The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

EQUAL OPPORTUNITIES COMMITTEE

Thursday 5 June 2014

Session 4

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EQUAL OPPORTUNITIES COMMITTEE
11th Meeting 2014, Session 4

CONVENER

*Margaret McCulloch (Central Scotland) (Lab)

DEPUTY CONVENER

*Marco Biagi (Edinburgh Central) (SNP)

COMMITTEE MEMBERS

*Christian Allard (North East Scotland) (SNP)
*John Finnie (Highlands and Islands) (Ind)
*Alex Johnstone (North East Scotland) (Con)
*John Mason (Glasgow Shettleston) (SNP)
*Siobhan McMahon (Central Scotland) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Anna Boni (Education Scotland)
Dr Kate Darlow (NHS Lothian)
Jim Doyle (Glasgow City Council)
Gillian Smith (Royal College of Midwives)

CLERK TO THE COMMITTEE

Ruth McGill

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equal Opportunities Committee

Thursday 5 June 2014

[The Convener *opened the meeting at 09:04*]

Equality and Human Rights Commission

The Convener (Margaret McCulloch): Welcome to the 11th meeting in 2014 of the Equal Opportunities Committee. Please set any electronic devices to flight mode or switch them off.

Agenda item 1 is an update from the Equality and Human Rights Commission. We agreed to seek an update from it on a range of policy areas. In paper 1, members will see its response, which we received last week.

I flag up that we sought information on the EHRC reforms from stakeholders in 2013 and that any further work should take the views that we received into account.

The current response from the EHRC could be used to feed into the committee's work programme considerations later this year, particularly on the public sector equality duty and the EHRC's business plan.

Members will also see that the EHRC is to publish its annual report and accounts for 2013-14 later in the summer. If members would like to hear formal evidence, we could either programme an evidence session with the EHRC in September or October or hold an additional committee meeting in August. I seek the committee's agreement on which approach we should take.

Siobhan McMahon (Central Scotland) (Lab): September or October would be a good time to have an evidence session. By that point the EHRC will have published more evidence on some of the things that it details, particularly on Gypsy Travellers. That will be quite interesting, so we should wait until then. An evidence session would definitely be helpful.

John Finnie (Highlands and Islands) (Ind): I agree entirely with Siobhan McMahon. However, in the interim—in line with the other work that the committee is doing—would it be possible to get the parameters of the research that the EHRC is conducting on Gypsy Traveller accommodation?

The Convener: Yes.

John Finnie: Thank you.

Christian Allard (North East Scotland) (SNP): We want to ensure that we get the research.

The Convener: Before we have the meeting.

Christian Allard: Yes, that is important. We must also have time to study it.

The Convener: Are we therefore agreed that we will have an evidence session with the EHRC in September or October?

Members *indicated agreement.*

The Convener: I suspend the meeting while we wait for some witnesses to arrive for an evidence session.

09:07

Meeting suspended

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09:22

On resuming—

Female Genital Mutilation

The Convener: Item 2 is an evidence session on female genital mutilation. I remind everyone who has just come in to switch off any electronic devices that they may have.

We will start with introductions. At the table, we have our clerking and research team as well as official report and broadcasting staff. Around the room, we are supported by the security office. I also welcome the observers in the public gallery. My name is Margaret McCulloch, and I am the committee's convener. I invite members and witnesses to introduce themselves, and I ask the witnesses to give a wee introduction about their organisation and any other information that they feel is relevant.

Marco Biagi (Edinburgh Central) (SNP): I am the deputy convener of the committee and the MSP for Edinburgh Central. Good morning.

John Finnie: Madainn mhath—good morning. I am an MSP for the Highlands and Islands.

Christian Allard: Good morning. I am a member for North East Scotland.

Siobhan McMahon: I am an MSP for Central Scotland.

Alex Johnstone (North East Scotland) (Con): I am a member for North East Scotland.

John Mason (Glasgow Shettleston) (SNP): I am the MSP for Glasgow Shettleston.

Gillian Smith (Royal College of Midwives): I am the director of the Royal College of Midwives in Scotland, which was involved in the intercollegiate guidelines and recommendations that were launched in the Westminster Parliament. I am particularly committed to the issue and I am engaged in the Scottish Government working group that deals with FGM and how we take forward some of those recommendations. I have also newly started with the national FGM charity group. In my time working overseas in the Sultanate of Oman, I experienced FGM issues on an almost daily basis, so I have considerable understanding of them.

Jim Doyle (Glasgow City Council): I work for Glasgow City Council. My job title is quality improvement officer, but my strategic remit is child protection. Basically, that involves working with partners in services such as social work and health and with voluntary sector bodies such as Barnardo's on any issue to do with child protection. One of the biggest parts of my job is to ensure that all the 300-odd child protection co-ordinators in schools receive biannual training on anything that is relevant and that children are protected.

Dr Kate Darlow (NHS Lothian): I am a senior registrar in obstetrics and gynaecology at the Royal infirmary of Edinburgh, so I am a front-line health worker. I have been asked to represent the Scottish committee of the Royal College of Obstetricians and Gynaecologists because I have an interest and first-hand experience in the issue, having worked in Ethiopia and lived in Somalia.

Anna Boni (Education Scotland): I am the lead officer for safeguarding in Education Scotland. That means ensuring that Education Scotland staff have a good understanding of all matters to do with safeguarding. I also support inspectors in schools, as safeguarding is an element of our inspection work.

The Convener: Thank you. Christian Allard will start the questions.

Christian Allard: I have a few questions about statistics and numbers. First, though, I have a question about what some of the witnesses said in their introductions. You talked about FGM. Do people know what FGM is, or do we sometimes need to use the term "female genital mutilation" just to ensure that people understand what it means?

Gillian Smith: That is a good point. Women who have suffered from that abuse might not know it as female genital mutilation—they might know it as female circumcision or as sunna or something else from their country. Because of their culture, they might not see it as mutilation. That is a great question to ask, because we have often not got the terminology right when we ask women whether they have been subjected to this form of abuse.

Anna Boni: In a recent letter that went to every school in February 2014, the terminology that we used was "female genital mutilation". That letter was signed by the Cabinet Secretary for Education and Lifelong Learning, Michael Russell, and Shona Robison. We are very open to getting the terminology right.

Christian Allard: I will follow that up with a question on statistics and numbers, on which we have had conflicting evidence. Some people attached more importance than others did to the statistics and numbers. One witness said:

> "it is not a matter of numbers but a matter of need and ... if one child is affected, that is one too many."—[*Official Report*, *Equal Opportunities Committee*, 30 January 2014; c 1803.]

I would like your views on that but, first, do you have an idea of the number of women and girls who have been subjected to FGM and the number of girls who are under threat from it?

Dr Darlow: We do not entirely know. I hope that, once we get the report from the Scottish Refugee Council, we will be able to understand the situation better. However, there is increased awareness, which is helping to generate more services for people. The hope is that, when there is more access to those services, we will understand exactly what we need to offer.

Gillian Smith: To build on that, the statistics that we have on the women who have had the procedure carried out are woefully inadequate. We have the Scottish woman-held maternity record, which is often the first time that we know about or encounter the issue. Every midwife is obliged to ask the question, on the basis of what is in the Scottish woman-held maternity record. However, it is difficult to extrapolate the information when we do not have an electronic maternity record. I have been plugging for that for some time, because it is a challenge to retrospectively go through 58,000 maternity records in Scotland to extrapolate the information, but if we had the information on an electronic system, it would be readily available. The statistics that have been given in our intercollegiate recommendations and elsewhere are woefully inadequate, so we do not know what the real challenge is.

The Convener: Why is there not an electronic system?

09:30

Gillian Smith: I think that it is a finance issue. To be fair, some areas have introduced an electronic patient record for maternity services. NHS Lothian and NHS Ayrshire and Arran have that, and NHS Greater Glasgow and Clyde is considering it. As we know, Glasgow is a major area because it was the dispersal area for asylum seekers. It would be good to have that kind of information electronically.

There are also challenges. I take it from my profession that the question is there to be asked. Some of the feedback that we have had from organisations such as the Dignity Alert and Research Forum indicates that, because of cultural sensitivities, midwives are not always asking the question when they book women in, but we must park cultural sensitivities. It is perhaps the terminology that they use in asking the question. We require to do work on that.

Dr Darlow: As Gillian Smith said, NHS Lothian has an electronic system, so we are considering the possibility of a service evaluation because we can access some information in that system. At booking, all the women are asked a question. We can tick that on our computer system so we have the potential to look back at it, but we are just considering that at the moment.

Christian Allard: Thank you very much for that answer.

An important question is whether gathering data should be a priority. The witnesses have touched on that. Will there be a problem with the relationship with certain communities if we try too hard to gather data to find out what the best way is to address FGM?

Gillian Smith: If we do not gather the data, it is difficult to have an idea of the benchmark and the size of the matter with which we have to deal. When resources are tight in, for example, education, health or justice, it is difficult to make a case to have resources put behind something if we do not know what the size of the issue is.

That does not take away from your initial comment about one child being one child too many, but we need to plan a service. Scotland currently has only one midwife who deals a lot with FGM—she is allocated to the asylum-seeking community in Glasgow—because we do not know the scale of the issue. If we do not have the data and do not know the scale, how do we channel our resources? That is my reasoning for collecting data.

John Finnie: It is important to bring about attitudinal change. How will we engage with communities to do that? I appreciate that it is a challenging issue.

Anna Boni: Where teachers are concerned, it is perhaps not a matter of attitudinal change but, certainly, we need to raise awareness.

A letter has gone to all schools and authorities making them aware of the concerns that Scotland has about female genital mutilation. That will be followed up. Authorities provide an update to all teaching staff on safeguarding and child protection issues—that is usually done at the beginning of term in August; some authorities vary, but they do it regularly—and female genital mutilation is an aspect of that. With partners, we are preparing some additional information that will go to every teacher.

That work is about awareness raising and being more sensitive to the issues, which will certainly help community awareness.

Jim Doyle: We are working with Anna Boni on that. I am one of a group that is putting the guidelines together for a presentation for staff in August.

I do training with child protection co-ordinators twice a year, in November and May. The May round has just finished. In each session I brought the subject up at a high level. All the teachers were concerned about it and needed some more information, but there is a question of sensitivity and how much information they need. We

emphasised to staff that, first and foremost, this is a child protection issue and staff follow child protection procedures.

On attitudinal change, teachers are always prepared to protect children, whether from FGM or anything else, but they need slightly more information about FGM.

The Convener: What information do they need and who should it come from?

Jim Doyle: Child protection co-ordinators and staff need to know what the issues are. If there was a possibility that a child was going to be taken away to be operated on, a teacher or a headteacher would need information to enable them to look out for the signs of that. Similarly, if a teacher or headteacher thinks that a child has had the procedure carried out on them, they need to know what to do and what to look out for.

Gillian Smith: The fact that we are here today is good. I was sharing my business card on the way up here in the lift, because we need to work more collaboratively. What Jim Doyle said is interesting. It would be good for midwives to go into schools to talk about this issue. That close working is needed.

We are picking up some work with the Scottish Refugee Council and yesterday I met the National Society for the Prevention of Cruelty to Children Scotland. We need collaborative working in all those areas. The Scottish Government group is looking to bring those groups together and it is only if we work together that we will deal with some of the issues.

An interesting aspect is that FGM generally is carried out in the communities by women on girls. We need to influence the imams or other religious leaders to turn it around. That is how we influence communities, so we need to work with those people.

Marco Biagi: Mr Doyle, I was intrigued when you said that FGM had come up in a context where there were a lot of teachers. Did anybody feed back specific concerns? Did anybody say that it rang a bell with them—that they were suspicious—or were people completely lacking in information at that stage?

Jim Doyle: They were not completely lacking; they were certainly aware that there was a general issue, although I did not get any specific examples of cases having taken place. The teaching profession is becoming more aware of the problem, like the general public is, probably.

John Finnie: I will say something that is not meant as a criticism of any of you. I have had a look at your designations and my question is maybe a bit unfair. It is to be commended that you seem to be talking to each other, but who are you talking to who is talking to the communities?

The Convener: Are there any volunteers?

Gillian Smith: The Royal College of Midwives is working with a number of groups. I have had conversations with DARF and some of the other groups. John Finnie is right. Usually when you speak to the groups that are there, you are preaching to the converted, because they understand the problem. We need to see how we can get in and around the communities, which is the challenge.

Jim Doyle: The city council education services are part of the Glasgow violence against women partnership, which works with the communities. It also works with the Women's Support Project fairly closely on FGM specifically. It links with the community and it has a role there.

Anna Boni: Jim Doyle mentioned child protection, as did I. Child protection is a multi-agency process that is well embedded in all local authorities and all schools in Scotland. It engages considerably with the parental communities.

Authorities in which there are particular worries or concerns, as Jim has been outlining, go much further than that. We know of good relationships, fact finding and working with partners to make sure that staff have the information that they require and that they can talk to communities about how to move forward. There are a number of good examples of engaging further.

Dr Darlow: I know that Dr Alison Scott, who is based in Edinburgh, would have liked to be here today but could not come. She sits on the Scottish Government group so she has a strong interest.

John Finnie: Thank you. That is very reassuring. There is a benefit in the unequivocal statement that this is child abuse, but it could be a double-edged sword. That brings me to my next question, which is about the balance between education and enforcement. Although there might seem to be a great attraction in having a significant penalty for someone who perpetrates such acts, that might have a negative effect in some communities. Do you have a view on that?

Gillian Smith: I feel as if I am hogging the discussion.

That is a big issue. I am sure that Kate Darlow has the same issues. When we get these women when they are pregnant, they are very vulnerable. We do not want to overegg the pudding and stop the women coming for maternity care because we have put so much emphasis on the issue. That is the difficulty with a number of these issues. We need to deal with them with sensitivity.

Some people say that the issue is culturally sensitive, but we cannot afford to use that label any more. We have to use sensitivity so that we do not prevent them from seeking help from us in the future. If we look back at some of the confidential inquiries into maternal death, they tell us that women who come from immigrant populations are less likely to seek help, and I worry that that is because of those types of sensitivities.

We need to know how we are going to deal with that in the future. We know that FGM is child abuse, but how do we highlight the female children of women who come from the communities in which women have been subjected to it themselves? How do we proceed when those women know that their children might be put on the at-risk register? That is a huge challenge for all health departments across the UK.

The Convener: Does Jim Doyle want to answer?

Jim Doyle: I have forgotten the thrust of your question, Mr Finnie.

John Finnie: It was about the balance between education and enforcement.

Jim Doyle: Our role is very much in child protection. It is about raising awareness among staff so that they know the procedure to follow if there is a concern. The procedure is an interagency one, and a case goes to the police and social work to investigate. We have to be careful about our relationships with the parents, but we are fairly skilled at that in schools.

Anna Boni: I agree with Jim Doyle; he is right. Teachers are very clear that they have a duty to raise any concerns that they have about any child that they are teaching. Although they are not necessarily the decision makers, they have a process to go through, and it is well embedded in Scotland.

There are other issues, such as how we relate to our pupil community. The guidelines for raising awareness for teachers have to come first. Education Scotland, along with other partners, is looking to develop some curricular material that can help to make young people more aware in a sensitive manner. That is why we will need a lot of experts to support that work so that pupils can explore the issues within the educational context.

Dr Darlow: I agree with Gillian Smith. As clinicians, we feel that we need to support women rather than criminalise them. We want them to feel comfortable enough to disclose that they have had FGM done in the past so that we can tailor the care that we offer them. We do not want them to go underground and for us to discover that they have had FGM when they are in labour. That is not a helpful time to find it out. We need to empower the women to feel comfortable disclosing that information to us.

09:45

John Mason: I may have picked up Gillian Smith's comment wrongly, but I think that she said at one stage that we should "park cultural sensitivities". I have lived in Asia, too. We in the west are used to our type of society, in which we talk about things—especially anything to do with the sexual realm—much more openly. Other cultures may be quite critical of us for doing so, and for not being a little bit more modest or sensitive. How do we strike a balance?

Gillian Smith: I said that we should park cultural sensitivities on this issue because FGM is child abuse; there is no other way we can look at it. Generally, given the age at which it is done, there is no consent to the procedure. The girls think that they are going off for a nice party, before they are pinned down and it is done to them. My point is that we cannot afford to say that we will not discuss the issue because it is culturally sensitive. We must discuss it and deal with it. We have to put a stop to this child abuse.

John Mason: I totally agree, but would you talk differently to somebody who was from a different culture?

Gillian Smith: It is partly about language and people's understanding. As I described earlier, we would not necessarily use the term "female genital mutilation" in some situations, because some women may not see the practice as being mutilation. That is when we use our cultural sensitivity in raising the issues. However, with FGM itself, we cannot just say that we will not deal with it because it is culturally sensitive. I hope that that clarifies what I meant.

John Mason: Thank you.

John Finnie: This is partly about public awareness. There has been more public awareness in the past week or so in connection with the deportation of a Nigerian woman with two young children, which I think is shameful. Do you think that that instance will help to address the problem in Scotland, or will it hinder your work in any way?

Anna Boni: I have been aware that there has been growing attention since January, and there have been a number of incidents. There has been a letter to schools in Scotland, and similar letters elsewhere in the UK. People are more aware, and there has been a big focus on women's education.

The wider issues of women and inequality and women's human rights, are being explored, so it is a very good time for us to explore FGM. It is more

in the public mind than it has been in the past. We can also become clearer on how we will move forward in addressing it.

Dr Darlow: Raising public awareness can only help the situation. We know from the DARF study that Fatou Baldeh presented to the committee at the previous evidence session that women were disappointed if they were not asked about it antenatally. We are raising awareness on both sides. Women expect the question to be asked, and health personnel are quite used to the concept.

John Finnie: I reassure the witnesses that I am not seeking to embroil them in some sort of constitutional issue. I just wonder whether they feel that it is in any way beneficial at some level that the issue is being raised. The perception is that, although it has been raised, the authorities—whoever they are—have disregarded it, and people have been deported.

Gillian Smith: There is no doubt that it has been beneficial. I get all the media reports daily through my organisation and—probably since the launch of the intercollegiate guidelines—coverage of FGM has taken off.

I was talking before the meeting to my colleagues on the Scottish Refugee Council about the International Confederation of Midwives congress, which has been going on all week in Prague. Day and daily, the issue of FGM has been on Twitter. There have been huge workshops on it, and recognition from some overseas countries that they are reducing the incidence of FGM. We perhaps need to learn some lessons from that.

My colleagues in the Royal College of Midwives have been heavily involved in the work in Prague this week, so we will see what comes out of that. Certainly, as an organisation, we are really interested in the issue, and the internet has been Twitter mad about it all week.

Marco Biagi: Moving away from the midwife-parent interaction, one concern that was raised in our previous evidence session on 30 January was that a strong criminalisation approach would make it very hard for family members, or the children themselves who are at risk, to come forward or raise suspicions because that would involve criminalising a close relative. What are your views on that? I am asking Mr Doyle and Ms Boni specifically, because they are dealing with the issue from a safeguarding approach. Do you agree with the concern, or is there a balance to be struck in that regard?

Jim Doyle: There is a balance to be struck. Again, it comes down to sensitivity and knowing what we are dealing with, and knowing the community. That is really important.

If we focus so much on criminalisation we change our role, which is child protection rather than law enforcement. That might sound contradictory, and obviously we want to enforce the law, but we have to ensure that children and their families feel safe and are safe.

To go back to the previous question about public awareness, I will make an analogy. I do a lot of work on child sexual exploitation, in which one of the big factors is the publicity around operation yewtree and Jimmy Savile, and all the other stuff that has happened around that. It is a mixed blessing, but there are more referrals and there is greater public awareness, and people are now much more likely to come forward to talk about that type of issue.

It is probably similar for FGM, but there is an added level of sensitivity because of the communities that we are dealing with and their own perceptions of the procedure. We are talking about a gradual process of awareness raising and education.

Marco Biagi: I was about to draw a similar parallel. I presume that in safeguarding and child protection there will be instances in which a child's report will lead to prosecution of parents. How do you handle that? How can you address that issue and get over that difficulty? Is it an issue that will just always be present?

Anna Boni: From a teacher's point of view, the duty of care and concerns about any child in their class, for whatever reason, overrides all that. Due process takes place, and there are discussions with colleagues in health and social work, and other people can be brought in. It depends on how the issue is progressed, but there are opportunities for discussions and thoughts.

It is not a brutal process. We have learned through various experiences with child protection issues that there must be good data gathering and exploration, and good dialogue with the families. People who are involved in child protection have gained the skills. For some people, FGM is a newer area to consider, so there must be further reflection and training on it, but the process is already probing, while being appropriately sensitive.

Alex Johnstone: I have a couple of questions that cover the background to your views. Does the Scottish Government's "National Guidance for Child Protection in Scotland 2014" give you enough information on FGM specifically?

Dr Darlow: Can you expand on the question?

Alex Johnstone: Is the specific section on FGM in Scottish Government's guidance on child protection sufficient for your needs?

Dr Darlow: We are still understanding exactly what we need to do. I usually deal more with the mothers who present in pregnancy, and we need to understand how best to ensure that we sensitively refer them either to health visitors or to social work. I do not think that we are fully in agreement on what the best approach is. We do not want to criminalise the women.

My understanding is that there is disagreement on the intercollegiate report, "Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting", with regard to whether we, on the Scottish side, should take on all that advice and go in with such a heavy-handed approach. We have not fully decided on that yet.

Anna Boni: The guidance was refreshed in May 2014 and it has a page and a half of information about female genital mutilation. Basically, the guidance outlines the areas where FGM can happen, the justifications that are made for it and possible early signs of it happening—for example, children having to leave school or being in discomfort when they come back to school. The guidance states, however, that detection of FGM is not for teachers; they should be sensitive to changes in children, but should not get involved in the physical aspect. The guidance also says where to get further advice and information. For example, it refers to the Foundation for Women's Health Research and Development, the United Nations Children's Fund—UNICEF—and the Prohibition of Female Genital Mutilation (Scotland) Act 2005. The fact that the guidance has been refreshed indicates that it can change in response to requirements. I was not involved in it, but I know that schools have found the guidance helpful.

Gillian Smith: To answer Alex Johnstone's question, I am not sure that we have got it right on female genital mutilation, although we have initiatives such as the early years collaborative, getting it right for every child and the named individual in the Children and Young People (Scotland) Act 2014. However, as I said yesterday to representatives from the GIRFEC team at NHS Education for Scotland, we must not forget that female genital mutilation is an important issue for GIRFEC and especially for the named individual. We are working with the maternity and children quality improvement collaborative to ensure that FGM is included in its work.

As I said, I am not sure that we have got it right on FGM, but we are at the start of the journey on how to change that. We must raise awareness and ensure that guidance refers to female genital mutilation.

Anna Boni: I have to disagree with Gillian Smith, because GIRFEC covers all aspects of education; child protection is one of them. We in Scotland have in our schools very strong pastoral care, going from the early years all the way through. The staff in schools deal with all sorts of issues and GIRFEC relates to all manner of issues that children bring to school. Child protection is an aspect of GIRFEC, additional support for learning and the 2014 act.

Gillian Smith: I want to clarify that I did not mean that the focus should be solely on female genital mutilation; I meant that it should not be ignored.

Anna Boni: I would not see it as being ignored. If that was the case, we would not be getting it right for every child.

Jim Doyle: To reflect what Anna Boni said, our training in August for all staff, including non-teaching staff—if there is such a thing, because you cannot be a non-teacher; I should have said support staff—will embed child protection as part of the GIRFEC approach. That is what most teachers do instinctively, anyway.

Alex Johnstone: What level of training on FGM do people with your professional responsibilities have? Do you receive training on it, or does your experience of it simply evolve?

Jim Doyle: The training involves collaborating with other agencies and learning from them. To go back to the child protection aspect, although FGM might present itself differently, the child protection procedures, concerns and so on are the same. However, I have had no formal training in dealing with FGM.

Alex Johnstone: Does the same go for the other professions?

Dr Darlow: We obstetricians are given formal training in FGM, and the training has increased noticeably, recently. It has been added to our core training so that all doctors must attend sessions on it. It means that we all understand different types of FGM and what women's needs are. It is part of the green-top guidelines of the Royal College of Obstetricians and Gynaecologists that it is preferable that there is still a named person in each unit who can give those women more expert care and have much more first-hand experience. All our other colleagues and midwives should be receiving the same sort of training.

10:00

Gillian Smith: FGM is talked about in the midwifery curriculum. We now have a challenge to raise awareness of FGM because our society is becoming more multicultural. There is an issue in respect of how that multiculturalism is spread out. We do not see as much FGM in the more remote areas as we do in Glasgow, Edinburgh and Aberdeen. We need to ensure that there is a little bit more emphasis on it than just including it in the

student midwifery curriculum; we need to do more continuing professional development on FGM. A number of groups are looking at that.

Marco Biagi: You referred to your own specialisms. Do you know whether paediatricians and general practitioners receive similar training?

Dr Darlow: I know that they can access it through choice, but I do not know whether it is a requirement.

Gillian Smith: I cannot comment on general practitioners, but I am fairly sure that it features quite strongly in paediatricians' training, although perhaps not so much for the neonatal paediatricians.

John Mason: My area of interest is resources, perhaps because I am on the Finance Committee. I was interested in the mention of the named person. If we are to take this forward, do we need more resources, or is it simply a question of midwives, GPs and everybody else being more aware, better trained and so on? Ms Smith, you said that there was just one dedicated midwife. Do we need 20 dedicated midwives or are we not at that stage yet?

Gillian Smith: That is an interesting question because it goes back to what I said before. Until we have the statistics, we do not really know what the issue is. Anybody who has to look at how they build their resources within a health board and put them out there really needs to know the size of the issue. Can this be done on a regional basis to ensure that someone is there to give specific advice? I am looking only at the midwifery side of things. As Kate Darlow says, there should be somebody in every unit, including obstetrics and gynaecology, who has a particular interest in the matter.

We need more awareness raising and training. We see the women antenatally, so there are education opportunities at that point. We also have the women for around 10 days before we discharge them into the care of the health visitor. Health visitors are probably quite a good group to talk about this. I am not sure whether the committee has already spoken to the health visitor community or, indeed, the Royal College of Nursing community, but RCN nurses will be in the accident and emergency and paediatric departments. The committee might want to take some evidence on that.

We have the women for a relatively short period; it might be 28 days or it might run to six weeks, depending whether there are particular issues. However, I see our role as perhaps raising a flag to say, "This female child comes from a community that might put her at risk."

John Mason: If I were to ask you what your top ask would be from a resources point of view, would you go back to your previous point about gathering data, putting more things on electronic records and so on?

Gillian Smith: Yes, and we also need to highlight somewhere in the personal child health record that this is a female child of a mother who has had FGM carried out on her, so that we can start the girl's health record knowing that there is a flag that we need to keep an eye on.

John Mason: And that would not stigmatise anyone, would it?

Gillian Smith: I would not say that it stigmatises; it is just a flag. This is the difficulty that I have: how else are people going to know about this without raising that flag at the start of the record? How am I, as a midwife, going to pass on to the health visitor the information that a woman who has had FGM carried out has had a female child and that her child is at risk of having FGM carried out on her by the community or of being taken overseas? If I do not raise that flag, how is the health visitor going to know?

John Mason: That is a fair point. What do the other witnesses think? Is this a resources question or is it about time, education, training and so on?

Anna Boni: It is not particularly a resource issue for the education sector. We have a good system; initially, we will develop three or four slides for thousands of teachers to use in August. We have a very far reach. On the basis of that, we will look at some curricular materials. However, we have to be sensitive to stigmatisation because the information that we present to a class might relate directly to one young girl in that class. That is why we are not rushing into this.

We want to take really strong advice to ensure that we strike the right balance between discussing and informing and considering the potential for stigmatising or alienating a young person to whom FGM has happened or might happen. That takes us back to work that we did a long time ago when we introduced "Keeping Children Safe: What we all need to know to protect our children" and other child protection matters. We will take the same approach. Again, it is something that we will be able to consider and budget for.

John Mason: Does having the named person help the whole process in any way? Does it make clearer to a young person whom they should speak to?

Anna Boni: Whatever process we put in legislation, we find that, as well as talking to the named person, the registration teacher or the pastoral support teacher, young people go to the

teachers they get on best with. All young people do that. We have legislation and there are other mechanisms, but young people talk to the people they feel comfortable with.

Jim Doyle: Another thing that we have to be sensitive to when we speak to all the staff in schools in August is that there might well be members of staff who have been subjected to FGM and who take a different line on it.

Anna Boni: Absolutely.

John Mason: Right. So, from the point of view of the council in Glasgow, where presumably there are certain schools where you would reckon more kids are at risk than in other schools, is this a resource issue or, again, is it more about teachers' awareness?

Jim Doyle: It is not a resource issue—it is an education issue. It is about information.

John Mason: Are you getting teachers from the wide variety of cultural backgrounds that we now have?

Jim Doyle: Increasingly, yes.

John Mason: Would you think of using some of those teachers?

Jim Doyle: I think that it is too early in the process to give an answer to that.

John Mason: Okay. Dr Darlow, do you agree that resources are not a problem?

Dr Darlow: We are still in the early days. Gillian Smith mentioned the midwife in Glasgow; she is only beginning to set up her service, and it will be interesting to find out how many women she sees. It is the same in Edinburgh. We are just setting up a service and are trying to take a very multidisciplinary approach to it. We do not really know how well utilised that service will be; we need to see what happens.

John Mason: Would you be supportive of the idea of putting more resources into improving the record system and perhaps having more information technology?

Dr Darlow: Absolutely. We definitely need to do that across Scotland. As we have said, NHS Lothian has already taken that approach, but we need to work on how information is gathered. That would be very helpful. Equally, if we ensure that every midwife is appropriately trained in FGM, they will feel comfortable about asking women the question at the beginning and not miss the opportunity to do so. Because, under the current system, midwives can opt not to ask the question, it looks as though the answer is no. However, if the question has not been asked, we do not really know the answer, which is why we need to ensure that that opportunity is not missed.

John Mason: Why are people not asking the question? Are they nervous about it? Are they trying to build up relationships?

Dr Darlow: I do not think that everyone thinks of it. They might want to build up relationships and therefore might not be entirely comfortable with asking a woman the question; indeed, they might ask it, but the woman might not understand what she is being asked. We need to use interpreters for women much of the time, and it is possible that that is not always done. Sometimes there are missed opportunities. We need to do a lot of work on that.

Siobhan McMahon: Do the witnesses know of any best practice or good practice in other countries from which we in Scotland could learn? The committee has heard about the 15 clinics for FGM in England and how they work. I know that we are waiting for statistics and that, as Dr Darlow has said, other parts of the country are establishing their practice at the minute, but can—and should—we consider other countries' approaches, or should we simply focus on the outcomes for Scotland at the minute?

Dr Darlow: We absolutely and definitely should consider others' experience. In fact, the Scottish Refugee Council is including that in its study. It will be interesting to see its findings from other European countries, and we look forward to its report.

We try to learn from our colleagues, particularly those down south. At some of the courses that I have attended, we have heard from midwives and obstetricians who work down there. We definitely need to use their experience because we lack experience in Scotland, and that is what we are doing.

Gillian Smith: Kate Darlow is right in everything that she just said. We need to examine what is happening. London and similar areas are probably further ahead on the issue than we are, and we have to take cognisance of some of that work.

That is not to say that we necessarily need to go down the same path as those areas. We might need to examine what has been done in certain overseas countries that have managed to reduce FGM significantly. I am sure that a lot about that issue will come back from the International Confederation of Midwives congress but, at the moment, I am not in a position to say what such countries have done to reduce the practice.

It would be difficult to say that we should stick to our own area and not think about some of the work that we do. We can consider reciprocity, determine what we can take to other countries and find out what they bring back to us.

Jim Doyle: From an education point of view and a safeguarding and child protection point of view, I think that the systems in Scotland are robust and have been proven to be so. That is not to say that we cannot learn from other people, but our structures and approach are good.

Anna Boni: I agree with Jim Doyle, but it is always helpful to benchmark our practice against that of other people. In developing the August refresh and the curriculum materials that I mentioned, we will certainly look far and wide to find the best practice that we can.

The Convener: The committee has no more questions to ask. Have the witnesses any final comments?

Gillian Smith: From a midwifery point of view, I should say that, having been around women who have been subjected to FGM and having seen babies and young children who are subjected to it, I am absolutely delighted that the Scottish Government and the committee are addressing the issue and considering the evidence. I am sure that Kate Darlow feels the same. It is probably the start of a long-overdue journey.

The Convener: Thank you very much. We appreciate that.

That concludes the public part of the meeting. Our next meeting will take place on Thursday 19 June and will include further oral evidence on female genital mutilation.

10:14

Meeting continued in private until 10:22.

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