The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

EQUAL OPPORTUNITIES COMMITTEE

Thursday 30 January 2014

Session 4

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EQUAL OPPORTUNITIES COMMITTEE
2nd 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:

Anela Anwar (Roshni)
Fatou Baldeh (Dignity Alert and Research Forum)
Amy Edwards (Rape Crisis Glasgow)
Annie Lawson (Dignity Alert and Research Forum)
Jan Macleod (Women's Support Project)
Mukami McCrum (Kenyan Women in Scotland Association)
Nina Murray (Scottish Refugee Council)
Dr Oonagh O'Brien (Queen Margaret University)
Alison Wales (NSPCC Scotland)

CLERK TO THE COMMITTEE

Douglas Thornton

LOCATION

Committee Room 1

Scottish Parliament

Equal Opportunities Committee

Thursday 30 January 2014

[The Convener *opened the meeting at 09:16*]

Witness Expenses

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

We will start with introductions. We are supported at the table by the clerking and research staff, official reporters and broadcasting services, and around the room by security officers. I am Margaret McCulloch, the committee convener.

John Finnie (Highlands and Islands) (Ind): Madainn mhath. I am a Highlands and Islands MSP.

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

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

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

Siobhan McMahon (Central Scotland) (Lab): I am an MSP for Central Scotland.

Christian Allard (North East Scotland) (SNP): I am an MSP for North East Scotland.

The Convener: Thank you. Today's first agenda item is witness expenses. In keeping with the usual practice, members are invited to delegate to me, as convener, responsibility for arranging for the Scottish Parliamentary Corporate Body to pay, under rule 12.4.3 of the standing orders, any expenses incurred by witnesses in our inquiries into female genital mutilation and into fathers and parenting. Do members agree to that?

Members *indicated agreement.*

Decision on Taking Business in Private

09:18

The Convener: The second agenda item is a decision on whether to take business in private. Do members agree to take in private item 3, on our approach to the fathers and parenting inquiry, at this and future meetings?

Members *indicated agreement.*

09:18

Meeting continued in private.

09:28

Meeting continued in public.

Female Genital Mutilation

The Convener: Good morning, everyone. The final agenda item is an evidence session on female genital mutilation, to inform our approach to an inquiry. I welcome our witnesses around the table and make you aware that the Parliament photographer will be here later to take some photographs.

When witnesses wish to speak during the discussion, please indicate that either to me or the clerk on my left. Please introduce yourselves.

Fatou Baldeh (Dignity Alert and Research Forum): Good morning. I work as a programme officer for Dignity Alert and Research Forum. We work in the area of FGM and we also educate professionals. I am a survivor of FGM.

Anela Anwar (Roshni): I am head of projects at Roshni. We are a charity that works with minority ethnic communities nationally to address child and adult protection issues.

Nina Murray (Scottish Refugee Council): I am the women's policy development officer at the Scottish Refugee Council.

Mukami McCrum (Kenyan Women in Scotland Association): Good morning. I have recently retired. I am a long-time campaigner against FGM and am currently involved in a number of African women's organisations and groups.

09:30

Dr Oonagh O'Brien (Queen Margaret University): I am from the institute of international health and development at Queen Margaret University. I have worked for many years in gender and health, in which FGM comes up. Fatou Baldeh did her dissertation research on FGM with us at Queen Margaret University.

Jan Macleod (Women's Support Project): I am the manager of the Women's Support Project in Glasgow, which is an organisation that works against violence against women. Our current work involves national capacity building for training and awareness raising around violence.

Amy Edwards (Rape Crisis Glasgow): I am the independent sexual violence advocate at Rape Crisis Glasgow. I work with refugee and asylum-seeking women on any problems that they have.

Annie Lawson (Dignity Alert and Research Forum): I lived in east Africa for 13 years in a community where FGM was absolutely normal—or considered to be normal. When I came back to the United Kingdom I worked with DARF, where Fatou Baldeh works, doing the job that Fatou is doing at the moment. I now volunteer for DARF and usually do training sessions for professionals on FGM.

The Convener: Thank you very much. I will start by asking a question about something that has been in the newspapers, in order to establish witnesses' views on it and to find out whether you think that it is true. There was a claim that Scotland is seen as a soft touch and that people travel here to have FGM carried out on their children. Is that true?

Jan Macleod: Several of us who are here today have discussed that view, which is raised quite often when I do awareness-raising sessions with professionals about violence. I have also heard from a small number of community activists that they have heard that view in the community, but that has always been at an anecdotal level.

When I asked workers who raised it with me—health visitors, midwives or whoever—it appears that the view almost always stems back to an interview that was carried out by "Newsnight" in, I think, July 2012, in which a young woman, who I think was Somali, made a statement on camera to say that FGM was happening to girls in the north of Glasgow. It has been discussed by the violence against women partnership in Glasgow and the police are part of that discussion. However, no hard evidence has been found.

We have recently established a strategic group in Glasgow to look at FGM. It would be fair to say that our view is as follows. On the one hand, it is hard to believe that FGM is happening here because no child has ever presented at hospital or to a general practitioner. On the other hand, when you look at the number of families from communities that traditionally practise FGM, and consider the motivations and pressures on parents to carry on the tradition, it is hard to believe that it is not happening. The answer is that we do not know. There is a gap in our knowledge.

Mukami McCrum: The statement to which Jan Macleod referred is alarming in many ways. People in the community, especially African women, have complained that they are not even given a chance to know where FGM is happening. If it is happening, those who know about or witness it are aiding and abetting the practice if they do not report it to the police or other authority.

It seems to me that, as Jan Macleod said, the statement was made because people want to draw attention to the issue. The important thing is to be clear about how we interpret the information that we read, including the statistics. Not every woman from a practising community has been

mutilated and not every woman who has been mutilated will go on to mutilate her daughters.

The view that the convener referred to is making a lot of people withdraw from the debate. I will give an example from when we used to complain about racism. If you said, "All white people are racist," the reaction was really negative. People are reacting in the same negative way on FGM, which is not helpful for us activists who want to stop the practice. Anybody who makes a statement about FGM like the one that we are discussing needs to be brought to account to explain and give evidence.

I have been working for the past four years on FGM and other harmful traditional practices. When I ask people, they always tell me that they were told by somebody else, who was told by somebody else, who was told by somebody else. We never get to the person who actually saw it happen. We should not say that FGM is not happening, but it does not help to hype the situation and to make it sound as though Scotland is the place where people come for FGM.

Fatou Baldeh: Regardless of the fact that people or the news say that FGM is happening when we do not have evidence for it, we do know that children are at risk; we know that some women from practising communities still support the practice of FGM. Research in other parts of the United Kingdom has indicated that many young girls have undergone FGM either here in the UK, or when they have been taken out of the UK. That is evident.

We must also consider that practising communities protect FGM. I am from a practising community, and because I work in this area, I get emails from people who tell me that I talk too much about our personal matters to other people. People are very protective about FGM. Because of that, even when they know that it is happening, it is very hard for someone from a practising community to speak out against their people.

Nina Murray: I agree with everything that has been said. A key issue is that we do not really know where practising communities are. That is one of the reasons why we have sought funding to carry out a scoping project, to understand the data about where communities are and the levels of prevalence in those people's countries of origin. Of course, prevalence in a country of origin does not necessarily equate to prevalence in Scotland, so we need to be careful to understand statistics that are in the public domain. Prevalence may be very high in a country, but certain groups in that country might not be practising. FGM practice tends to be located in particular ethnic groups or communities.

Our casework teams, which work with refugee and asylum-seeking women, have not heard people report instances of FGM here, but we have heard instances of women in the asylum process who have left parts of the UK because of the pressures in larger communities. Those women come to Scotland because they see smaller communities here and think that there will be less pressure to practise FGM, so we have almost seen the opposite situation in Scotland.

The Convener: Moving on from that, what are witnesses' views of screening of girls at an early age, as happens in France? Would such screening be practical or helpful here?

Amy Edwards: My organisation works with survivors of sexual violence, and I would say that such screening is definitely not appropriate. Screening of young girls is very invasive and would lead to racial profiling and could stigmatise certain groups. If a girl had been cut, there would be a huge risk of retraumatisation when she was examined. If she had not been cut, we would have to question why we had subjected her to such an invasive examination.

On the counter side of that, in France screening has led to prosecutions and a drop in cases. Prosecutions have happened because people have been examined, so perhaps fewer people are doing FGM because they know that girls might be examined. There are arguments why people would want to go down that route, but we must question the overall effect of screening and how it might affect the girls who are examined.

Jan Macleod and I were discussing the age up to which girls might be screened. One option is that they would be examined up to six years of age. We know that the majority of girls are cut between the ages of five and 12, with the highest number being cut between the ages of five and eight. There is nothing to say that the age at which girls are cut would not rise to above the age of examination. We could only enforce screening to a certain extent, and there are arguments for and against it.

The Convener: Will you clarify why you think that it would lead to racial profiling? My understanding is that all young girls in France go through the screening process.

Amy Edwards: Racial tensions in the UK are already problematic. If girls are to be examined, then every girl must be examined. That would lead to kickback from groups who do not deem themselves to be at risk, who would ask why their daughters should undergo examinations.

It would lead to either further racial tensions or racial profiling and stereotyping of who is at risk.

The Convener: Thank you.

Mukami McCrum: I was speaking recently to a friend in France, who said that we must remember

that we have different systems and a different way of thinking, so we cannot import something to Scotland that perhaps has a long tradition and has been part of the people's culture. In France there is openness and families expect screening to happen when girls grow up—girls are screened not just because of FGM. We are not used to that.

As Amy Edwards said, there is also the question of how we would identify which girls should be screened. There is an assumption that because the figures show that FGM happens most in Africa, people who look African would be targeted. That would have serious implications for, for example, the children of a white woman who was married to a man from a practising community. If you looked at statistics and looked at children at risk because of the mother, you would never consider such a child to be at risk. However, that child could be taken anywhere, if the father believed in the practice. A focus on the mother and the child could mean that we would lose children at risk.

I came to this country when virginity tests were carried out at Heathrow—I was made to stand in a queue. It was the most embarrassing and humiliating thing that someone could go through. That was way back; I do not think that many people remember it. If we were to go down the screening route, we would need many safeguards. Regardless of the fact that we have equal opportunity and that we should be checked at random when going through immigration at airports, the number of times that that randomness falls on black people is amazing. The same thing would happen with screening. I know some women who have been fighting FGM for 50 years or more, who would kick up hell if they saw their children being dragged through the system just because they come from one particular country or community. It would be completely wrong, so we have to find other ways.

I would say yes to screening if it would protect children. I would hate to think that we would ever find a child who had been mutilated in Scotland—that would be enough for me to say, "Yes. Let's do screening." However, we do not have enough measures in the system to protect people's civil rights, dignity and liberty in the screening process.

Jan Macleod: I largely agree with what Amy Edwards said. If it was going to be done at all, it would have to be done to every girl and I cannot see that the evidence justifies that, when we consider the difficulties with it.

It has to be weighed up against the fact that, for a long time, we have had information about the prevalence of child sexual abuse, for example. The University of North London conducted a UK-wide study that found that one female in 20 had suffered serious sexual abuse such as rape or forced masturbation and there was no question then of every girl in the country being examined regularly to look for evidence of sexual abuse. If we are not going to do that for such a prevalence level, why would we introduce examinations for FGM? I am not saying that FGM is less serious because the numbers are low. It is obviously very serious, but the numbers are much lower than one in 20. Therefore, we need to find other safeguards.

09:45

I believe that the health services propose that each child should be given a nominated health worker who would follow them through childhood. That would provide opportunities to consider how risk assessment for FGM could be strengthened through having named workers so that there would be a clear responsibility for it and for raising the alert if it did not come from elsewhere. That has a lot of possibility for future safeguarding of children.

Anela Anwar: I largely agree with a lot of what has been said. My concern is that we need to use more culturally affirmative approaches, not approaches that will stigmatise a community that is already putting up walls around the issue, which would not be helpful.

Screening seems to me to relate to the end of the process. We would be screening to try to prosecute, whereas we should concentrate on the beginning: trying to prevent FGM. As Jan Macleod said, we should consider processes and procedures that we can put in place to try to prevent it from happening in the first place, whether that be providing a named health professional or more training and awareness raising for front-line staff in the health service and schools who can spot signs and spot girls who are at risk and try to prevent it from happening. That is where the focus needs to be.

Over and above that, we will not break the cycle or stop FGM until we create attitudinal change within communities, so we need to put a lot of sustainable effort into community engagement programmes. Without engaging communities—men, women and girls—on it and empowering young girls and women to make their own choices while staying safe, we will not get anywhere. That is key to tackling FGM in Scotland.

The Convener: I welcome Alison Wales to the committee. I ask her to introduce herself and then to answer the question.

Alison Wales (NSPCC Scotland): I am a policy and information officer at the National Society for the Prevention of Cruelty to Children Scotland.

The NSPCC agrees strongly with what everybody has said so far, especially on the focus being on the prevention of FGM. Jan MacLeod mentioned the named person. Although the

NSPCC has been supportive of that approach in principle, I sound a note of caution on it.

Everyone is aware of the lack of resources for the named person. Let us take health visitors' case loads. We know that there are health visitors with enormous case loads, so the idea of the named person being a sufficient preventive tool without many more resources being directed towards the service would really need to be examined. However, in theory, an attached named person who would follow the child from birth to school age would be good.

The same implications exist for the named person in schools. The teacher who was the named person may also be underresourced in relation to the other things that they deal with, especially if they are the headteacher or deputy head.

Dr O'Brien: I echo what everyone else has said. On prevention, there are some basic, obvious measures that are simple to begin to implement. Fatou Baldeh's research on women going through maternity services shows that, within hours of giving birth, I think—Fatou can clarify it—the women are sort of attacked by somebody asking whether they will carry out FGM on their child. That could be a much more positive and engaging experience.

Two dissertations on FGM were carried out at masters level last year and both highlighted such a lack of training and awareness among mainstream NHS professionals that it is a no-brainer to start at that level.

The Convener: Marco Biagi has a few questions on the collection of data and information.

Marco Biagi: We have heard about the evidence possibly being anecdotal. Dr O'Brien might be in a good position to say whether other countries have achieved effective data collection. It seems to me that that would pose real problems.

Dr O'Brien: Fatou Baldeh has collected some of the latest literature. I think that Switzerland is one of the places that has recently carried out a good piece of work and has done some quite in-depth research.

Marco Biagi: How do countries that have done in-depth research gather the information? The only statistics that I have seen are estimates based on the number of people who come from practising communities. There must be a better way than that.

Fatou Baldeh: It is very hard to know the exact figures. That is why, in most countries, the figures are mainly estimates. They look at data from the census and estimate from among the number of migrants. I believe that we would still have the same problem in Scotland, but what is most important is that we know that a huge number of African women from practising communities live in Scotland. That indicates that there are a lot of women from practising communities who might have had FGM back home, so their kids are at risk.

I come from a practising community. I have not even had a daughter yet and I know the amount of pressure that I have come under. I am getting questions about what I would do if I had a daughter from my parents and my mother-in-law, so imagine the situation for women who already have daughters. It is evident that there are children in Scotland who are at risk—the numbers are here—but it would be very hard to get the exact figures.

Marco Biagi: Is it the case that we can estimate reasonably well the number who are at risk but that we do not know—we almost cannot know—how many of them are undergoing the practice?

Fatou Baldeh: Yes.

Nina Murray: Various attempts have been made to estimate prevalence and risk in European Union countries. A recent report by the European Institute for Gender Equality collated all the studies that have been done across the EU and Croatia. The only studies that have been done in the UK are for England and Wales, so nobody has gone beyond having a look at basic census data and taken that further to estimate risk or prevalence in Scotland.

There is a useful narrative in the report about the pros and cons of different methods of gathering data. The census is an obvious place to start and we have new census data that we can look at as an indication of where the affected populations might be, but beyond that we need to look at administrative records such as health records, child protection records, international protection records and Home Office records. However, each of those has its own issues, because it all depends on how well data has been recorded and whether there are particular codes and methods for recording FGM.

That is one reason why we will work with the London School of Hygiene & Tropical Medicine to carry out a short scoping project for which we have received funding from the Scottish Government. In six or seven months' time we hope to be able to provide a bit more of an evidenced estimate of prevalence and risk in Scotland. For many different reasons, it will only ever be an estimate, but at least it will be a baseline from which to start and it may indicate areas in which more in-depth research by academics such as those who are here may be useful.

Amy Edwards: I will answer the question about whether we can ever know the figures. To echo what Nina Murray said, unless we go down the same route as France, which we have already discussed, I do not think that we can ever know the numbers for sure. The more that we increase the stigma around FGM, the less access we will have to understanding the prevalence rate. We can be sure that, if we know from anecdotal evidence that it is happening, we have a duty to act on it and start putting in place things that will counteract it.

Mukami McCrum: As has been said, it is difficult to get accurate numbers, even in countries where prevalence of the practice has been falling. That is because fewer people put up their hands and say that it has happened to them or they are likely to do it.

We need to think about what we want those data for. If it is about prevention, we should be looking at prevention for all children. Sometimes people use data to identify the largest community that practises, and they forget the people in the other smaller communities. For example, the current focus on Somalis and refugees means that everyone else can go free because no one is paying any attention. We need to look at other ways of engaging with people.

We need statistics because they help with the planning of services, and as has already been said, resources are not adequate. However, statistics also have to take into account the fact that women who come from practising communities come from countries in which the rate of the practice has been falling. Burkina Faso is one of the countries in Africa that has recorded a dramatic fall; Kenya is another. When I was growing up there, the rate was something like 90 per cent and it is now down to between 25 and 30 per cent. If we just look at those people as they appear, we could be getting the message wrong and stigmatising people all the more.

Even now, it is difficult to encourage people. I emailed a few people to tell them that I was coming to the committee and to ask for feedback, and some of them said that although everyone is talking about it, they and what they have to say are not included. They feel as though they are criminals, and that this is another reason for targeting Africans. I keep telling people that it is not about that, but we all know that perceptions are more important than facts when we are dealing with communities because people decide things based on the rumours that are going round. We need to look at statistics in a way that helps the community to understand that we are talking about providing support and better services, not about finding out who is doing the practice and criminalising them.

The Convener: Why have the numbers reduced in countries such as Kenya?

Mukami McCrum: That has happened because of the campaigns. There have been a number of factors. First, the initiative has come from the people themselves, and people from outside support what the women are doing.

There is also the issue of leadership. In Burkina Faso, when Thomas Sankara became president, he made it clear that he wanted to eradicate all harmful traditional practices, and he encouraged women who were living in a male-dominated community to reject those practices. Laws were then put in place that protected those who were at risk and supported women and their children. That empowerment process involved the whole community.

Then things turned around. FGM stopped being desirable and people started looking at other ways for women to get an income than being married. The reasons for using FGM became less important than other factors. The process is gradual. I am more than 50 years old and it has taken that long for Kenyan numbers to fall. However, in the 21st century, we can move things a bit faster because we have more knowledge and more information, and more people are against FGM than ever before.

However, without involving and engaging those communities, and letting them lead the way, we will have the same problem over and over again because people just vote with their feet and activists end up being left talking to themselves.

10:00

Dr O'Brien: Although the numbers are really important, there are many other issues to consider. After all, even if the practice is going to happen to only one child, that still matters. If we are to deal with the complexity of the surrounding issues, we need innovative research methods. The kind of research that Fatou Baldeh carried out in her community, where she is able to access people and where people trust her, provides an important part of the picture.

It is one thing to get the numbers; however, I do not think that we will ever get accurate numbers and, in any case, what would we do with them? All that they would show is what we know anyway: people in Scotland are being affected by this practice. We need to take a multifaceted approach to data collection and employ lots of innovative research methods.

Fatou Baldeh: I am glad that Mukami McCrum has mentioned some of the countries where the prevalence of FGM has fallen but I should point out that FGM is still widely practised in many

countries. I myself come from a country where the practice is still very common. In the summer, it is treated as if it were a birthday party. Everyone celebrates it; it is not hidden; and people who come from such countries know that there is still a very high risk of their children undergoing FGM.

On the issue of numbers, a practice that was introduced in England and which has since been adopted in Scotland is to ask pregnant women a number of questions and, if they are found to have had FGM, to monitor them. Moreover, if they give birth to a daughter, social services will get involved and monitor the child as she grows up. I have an eight-year-old niece and know that my sister, who had FGM, still gets visits and that her daughter is still monitored to ensure that she is not taken back home to get FGM done. She has also been made aware of the law. I think that such strategies would get the practising communities involved. The fact is that people from practising communities do not see FGM as illegal or even know that it is illegal and it is very important to educate them about the law on FGM.

Marco Biagi: How do social services ensure that the monitoring is carried out sensitively?

Fatou Baldeh: It is all about training professionals properly before they are sent out to do the work. I know that healthcare professionals have received a lot of training; indeed, we at DARF work with and train not only healthcare professionals in Scotland but social workers, teachers and others to ensure that they can recognise the signs of a child at risk.

Jan Macleod: With regard to the numbers and prevalence of FGM, it is important to highlight that the situation is constantly shifting. As for training professionals, the fact is that people need to retain quite a lot of information in order to deal with what might be a very low number of cases.

I have found a general ignorance of the issue. When I do awareness work and ask people what countries they associate with FGM, they almost always say Somalia first. That is not an unreasonable answer, given how high the rates are there. Besides that, the most common answers are Kenya and The Gambia, but those countries are not necessarily the next highest on the list. There is a real lack of awareness of FGM in Arabic countries. For example, people are very surprised at the high rates in Egypt, and are even more surprised at the high percentage of FGM that is carried out in that country under hospital conditions. We are not necessarily talking about poor or uneducated people here; the people involved might be professionals who will obviously travel and come into the country in a different way from, say, asylum seekers or refugees. People do not realise that, and the professionals here are less likely to be alerted.

I myself did not realise until recently that the rates are very high in Iraqi Kurdistan—indeed, we have quite a few people from that region who have been affected—and FGM also happens in parts of eastern Europe and Georgia. Because there is a constant learning curve for everyone, it is difficult to embed such information in professionals' knowledge. That highlights the absolute importance of changing attitudes in the community. After all, the community will be the first point of information, the first to alert others so that girls who are at risk can be safeguarded and the first to give women information about health services.

The other point is awareness of the signs. There are some indications that people are moving away from type III FGM to type I FGM, which has a less serious physical and long-lasting health impact and would be much less noticeable. For example, I would imagine that, if a girl was taken away for a few weeks and brought back, the recovery would be much quicker. However, the human rights issue and, to a large extent, the trauma and the impact on the person's sexuality and sexual relationships remain. So, it is difficult to say that there are just one or two actions that will solve the problem.

Nina Murray: I want to go back to what Oonagh O'Brien and others said about innovative research methods and looking at community engagement as a key area for prevention. We will be working closely with our women's community development worker to look at best practice approaches to prevention work in other parts of the UK and Europe as part of our project. Doing that throughout any work on FGM is key. As Mukami McCrum said, community engagement and long-term investment in that is key, but that kind of work is resource intensive.

Our project at the Scottish Refugee Council works closely with a group that is led by refugee women. We know from experience that it takes time to support groups to work through issues and that it takes a lot of financial investment. Throughout the work, a key issue will be investment in community development and community engagement in Scotland, which is an area that has suffered over the past few years as a result of cuts.

Alison Wales: I welcome what various people have said, especially Mukami McCrum when she talked about an approach that is based on encouraging women and girls to reject the practice of FGM and move on from that. I hope that men can be encouraged to reject the practice as well.

I want to draw attention to a couple of things. A strategy on tackling violence against women is being developed. As far as I am aware, it was supposed to be out for consultation, but it has not appeared so far. I guess that the strategy will have

something to say about FGM and how that will be embedded in the strategy on violence against women in general. Again as Mukami McCrum said, communities will need to lead on how FGM is tackled in the strategy. There is also the national child protection guidance in Scotland, which has recently been undergoing a process of being refreshed. It has a fairly comprehensive—albeit incredibly short—section on FGM, but it has no real background information. However, FGM is recognised as a significant child protection risk. Certain things are already in place, although a huge amount more needs to be done. What the strategy on violence against women and the national child protection guidance have to say about FGM at a strategic level is incredibly important.

On community engagement and community awareness raising, I want to raise awareness of the NSPCC's national helpline on female genital mutilation, which is a recent aspect of the national child protection helpline that the NSPCC runs. It is incredibly early days in Scotland for that and there has been no awareness raising of it so far—it has been around for only six months. It was introduced in response to freedom of information requests in England and Wales that showed a large number of women presenting at specialist clinics with regard to FGM. As I said, it is early days in Scotland in terms of raising awareness of the helpline, but UK wide there have been 152 contacts to the helpline since it was opened in June last year. I think that around half of the contacts were from professionals and the public and that about 70 of them have resulted in referrals.

Annie Lawson: This will be slightly rambling, so I apologise. A friend visited me at home a couple of years ago and brought along a friend of hers who is British but who came from another country decades ago. I was talking a little bit about FGM and that friend said that 100 per cent of her community have it done here in the UK and always have, so it is not just about people who are relatively recent immigrants. There is an embedded system. I could not tell you how much it happens but, for that woman, it seemed normal and it was being done in the UK. We therefore have to be a bit careful about pinning FGM on recent immigrants, because it is not just about them.

The most important thing in this discussion is that the approach should have the right ethos. We need responsible press releases and everything that we say has to be considered. Due to a lot of what has been said, people feel stigmatised and that there is hostility because, when things are reported in the press, the press want to make a big splash—they want it to be a big story. That is not the right approach. Responsibility on the part of the press would be a massive thing. How we speak about FGM is also important. We have to make sure that our attitudes are right, because the words that come out of our mouths are not the only thing that comes across—our whole attitude does.

Two approaches seem to be being considered: the legal approach, where we prosecute, and the other approach, where we try to get the community on board. We have not really come up with a good strategy. It seems to sway one way and then the other. One approach looks a little too gentle and a bit wishy-washy and the other approach is very legalistic and will probably just drive the practice underground. I am not sure that we have quite found the right approach yet. That point is worth considering.

Mukami McCrum made a good point about how the French system for monitoring numbers does not apply in this country, because it has not been embedded in our system. Remember that, when people come into this country, our legal system is completely alien and our approach will grate with their culture, so quite a lot of work needs to be done. Although we are having a sensible discussion about it, I still feel that we have not yet come up with the right approach.

Those are a few of the points that came into my mind. My plea to everyone is: let us at least try to have the right heart, because what we want is for this not to happen to women and girls. How can we make that happen?

The Convener: We have some other topics that we would like to discuss so, if the panel is okay for us to move on, we will look at the healthcare issues. My colleague Christian Allard has some questions on those.

Christian Allard: We have talked about healthcare already, but I want to ask about the experience of female genital mutilation victims and their treatment in the Scottish healthcare system. In particular, I want to know whether there are existing policies and protocols. If there are, are they sensitive enough and fit for purpose? Also, what is being done to raise awareness and sensitivity to the issue in the medical profession? We have talked a little about training, but is that done across Scotland or just in some areas?

10:15

Jan Macleod: As a point of information, the strategy on violence against women that Alison Wales mentioned has just come out for consultation and there is an opportunity to comment on it before the end of February.

Part of the work that we do, which is funded through the Scottish Government violence against women unit, is on training and recently I did a

scoping exercise with the violence against women partnership. I am sure that some members will be aware that, throughout Scotland, there is a framework for strategic work on violence against women. Most local authority areas have some sort of multi-agency partnership or forum and very often they oversee training.

I have found that, although there was a flurry of activity and awareness raising around 2005 and 2006, when the legislation came in, very little of that has been maintained and delivered consistently. People such as Fatou Baldeh and her colleagues at DARF, Shakti Women's Aid, Saheliya and others who are involved in training and awareness work on the issues are called on, but that tends to be for one-off events. We are seriously lacking systematic training for key staff. With the best will in the world, if you do training for workers you will be lucky to get more than two hours on an issue such as FGM, given all the pressures of vacancies and funding cuts. That is particularly difficult with health staff, where posts have to be backfilled to allow clinics to run. Staff will not get a deep understanding of FGM in such a little slot, so we need to look at key members of staff.

Because of the recent media coverage and interest in FGM, the health service is looking again at its training and at key places such as smear testing clinics, well woman clinics and maternity services. The health board in Glasgow has a specialist post in maternity, and all roads lead to that one woman if anyone asks a health question about FGM. Especially in the central belt and the cities, where, as far as we know, we have significant numbers of people from FGM-practising communities, we need a health champions system. We could have someone in mental health, somebody in child protection and somebody in maternity with raised knowledge of FGM. They would be the go-to people who would inform the service, although they would not do all the work.

At the moment there is a lack of consistent training. With our funding this year, we will look at developing training resources, including a short Scottish DVD that will include information on the Scottish legal and child protection systems—we do not have anything like that to resource training. We will also look at a risk assessment for child protection. Risk funding has recently been awarded, and I will be speaking to some of the people round the table about that.

The Convener: Another five people would still like to speak, and we would like to cover another couple of areas. I ask everyone to be as precise as possible so that we can cover the range of speakers and subjects.

Mukami McCrum: Health is an important area to look at. All women who have children will, at one time or another, be in contact with health professionals. That would be the starting point of practical support for those who have been mutilated, and the starting point for engaging with them so that their children are protected.

The NHS has guidelines on FGM and midwives have guidelines. The question is why it is so difficult to implement those guidelines and to share information. I understand from professionals that one of the biggest problems is that everybody keeps information to themselves. Some organisations that work with communities do not allow health professionals, the police or other people to speak to the group, which means that there is no exchange of information.

Lessons learned from other areas, where communities and professionals—all stakeholders—are involved, tell us that it is not just about taking people to court; it is about preventing the need to take people to court. That should be the focus not just in the work of health professionals but in the work of everyone who is involved in the lives of children and women who might be affected by the issue. We are talking about schools, the police and social workers. Proper information on child protection is available and we already have guidelines that explain clearly what people should do. If we had a pathway for tracking a child from midwife to health visitor to nursery school, we might begin to be a bit confident that we were doing the right thing or going in the right direction.

Having said that, we know that FGM is a highly complex issue. The diversity of opinion that exists reflects the diversity of the communities in which FGM is practised and the diversity of views of the professionals on what we should do. The training is extremely haphazard. Everyone has their own way of training. It is possible to download a whole training package from the internet, but the training that the police need might not be the same as the training that social workers or midwives need. There must be a targeted approach, so that the training that is provided is useful. A one-size-fits-all approach does not work.

Fatou Baldeh: We all agree that it is extremely hard to identify women who have undergone FGM. I believe that one of the best ways to find out is through healthcare when women are pregnant. Eventually, it will come out if the woman has had FGM.

One of the findings of my research is that healthcare professionals do not discuss FGM properly with practising communities. None of the women I interviewed in the course of my research were asked about FGM during antenatal care. The fact that some of them had had FGM type III was not known until they went into labour, unless they had spoken out about it. It is extremely important

that women are asked about FGM during antenatal care, as that will allow us to carry out monitoring when a woman who has had FGM gives birth to a daughter. We can educate the woman about the law and let her know that it is illegal to perform FGM on the child, and healthcare professionals will be able to keep a record of the number of cases and share that information.

My colleague Katie Moore, who carried out research in the same area, found that healthcare professionals were too afraid to ask women about FGM because they were worried about offending them or being insensitive. They avoided the question. Another issue is that of terminology. We are all using the term "FGM", but people in practising communities will not know what that means unless they work in this area. If I did not know what FGM meant and I went to a midwife who asked whether I had had FGM, I would say no because I would not know what it meant. Women need to be asked the right questions, which leads us back to training. If professionals know what terms to use and how to approach the women, they will ask the right questions. I am sure that they all want to ask them but, for complicated reasons, they are not doing so.

The Convener: You said that awareness of the issue should be raised at the antenatal stage and that the woman should be kept informed, but if she knows that the practice is illegal how can we combat the pressures on her to proceed with it that come from within the family circle? It is okay to give out the information and say that FGM is wrong, but what support is available for women who decide that they do not want it to be done to their children? Where can they go for help?

Fatou Baldeh: That is lacking—they do not get that support.

FGM is usually carried out when a woman goes back home with her daughter, and in countries such as Holland the women are issued with a certificate before they go home. I understand that that is also being done in England. The women take the certificate with them to show to their families when they go back home with their daughters. They will say, "I've been given this document for my daughter's safety, and if she undergoes FGM I will end up in prison on my return and you won't get any money from me." Most Africans in this country support their families back home, and that approach seems to work.

The Convener: I do not know what to say in response to that, so I will pass over to Anela Anwar.

Anela Anwar: I echo some of Fatou Baldeh's and Jan Macleod's points. Far too much onus is put on girls and women to report FGM, and that is not acceptable. The onus must be put on healthcare professionals and teachers—the front-line staff in girls' and women's lives. Community engagement and change from within the community are key. Because of all the difficulties and the potential consequences of someone's going against their family when reporting FGM—we know how extreme those can be—it is important that the onus is put on healthcare professionals and teachers.

Training has been inconsistent and ad hoc. We have been delivering training on FGM for quite a while. We have held face-to-face sessions with local authorities and have carried out multi-agency training with teachers, healthcare professionals and the police. However, problems with budgetary constraints mean that they cannot always train as many people as they want. In addition, staff time is limited and they cannot get away for face-to-face sessions. Consequently, we have developed e-learning programmes as an alternative. One programme covers child protection issues that are specific to minority ethnic communities and includes a section on FGM, and that has really helped in raising basic awareness levels among staff across the board. We are working on an FGM-specific e-learning programme that will go into more detail and will help some of those staff who have been identified and targeted for training, perhaps including, as Jan Macleod said, health champions. That could be followed up with face-to-face sessions.

In essence, a consistent approach is needed. The position cannot be that I train someone and say one thing while another person trains someone else and contradicts that. If we work in partnership, e-learning is a medium through which we can ensure consistency. It is also a sustainable resource because people can continue to access the training. We need something at a national level that people can access to find out information about FGM.

The Convener: Everyone has talked about the women, the children and the health visitors. I would like Oonagh O'Brien, in her response, to say, if she can, what is being done to raise awareness in the male community.

Dr O'Brien: I do not know what is being done in the male community, but awareness raising is absolutely essential and there may be real support and allies there. In countries where the FGM rates have come down—I know that as an academic; it is not because I am involved in the matter, although I have a campaigning background in gender issues—there is a duality in the legal system whereby all the Governments have signed up to international human rights instruments but there is also action at the grass-roots level. One does not work without the other—indeed, both must work together.

The other people who are left out are women who have experienced FGM. I first taught about FGM in an anthropology class in the 1980s. I remember realising at the time that some of the students were from practising communities and that I could not teach the topic in the abstract. Since then, many people have come to me and said, "That's what happened to me. I didn't know that's what it was or what it was called. I didn't know this is how it is." My colleagues have had that experience as well.

As Fatou Baldeh said, when people see the acronym "FGM" they do not understand what that stands for. A whole level of understanding needs to take place. I do not think that much work has been done with men, but it is really important to do that.

Amy Edwards: To return to Fatou Baldeh's point, the policies and guidelines are in place but translating them to the communities is an issue. I recently spent time in maternity care with a woman who had undergone FGM. Although all the healthcare professionals had the knowledge, the translation of that knowledge to the woman was lacking. We need a consistent approach to training on FGM. A huge amount of training is needed not only on cross-cultural communication generally, but on approaching healthcare workers' nervousness about bringing up such issues. That is a resource-heavy approach, but we want the training to be used rather than just to stay with the person who has been trained. We need to do some general work on the use of terminology and how to approach women.

10:30

The Convener: Alison Wales is up next. Alison, what terms do women or the community recognise other than FGM?

Alison Wales: I cannot talk about that because I do not have specific information from the helpline yet. All that I have managed to obtain so far is basic information about the number of people who are contacting the helpline and the groups from which they are drawn, such as professionals, the public, and so on—and the groups within those groups. However, the data are looked at regularly and any opportunities to explore those data would be extremely welcome, especially if that were done in conjunction with colleagues who know far more about the subject than we do. As I say, it is early days in Scotland and this is not where NSPCC Scotland's expertise lies.

I want to make two points, and I am sorry to return to issues that have already been covered. Although policy—national child protection guidance—dictates what should be happening in relation to children, the guidelines are not in place in some cases. That is what a 2013 BBC Scotland investigation uncovered. Less than one third of the 32 local authorities had specific local guidelines on FGM, and fewer than 10 cases had been referred to social work.

On the issue of information sharing and what is being passed between professionals, and on the understanding that professionals have when they are working together on the issue in conjunction with children and families, my understanding from working closely with practitioners in the NSPCC and in other areas such as young people's sexual health services, with which we have close working relationships given the nature of contacts to ChildLine, is that the thing that has the biggest impact on information sharing is a trusting relationship between professionals. Work needs to be done continuously if people are to have close working relationships. Jan Macleod talked earlier about champions for FGM, meaning people who are able to go out and develop those trusting relationships and gather expertise on the issue.

The only other thing that I would say is about having an understanding. You asked for the emphasis to be taken off children and women, convener, and for us to look at men or the wider community, but I want to talk about the understanding that children have of what is happening to them. I relate it firmly to sexual abuse, which is another issue that impacts deeply on children but which they might, for quite a long time, not understand as something that is unusual and that should not be happening to them, because it might be happening within a loving family or with close friends. What ChildLine hears from children about sexual abuse is that it can be a slow process for what has happened to them to dawn on them and for them to realise that it is profoundly wrong. Embedding within education the right of children to be protected from violence and harm from the word go is totally crucial in the global sense, and we need to get the messages across to children. That is not to put the onus on children to feel responsible for coming forward. Children can be full of incredibly complex emotions about what has happened to them, including guilt, and they can be torn between loving their family and hating people for what has happened to them.

Christian Allard: I have two quick questions and I hope that we can get two quick answers, because we do not have much time.

We heard that people have friends in the health services who question the kind of language that is used in the community. We do not know what kind of language to use. To tell the truth, I did not know what language to use. Is talking about "FGM" the right way to talk about the practice and issues that we have talked about? Should we talk about

"female genital mutilation", or should we use different language? There is a call by campaigners to treat female genital mutilation as child abuse. Does anybody around the table agree with that?

Mukami McCrum: I will answer your last question first. Female genital mutilation is child abuse, because children do not make the choice. It is imposed on them and it is brutal, and there are long-term consequences that cannot be reversed.

The language that people use in communities depends on where they come from. People use terms such as "cutting", "circumcision", "going to a party", "cleansing" and "growing up". The term "female genital mutilation" is used by activists, and has been agreed by the World Health Organization and the United Nations as the one to use. That was agreed to show the brutality of the act. It is not a rite of passage or something nice, as communities present it.

Opinion is divided, because some people say that, when we use the term, we push people underground and they do not want to engage with us, as the issue is too emotive. However, they also say that the experience that they go through is brutal. Some organisations and groups say that the professionals can continue to use the term "FGM", but if we are going to engage with a community, we need to understand that community and know the language that it uses and how it feels about the matter.

It is also about people's shame and embarrassment in having to defend a practice that they do not like. They defend it only because they feel that they are under attack from the outside. We need to bring them on board so that it is a not a matter of us and them; there should be one group of people challenging FGM.

I have spoken to men and faith leaders and am disappointed that they all tend to blame women. They tell me, "You do this to yourselves. You are the ones who carry it out," although we know that FGM is carried out by some medics who are men. I have read that men carry it out in clinical settings.

We need to understand the issue in the wider context of violence against women and the factors that drive women to do things that they think men like or which will give them status in the community, make their girls marriageable and increase their dowry or the bride price. There are so many things associated with FGM. Bride price is really about selling a daughter to the highest bidder; that is not really a love relationship. We understand that context and challenge it in terms of gender equality. Women will then start to feel included.

On the first question, when I speak to some women, they say, "How dare you speak to us like that while white women can do whatever they want? They have all sorts of cosmetic operations on their genitals, and that is okay." They say that there are double standards. We need to understand that so that we can approach the issue in a way that means that we do not say that some practices in one section of the community are okay; we say that they are all bad.

Some may choose FGM, but children do not. We need to take the position that their rights are being violated.

We also need to break the silence. It seems to be taboo to talk about FGM. That is because the communities that we come from do not discuss sex openly. Sex and genitalia are not discussed openly with people, so that becomes an issue when people are going to talk about health.

Christian Allard: Perhaps I should have been more precise. My question was about using "FGM" as opposed to "female genital mutilation". "FGM" seems to be an acronym that means nothing to most people, even the communities.

Mukami McCrum: I use it because my computer keeps refusing to send emails when I put the full term. That is one of the reasons why people use it as a shorthand, but most documents and conversations will say "female genital mutilation".

The Convener: After I call Fatou Baldeh, John Mason will ask questions about the multi-agency approach.

Fatou Baldeh: When I was writing my dissertation, I was very wary of using the term "mutilation" and was not comfortable with using it. Until I finished my dissertation, I used "circumcision"; I could not use the term "mutilation" about myself. That is a problem that many women who have had FGM have with the term. They do not regard it as mutilation. Now I can use the term "mutilation"; I am getting used to it, but many women do not like to use it and, if we use it when we speak to them, they will find it very offensive.

However, there are ways. Instead of asking, "Have you been mutilated?" we can explain, "I understand that, in certain parts of Africa, a woman goes through this procedure where they are cut. It is a tradition." If we explain to them, they will understand, but if we start asking them, "Have you been mutilated?" they will answer no because they do not see it as being mutilated.

To go back to the NSPCC helpline, children will not phone to report FGM because most children from practising communities do not know that FGM exists if they live here—how will they know that something is about to happen to them? They would say things like, "My parents are taking me home for a party." Professionals are being

encouraged to recognise what children would say. Most children would not talk about going to get cut or things like that.

Another problem that I have with the NSPCC helpline is this: although professionals working in the area know about it, how many practising community members know that it exists? They are not being made aware of the helpline, so what are the chances that one of them would report incidents of FGM?

The Convener: I correct what I said earlier: it is John Finnie who will ask questions now. I apologise.

John Finnie: No problem, convener. Thank you.

First, I will make a couple of comments on issues that have been picked up. I was going to ask questions on the multi-agency approach, some of which has been covered.

Mukami McCrum mentioned the purpose of the witnesses being here. It is clear in our papers—and I hope it was to the witnesses—that they are here to inform the remit for a potential inquiry. I am interested first and foremost in whether they think that there should be an inquiry. None of the committee members would want to do anything other than help the situation rather than create difficulties, so I am interested in the issues of terminology that have been mentioned.

The witnesses are all welcome here and I have found their information fascinating, but the fact that there are no male witnesses is inescapable. As things stand, in most communities males have a predominant role. That is not always a great idea. That is also the case for decision making in the public sector. If we go ahead with an inquiry—I imagine that we will—from whom should we hear and what should we ask them?

The Convener: The witnesses' hands are all up.

Amy Edwards: To take your second point—the involvement of men—first, Mr Finnie, the practice is kept predominantly on the female side of the family and the men largely do not get involved. As we touched on earlier, the reasons for doing it are often related to pleasing the man, so there is definitely a role, but, on the nuts and bolts of how the practice is carried out, we are focusing very much on women. The representation of women speakers at the meeting reflects that. As we touched on previously, if we send a man into the communities to talk about the issue, he will just come up against brick walls, because sex and sexual health are not widely discussed.

10:45

There have been examples of faith leaders being involved in work on the issue, which is useful. However, we have also been warned by people who have worked with faith leaders that we need to be absolutely clear about the point that we are trying to get across. One woman was doing some joint work with a faith leader and thought that they were on the same page but, right at the end of the talk, he said, "But you can do this and that's fine." The trainer had to say, "No, it is not fine." Involving faith leaders is important, but making sure that they are on the same page as you is even more important.

Jan Macleod: It is very difficult to get men involved in any work on gender-based violence. We can barely get 5 per cent males at a training day about domestic abuse and we have been talking about domestic abuse for about 40 years. We have a long way to go unless we bring in some sort of law making it compulsory.

In relation to the inquiry, Nina Murray can perhaps say more about this, but the point in the Scottish Refugee Council submission made a lot of sense to me, which is that the Government has commissioned various pieces of work fairly recently, including looking at the data collection and there is quite a lot of discussion going on. Most of that work will, I hope, be completed towards the autumn, so it might make sense to wait a while and consider the inquiry again when that work is completed.

Nina Murray: I was just going to make the same point. There are so many unknowns at the moment and there has been quite a lot of investment recently in taking forward work—on data collection and on looking at best-practice approaches in other parts of the UK and Europe, for example. The Women's Support Project is being funded for some community engagement work as well. It might therefore be more fruitful to look again at what has been produced by the summer to see whether that sheds any further light on particular areas that the inquiry might like to focus on or on particular areas where perhaps we have been unable to get data because it is not public, not available or not there.

On the issue of involving men, as everyone else has said, it is definitely important to engage the whole community on this issue. However, I am not aware of any work that is being done with men at the moment—others may be aware of something happening. We would need to make sure that any witnesses represent the views of the community rather than an individual view. If no community development work is done with men, we would run the risk of getting individual views rather than a representative view following some sort of community development engagement work.

Anela Anwar: I echo Nina Murray's concern about ensuring that we do not just get an individual person's viewpoint.

Engaging male members of the community is essential and it is a starting point for addressing FGM. We address a variety of issues in our work, including child abuse and other forms of sexual abuse, honour-based violence and forced marriage. In our work, we have found it essential to engage with male members of the community to create the change in cultural attitudes. We have had to do it very sensitively, very quietly, and often on a one-to-one basis. It takes a long time—it cannot be done overnight—and a sensitive approach is essential. It definitely needs to be done.

As I was saying earlier, more baseline information would perhaps inform the remit of a potential inquiry—such information is lacking in the area of FGM at the moment. It may be something that we could revisit to see what the benefit of the inquiry would be—what is it going to bring?

The key point for me is about holding statutory agencies to account. We need to ask why, if we have guidelines and policies, they are not being implemented. From my work with front-line professionals, I know that there is a big lack of awareness of FGM and that guidance and policies are not being implemented. Perhaps we need to look at what can be done to provide sustainable support for community engagement programmes. I completely agree with what Alison Wales said earlier on that. When I said that the onus should be on professionals and staff, I meant in relation to reporting, but of course we need to engage with community members on the issue.

We already run educational programmes with children and young people on all forms of child abuse—we do not stigmatise one community or focus just on FGM. A lot could be done with an inquiry in the future, but it would be good to see the outcome of the information gathering over the summer.

Dr O'Brien: I think that John Finnie was talking about engaging not just with men from the communities but with men who may be the budget holders. Following on from what Anela Anwar said about statutory agencies, it is important to include people in management from agencies that are not delivering, in order to hold them to account. Any inquiry on the issue would also function as an awareness-raising exercise, because there would be attention focused on it; it is important that we keep that in mind.

Alison Wales: I was obviously not clear enough when I was talking about the NSPCC helpline. It is aimed at adults and professionals who want to call and report concerns, rather than at children. On Fatou Baldeh's point about children not calling to report FGM themselves, I understand that the barriers to that are very extreme.

That said, ChildLine has had a very small number of calls—22, to be precise—in the past year. Those calls have obviously come from children who are a bit older and who have developed a bit of understanding, possibly as a result of the awareness raising that all the organisations have been doing.

I agree with the points that have been made on the timing of the inquiry, following the work of the Scottish Refugee Council, but the NSPCC would be happy to do anything that it can, such as analysing what comes into the FGM helpline as well as the ChildLine helpline on FGM in order to provide written evidence to the inquiry.

John Finnie: For the avoidance of doubt, I was not being in any way disparaging to our witnesses—it is quite the reverse, as the discussion has been very helpful. I have one brief question. A well-established multi-agency approach has been adopted on child protection issues. Looking at the issue generally, can we learn any lessons from the child protection arrangements that are in place at the moment?

Anela Anwar: FGM is a child protection issue, and it should be dealt with—

John Finnie: But everything that we are hearing suggests that it is not being picked up on that basis.

Anela Anwar: The issue concerns the implementation side. We do not need to create a new procedural system; the current child protection arrangements are fine. We need to encourage front-line staff and give them the confidence to tackle FGM issues and follow the correct procedures that are already in place in local authorities. That is the key—a lot of the time, it is about building confidence. Sometimes they have the knowledge base, but they have a fear.

Mukami McCrum has said quite a lot of things today, most of which I agree with, but sometimes when we are working with communities we can err too much on the side of caution or sensitivity. Sometimes we need to take a stand and say, "This is child abuse and a child protection issue." I do not mean to stigmatise or criminalise a community, and I want to have it on board, but at some point I have to say, "We do not agree with this and we need to take steps to try to stop it."

I hope Mukami knows where I am coming from on that. We have found it very difficult to get any concrete information on FGM because people are afraid of being criminalised. We have legislation in place and the potential for prosecution, which is why we only get anecdotal evidence, such as, "I've

heard that someone has said this or that about someone else."

It is difficult to piece the pieces together, but I must be clear in the work that I do with all minority ethnic communities that whatever form child abuse takes, it is not acceptable. We cannot use our culture as an excuse and say, "I am being victimised—this is racism." We have to be very clear on that.

Mukami McCrum: I think that Anela Anwar may have got me wrong. The people around this table who know me will know that I take no prisoners on the issue of FGM. I was simply trying to encourage people to understand what the other side says when I try to say that there is no place for FGM in 21st century Scotland. I am very critical of organisations that wrap women in cotton wool and hide them, and say that nobody can engage with or speak to them because they need to be protected. I do not think that, when it comes to child abuse, FGM or anything like that, we can protect the adults, no matter who they are. I hope that that has made my position clear to Anela.

Anela Anwar: Yes.

Mukami McCrum: I would be really cross if anybody misunderstood that.

The bottom line for an inquiry is what we want to find out about—what end product the inquiry is aiming for. If the inquiry is going to happen, it is very important that all stakeholders are involved in it. We need the police because, ultimately, if persuasion or prevention does not work, we need to have people who are able to address the issue, especially if women feel that they are not able to report and do not feel protected enough. We need health professionals, education professionals—the children go to schools and teachers can find out a lot about what is going on from them—and people from social services.

However, one thing that I am really concerned about is that, most of the time when I speak to professionals, they tell me that they are on a steep learning curve. We cannot wait until all professionals are trained before we say what we are going to do in our work on prevention. The inquiry must look at what prevents professionals from using existing guidelines such as child protection guidelines. I know that many people have said that it is a matter of numbers and that there are not enough cases, but I always tell them that it is not a matter of numbers but a matter of need and that if one child is affected, that is one too many.

When we are clear about what end the inquiry is aiming at or what area we are planning to look into, it will be easier to input suggestions about other people who could be involved in the inquiry. However, faith leaders have to be involved, because people from communities practising FGM also have a profound faith and really listen to their leaders. For example, a woman from Kurdistan, which is one of the countries where the numbers for FGM have gone down, used to mutilate girls, but she now has television and has heard imams saying on it that the practice is not in the Qur'an, so she is not going to do it any more because it is not a religious requirement. If imams have condemned the practice, we find that more and more women feel empowered to say no. Previously, they might have been willing to say no to the family but not to God.

It would be good to look at what other people could have an impact on the inquiry.

John Finnie: This has been touched on by a few speakers, but could the witnesses detail what is happening elsewhere in the UK and in Europe and say what we in Scotland could learn from that? We have heard about examples of good practice, but we are keen to hear more.

Nina Murray: I am not sure that I am in a position yet to detail what the best practice is and what is happening in other parts of the UK and in Europe, but we certainly hope to look at that as part of the scoping project and to carry out interviews with a few people who have done some very successful work in the area. The European Institute for Gender Equality report is a starting point as it draws together some work that has been done by organisations such as FORWARD—the Foundation for Women's Health Research and Development—and Equality Now down in England. In addition, the Rosa fund for women and girls has been carrying out a special initiative on FGM, with small bits of funding for community awareness and peer research and peer engagement work, which I think is mainly in England.

Those are a few examples, but some of the best work is work that has drawn together all the different aspects that we have been talking about today—for example, community engagement as a key factor; and training for front-line professionals. Having a legislative framework and prosecutions is important, but that needs to be combined with all the other elements of prevention and service provision. The best examples are the ones that combine all those areas.

Fatou Baldeh: One of the things that I gathered from my research in the area of health is that there is a monitoring system for pregnant women in England. I think that it would be good if Scotland collected the same data. I know that in both England and Wales information is collected, recorded and passed on.

Another problem that we have in Scotland is to know who to refer to. If we find out about an

incident, who do we refer it to? Is it the police? People are not very clear about that. We have had a lot of organisations ask, “What do we do?” We need to have a clear referral structure.

Dr O’Brien: I think that we could also learn from countries outside Europe where there is some excellent work being done. My main work is in HIV. In Scotland there is some excellent practice on HIV with very similar issues on which we have had to engage particularly with African communities. There is a Lothian strategy group, which I sit on, which does training with GPs in Lothian on cultural competency. It struck me that there could be some profitable learning from that for other areas.

The Convener: If my colleagues have no further questions, I thank all the witnesses for coming along and for being so open and honest in the information that they have given us. I cannot thank you enough for that.

Our next meeting, which will take place on Thursday 20 February, will include oral evidence from the advisory group on tackling sectarianism.

Meeting closed at 11:01.

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e-format first available
ISBN 978-1-78392-625-1

Revised e-format available
ISBN 978-1-78392-642-8

Printed in Scotland by APS Group Scotland