EQUAL OPPORTUNITIES COMMITTEE

Tuesday 14 December 2004

Session 2

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EQUAL OPPORTUNITIES COMMITTEE
19th Meeting 2004, Session 2

CONVENER

*Cathy Peattie (Falkirk East) (Lab)

DEPUTY CONVENER

*Nora Radcliffe (Gordon) (LD)

COMMITTEE MEMBERS

*Shiona Baird (North East Scotland) (Green)
Frances Curran (West of Scotland) (SSP)
*Marlyn Glen (North East Scotland) (Lab)
*Marilyn Livingstone (Kirkcaldy) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Elaine Smith (Coatbridge and Chryston) (Lab)
*Ms Sandra White (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Jackie Baillie (Dumbarton) (Lab)
Linda Fabiani (Central Scotland) (SNP)
Patrick Harvie (Glasgow) (Green)
Carolyn Leckie (Central Scotland) (SSP)
Mr Jamie McGrigor (Highlands and Islands) (Con)

*attended

THE FOLLOWING GAVE EVIDENCE:

Efua Dorkenoo (Foundation for Women's Health, Research and Development)
Fariha Thomas (Amina – The Muslim Women's Resource Centre)
Witness A (Somali Women's Action Group)
Witness B (Somali Women's Action Group)
Witness C (Interpreter)

CLERK TO THE COMMITTEE

Steve Farrell

ASSISTANT CLERK

Roy McMahon

LOCATION

Committee Room 4

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' reproductivity 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 Fariha 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?

11:00

Fariha Thomas: 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 gudniin. 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: "Sunna" is related to the Prophet, so it is seen as a good thing. Therefore, the term is not appropriate in this context.

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 antenatal 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."

Marlyn 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 about 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 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 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?

Witness C: It is perhaps the result of their having different ideas. People who have lived in the UK for a long time do not have the same mentality as people who have just come from Somalia.

The Convener: I thank the witnesses very much for their evidence. It is important that we get as much information as possible to feed into our report.

Prohibition of Female Genital Mutilation (Scotland) Bill (Witness Expenses)

The Convener: Item 2 concerns witness expenses. A number of the groups that are giving evidence on FGM are small voluntary groups with limited resources. Is the committee happy to delegate to me the authority to authorise payments for expenses?

Members *indicated agreement*.

Meeting closed at 12:56.

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