The time is right for the UK government to introduce an independent anti-FGM Commissioner

Professor Andrew Rowland[1,2]

Professor Felicity Gerry QC[5,6]

Dr Charlotte Proudman[3,4]

Dr Joseph Home[1,2]

AFFILIATIONS

1 North Manchester General Hospital, Manchester, UK

2 School of Health and Society, The University of Salford, Salford, UK

3 Goldsmith Chambers, London

4 Queens' College, Cambridge, UK

5 Libertas Chambers, London, UK

6 Deakin University, Melbourne, Australia

CORRESPONDING AUTHOR

Professor Andrew Rowland, Consultant in Children's Emergency Medicine, Emergency Department, North Manchester General Hospital, Delaunays Road, Manchester, M8 5RB: Andrew.Rowland@pat.nhs.uk

LETTER

Dear Editor,

We welcome the opportunity to reply to the letter in response to our earlier article (**Home et al 2020**) and we believe it is important to continue the debate about how to end the practice of Female Genital Mutilation (FGM).

We are pleased to learn that others support the appointment of an anti-FGM Commissioner accepting that such a post is “totally relevant, highly needed and should be supported” and that it would be “an important step in ensuring good practice in the prevention, detection, investigation and prosecution of FGM crimes, as well as in the identification of victims”.

We are interested to read the suggestion that an anti-FGM Commissioner could be involved in a comprehensive evaluation of FGM specialist services and, on reflection, we agree with this proposal which would go towards ensuring continuity, consistency and the dissemination of good health practice.

We consider a crucial part of the role of an anti-FGM Commissioner would be to ensure the interconnection of legislation and health and legal measures *with* education campaigns (**Pandve 2014**). In addition to ensuring non-discriminatory approaches of courts and health practitioners, we argue that the combination of law, health and education interventions can be implemented through ‘upstream’ and ‘downstream’ approaches. Downstream approaches are individualised, catering to specific needs. Upstream approaches are system-wide, such as legislation or statutory guidance and educational policy. Whilst sometimes seen as a heavy-handed approach by policymakers, the effectiveness of upstream interventions improves over time, as resistance to change fades and subsequent generations grow up with changes

normalised (**Capewell 2018**). In this regard we consider the role of a future anti-FGM Commissioner to involve both upstream and downstream approaches to the coordination of national work to recognise and combat FGM in a non-discriminatory way. Over time it would be hoped that the need for downstream approaches should diminish as upstream approaches become (more) effective (**World Health Organization n.d.)**. Indeed, a recent study has already suggested that it is possible that FGM is abandoned after migration to the UK (**Hodes et al 2020**) and that anti-FGM measures need to be proportionate to the empirical evidence of the risk of FGM, however it would be unwise to suggest that the effectiveness of current anti-FGM measures will increase over time without additional interventions, especially where legal approaches can risk community disengagement.

The authors raise the incredibly vexing issue of Mandatory Medical Examinations (MME) in suspected FGM cases. We are concerned by the suggestion that MME is a mandatory prerequisite before an FGM Protection Order (FGMPO) can be made by the court. Notwithstanding that, we absolutely agree that a number of ethical (**British Medical Association 2020**) and consent (**General Medical Council 2018a** and **General Medical Council 2018b**) issues are raised by MMEs in potential FGM cases; however that debate was beyond the scope of our original article (**Home et al 2020**).

Nonetheless, we welcome the furtherance of that debate. For the purposes of an FGMPO, it should not be presumed that a survivor of FGM would seek FGM for their child. The evidence that a child is at risk should be specific to that child, not a generalised assumption about a parent or a particular community. The case law and legislation relating to FGMPOs has been considered by the Court of Appeal in the

case of X (A Child FGMPO) (**Re X 2018**). The rights engaged by both Article 3 and Article 8 of the European Convention on Human Rights (**Council of Europe 1950**) will clearly be relevant to the exercise by the court of its powers to make an FGMPO. When deciding how to exercise its powers, the court must balance a number of factors including the degree of the risk of FGM (which it is suggested needs to be at least a real risk); the quality of available protective factors (which could include a broad range of matters including the court's assessment of the parents' attitudes towards FGM); and the nature and extent of the interference with family life which any proposed order would cause. An order being made by the court in respect of a child will be intended, and it is suggested should be designed, to protect and promote a particular child's welfare not as a broad method of targeting parents or communities (**Re X 2018**).

We further agree with the authors that an additional role of an anti-FGM Commissioner would be to oversee a thorough review of existing healthcare policy, with regard to the responsibility of regulated health professionals in clinical examinations, whilst this might include a medical examination of mother and/or daughter in very specific cases, we do not believe this should be a mandatory requirement.

With growing support for the introduction of an anti-FGM Commissioner being demonstrated by the authors' reply to our article and our expansion of those arguments (**Gerry et al 2020**), we hope that the United Kingdom government will now give serious consideration to this proposal. Perhaps this is something that can be considered by the All Party Parliamentary Group (APPG) on FGM (**UK Parliament n.d.**) in the first instance?

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