. Indeed the contrary may be the case. These procedures seek to narrow the vaginal introitus and reduce clitoral sensitivity, to a greater or lesser degree. The results are mutilating and may result in obstruction to urinary and menstrual flow, the promotion of poor personal hygiene and cause problems with normal vagina intercourse and childbirth. There is an associated Morbidity and Mortality.

As with all cosmetic procedures there are grey areas. Who should be undertaking Reduction Labioplasty? Clearly suitably qualified personnel would include Gynaecologists and Plastic Surgeons, if they have been appropriately trained, but how do you regulate this? Should there be a lower age limit for such surgery? Clearly there should be consent. If Reduction Labioplasty includes complete removal of the Labia Minora and the Clitoral Hood, then is this Cosmetic Surgery or Genital Mutilation?

As a Consultant Plastic Surgeon, who specialises in Gynaecological Reconstruction, I feel that there are circumstances in which Reduction Labioplasty can be justified on physical and/or psychological grounds. In addition, for some women who do not have physical problems or significant psychological upset, there may still be some gain from such surgery, on purely cosmetic terms, in much the same way as with many other cosmetic procedures. It would therefore, seem inappropriate to outlaw such procedures specifically or by including such surgery under the terms of the Prohibition of Female Genital Mutilation (Scotland) Bill and yet allow other forms of cosmetic surgery. However, the terms used to describe Reduction Labioplasty and the circumstances in which this type of surgery may be undertaken, needs to robustly distinguish the nature of this procedure and other surgery to the female genitalia from any type of Female Genital Mutilation.

It would be desirable to regulate the practice of all forms of cosmetic surgery more stringently than the current system dictates, and this particular area should be no exception.

John RC Telfer
Consultant Plastic Surgeon, with a Specialist Interest in Gynaecological Reconstruction.
Canniesburn Plastic Surgery Unit,
Glasgow Royal Infirmary

Supplementary Evidence from Dr Pamela Buck

Thank you for giving me the opportunity to present evidence to the committee. Inevitably, following the meeting [on 18 January], I reflected on the discussion and my evidence. I wish to make a supplementary submission to clarify the difficult area of cosmetic surgery.

I do not think that cosmetic surgery to the genital area should be made illegal in the adult woman, provided she consents to surgery, having been fully informed of the procedure, its limitations and complications.

I perceive a difference between Female Genital Mutilation, which is a “destructive” and negative practice and cosmetic surgery, which has a positive intention and outcome.
**The vagina**
The vagina is stretched and sustains some damage to the muscles and supporting tissues during normal childbirth. Some women complain that following delivery (or more likely two or three), they no longer enjoy intercourse because of the “slackness”. It is perfectly reasonable that they should be permitted to seek surgical correction to restore normal anatomy and function. In contrast, FGM narrows the opening to less than normal so that intercourse is more difficult and painful, if not impossible.

**The labia**
Gynaecologists see young women whose labia are genuinely excessively long and which cause embarrassment, by virtue of an over large bulge when wearing a swimming costume or being caught in underclothes causing physical discomfort. I do not think that any reasonable person would wish to deny surgery to reduce the labia in such cases.

More controversially, we see women who complain about the size and/or shape of their labia, but whose labia appear to be normal. These women perceive their anatomy to be abnormal and their self esteem and sexual function is diminished as a consequence. Such women should be permitted to undergo surgery, even if removal of tissue is involved, provided that they are counseled and give informed consent.

**The clitoris**
There are some, fortunately, rare medical conditions where the clitoris is abnormally large, either at birth or becomes so at puberty. Removal of some of the tissue to create a more normal sized organ is recognized medical practice.

Removal of the clitoris (usually together with all or part of the vulva) is also performed when treating cancer. This is a mutilating operation and is only performed with the intention to cure. I can think of no other circumstance in which a gynaecologist would remove the clitoris.

**In summary**
Cosmetic surgery to the genitalia should be permitted in consenting adults. I see no difference in principle between this and cosmetic surgery to the breast.

Dr Pamela Buck  
January 2005

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**Gender Reporter’s Meeting with the Somali Women Action Group (SWAG) 28 January 2005**

**Introduction**  
Following the Committee meeting of 14 December 2004, at which the Somali Women Action Group gave oral evidence on the Prohibition of Female Genital Mutilation (Scotland) Bill at stage 1, it was agreed that it would be useful for the Gender Reporter to hold a further meeting with the group to clarify a number of issues. That meeting was held in Glasgow on 28 January 2005.

**Asylum seekers**  
When asked for views on a UK national organising for an asylum seeker to carry out FGM on another asylum seeker abroad, group members felt quite strongly that this situation was unlikely to happen because the asylum seeker would not have the appropriate documents to leave the country. However, they also felt that if a person in the UK organised for FGM in this way, they should be liable for prosecution under the Bill.

**Age/consent**  
SWAG clarified a point they had made when giving formal evidence to the Committee. Group members had, in evidence, expressed the view that an age limit could be included in the Bill to allow women to make decisions about their own bodies when they are 18 years old. However, during this meeting, SWAG made it clear that while they believe women should have the right to make their own decisions from the age of 18, that does not mean that FGM should be legalised at
that age. SWAG stated that the group does not support FGM on any female of any age, that their aim is to eradicate FGM and that the Bill should, therefore, make FGM illegal irrespective of age.

**Education**

SWAG expressed the view that education is essential in order to eradicate FGM. As a newly organised group they have been visiting other women in their community telling them of the dangers of FGM. Having spoken to many women, SWAG say that what is needed is more information in different formats, in Somali, and that most women they have spoken to would like a Somali woman to educate them about the dangers of FGM and the cultural and historical reasons behind the practice.

The group has also spoken with the men in their community, but their main concern has been the women, as they are the victims of FGM. While they recognise the need to educate the men, they also note that male attitudes towards FGM have been changing in recent years (in the UK).

It was noted that, in general, society in the UK seemed less pressured than in Somalia, as people perceive they have more rights here. One of the group members felt that just being in this part of the world helped to change views, and said that if she was in Somalia her daughter would probably have undergone FGM, but she would not allow it now.

It was recognised that the older generation are more likely to try to maintain the practice of FGM, and SWAG have approached older members of the community and are working on raising awareness.

**Resources**

So far the group has had access to few resources. The only assistance the group has received to date has been the support provided by the Glasgow City Council social worker, funding from the council to put on a play, and money for a children’s party. The women of SWAG are asylum seekers and therefore have access to little money of their own.

Ideally, the group needs a computer and office space to operate more effectively. They also need a female Somali community worker who could raise awareness and pass on information in the Somali language and who would be in a position to gain confidence within the community alongside having an understanding of the cultural issues.

**Reporting FGM**

Group members felt that if they were aware of FGM being carried out, they would report it. Whilst in the past they might have felt that reporting it would exclude them from the community, they believed that this was no longer the case. The women, however, also said that some people might not report incidences of FGM if they had not been made aware of its dangers or of the fact that it was illegal.

**Health**

SWAG stated that health professionals had very little, if any, knowledge of FGM. In their experience, health professionals had been surprised and shocked on encountering FGM. The women also found it difficult to talk to health professionals about FGM as it was a sensitive subject and could make them feel embarrassed.

The group was clear that most women who had undergone FGM would not ask to be re-infibulated after childbirth because they would want to stay as they were meant to be. They also said that Somali women disliked the idea of caesarean sections in general and would be unlikely to request such a procedure. The women said that they suspected that doctors might be performing caesarean sections as a result of their lack of understanding of FGM. The group saw this as resorting to the easiest method for doctors rather than for the women.

**SWAG question**

The women asked whether a mother could be prosecuted for having FGM carried out on her daughter if she was not aware of it being illegal.
Once they were told that would probably not be an acceptable defence, the women pointed out the importance of education for their community because of the impact the law was going to have on their lives.

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Gender Reporter
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