

# FEMALE GENITAL MUTILATION

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Previous Queensland Law Reform Commission publications on this Reference:  
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*Female Genital Mutilation*, Research Paper, December 1993. (limited circulation)  
*Circumcision of Male Infants*, Research Paper, December 1993. (limited circulation)

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## TABLE OF CONTENTS

1.	INTRODUCTION .....	1
	(a) Terms of Reference .....	1
	(b) Consultation .....	2
	(i) Information Paper .....	2
	(ii) Research Paper .....	2
	(c) The Draft Report .....	3
	(d) Summary of Recommendations .....	3
2.	MEANING OF FEMALE GENITAL MUTILATION .....	5
3.	AUSTRALIAN WOMEN'S EXPERIENCE WITH FEMALE GENITAL MUTILATION .....	8
4.	HISTORY .....	13
5.	COUNTRIES WITHIN WHICH FEMALE GENITAL MUTILATION IS PRACTISED .....	15
6.	REASONS FOR THE CONTINUED PRACTICE OF FEMALE GENITAL MUTILATION .....	16
	(a) Psycho-sexual .....	16
	(b) Religious .....	17
	(c) Sociological .....	18
	(d) Hygiene and aesthetics .....	19
	(e) Economics .....	19
7.	HEALTH ISSUES .....	20
	(a) Physical .....	20
	(i) Short-term complications .....	20
	(ii) Long-term complications .....	21
	(b) Psychological .....	24
8.	THE LEGALITY OF FEMALE GENITAL MUTILATION .....	25
	(a) Body-altering acts and the Criminal Law .....	25
	(b) Offences under the <i>Criminal Code</i> .....	28
	(c) The applicability of Section 282 .....	29
	(i) "Benefit" - health .....	30
	(ii) "Benefit" - cultural .....	32
	(iii) Reasonableness .....	32
	(iv) Reform of the Code .....	33
	(d) Parties to offences .....	34

(iii)

(e)	Child protection issues .....	34
<b>9.</b>	<b>CONSENT BY YOUNG PERSON OR SUBSTITUTED CONSENT .....</b>	<b>36</b>
(a)	Criminal liability .....	36
(b)	Civil liability .....	38
(c)	Professional misconduct .....	39
<b>10.</b>	<b>OVERSEAS LEGISLATION AND INITIATIVES .....</b>	<b>41</b>
(a)	Legislation prohibiting and education discouraging female genital mutilation .....	41
(i)	African countries .....	41
(ii)	The United Kingdom .....	42
(iii)	Europe .....	45
(iv)	The United States of America .....	47
(b)	International .....	47
(i)	World Health Organisation .....	47
(ii)	United Nations .....	49
<b>11.</b>	<b>CONCLUSION .....</b>	<b>50</b>
<b>12.</b>	<b>RECOMMENDATIONS .....</b>	<b>55</b>
(a)	Education .....	55
(b)	Prohibition in <i>Medical Act 1939</i> .....	55
(c)	Removal of children interstate or overseas .....	57
(d)	Definition of children "in need of care and protection" .....	59
(e)	Child protection protocols .....	59
(f)	Protection of health and social workers .....	59
(g)	Incitement to racial hatred .....	60

## APPENDICES

1	List of Respondents to the Research Paper
2	New South Wales Legislation
3	United Kingdom Legislation
4	Proposed United States of America Legislation
5	Swedish Legislation
6	Prevalence of Female Genital Mutilation



# 1. INTRODUCTION

## (a) Terms of Reference

This reference is part of a wider reference given to the Commission by the Attorney-General in its Fourth Programme of work.<sup>1</sup> The full terms of the reference are set out in Item 4 of the Programme, namely:

**"Examine the rights relating to consent to medical procedures by:-**

- (a) children;**
- (b) intellectually disabled adults (including consent to sterilisation)."**

The Commission has divided the terms of reference into two major parts. The first part concerns consent by young people to medical procedures. The second part concerns consent to medical procedures on intellectually disabled adults.<sup>2</sup>

The first part of the reference has also been divided into distinct research projects to enable the Commission to deal with particular issues in detail and to avoid confusion between seemingly disparate matters. The research projects currently being undertaken include:

- (i) female genital mutilation;
- (ii) male circumcision;
- (iii) general legislation on consent to medical treatment of young people;
- (iv) treatment of young people where special consent is required.

This Draft Report concerns item (i) above.

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<sup>1</sup> September 1990.

<sup>2</sup> The latter part is being dealt with by the Commission in its forthcoming Report on *Assisted and Substituted Decision-Making*.

**(b) Consultation**

**(i) Information Paper**

In May and June 1993, advertisements were placed in the Courier-Mail calling for public submissions on this reference. An Information Paper outlining a wide range of issues was available to assist anyone interested in making a written or oral submission. Also, a number of media interviews were given by the Commission to elicit public interest in the matters being dealt with.

Approximately 300 copies of the Information Paper have been distributed and, to date, approximately 160 oral and written submissions have been received in response to the Information Paper. Nineteen of those submissions related specifically to female genital mutilation.

Subsequent to the release of the Information Paper, a number of individuals and organisations with a particular interest in female genital mutilation were approached for information and opinions on relevant matters raised by this reference.

**(ii) Research Paper**

In December 1993, a Research Paper on Female Genital Mutilation was published by the Commission.

The Research Paper was produced to assist the Commission in understanding the issues surrounding female genital mutilation and to contribute researched information to the public discussion on female genital mutilation. It was circulated to individuals and organisations with an interest or expertise in the issues raised, to verify the accuracy and significance of the information contained in the Research Paper, and to seek suggestions as to the most appropriate approach to adopt.

Approximately 50 submissions were received in response to the Research Paper, primarily from individuals and organisations with a strong interest, experience or expertise in the relevant issues.

In the Research Paper, a number of possible reforms were set out which would need to be considered by the Commission.<sup>3</sup> They were:

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<sup>3</sup> *Female Genital Mutilation Research Paper December 1993 at 28, 29.*



- \* insertion of specific provisions in the *Criminal Code* prohibiting female genital mutilation except for recognised medical procedures
- \* a culturally and linguistically appropriate education campaign
- \* Commonwealth immigration authorities to clarify the new laws in Queensland to all immigrants
- \* gynaecological, psycho-sexual and other assistance to be made available by relevant State Government agencies to women who have already undergone female genital mutilation
- \* prohibition on the removal of a child from Queensland for the purposes of having female genital mutilation performed elsewhere

**(c) The Draft Report**

This Draft Report has been produced to place before the public and individuals and organisations with a particular interest in the issues surrounding female genital mutilation, a number of draft recommendations for reform. The draft recommendations have been developed after careful consideration of all submissions and other information provided to, or gathered by, the Commission on female genital mutilation.

The Commission would welcome any comments on the recommendations or other contents of this Draft Report by 31 August 1994. It is anticipated that a final Report will be submitted to the Attorney-General by 30 September 1994.

The Commission is most grateful to all those who have made submissions in response to the Research Paper for the information and opinions provided. Those submissions greatly assisted the Commission during its deliberations for this Draft Report. A list of all respondents to the Research Paper is found in Appendix 1.

**(d) Summary of Recommendations<sup>4</sup>**

In this Paper, the Commission provisionally recommends -

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<sup>4</sup> See page 55 for the detailed recommendations.

- (i) an appropriate education program be introduced and adequate support facilities be made available to people in Queensland from communities in which female genital mutilation is practised.
- (ii) an appropriate education program on female genital mutilation be introduced for health professionals and medical and nursing students.
- (iii) information on female genital mutilation be made available to child protection workers, police and the Queensland judiciary.
- (iv) a prohibition of female genital mutilation except for certain medical reasons, be included in the *Medical Act 1939*, the introduction of which should follow the satisfactory implementation of the education program.
- (v) prohibition of one or more acts constituting the offence of female genital mutilation being performed in other Australian jurisdictions on a young person normally resident in Queensland.
- (vi) a prohibition against denying a person medical care or services on the basis that the person has been the subject of female genital mutilation.
- (vii) children "in need of care and protection" be defined in the *Children's Services Act 1965* so as to place beyond doubt that it includes the threat or fear of female genital mutilation in whatever form, being performed upon a young person under the age of 18.
- (viii) child protection protocols be developed by the Department of Family Services and Aboriginal and Islander Affairs and the Queensland Police Service for the investigation and handling of families "at risk" and families suspected of having had their daughters mutilated in Queensland.
- (ix) health or social workers who believe a child is at risk of undergoing female genital mutilation be immune from liability for breaching a duty of confidence to any person in taking action to protect the child in question.
- (x) the inclusion in any future incitement to racial hatred legislation of an offence relating to taunting with regard to a person's cultural beliefs and practices and to a person's bodily characteristics resulting from cultural or religious practices.

## 2. MEANING OF FEMALE GENITAL MUTILATION

The term "female genital mutilation" has been used to describe a variety of ritual practices in certain communities throughout the world.<sup>5</sup> These practices range from a cut to a female's genitals, to the removal of a genital organ. There are three main types of female genital mutilation:<sup>6</sup>

- \* **Circumcision**<sup>7</sup> involves the excision of the prepuce or hood of the clitoris.<sup>8</sup> This is the least intrusive procedure.<sup>9</sup>
- \* **Excision** includes:
  - \* the excision of the clitoral prepuce; and
  - \* the removal of the gland of the clitoris or removal of the whole of the clitoris itself; and
  - \* the removal of all or part of the labia minora.<sup>10</sup>
- \* **Infibulation or pharaonic circumcision** consists of the excision of the clitoris, labia minora and parts of the labia majora.<sup>11</sup> The two sides of the vulva are then sewn together. A small opening is allowed for the passage of urine and menstrual blood. The legs of the girl<sup>12</sup>

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<sup>5</sup> See page 15 of this Draft Report for a list of countries where at least one form of female genital mutilation is practised.

<sup>6</sup> Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation Forward 1992* at 5 and 20.

<sup>7</sup> This may also include the removal of the tip of the clitoris.

<sup>8</sup> The small erectile organ of the female genitals, partially hidden by the ends of the labia minora (as defined in footnote 10 below).

<sup>9</sup> This procedure is known as 'sunna' in some Muslim countries.

<sup>10</sup> The inner lips bounding the vagina in the female genitals.

<sup>11</sup> The outer lips of the female genitals.

<sup>12</sup> Female genital mutilation is usually performed on young women. See page 7.

are then bound together and she is immobilised for several weeks to ensure the wound heals. This is the most intrusive procedure.

The term "female circumcision" has also been widely used to describe the genital mutilation of females. However, the Commission uses the term 'female genital mutilation' rather than 'female circumcision'. Factors which influenced the Commission to use this term included:

- \* "female genital mutilation" more accurately describes the results of the surgical procedures: the word "mutilate" means to "deprive a person of a limb or essential part ... to damage or injure by the removal of an important part or parts";<sup>13</sup>
- \* "female genital mutilation" describes all forms of mutilation; "female circumcision" is commonly used to describe only the first type of mutilation outlined above;
- \* the term "female genital mutilation" has gained international acceptance as the more accurate description of the results of the procedures. The term "female genital mutilation" has been used in the United Nations *Draft Declaration on the Elimination of Violence against Women* Article 2(a) and the United States *Federal Prohibition of Female Genital Mutilation Act* of 1993.

As Gérard Zwang states:

Any definitive and irremediable removal of a healthy organ is a mutilation. The female external genital organ normally is constituted by the vulva, which comprises the labia majora, the labia minora or nymphae, and the clitoris covered by the prepuce, in front of the vestibule to the urinary meatus and the vaginal orifice. Their constitution in female humans is genetically programmed and is identically reproduced in all the embryos in all the races. The vulva is an integral part of the natural inheritance of humanity. When normal, there is absolutely no reason, medical, moral, or aesthetic, to suppress all or any part of these exterior genital organs.<sup>14</sup>

The Commission is aware of the criticism that the term 'female genital mutilation' on its face includes a value judgment with respect to the practice.

<sup>13</sup> Webster's *Comprehensive Dictionary* (Encyclopedic ed).

<sup>14</sup> *Mutilations Sexuelles Féminines, Techniques et Résultats* referred to in Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 7.

However, it is now such a widely used term covering a range of procedures that it could be misleading to use any other term.

The practice of female genital mutilation is almost always performed by an older woman or a traditional birth attendant in certain communities,<sup>15</sup> although the Commission has been advised that in certain communities men traditionally perform the procedure.<sup>16</sup> Anaesthetics are rarely used.<sup>17</sup> Instruments used in the procedure include unsterilised knives, razors, broken glass and sharp stones. It is now less common for any traditional ceremony to accompany the operation. In some communities the ceremony has been simplified.<sup>18</sup>

The age at which these operations are performed varies depending on the custom of the community and "whether legislation against the practice is foreseen or not".<sup>19</sup> Ages range from a few days old to seven years old to puberty. The age at which these operations are being performed is becoming younger.<sup>20</sup>

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15 Some medical personnel in African countries are now performing the operation in hospitals and clinics. Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 28. In Djibouti the Union Nationale des Femmes de Djibouti runs a clinic where a milder form of infibulation is performed under local anaesthetic.

16 Submission 51.

17 One submission to the Commission described how the respondent was given an anaesthetic injection in the veins of her groin so that she would feel no pain. An unsterile knife was used and a great deal of pain was experienced when the effects of the anaesthetic wore off. Submission 51.

18 Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 28.

19 Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 7.

20 Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 28.

### 3. AUSTRALIAN WOMEN'S EXPERIENCE WITH FEMALE GENITAL MUTILATION

The Commission has been aware from the outset of its research that the subject of female genital mutilation may be a very difficult one for women who have undergone the procedure to talk about. Further, it could be seen as a gross invasion of an individual's privacy to raise the issue at an individual level. One reason why the Commission decided not to make its Research Paper a public document and not to approach the media at an early stage on this project was our concern with the adverse effect an uninformed public debate could have on particular communities and individuals in Australia.

Coincidentally, at about the time of the distribution of our Research Paper in December 1993, female genital mutilation became a major issue in the Australian print and electronic media. Two Victorian girls who had been "genitally mutilated" overseas were the subject of a widely and often incorrectly reported Victorian Magistrate's Court case involving allegations of mistreatment after their arrival in Australia.<sup>21</sup> In January 1994, the Family Law Council publicly released its Discussion Paper on female genital mutilation. A media blitz on female genital mutilation ensued.<sup>22</sup> Female genital mutilation became a topic widely discussed in public as well as in State and Federal Parliaments.

Fortunately, the Commission has been able to make contact with a number of women living in Queensland who have experienced female genital mutilation and who are aware of the significance the procedures have to the

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<sup>21</sup> For example:

- Circumcision shock* Courier-Mail 2 December 1993 at 23.
- Girls circumcised here, court told* The Australian 2 December 1993.
- Court told of assault on sisters* The Age 2 December 1993.
- Plea for mutilated girls* Herald Sun 2 December 1993 at 7.
- Out with female circumcision* The Age 3 December 1993 at 14.
- Crime and culture* The Age 3 December 1993, Editorial.
- Agency calls on media to back off on circumcision* The Age 3 December 1993 at 8.
- We must set limits, for the sake of little girls* The Age 3 December 1993 at 16.
- Doctor calls for circumcision ban* Herald Sun 3 December 1993.
- Mothers fear action over female circumcision* The Weekend Australian 4-5 December 1993 at 9.

<sup>22</sup> For example,

- Ban circumcision: AMA* The Australian 7 February 1994 at 9.
- Education better than bans, say African women* The Age 17 February 1994 at 6.
- Wade may place ban on female circumcision* The Age 17 February 1994 at 6.
- Ministers to ban female circumcision* The Australian 22 March 1994 at 4.
- Girls saved from mutilation* Courier-Mail 25 March 1994.
- Painful scars of tradition* The Australian 17 May 1994.
- Television and radio coverage of female genital mutilation was exhaustive on news and current affairs programs such as the Seven Network's *Real Life*, and ABC Radio National's *Australia Talks Back* (7 March 1994).

communities within which they are practised.<sup>23</sup> The Commission has also contacted organisations in Victoria who work closely with women who have had experience with female genital mutilation. It is worthwhile referring in detail to those submissions to gain some insight into the significance of female genital mutilation and the female genital mutilation debate for these Australian women.

In Australia, most women affected by the issues surrounding female genital mutilation are originally from Horn of Africa countries, such as Eritrea, Somalia, Ethiopia and Sudan. The Commission has also spoken to a woman from Kenya. Many are refugees and have experienced great traumas in their lives prior to their arrival in Australia. Many have experienced rape and torture and the death and disappearance of close relatives and friends. Many come from countries run by repressive regimes and have fled persecution by coming to Australia.

These women are relatively small in number and most have been in Australia for five years or less. Prior to their arrival in Australia, many of these women have been homeless for up to 20 years, including protracted periods in refugee camps.

In Australia, they must adjust to a very different lifestyle, culture, value system, political climate and economic/social system. They are highly visible, often with distinct clothing and racial features. They are often the subject of racist taunts and other manifestations of racism in Australia. One organisation wrote:<sup>24</sup>

Unless the issue of female circumcision [FGM] is dealt with sensitively the women are likely to be potential targets of even greater racism. In fact it can be argued that the process of 'silencing' or 'closing out' the views and experiences of these women affected by circumcision, which has so far characterised the 'discussion' in legislation, has itself been experienced as a series of racist attacks through innuendo and unfounded assumptions. In addition, the refugee experience has left many women with enormous fear of authorities including the State, the police, and the legal system. In the face of this fear many of the women's first experience of the law in Australia has been associated with the 'debate' on female circumcision.

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<sup>23</sup> We have also received submissions from the principal Islamic organisation in Queensland and have attended a conference in Melbourne held on 2 July 1994 by the Multilingual Community Education Services on 'Unanswered Questions on Female Genital Mutilation' at which the views of men and women affected by the practice were expressed. We have also discussed with a doctor from Somalia, now resident in Queensland, his experience with female genital mutilation in Somalia and, in particular, his work treating complications resulting from female genital mutilation performed by traditional practitioners.

<sup>24</sup> Submission 47.

Even in the countries within which female genital mutilation is a culturally accepted practice, it is not a subject freely or openly talked about. An organisation noted the significance of this in Australia as follows:<sup>25</sup>

It means that deeply held spiritual and religious beliefs of the community which have been invoked to legitimise female circumcision are being challenged often for the first time. The realisation that circumcision is not a requirement of Islam is quite shocking to many of the communities. The historical silence surrounding this issue means that the first time many of these women have been called upon to talk on the issues is in relation to its criminalisation in Australia.

There also appears to be a concern amongst Australian women from African countries where female genital mutilation is a culturally accepted practice that the debate on female genital mutilation is led by the white dominant culture proclaiming that "we will civilise you because we know and live the truth". As one organisation submitted:<sup>26</sup>

This not only actively recolonises these communities, it is a failed attempt to disguise racism as benevolent concern. In this case our past remains dangerously present.

As a consequence of the public debate to date on female genital mutilation, some women affected by female genital mutilation in Victoria:<sup>27</sup>

- \* have felt rejected, self-conscious, as if fingers are being pointed at them, and as if they have a disease:

In sum they are experiencing further abuse and humiliation by those who claim to be concerned about the safety and protection of women and children.

- \* feel humiliated and further victimised.

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<sup>25</sup> Submissions 47 and 51. This was also the reaction of some of the women who were spoken to by the Commission. Submission 51.

<sup>26</sup> Submission 47.

<sup>27</sup> Submissions 43 and 47.



- \* are fearful of taking daughters to doctors or hospitals for general medical treatment in case their children are removed from them, they end up in Court or the State intervenes in the family's life.
- \* are fearful of continuing to attend community education aimed at altering views and perceptions about female genital mutilation.
- \* are not receiving supportive information and education through the health and welfare systems, or through community education even though they are among those most in need of it.
- \* have experienced tensions between mothers and daughters in families who are new to Australia and already vulnerable.
- \* are feeling embarrassed.
- \* believe that ultimately mothers who have also suffered as a result of the practice are, or will be, blamed and this is counter productive in working with all generations of women to eliminate the practice.<sup>28</sup>

The way in which the issue of female circumcision has and is being handled is contributing towards a notion of otherness or difference amongst women from affected communities. The women are also feeling objectified, the focus being on their genitals rather than on them as human beings with rich and diverse life experience, history and culture.

Some of those feelings have also been expressed to the Commission by Queensland women who have experienced female genital mutilation, although not with the same degree of passion as the Victorian women. This may be because the media debate on female genital mutilation has not been as intense in Queensland. Also, there are fewer families in Queensland who have had experience with female genital mutilation than in Victoria, although a trend appears to be emerging of Victorian families of African migrants moving to the warmer climate of Queensland. The Queensland women did not consider that the media campaign has victimised them, particularly in light of the fact that by having been mutilated they were already victims.

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<sup>28</sup> Submission 47.

These women felt it was more important to prevent girls from being genitally mutilated in Australia.

The women consulted in Queensland did express a concern that a law prohibiting female genital mutilation might discourage people from taking girls who had undergone the procedure to hospital or a doctor for medical reasons, if there were a possibility that it may be discovered and reported.

Nevertheless, they were all very much supportive of the idea of laws prohibiting female genital mutilation but were equally of the belief that appropriate education programs should commence before such laws are introduced and should continue for new migrants. In fact, people should be made aware before leaving their country of origin that the practice is unacceptable in Australia. Strategies may also need to be devised to discourage families arranging for their daughters to be mutilated prior to moving to Australia.

#### 4. HISTORY

The origin of the practice of female genital mutilation is not known. It is not possible to conclude whether the practice emanated from one region or whether it developed independently in various regions at different times.<sup>29</sup>

Mummies of Egyptian females dating back to the 16th Century BC show evidence of excision.<sup>30</sup> Evidence of this practice pre-dates the Islamic religion in different African regions. Hosken<sup>31</sup> notes:

Circumcision of both boys and girls came into fashion long before Islam, and was practised in many different areas in Africa. The practice was unknown to the Romans until they conquered Egypt and the Middle East. The Copts in Egypt, and the Abyssinians (Ethiopians) have practised circumcision of boys and girls (at a much younger age than the typical puberty rites of Subsaharan Africans) from prehistoric times.

The practice of one form or another of female genital mutilation in certain communities has continued without interruption throughout the centuries. Reasons given for the development of this practice vary. Historically, it has been said that the practice developed as: a method to curb sexual behaviour; proof of virginity on marriage; a cleansing rite based on the belief that a female was polluted; protection of females from rape; a sign of distinction; a method of gaining inheritance rights; and a method of affirming the sex of the child, as the clitoris was regarded as the male element in the female.<sup>32</sup>

The practice of female genital mutilation does not stem from any religious rite. As Hosken<sup>33</sup> observes:

In all the literature, it is stressed time and again that genital mutilation is not a religious rite, but rather, that it is a custom of the people or certain ethnic groups. It was and is practised by all religious denominations in Africa, including Christians; that is, Copts, Ethiopian Christians, Catholics

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<sup>29</sup> Id at 51.

<sup>30</sup> Huber A *Die Weibliche Beschneidung* Tropenmedizin und Parasitologie Vol 20 No 1 Mar 1969 at 3 referred to in Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 54.

<sup>31</sup> Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 55.

<sup>32</sup> Id at 54 and 55.

<sup>33</sup> Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 56.

and Protestants, as well as Animists and Moslems...

The Islamic Council of Queensland advised the Commission that it "is not a part of Islamic law, and is not a recommended practice."<sup>34</sup>

The tradition of female genital mutilation has not been limited to Africa and Middle Eastern countries.

In Roman times a (mechanical) form of infibulation was used on female slaves for contraceptive purposes. This method consisted of pushing rings through the labia which were sometimes then closed by a padlock or wire.<sup>35</sup>

In England during the 19th Century the performance of female genital mutilation<sup>36</sup> on women, particularly from the upper class, gained medical acceptance mainly as a cure for masturbation.<sup>37</sup> Masturbation was seen to be the cause of "many of women's diseases such as uterine haemorrhage, falling of the womb, cancer, functional disorders of the heart, spinal irritation, hysteria, convulsions, haggard features - emaciation, debility, mania - many symptoms called nervous ..."<sup>38</sup> Female genital mutilation was also practised in Europe.<sup>39</sup> Around the 1890's the performance of female genital mutilation was taken up by doctors in the United States of America.

It was not until the 1930's when the dangers of masturbation were exposed as a myth and mothers rejected the procedure for their daughters that United States' doctors no longer recommended the practice.<sup>40</sup>

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34 Written submissions to the Queensland Law Reform Commission by the Islamic Council of Queensland prior to and following the Research Paper.

35 Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 53-54. The Crusaders brought to Europe the practice of using 'chastity belts' as a means of ensuring fidelity.

36 The main form of female genital mutilation performed was the removal of the clitoris.

37 Infibulation never gained acceptance and was discarded as a remedy in England.

38 Duffy J *Masturbation and Clitoridectomy: A 19th Century View* *Journal of the American Medical Association* Vol 186, Oct 19, 1963 at 245-248 referred to in Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 252. There is anecdotal evidence that the procedure was performed up to fairly recently in Australia for similar reasons.

39 The main form of female genital mutilation performed was the removal of the clitoris.

40 Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 255.

## 5. COUNTRIES WITHIN WHICH FEMALE GENITAL MUTILATION IS PRACTISED

At present, it is estimated that between 85 million and 114 million girls and women in the world are genitally mutilated.<sup>41</sup> The World Health Organisation has listed the following countries as those in which female genital mutilation is most prevalently practised on a traditional basis within certain communities: Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Ethiopia and Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, United Republic of Tanzania, Togo, Uganda, Zaire.<sup>42</sup> There are also reports that female genital mutilation is performed in Oman, South Yemen, the United Arab Emirates, Indonesia and Malaysia.<sup>43</sup> Female genital mutilation has occurred in other countries within migrant communities for whom the practice is traditional. There are reports that such operations, mostly on very young girls, have occurred in the United Kingdom, Sweden, France, Holland, Italy, Germany, Australia, Canada and the United States of America.<sup>44</sup>

The extent to which any form of female genital mutilation is practised in Australia is not known.<sup>45</sup>

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<sup>41</sup> World Health Organisation *Maternal and Child Health and Family Planning : Current Needs and Future Orientation* Report by the Director General January 1994 at 8. See Appendix 6 to this Draft Report.

<sup>42</sup> World Health Organisation *Maternal and Child Health and Family Planning : Current Needs and Future Orientation* Report by the Director General January 1994. Table 1 of that Report has been reproduced with the kind permission of the Director-General of the World Health Organisation in Appendix 6 of this Draft Report.

<sup>43</sup> Hosken F *The Hosken Report: Genital & Sexual Mutilation* (1982 3rd ed), UNICEF *State of the World's Children Report* 1992, UNDP *Human Development Report* 1991 and *Third World Guide* 1991-2, Instituto de Tercer Mundo, Uruguay referred to in *Minority Rights Group International Report* by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 22 and also see in the same report at 11. It has been reported that Bohra Muslims from India, Pakistan and East Africa practise female genital mutilation. Ghadially Q *All for 'Izzat'; The Practice of Female Circumcision among Bohra Muslims* Manushi No 66 New Delhi, India 1991 referred to in *Minority Rights Group International Report* by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 11.

<sup>44</sup> See, for example, Hosken F *The Hosken Report: Genital and Sexual Mutilation* (1982 3rd ed) at 257 and World Health Organisation *Maternal and Child Health and Family Planning : Current Needs and Future Orientation* Report by the Director-General January 1994 at 8.

<sup>45</sup> See *National Times* April 13 to 19, 1980 *Racist backlash: fear on female circumcision*; *The West Australian* 4 March 1986 *Circumcisions upset Moslem*; *Great Southern Herald* 5 March 1986 *Anger over accusations of barbarism*; *The Age* 19 February 1987 *Female Circumcision is child abuse: policewoman*; *The Age* 20 February 1987 *AMA agrees, baby girls are being circumcised*; *The Age* 21 February 1987 *Circumcision of girl babies to be checked*; *Daily News* 27 February 1987 *Young girls die from mutilation*; *The Australian* 2 March 1987 *The unspeakable horror of female circumcision*; *Health Sharing Women March/April* 1991 no 5 *Female Genital Mutilation* at 1-2; *The Bulletin* August 25 1992 *Customs and excise - What is female circumcision and how common is it in Australia?*; *Medical Observer* 1 October 1993 *It's official: genital mutilation is here* at 2; *The Age* 2 December 1993 *Court told of assault on sisters*; *The Australian* 2 December 1993 *Girls circumcised here, court told*; *Courier Mail* 2 December 1993 *Circumcision Shock*; *Herald Sun* 2 December 1993 *Plea for mutilated girls*; *The Age* 3 December 1993 *Agency calls on media to back off on circumcision*; *The Age* 3 December 1993 *We*

## 6. REASONS FOR THE CONTINUED PRACTICE OF FEMALE GENITAL MUTILATION

The continuation of the practice of female genital mutilation is related to one or more of the social, cultural, economic, traditional and religious values of the communities where it is practised. Many diverse reasons and justifications are given for female genital mutilation. The reasons have commonly been divided into five main groups - psycho-sexual, religious, sociological, hygiene and aesthetics, and economics. Each will be discussed in turn below.

### (a) Psycho-sexual

The mutilation of a woman's genitals is seen as a means of controlling her sexuality.

Some communities believe that a woman must be protected against her "oversexed nature, saving her from temptation, suspicion and disgrace, whilst preserving her chastity."<sup>46</sup> This protection is believed to be achieved by excising the clitoris. Others believe that men prefer their sexual partners to have undergone the procedure.<sup>47</sup>

In some areas it is a commonly held belief that removing the clitoris of a young female affirms the sex of the child as the clitoris is regarded as the masculine element in the child.<sup>48</sup> Underpinning this mythology is the belief

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*must set limits, for the sake of little girls; Herald Sun 3 December 1993 Doctor calls for circumcision ban; The Weekend Australian 4-5 December 1993 Mothers fear action over female circumcision. Note also, the anecdotal evidence which this Commission has not relied upon, referred to by the Family Law Council in its Discussion Paper on Female Genital Mutilation (31 January 1994) at paras 2.26-2.32. The Commission has also been informed of other hearsay accounts of female genital mutilation being performed in Australia. One submission referred to an 'Anglo-Celtic woman who had 'her clitoris excised ... without consent or prior knowledge, whilst under anaesthetic for another procedure [in the late 1960's]'. Most medical authorities and relevant specialists in Queensland who have responded to the Research Paper are unaware of any known or suspected incidents of female genital mutilation in Queensland although one submission to the Commission referred to a woman being admitted to a labour ward, having been infibulated overseas. Recent correspondence to the Commission from a German doctor with a particular interest in female genital mutilation suggests that evidence of female genital mutilation occurring in Germany is also only anecdotal despite a great influx of African refugees to Germany. A number of incidents of female genital mutilation have been reported in France among African immigrant populations.*

<sup>46</sup> Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 13.

<sup>47</sup> See, for example, Asead, MB *Female Circumcision In Egypt: Social Implications, Current Research, and Prospects for Change* (1980) 11 *Studies in Family Planning* 3 at 7.

<sup>48</sup> Likewise, it is believed that the foreskin on the penis which is regarded as the female element in a male should be removed. Hoaken F *The Hoaken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 31.

that each child is born with male and female elements.

Some communities believe that the operation will increase a woman's fertility. Others believe that if the clitoris is not excised then it will grow and dangle between the legs like a man's genitals.

Generally, in the communities concerned, an absolute prerequisite for marriage is the virginity of the bride. Infibulation is seen in some groups as a means of ensuring virginity. A factor in determining the brideprice can be the size of the infibulated opening. Women who are not infibulated, regardless of their virginity, have little or no prospects of marrying and may be regarded as prostitutes.<sup>49</sup> In a study of 651 women who had been genitally mutilated, Karim and Amman argue that the mutilation did not decrease a woman's desire for sexual intercourse.<sup>50</sup> As Dorkenoo and Elworthy observed:

Although the intention of the operation may be to diminish a woman's desire, the facts, from a medical point of view, are that excision of the clitoris reduces sensitivity, but it cannot reduce desire, which is a psychological attribute.<sup>51</sup>

## (b) Religious

Female genital mutilation is not a religious practice although one form or another of female genital mutilation is practised by people of various religious denominations including Muslims, Copts, Christians, Catholics, Protestants and Animists in the countries concerned.<sup>52</sup> These practices have been traditionally linked with the Islamic religion, even though they pre-date it.<sup>53</sup> There is no clear reference to female genital mutilation in the Koran, although some Muslims may practise this type of mutilation in the

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<sup>49</sup> Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 13. This has also been confirmed by Commission consultations.

<sup>50</sup> Karim M and Amman R *Female Circumcision and Sexual Desire* Ain Shams University Press Cairo 1965 at 36 referred to in Lovejoy F and Harmoun-Khilla M *Female Circumcision in the Sudan: Traditional Practices and Government Policies* at 4.

<sup>51</sup> Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 13.

<sup>52</sup> See above. The World Health Organisation has noted that although it is practised in many societies with diverse cultures and religions there is no definitive proof that circumcision of girls is required by any religion. *Maternal and Child Health and Family Planning : Current Needs and Future Orientation* Report by the Director-General January 1994 at 8.

<sup>53</sup> See page 13.

belief that it does form part of their Islamic faith, and have done so for centuries. There are reports that many women within communities which practise female genital mutilation believe that it is a practice required by Islam.<sup>54</sup> An oral submission to the Commission confirmed that this is also the case for some recent Australian migrants.<sup>55</sup> A religious value placed on female genital mutilation may have a very strong hold on members of certain communities - this may be particularly so in religions considered to be all-embracing codes of conduct.

The Islamic Council of Queensland has advised the Commission that female genital mutilation does not form part of Islamic law.<sup>56</sup>

### (c) Sociological

For some communities, the practice forms part of an initiation into adulthood. It is seen as a cause for great celebration accompanied by special songs, dances and chants. It is "intended to teach the young girl her duties and desirable characteristics as a wife and mother",<sup>57</sup> although today, in many of the communities concerned, the celebrations are disappearing while the operation continues to be performed.

One submission indicated the role of peer group pressure in her country of origin in conforming to cultural norms.<sup>58</sup> The respondent, at age 14, begged her mother to have her "circumcised" because the other girls who had been "circumcised" were teasing her and she did not want to be left out.

The age of girls being mutilated is becoming younger. Consequently, the practice is moving away from an initiation rite.<sup>59</sup> Other groups rely on a need to maintain tradition as a reason to continue the practice.

It appears that in most, if not all, of the communities within which female genital mutilation is a culturally accepted practice, female genital mutilation is

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<sup>54</sup> See, for example, Assaad, MB *Female Circumcision in Egypt: Social Implications, Current Research, and Prospects for Change* (1980) 11 *Studies in Family Planning* 3 at 5.

<sup>55</sup> Submission 51.

<sup>56</sup> Written submission to the Queensland Law Reform Commission by the Islamic Council of Queensland.

<sup>57</sup> Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 14.

<sup>58</sup> Submission 51.

<sup>59</sup> *Ibid.*



arranged by the girl's mother or other members of the girl's family as an act of love, care and protection.<sup>60</sup>

#### (d) Hygiene and aesthetics

Some groups consider a woman to be dirty unless her external genitals are removed.<sup>61</sup> Others regard female genitalia as ugly in their natural state. They therefore believe that removal improves the appearance.

#### (e) Economics

In many of the communities within which female genital mutilation is a culturally accepted practice, a woman's economic survival is dependent on marriage. Often an essential prerequisite for marriage is the virginity of the woman. Female genital mutilation has become a symbolic and, in many cases, a practical guarantee of a woman's future.<sup>62</sup>

This surgery also provides a source of income to the traditional operators performing it, who are usually women, although the Commission has received reports of the operation having been performed by men.<sup>63</sup> Further assistance from the operators may be needed to permit a woman to have sexual intercourse<sup>64</sup> and to assist her in childbirth. Also, some women are reinfibulated after divorce and childbirth or during prolonged absences by the husband. All these attendances provide a source of income to the operator. If the practice were to be abandoned, the operators would lose this source of income.<sup>65</sup> Naturally, many exercise their influence to maintain the ritual.

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<sup>60</sup> Submission 47, an organisation working with African women in Australia.

<sup>61</sup> Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation* 1992 at 6.

<sup>62</sup> Submission 47, an organisation working with African women in Australia.

<sup>63</sup> Submission 51. In some communities, the operator may even be a barber. See case studies in Assaad MB *Female Circumcision in Egypt: Social Implications, Current Research, and Prospects for Change* (1980) *Studies in Family Planning* 3 at 5.

<sup>64</sup> This assistance is in the form of cutting the infibulated opening wider so as to allow penetration.

<sup>65</sup> This may be the only source of income for these women.

## 7. HEALTH ISSUES

There are no known medical advantages in performing these operations on normal healthy female genitalia, although in some communities there is a belief that "once you have the operation you will grow taller and prettier and your complexion will be fair and clear".<sup>66</sup>

The adverse health effects arising from the operation can be divided into two main categories - physical and psychological.

### (a) Physical

Health complications can arise from any of the three forms of mutilation. However, when infibulation and excision are performed, the complications can be more severe. The operations are usually performed by non-medically trained personnel, in unhygienic conditions, using unsterilised instruments, often without anaesthetics.

#### (i) Short-term complications

Some of the complications include<sup>67</sup> -

- \* pain;
- \* haemorrhaging from sections of the pudential artery or of the dorsal artery of the clitoris or severe bleeding;
- \* septicaemia;
- \* infections, including tetanus;

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<sup>66</sup> Assaad MB *Female Circumcision in Egypt: Social Implications, Current Research, and Prospects for Change* (1980) *Studies in Family Planning* 3 at 11.

<sup>67</sup> The Minority Rights Group Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 8 and Slack A *Female Circumcision: A Critical Appraisal* *Human Rights Quarterly* Vol 10 No 4 at 451.

- \* accidental cuts to other organs such as the urethra, the bladder (frequently resulting in urine retention and bladder infections), anal sphincter, vaginal walls or the Bartholin glands;<sup>68</sup>
- \* a more severe form of mutilation being performed than was intended;<sup>69</sup>
- \* a range of non-specific complications. One woman described to the Commission how some "medicine" had been put on her from her waist to her knees to stop the bleeding. However, the "medicine" took all the skin off in that area and consequently she was hospitalised for one month and could not go back to school for three months;<sup>70</sup>
- \* death.<sup>71</sup>

Lightfoot-Klein reports that doctors from one African country estimate that the number of deaths resulting from female genital mutilation, especially from infibulation, is "approximately one-third of all girls in areas where antibiotics are not available".<sup>72</sup>

#### (ii) Long-term complications

More severe long-term health complications usually arise for infibulated women.

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<sup>68</sup> This may be due to the lack of skill of the operator or the degree of resistance exerted by the child.

<sup>69</sup> *Ibid.*

<sup>70</sup> Submission 51.

<sup>71</sup> Submission 51 described how the respondent's cousin had died as a result of the procedure.

<sup>72</sup> Lightfoot-Klein H *Pharaonic Circumcision of Females in the Sudan* *Medicine and Law* 2 (1983) at 356 referred to in Slack A *Female Circumcision: A Critical Appraisal* *Human Rights Quarterly* Vol 10 No 4 at 451.

Some of the complications include:<sup>73</sup>

- \* chronic recurrent infections including infections of the vagina, uterus and urinary tract;
- \* time taken and pain associated with urination;<sup>74</sup>
- \* keloid and severe scar formation<sup>75</sup> which may make walking difficult;<sup>76</sup>
- \* sterility;
- \* the build-up of menstrual blood which is not allowed to escape and the swelling of the abdomen caused by the blockage of the menstrual flow;<sup>77</sup>
- \* very painful periods;<sup>78</sup>
- \* painful sexual intercourse;

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<sup>73</sup> The Minority Rights Group Report by Dorkenoo E and Elworthy S *Female Genital Mutilation; Proposals for Change* 1992 at 8-9 and Slack A *Female Circumcision: A Critical Appraisal* Human Rights Quarterly Vol 10 No 4 at 452-454.

<sup>74</sup> Lightfoot-Klein reports:

The average period of time required by a Pharaonically [infibulated] circumcised virgin to urinate is 10 to 15 minutes. She must force the urine out drop by drop. Some women reported requiring up to two hours to empty their bladders.

Lightfoot-Klein H *Pharaonic Circumcision of Females in the Sudan* Medicine and Law 2 (1983) at 356 referred to in Slack A *Female Circumcision: A Critical Appraisal* Human Rights Quarterly Vol 10 No 4 at 452.

<sup>75</sup> "Keloid" is defined in Butterworth's *Medical Dictionary* (2nd ed) as "the cellular overgrowth of fibrous tissue in a scar at the site of a skin injury."

<sup>76</sup> World Health Organisation *A traditional practice that threatens health - Female Circumcision* WHO Chronicle 40 No 1 (1986): 33 referred to in Slack A *Female Circumcision: A Critical Appraisal* Human Rights Quarterly Vol 10 No 4 at 452.

<sup>77</sup> This type of complication has been experienced by a number of the infibulated women who have made submissions to the Commission. (Submission 51). Sometimes these symptoms lead the family to believe the girl is pregnant. The girl can be ostracised or, in some cases, killed.

<sup>78</sup> This type of complication has also been experienced by a number of the infibulated women who have made submissions to the Commission. (Submission 51).

- \* the need for further surgery to enable sexual intercourse to take place;
- \* childbirth complications including: the necessity to cut the scar left by infibulation to allow the baby passage (if not re-opened in time, tearing of the perineum can result); labour may be long and obstructed, which can lead to foetal death or brain damage to the baby; fistula formation (which can lead to incontinence later); haemorrhaging and infections. It is also likely that the risk of maternal death is greatly increased by these factors. During childbirth, the risk of haemorrhage and infection is greatly increased and long-term morbidity becomes cumulative and chronic.<sup>79</sup>

Besides the risks of infection and haemorrhaging, excision results in the development of neuroma<sup>80</sup> at the point of section of the dorsal nerve of the clitoris which makes the area permanently and unbearably sensitive to touch.<sup>81</sup> Vulval abscesses may also develop. After "sunna"<sup>82</sup> circumcision the exposed clitoris may become hypersensitive and painful to touch.<sup>83</sup>

Operations resulting in female genital mutilation are often performed with unsterilised instruments which may be used repeatedly for similar operations. These factors may contribute to the spread of infections including the HIV infection.<sup>84</sup>

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79 World Health Organisation *Maternal and Child Health and Family Planning : Current Needs and Future Orientation* Report by the Director-General January 1994 at 8.

80 "Neuroma" is defined in Butterworth's Medical Dictionary (2nd ed) as "a tumour composed of nerve cells and nerve fibres".

81 Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 8.

82 See footnote 9 above.

83 Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation* Forward 1992 at 6.

84 Aidsline Citations Search Results: See Extracts from articles: Hardy D *Cultural practices contributing to the transmission of human immunodeficiency virus in Africa* Rev Infect Dis 9 (6) 1987 Nov-Dec PG 1109-19, Latif A *Women at risk - research needs and priorities* Int Conf AIDS 5 1989 Jun 4-9 PG 991 (abstract no Th GO 15), Odero T *The role of herbalists in HIV/AIDS information and prevention in Kenya* Int Conf AIDS 6 (2) 1990 Jun 20-23 PG 280 (abstract no FD 793), Sy A, Etchepare C, Etchepare M, Bacha A, Djigaly L *Impact of cultural aspects on AIDS prevention in Africa* Int Conf AIDS 8(2) 1992 Jul 19-24 PG D472 (abstract no PoD 5514), Mboya T *Traditional behaviour and AIDS...analysis and change through community participation* Int Conf AIDS 8 (2) 1992 Jul 19-24 PG D505 (abstract no PoD 5697).

(b) Psychological

There has been scant research undertaken on the psychological effects of these operations on the women concerned. Dr Ba'asher who has treated Egyptian and Sudanese female patients supports the view that these operations would have a psychological effect on the women involved:

It is quite obvious that the mere notion of surgical interference in the highly sensitive genital organs constitutes a serious threat to the child and that the painful operation is a source of major physical as well as psychological trauma.<sup>85</sup>

A number of the women who have experienced female genital mutilation who have spoken to the Commission about their experiences, have described the mental distress and pain they continue to feel when they recall their own mutilation.<sup>86</sup>

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<sup>85</sup> Ba'asher T *Psychosocial Aspects of Female Circumcision* a paper presented to the Symposium on the Changing Status of Sudanese Women referred to in Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 10.

<sup>86</sup> Submission 51.

## 8. THE LEGALITY OF FEMALE GENITAL MUTILATION

As noted above, the extent to which any form of female genital mutilation is practised in Australia is not known.<sup>87</sup>

There is no legislation in Queensland or any other State or Territory of Australia which specifically prohibits female genital mutilation, although legislation has been introduced in New South Wales.<sup>88</sup>

The Australian Law Reform Commission believes that there is little doubt that it would be regarded as an assault.<sup>89</sup> As far as the Queensland Law Reform Commission is aware, there have been no criminal prosecutions for female genital mutilation in Queensland or elsewhere in Australia.

### (a) Body-altering acts and the criminal law

Whether or not body altering acts which are not the subject of specific legislation are unlawful at common law in the United Kingdom and under the *Criminal Code* in Queensland even though performed with the consent of the subject of the alteration is still a matter of debate.

Some body altering acts can lawfully be performed upon a person who has given consent - usually depending on the status of the person performing the alteration. Bibbings and Alldridge observe in relation to the common law position:<sup>90</sup>

For instance, cosmetic surgery<sup>91</sup> is apparently permitted where it is carried out by a qualified or registered practitioner. This includes a wide range of techniques which are possibly analogous to the less conventional

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<sup>87</sup> See footnote 45 above.

<sup>88</sup> *Crimes (Female Genital Mutilation) Amendment Bill 1994* passed through the New South Wales Upper House on 10 May 1994 but is yet to be debated in the Lower House. The Bill is set out in Appendix 2.

<sup>89</sup> Australian Law Reform Commission *Multiculturalism: Criminal Law* (Discussion Paper 48) 1991 at paragraph 2.35.

<sup>90</sup> Bibbings L and Alldridge P *Sexual Expression, Body Alteration and the Defence of Consent* (1993) 20 *Journal of Law and Society* 356 at 361.

<sup>91</sup> The authors note that cosmetic surgery can also include breast alteration, fat suction or penis lengthening techniques - most of which are medically unnecessary, vanity-motivated procedures. Such surgery can be used solely for aesthetic purposes.

forms of body alteration.<sup>92</sup> Male circumcision is considered to be lawful when performed by a medical practitioner or a religious actor as part of a ritual.<sup>93</sup> Face-lifts involve the cutting of facial tissue although the object is that no scarring should be visible. In contrast, it would appear that branding, scarification, and cutting for the purpose of body decoration when performed by a third party who is not a doctor constitutes a criminal act. In *Adesanya*<sup>94</sup> a mother was convicted of assault occasioning actual bodily harm when she cut the cheeks of her sons, aged nine and fourteen, in accordance with tribal custom and with (so far as they were able to give consent) their consent.

Other forms of body modification (such as tattooing and piercing) are popular in Australia. There are legal requirements in relation to both tattooing and piercing.<sup>95</sup> When these requirements are met, neither tattooing nor piercing is apparently criminal, although if either is done for other than cosmetic reasons there may be an argument that they would amount to assault even if done with consent.<sup>96</sup>

Whether or not genital piercing of males or females with their consent amounts to an unlawful wounding or a criminal assault, in the United Kingdom piercing of female external genitalia may be an offence under the *Prohibition of Female Circumcision Act 1985*, section 1(1)(a) which makes it a crime to:

excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person.

Bibbings and Alldridge suggest that it would be odd that a provision whose introduction stemmed, among other reasons, from protecting women's

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<sup>92</sup> The authors note that unconventional procedures (in Western cultures) range from scarring the flesh to more radical surgical procedures. See, for example, reference to subincision - Queensland Law Reform Commission, Research Paper on *Circumcision of Male Infants*, December 1993 at 9, 10.

<sup>93</sup> See Queensland Law Reform Commission, Research Paper on *Circumcision of Male Infants*, December 1993.

<sup>94</sup> *Adesanya* Times 16, 17 July 1974.

<sup>95</sup> *Children's Services Act 1965 (Qld)* s.69A prohibits tattooing of children. See also Regulations made pursuant to s.100A *Health Act 1937*.

<sup>96</sup> See Bibbings L and Alldridge P *Sexual Expression, Body Alteration, and the Defence of Consent* (1993) 20 *Journal of Law and Society* 358 at 361 where the authors refer to a case where a professional tattooist and piercer pleaded guilty to assault charges for piercing his lover's penis. The only difference between this piercing and other genital piercings which he had performed on men and women was its erotic nature. Charges against him in relation to the latter practices were dropped as a result of the judge's ruling that body piercing for decoration was not an offence.



interest in sexual pleasure,<sup>97</sup> should be used to prevent piercing, the purpose of which is to enhance sexual pleasure.

Sex-change operations - potentially an extreme form of modification - are assumed to be legal.<sup>98</sup> But, as Bibbings and Alldridge note:<sup>99</sup>

They are not ... mere cosmetic procedures because they are not undertaken merely for decorative purposes, but are viewed in terms of self-definition, identity, expression, and sexuality. They represent the most sophisticated and far-reaching body alterations which the law authorizes.

Also, where a person pierces or mutilates himself or herself, or in any other way damages his or her flesh, no offence is committed.

Female genital mutilation is a body-altering act which, even in Australia, may be seen as an acceptable cultural practice, even as a cultural right.<sup>100</sup>

However, the purpose of female genital mutilation is different from plastic surgery, scarification, tattooing and piercing. It is generally not performed primarily for decorative purposes. It appears principally to be a product of the desire to control and oppress women and their sexuality.<sup>101</sup>

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<sup>97</sup> Although see pp 16 to 19 above where other origins of the practice are discussed, in particular, an attempt to ensure virginity and marriageability.

<sup>98</sup> See *Cossey v United Kingdom* (1991) 3 EHRR 622, *United Kingdom v Rees* (1987) 9 EHRR 56, *Corbett v Corbett* [1970] 2 All ER 33.

<sup>99</sup> Bibbings L and Alldridge P *Sexual Expression, Body Alteration and the Defence of Consent* (1993) 20 *Journal of Law and Society* 356 at 362. The law in Queensland does not recognise a person's changed sex or adopted sex identity. It is still not possible for transsexuals and transgenderists, whether gender reassignment (sex change) has occurred or not, to alter the sex recorded on their birth certificates. The Electoral and Administrative Review Commission in its Report on *Review of the Preservation and Enhancement of Individuals' Rights and Freedom* August 1993 at 398 noted:

This is not only discriminatory in terms of matters such as employment, but also causes enormous personal stress for the individual involved.

<sup>100</sup> Poline Nyaga of Brent London Borough Council called for the legalization of female genital mutilation as a cultural right. *Guardian* 8 February 1993:

One day it should be available on the NHS [National Health Service] ... The operation is not just a medical one. It is a spiritual act which divides childhood from adulthood.

Poline Nyaga quoted by Allison Boulton *Observer* 14 February 1992.

<sup>101</sup> See also the adverse health effects of the procedure described at page 20.

**(b) Offences under the *Criminal Code***

It is considered by the Commission that, under the Queensland *Criminal Code*, female genital mutilation would fall within the offences of unlawful wounding<sup>102</sup> and grievous bodily harm.<sup>103</sup>

Although a person may consent to such a procedure, arguably consent provides no defence to these criminal offences.<sup>104</sup> As consent is not an element of either of these offences, the consent of a parent, or of a child who is old enough to understand the nature and consequences of the procedure, is immaterial.

A person who unlawfully wounds another is liable to a maximum period of imprisonment of seven years.<sup>105</sup> To constitute a wounding the true skin of the victim must be broken.<sup>106</sup> This would be an obvious result to the child in all three forms of female genital mutilation outlined at page 5.

For a person to be found guilty of grievous bodily harm, which may be punishable by imprisonment for life, the elements contained in section 317 of the Queensland *Criminal Code* must be satisfied:

Any person who, with intent to maim, disfigure, or disable, any person, or to do some grievous bodily harm to any person... unlawfully wounds or does any grievous bodily harm to any person by any means whatever... is guilty of a crime.

Female genital mutilation may result in maiming (mutilate),<sup>107</sup> disfigurement (detracting from personal appearance),<sup>108</sup> and disablement (creating a

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<sup>102</sup> S.323 of the Queensland *Criminal Code*.

<sup>103</sup> Sections 317 and 320 of the Queensland *Criminal Code*.

<sup>104</sup> See *R v Raabe* (1985) 1 Qd R 115; *R v Watson* (1987) 1 Qd R 440 and *Lergesner v Carroll* (1991) 1 Qd R 206. See also Kell D *Consent to Harmful Assaults under the Queensland Criminal Code : Time for a Reappraisal* (1994) 68 ALJ 363 and *Final Report of the Criminal Code Review Committee to the Attorney-General 1993* (Qld) at 199 and 200.

<sup>105</sup> Section 323 of the Queensland *Criminal Code*.

<sup>106</sup> A break in the outer skin would not be sufficient and an injury is unlikely to be a 'wound' unless it bleeds. *R v Devine* (1983) 2 A Crim R 45.

<sup>107</sup> See *R v Woodward* [1970] QWN 30 at 76 per Douglas J: "When you do maim you ... mutilate or cripple".

<sup>108</sup> *Stroude Judicial Dictionary* (1974 4th ed).

permanent disability).<sup>109</sup>

"Grievous bodily harm" is defined in section 1 of the Queensland *Criminal Code* as meaning:

Any bodily injury of such a nature as to endanger or be likely to endanger life, or to cause or be likely to cause permanent injury to health.

Because of the nature of female genital mutilation it could be regarded as an act endangering life or causing permanent injury to health.<sup>110</sup>

Grievous bodily harm without intent is also an offence which may be punishable by imprisonment for 14 years.<sup>111</sup>

**(c) The applicability of Section 282**

A person who performs these operations may seek the protection afforded by section 282 of the Queensland *Criminal Code*.

Section 282 provides a possible defence for surgery performed without the consent of the 'patient':

Surgical Operations. A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable having regard to the patient's state at the time and to all the circumstances of the case.

In Queensland there is no statutory definition of "a surgical operation", nor is there a statutory restriction on who can perform a surgical operation.

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<sup>109</sup> *R v Boyce* 1 Mood 29, 168 ER 1172.

<sup>110</sup> See page 20 above.

<sup>111</sup> S.320 of the Queensland *Criminal Code*.

## (i) "Benefit" - health

It is highly unlikely that female genital mutilation could ever be seen to be for the health benefit of a female, unless it involved a surgical procedure for recognised medical purposes. The Royal Australian College of Obstetricians and Gynaecologists regards female genital mutilation as "unethical if performed for other than genuine medical reasons".<sup>112</sup> The College supports sympathetic measures to discourage the practice of female genital mutilation and related procedures.<sup>113</sup> A recognised medical procedure would obviously include genital reconstructive surgery to correct a birth abnormality and possibly appropriate procedures performed by medical practitioners before and after giving birth.<sup>114</sup> It would also include surgery on an infibulated woman at her request to correct gynaecological problems. A gynaecologist has written:<sup>115</sup>

[A] Woman may present with dyspareunia, non-consummation of marriage or trauma resulting from attempts by the husband to break down a severe infibulation either digitally or with knives or other instruments. Some women may request or be helped by surgery to enlarge the vaginal opening, while for others, however necessary this may appear to us, it will be unacceptable. Usually, division of the scarring with suture of the raw edges is appropriate, but sometimes an accompanying Fenton's or McIndoe type procedure is necessary.<sup>116</sup> Lesser adhesions may be divided with a probe and healing encouraged with oestrogen cream.

Also, during and following child birth, surgery on an infibulated woman may be required.<sup>117</sup>

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<sup>112</sup> Letter from the College dated 12 October 1993.

<sup>113</sup> Submission 40. The Australian Medical Association was of a similar view [submission 6A].

<sup>114</sup> Submission 8 noted:

"Recession of the clitoris and reduction of the clitoral size is often required to be performed in 'inter-sex' conditions. Our aim is to reduce the size of the clitoris but to retain the sensitive glans".

Note also Medicare Item 35533 - amputation for medical reasons, of clitoris. It is interesting to note that no case history is required to be attached to the claim.

<sup>115</sup> Bayly C *Female Circumcision and Related Practices* Royal Australian College of Obstetricians and Gynaecologists, Continuing Education Resource Unit 108 December 1993.

<sup>116</sup> Fenton's procedure is 'a plastic operation for enlarging the vaginal introitus [entrance]'. A McIndoe procedure is for reconstruction of the urethra (*Butterworths Medical Dictionary*, second edition 1990 reprint).

<sup>117</sup> Bayly C *Female Circumcision and Related Practices* Royal Australian College of Obstetricians and Gynaecologists, Continuing Education Resource Unit 108 December 1993.

It is generally accepted that the scarred area should be divided late in the second stage of labour and an episiotomy cut only if needed thereafter. The remaining vaginal opening will be the posterior part of the introitus, so a finger should be inserted between the fetal presenting part and the infibulation which should then be incised with appropriate anaesthesia in an anterior direction using episiotomy scissors. It is the usual practice in these cultural groups to resuture the vulva repeating its closure immediately following delivery. This must be discussed by doctor and patient antenatally if possible; some women will find it acceptable not to resuture, while for others there may be difficult social consequences if resuture is not performed.<sup>118</sup>

All Queensland Regional Health Authorities responding to the Commission's Research Paper condemned the practice of female genital mutilation.<sup>119</sup>

A gynaecologist wrote:<sup>120</sup>

It is very clear that female genital mutilation of any sort on a social or religious basis is clearly unacceptable.

A Women's Health Centre in Brisbane agreed<sup>121</sup> as did the Royal College of Nursing.<sup>122</sup>

The Commonwealth Department of Human Services and Health also supported the prohibition of female genital mutilation.<sup>123</sup>

Given this strong medical opposition to female genital mutilation for traditional purposes, in the Commission's view, no Australian court would find that such an operation is for the child's health benefit.

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<sup>118</sup> A gynaecologist with experience treating women who have been infibulated has told the Commission she cannot foresee any medical indications for re-infibulation after childbirth. She also noted that all women she has treated who ask about re-infibulation are happy not to be re-infibulated once the health consequences have been explained to them.

<sup>119</sup> Submissions 13, 21, 23, 29.

<sup>120</sup> Submission 1.

<sup>121</sup> Submission 32.

<sup>122</sup> Submission 52.

<sup>123</sup> Submission 52.

(II) "Benefit" - cultural

It may be possible, however, that, given the community in which the girl lives and the strong cultural beliefs and traditions of that community, female genital mutilation may be seen as being for the girl's cultural or social benefit. It may be arguable that the girl will not be accepted by her community unless the procedure is performed. However, consultation by the Commission with women from communities where female genital mutilation is practised in their country of origin, refutes the view. These women are convinced that female genital mutilation is cruel and they would not subject their daughters to it.<sup>124</sup>

'Benefit' in section 282 has not been judicially considered. Although the Commission considers it unlikely that a jury in Queensland would decide that female genital mutilation could be for the benefit of a child - be it a cultural or health benefit - the question could still be left to the jury.

(iii) Reasonableness

A further restriction within section 282 is that the operation must be performed "in good faith and with reasonable care and skill". It is unlikely, in Australia, that an operation such as female genital mutilation, in any of its forms, could be performed in aseptic conditions using appropriate surgical equipment by anyone other than a medically qualified person. However, it could be argued, and left to the jury to decide, that a very experienced non-medically qualified practitioner of female genital mutilation uses "reasonable care and skill".

Section 282 also states that the performance of the operation would have to be "reasonable having regard to the patient's state at the time and to all the circumstances of the case". It is unlikely that the performance of female genital mutilation in Australia would be regarded as reasonable. Nevertheless, the question could be left to the jury to decide and given the cultural beliefs and strong cultural rights and responsibilities within a particular community in Australia - it might be considered reasonable to perform female genital mutilation on a girl within that community.

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<sup>124</sup> Submission 51.

## (iv) Reform of the Code

The Criminal Code Review Committee (Queensland) has not recommended any substantial amendments to the section 282 provision which would affect the above analysis except perhaps by reaffirming the wide meaning of the term "benefit". The proposed new section 49 of the *Criminal Code* states:<sup>125</sup>

**Medical treatment.** A person is not criminally responsible if he or she gives in good faith and with reasonable care and skill, surgical or medical treatment to any person for his or her benefit or performs a surgical operation upon an unborn child for the preservation of the mother's life, if the performance of the operation or the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

Without limiting the term 'benefit', surgical or medical treatment that is performed for the purpose of rendering the patient sterile is deemed to be performed for the patient's benefit if it is performed with the patient's consent.

There is a strong argument that the term "benefit" should be able to be interpreted widely in appropriate circumstances. Some surgical procedures, which are widely practised in Australia, have very little if any health benefits to the "patient" and in many cases are not performed by medically qualified people. Examples include tattooing, ear piercing and some cosmetic surgery. Many of these procedures are performed for purely cultural or religious purposes.

A person performing the operation may argue that he or she was acting according to his or her cultural tradition. This is not a recognised defence under the Queensland *Criminal Code*<sup>126</sup> unless "benefit" within the meaning of section 282 can be shown.

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<sup>125</sup> *Final Report of the Criminal Code Review Committee to the Attorney-General June 1992 at 53.*

<sup>126</sup> In its Report No 57 *Multiculturalism and the Law* 1992 at para 8.13, after commenting on the list of factors which the court must take into account for sentencing federal offenders, the Australian Law Reform Commission states:  
 The decision what sentence to impose on an offender involves a delicate balancing of these and other factors. It seems that, both at general law and under this provision, cultural considerations can be and sometimes are taken into account on sentencing.  
 S.22 of the *Criminal Code* (Old) provides, in part, that a person is not criminally responsible for an offence relating to property "for an act done or omitted to be done by a person with respect to any property in the exercise of an honest claim of right and without intention to defraud". The High Court in *Walden v Hensler* (1987) 163 CLR 581 held that provision did not afford a defence for an Aboriginal found in possession of fauna, without a licence - despite the person's belief that in accordance with Aboriginal custom and his own practice of a lifetime, he was entitled to take the fauna as "bush tucker".

**(d) Parties to offences**

There may also be other parties involved with the procedure to whom criminal liability attaches. Under the Queensland *Criminal Code*, a person who assists another person to commit an offence or procures the commission of an offence may be charged with the actual offence.<sup>127</sup> For example, a parent who arranges for, gives consent to or assists with the operation may be criminally liable.

**(e) Child protection issues**

Even if there is a doubt whether female genital mutilation is a crime in all circumstances, it most likely would be treated as a child protection matter. Section 46 of the *Children's Services Act 1965* (Qld) provides, among other things, that a child<sup>128</sup> is deemed to be "in need of care and protection" if he or she is exposed to physical danger. If it were suspected that a child was about to undergo and was in real danger of undergoing female genital mutilation, an application could be made to the Children's Court on behalf of the Director of Family Services and Aboriginal and Islander Affairs for an order that the child be admitted to the care and protection of the Director.<sup>129</sup>

If the Children's Court is satisfied that the child is in need of care and protection, it can make any one of a number of orders: for example, it could order that the parent or guardian of the child enter into a recognizance of such amount as the Court fixes conditioned that such parent or guardian exercise proper care, protection and guardianship in respect of such child.<sup>130</sup> The Court could also order that the Director have protective supervision over and in relation to such child, or that the child be admitted to the care and protection of the Director.

The Court cannot order a child to be admitted to the care and protection of the Director unless satisfied that the child is in need of care and protection,

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<sup>127</sup> S.7 of the Queensland *Criminal Code*.

<sup>128</sup> For the purposes of this Act, a "child" is defined as a person under or apparently under the age of 17. The Act is administered by the Minister for Family Services and Aboriginal and Islander Affairs.

<sup>129</sup> S.49 *Children's Services Act 1965*.

<sup>130</sup> S.49(4) *Children's Services Act 1965*.



and that such care and protection cannot be secured by any other order.<sup>131</sup>

The Court must determine such matters in the best interests of the child.<sup>132</sup>

The Commission has been advised by the Division of Protective Services and Juvenile Justice, Department of Family Services and Aboriginal and Islander Affairs (Queensland) that:<sup>133</sup>

Female genital mutilation would be regarded by this Division as a child protection matter and referred to the Queensland Police Service for investigation in relation to possible breaches of the Criminal Code. As such it should be dealt with under the Criminal Code. Attention to the child's protective needs would be of paramount importance. The cultural context of the child and family would be a significant consideration in case management.

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<sup>131</sup> S.52(1) *Children's Services Act 1965*. (Note also s.52A which provides an appeal against such orders to the Court of Appeal).

<sup>132</sup> S.52(2) *Children's Services Act 1965*.

<sup>133</sup> Submission 18.

## 9. CONSENT BY YOUNG PERSON OR SUBSTITUTED CONSENT

As female genital mutilation is usually performed on girls or women under the age of eighteen years, the ability of a young person or a parent or guardian to consent to the procedure and the effect of such consent need to be examined.

### (a) Criminal liability

A person performing an operation on a patient under 18 years of age avoids criminal liability for a simple assault if the young person consents to the operation and has sufficient intelligence and understanding to enable him or her to make the treatment decision for himself or herself. A young person who has this degree of understanding is described as being *Gillick*-competent.<sup>134</sup> However, it is unlikely a young person can ever consent to criminal acts which result in grievous bodily harm or unlawful wounding. As outlined above,<sup>135</sup> the Commission is of the view that female genital mutilation would be classified as an act causing grievous bodily harm or unlawful wounding. Parental consent would also be ineffective on this basis.

<sup>134</sup> See *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1986] AC 112 (*Gillick's case*) for the common law on a young person's ability to consent to medical treatment. The High Court in Australia in *Secretary Department of Health and Community Services v JMB* (1992) 175 CLR 218 (*Re Marion*) said that the law as stated in *Gillick's case* reflects the common law in Australia although as Anthony Dickey QC observes [*Child's Ability to Consent to Sterilisation* (1994) 68 ALJ 222]:

There is no authority in *Marion's case* for the proposition that where a child is *Gillick*-competent, he or she is unable to authorise his or her own sterilisation, even for non-therapeutic purposes.

A contrary argument has been expressed by Professor Regina Graycar in *Sterilisation of Children* (1994) 68 ALJ 455. See also Blackwood J *Medical Treatment of the Intellectually Disabled Child* (1994) 1 Journal of Law and Medicine 252 at 255.

It seems that a decision by a *Gillick*-competent child need not be reasonable in any objective sense, just as decisions by adults affecting their welfare need not be reasonable. In *Re W (A Minor)* [1993] Fam 64 (UK) Lord Donaldson MR, in relation to refusal by a child to undergo medical treatment at pp 80-81, stated:

I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less '*Gillick*-competent'. They may well have sufficient intelligence and understanding fully to appreciate the treatment proposed and the consequences of their refusal to accept that treatment.

Dickey does note, however, that pursuant to its 'welfare' power [s.64(1) *Family Law Act 1975*] the Family Court can override a decision by a *Gillick*-competent child.

<sup>135</sup> See pages 28 to 29.

Parental consent may not relieve someone performing the operation from criminal liability if the procedure is:

\*invasive, irreversible and major surgery<sup>136</sup> and if there is a

\*significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave.<sup>137</sup>

In these instances the approval of the Family Court would most likely be required.<sup>138</sup> The Chief Justice of the Family Court, the Honourable Justice Nicholson, has expressed the concern that without the need for court approval, parental consent might be used to justify the surgical removal of a girl's clitoris (one form of female genital mutilation).<sup>139</sup> The Commission agrees with His Honour's concern.

The Commission is of the view that any form of female genital mutilation required as a matter of custom or ritual would require the Family Court's authorisation.<sup>140</sup>

Parents are also prohibited from consenting to the treatment of a child which is not in the best interests of the child.<sup>141</sup> It is highly unlikely that a parent seeking the Family Court's approval for an operation resulting in female genital mutilation required as a matter of custom or ritual would gain such an approval as the operation would not be regarded as being for the benefit of the child.<sup>142</sup>

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<sup>136</sup> *Re Marion* (1992) 175 CLR 218 at 250.

<sup>137</sup> *ibid.*

<sup>138</sup> *Re Marion* (1992) 175 CLR 218.

<sup>139</sup> *Re Jane* (1988) 85 ALR 409 at 435.

<sup>140</sup> The Family Court has recently given its approval for a 14 year old child to undergo gender reassignment by the construction of male sexual organs. At birth, the child had been diagnosed as a female child with masculinisation of the genitalia. The child had undergone genital reconstruction to give her a feminine appearance but received inadequate hormone replacement treatment. Recurrent masculinisation of the child's physical structures had occurred with a change in mental behaviour and attitude. The child wanted to undergo the reassignment procedure but in this case the Court held that the child was not mature enough to understand the nature and consequences of the procedure. As the procedure would require invasive, irreversible and major surgery, the child's parents could not consent - and Family Court approval was required. *Re A* (1993) 16 Fam LR 715.

<sup>141</sup> *Re Marion* (1992) 175 CLR 218.

<sup>142</sup> *Re Marion* (1992) 175 CLR 218 at 239-240.

The Commission is also of the view that female genital mutilation is not a procedure which young people under the age of 18 should be competent to consent to. Even though a 17 year old young woman may be *Gillick*-competent with respect to many medical procedures, it is unlikely that she would be aware of all the short and long-term detrimental consequences which could result from female genital mutilation in any of its forms - particularly if she has not had the benefit of discussing the procedure with a medically qualified person who is knowledgeable about female genital mutilation. Furthermore, it is unlikely that a young woman or girl 16 years of age or younger who feels obliged to consent to such a procedure would be giving a real consent - that is, consent devoid of family or community or cultural influence. One woman consulted by the Commission described how she succumbed to peer group pressure at fourteen years of age and begged her mother to arrange for the procedure to be performed. She soon regretted her decision.<sup>143</sup>

Queensland's child protection legislation relates to children under the age of 17 years. Above that age there appears to be a presumption that young people are more able to fend for themselves.

The Commission is of the view that a young woman of over 17 years of age is far more likely to be able to seek appropriate information upon which to make her own decision relating to bodily mutilation. Whether or not an adult woman can consent to any body-altering procedure which has no acknowledged health benefit depends upon the interpretation of the relevant assault and defence provisions in the *Criminal Code*<sup>144</sup> which is outside the scope of the Commission's reference.

#### (b) Civil liability

The principal civil remedies available to a person who has been the subject of an operation or medical treatment without his or her consent, are the torts of trespass to the person and negligence. Trespass to the person comprises three separate torts: assault, battery and false imprisonment. Each of these may have relevance to the practice of female genital mutilation.

Assault is conduct by the defendant which causes the plaintiff to apprehend the infliction of bodily harm. Battery is the actual application of force to the person of the plaintiff, and false imprisonment is the wrongful detention of a

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<sup>143</sup> Submission 51.

<sup>144</sup> See page 28 above.

person against that person's will. To subject a patient to a procedure or treatment without the patient being made aware and understanding the general nature of what is to be done is battery.

The consent of a parent for an operation resulting in female genital mutilation to his or her child can only relieve the person performing the operation from civil liability if it is in the best interests of the child.<sup>145</sup> In the Commission's view, female genital mutilation would never be regarded by the courts as being in the best interests of the child.

In negligence, the plaintiff alleges that the defendant owed the plaintiff a duty of care, and by acting carelessly, breached that duty, causing damage. Although lack of consent is not an element of negligence, a person who operates upon or treats another without giving sufficient information to enable the other person to decide whether or not to consent may well be in breach of the duty of care owed to the other person.<sup>146</sup>

The High Court in *Rogers v Whitaker*<sup>147</sup> confirmed that a medical practitioner has a duty to warn the patient of a material risk inherent in the proposed procedure. The Court determined that a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

### (c) Professional misconduct

A medical practitioner may also be the subject of disciplinary action if he or she treats a patient without the patient's or appropriate substitute decision-maker's consent.<sup>148</sup> Registered medical practitioners are subject to the supervision of the medical assessment tribunal established under the *Medical Act 1939* (Qld). The Act regulates the circumstances in which a medical practitioner's right to practice may be restricted or suspended. For

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<sup>145</sup> *Re Marion* (1992) 175 CLR 218.

<sup>146</sup> *Rogers v Whitaker* (1992) 175 CLR 479 at 490. A possible defence to negligence is that the plaintiff voluntarily assumed the risk of harm. This defence corresponds to the plea of 'consent' in actions for intended harm, such as assault and battery. This involves consent to the risk of harm rather than to the harm itself. It is unlikely that the defence would apply to an operation performed on a young child. It would apply only after sufficient information had been given and in relation to a claim that the procedure had been performed negligently.

<sup>147</sup> (1992) 175 CLR 479.

<sup>148</sup> In the UK a Harley Street gynaecologist was struck off by the General Medical Council for agreeing to perform an illegal female circumcision on a journalist posing as a Nigerian engaged to be married. *Gynaecologist struck off over female circumcision* (1993) 307 *British Medical Journal* 1441-1442.

example, a person may be charged with "infamous conduct in a professional respect." Other professional bodies may have disciplinary procedures for members who treat patients or clients without consent.

## 10. OVERSEAS LEGISLATION AND INITIATIVES

There is widespread international support for the elimination of the practice of female genital mutilation. Some countries have specifically prohibited the practice.<sup>149</sup> The World Health Organisation and United Nations support its prohibition and eradication. Some countries regard it as a child protection issue. In many countries where the practice has been of concern, education has been the primary initiative for reduction and eventual eradication of the practice.

### (a) Legislation prohibiting and education discouraging female genital mutilation

#### (i) African countries

In 1946 the Sudanese Legislative Assembly passed legislation prohibiting all forms of female genital mutilation except the less invasive procedure of "sunna". The law was later modified to allow the removal of the free and projecting part of the clitoris.

The Sudanese legislation was introduced by the British colonial administration in an effort to eliminate the practice. The general Sudanese population was not prepared for the change, particularly as it was introduced by a foreign ruler. Consequently, the Sudanese attempt to prevent the practice failed. As Ras-Work states:

Legislation can be effective only if there is a general consensus among the population concerned. For such an agreement to be reached, tactful sensitization is needed.<sup>150</sup>

Many African countries<sup>151</sup> are participating in educational projects and programs aimed at eliminating the practice of female genital mutilation.

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<sup>149</sup> The United Kingdom, Sweden and the United States of America (refer to footnotes 153, 162 and 169 below) have specifically prohibited or are in the process of legislating to prohibit female genital mutilation. See Appendices 3, 4 and 5.

<sup>150</sup> *Inter-African Committee Newsletter* 2 July 1986 at 4-5 referred to in Magarey K and Evatt E *Genital Mutilation A Health and Human Rights Issue* Australian Development Studies Network (ANU) Briefing Paper No 18 October 1990 at 5.

<sup>151</sup> These countries include Egypt, Sudan, Somalia, Kenya, Nigeria, Kenya and Burkina Faso.

Some of the programs include:<sup>152</sup>

- \* training in hospitals, nursing and medical schools on the medical complications and consequences of female genital mutilation;
- \* retraining traditional operators in alternative endeavours so that they will be able to maintain similar incomes;
- \* use of the mass media for information campaigns to prevent female genital mutilation;
- \* education through schools, colleges, women's groups, work places etc;
- \* organisation of local discussion groups;
- \* encouraging leaders to speak out publicly against the practice;
- \* undertaking research projects in this area.

#### (ii) The United Kingdom

In 1985 the United Kingdom enacted legislation<sup>153</sup> making it illegal, subject to certain exceptions, to perform a surgical operation resulting in female genital mutilation. An offence is not committed if the operation is necessary for the physical or mental health of the woman and is performed by a registered medical practitioner; is performed on a woman who is in any stage of labour or has just given birth for purposes connected with the labour or birth and is performed by certain health professionals. In determining whether the operation is necessary for the mental health of the woman, no account is to be taken of the effect of any belief that the

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<sup>152</sup> See the Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 24-34. Australian agencies are also involved in these programs. For example, the non-government aid agency *International Women's Development Agency* provides funding assistance to the Inter Africa Committee for their work countering female genital mutilation in 28 African countries and is currently assisting the Tanzanian Committee with its program.

<sup>153</sup> *The Prohibition of Female Circumcision Act 1985* (UK) is set out in Appendix 3.



operation is required as a matter of custom or ritual.

While the United Kingdom Parliamentary Debates on the *Prohibition of Female Circumcision* legislation show that Parliament was aware that female genital mutilation is a cultural practice within some communities, it was acknowledged that it is not an acceptable practice which should be allowed in Britain. As the then Minister for Health stated during the debates on the legislation:

Although we believe that female circumcision has been carried out in only a handful of cases in this country, it does not mean that there are not compelling reasons for legislation to make sure that there are no more such operations here. The mutilation and impairment of young girls and women have no part in our way of life.<sup>154</sup>

The debates also highlighted the importance of education and counselling<sup>155</sup> being made available within communities in which female genital mutilation is traditional.<sup>156</sup>

Despite legislative intervention prohibiting female genital mutilation, it appears the practice is still continuing underground in the United Kingdom -

There is evidence to show that if doctors or midwives cannot be found in the UK, families bring traditional circumcisors from abroad, or take their daughters abroad to have the operation performed.<sup>157</sup>

Since then female genital mutilation has also been recognised as a child protection issue in relation to girls who may be at risk. The first *United Kingdom National Conference on Female Genital Mutilation* was held at London in 1989. The conference reached the following agreement:<sup>158</sup>

- i. The terminology female circumcision should be avoided and be replaced by female genital mutilation.

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<sup>154</sup> House of Commons *Parliamentary Debates* 19 April 1985 at 586.

<sup>155</sup> See, for example, the recent United Kingdom developments in child protection strategies for young girls who may be at risk of female genital mutilation as outlined on pages 44 to 45.

<sup>156</sup> See, for example, the House of Lords *Parliamentary Debates on the Prohibition of Female Circumcision Bill* 15 May 1985 at 1224 and 18 June 1985 at 219-224.

<sup>157</sup> Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation* 1992 at 8.

<sup>158</sup> Report on the *First National Conference on Female Genital Mutilation* 1989 at 3.

- ii. Female genital mutilation is cruel and outmoded....
- iii. Female genital mutilation constitutes child abuse. In this context however it does not constitute child sexual abuse.
- iv. Although female genital mutilation does constitute child abuse, it was acknowledged that the label child abuse has unnecessary pejorative connotations and use may be counterproductive.<sup>159</sup>
- v. Female genital mutilation is a denial of a child's basic human rights.

A number of practical strategies were also developed at the conference to deal with cases, or potential cases, of female genital mutilation:<sup>160</sup>

- i. that the DHSS (now the Department of Health) should alert local authorities and social services to the existence of female genital mutilation and seek to educate their workers about the practice.
- ii. that the DHSS guidelines which list six categories which merit registration of a child on the 'at risk' register should be increased so that risk of female genital mutilation would appear as a seventh category.
- iii. that social workers, teachers, police, lawyers, judges and most critically the educators of these groups be educated about female genital mutilation.
- iv. that a consultative body within social services departments incorporating black community members be set up to bridge the community and profession so that there can be community cooperation with respect to this issue.

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<sup>159</sup> Hedley R and Dorkenoo E note:

There are still people who are sensitive to the use of the term 'child abuse'. This, however, is not without precedent. It took ten years to achieve consensus on the use of the term 'Female Genital Mutilation' rather than 'Female Circumcision' as a more accurate definition of the phenomenon. Thus the current reservations should not be allowed to impede efforts to deepen the understanding of the term 'child abuse' in relation to sexual mutilation of girls and to promote its wider acceptance and usage. *Child Protection and Female Genital Mutilation* 1992 at 12.

<sup>160</sup> Report on the *First National Conference on Female Genital Mutilation* 1989 at 3 and 4.

- v. that the wardship jurisdiction<sup>161</sup> is perhaps the most appropriate legal strategy where a child is truly at risk. Wardship freezes the situation, the child is not necessarily removed from the home, but all decisions concerning the child are made by the court.
- vi. educational programmes concerning the practice that are currently available be expanded and made as widespread as possible.
- vii. groups like Forward ... who are in the forefront of the campaign be supported financially and in all other ways so as to advance the campaign.
- viii. sub-groups should be set up at local level to sensitise and counsel parents on the ill-effects of female genital mutilation and to support parents who might be thinking of refraining from it.
- ix. a conference/seminar should be convened .... to bring the issue of female genital mutilation to the attention of the wider black community in order to enlist their greater involvement in the campaign.
- x. health workers (particularly school nurses, health visitors, general practitioners, midwives) and school teachers should integrate health promotion and counselling against female genital mutilation in their work.
- xi. health training material be prepared for the use of grassroots workers.
- xii. articles should be placed in medical journals and other professional journals to raise the awareness and to attract the interest and involvement of health workers.

### (iii) Europe

In 1982 Sweden prohibited female "excision", regardless of whether consent was given or not.<sup>162</sup> Belgium has banned the practice.<sup>163</sup> In 1985

<sup>161</sup> A "prohibited steps order" contained in s.8 of the *Children Act 1989* now replaced wardship in this context. A "prohibited steps order" is an order that no steps which could be taken by a parent in meeting his or her parental responsibility for a child and which are of a kind specified in the order, shall be taken by any person without the consent of the court.

<sup>162</sup> The Swedish Embassy in Australia has provided the English translation of the Swedish Law set out in Appendix 5.

Norwegian hospitals were alerted to the practice.<sup>164</sup> Under Article 312-3 of the French *Penal Code* female genital mutilation may be prosecuted as a criminal offence.<sup>165</sup> Prosecutions have been successful.<sup>166</sup>

The Netherlands' Secretary of State of the Ministry of Welfare, Health and Cultural Affairs has advised the Commission on the Dutch Government's policy on female genital mutilation in the light of African refugees and asylum seekers practising female genital mutilation in the Netherlands.<sup>167</sup> The Dutch Government rejects all forms of female genital mutilation unequivocally and has refused to distinguish between "mutilating" and "non-mutilating" (for example, ritual nicking) forms of female circumcision. The Government's policy is directed towards prevention and information and has been expressed in the following terms:<sup>168</sup>

Female circumcision is a practice which runs contrary to prevailing attitudes in the Netherlands on the equality of women and their place in society. It is viewed here as a form of repression, and as Dutch policy aims to combat the repression of women, it opposes all forms of female circumcision.

Although there is no separate offence under the *Dutch Criminal Code* relating to female genital mutilation, it is considered that all forms of the practice would be punishable as an intentional or negligent assault (Article 436 of the *Criminal Code*) and pursuant to the prohibition against the unlicensed practice of medicine (Articles 300 - 309 *Criminal Code*). Work has commenced on education and consultation for refugee women in relation to female genital mutilation.

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<sup>163</sup> Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 11.

<sup>164</sup> *Ibid.*

<sup>165</sup> *Ibid.* By contrast, no specific law against female genital mutilation exists in Germany despite a large African immigrant population and the widespread belief that female genital mutilation is practised in Germany. [ref. submission 50 from a doctor working in Hamburg].

<sup>166</sup> In France in 1989 a mother who paid a traditional operator to excise her week old daughter was given a three year suspended sentence; a traditional operator was gaoled for five years in 1991 - Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 11.

<sup>167</sup> By letter dated 31 January 1994.

<sup>168</sup> Netherlands Government's Standpoint on Female Circumcision, undated.

## (iv) The United States of America

The United States of America has introduced legislation specifically prohibiting female genital mutilation.<sup>169</sup> The legislation is yet to be enacted.

In March 1994 the *New York State Prohibition of Female Genital Mutilation Act* was introduced into the Senate and the Assembly of the State of New York as an amendment to that State's Penal Law. The relevant provisions are set out in Appendix 4. Female genital mutilation was regarded by the promoters of the Bill as a form of dangerous child abuse. Education and prosecution against female genital mutilation was considered necessary immediately to combat its practice. The New York legislation is yet to be enacted.

## (b) International

## (i) World Health Organisation

In 1984 the World Health Organisation released a position statement on female genital mutilation:<sup>170</sup>

WHO support the recommendations of the Khartoum Seminar of 1979 on Traditional Practices Affecting the Health of Women. These were that governments should adopt clear national policies to abolish female circumcision, and to intensify educational programmes to inform the public about the harmfulness of female circumcision. In particular, women's organisations at local levels are encouraged to be involved, since without women themselves being aware and committed, no changes are likely. In areas where female circumcision is still being practised, women are facing many other problems of ill health and malnutrition, lack of clean water, death in childbirth, overburden of work. These occur in extremely adverse

<sup>169</sup> *Federal Prohibition of Female Genital Mutilation Act of 1993* (H.R. 3247) introduced as part of *Women's Health Equity Act*. The *Federal Prohibition of Female Genital Mutilation Act of 1993* is set out in Appendix 4. The Bill was kindly provided to the Commission by Congresswoman Pat Schroeder. The Bill has been referred to the Judiciary and Energy and Commerce Committees. A further piece of legislation, the *Minority Health Initiatives Act*, passed by Committee on 22 February 1994 is expected to be considered by Congress soon. That Bill which is also set out in Appendix 4 provides, by s.603, that: data be collected on females living in the US who have been subjected to female genital mutilation; communities in the US that practise female genital mutilation be identified; education programs on the physical and psychological health effects of female genital mutilation be designed and carried out; recommendations for the education of medical and osteopathic medical students on female genital mutilation and complications from female genital mutilation be developed. For the purposes of section 603, female genital mutilation is defined as meaning 'the removal or infibulation (or both) of the whole or part of the clitoris, the labia minor or the labia major'. S.603 is set out in Appendix 4.

<sup>170</sup> World Health Organisation *Female Circumcision Statement of WHO Position and Activities 1984*.

social and economic circumstances. Surveys carried out recently with WHO support, also point to the continuing cultural and traditional pressures which perpetuate the practice...

WHO, together with UNICEF, has assured governments of its readiness to support national efforts against female circumcision, and to continue collaboration in research and dissemination of information...

WHO has consistently and unequivocally advised that female circumcision should not be practised by any health professional in any setting - including hospitals or other health establishments...

In May 1994 the World Health Assembly urged all Member States:

- (1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;
- (2) to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;
- (3) to collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment.

The Director General of the World Health Organisation (WHO) has described national and international (including WHO) efforts to eradicate female genital mutilation:<sup>171</sup>

For several years increased attention has been focused on female genital mutilation by women's organizations, human rights groups, and national and international media. National authorities in many countries in Africa, working with the network of nongovernmental organizations, the Inter-African Committee for the Elimination of Harmful Traditional Practices and others, have developed programmes to educate and inform women and persuade them to abandon mutilation. Combined efforts have been made to convert men in order to ensure a positive effect for the campaign by women. Many lessons have been learned, resulting in the present approach through national and/or local organizations and using as far as possible the skills and experience of those whose work is among villagers, such as teachers, social workers and health personnel.

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<sup>171</sup> *Maternal and Child Health and Family Planning : Current Needs and Future Orientation Report by the Director-General January 1994 at 8-9.*

Although it is now generally accepted that the initiative for abolition of female circumcision must be taken by women from the societies that practise it, it is also recognized that national and local initiative can benefit greatly by outside support. For the past 15 years, WHO's role has included technical and financial support for national surveys, for the relevant training of health workers, and for grassroots initiatives. A joint task force of nongovernmental organizations and WHO is also being established to strengthen coordination between the various agencies and organizations active in this field.

## (ii) United Nations

Genital mutilation is usually performed on young females. Article 24(3) of the United Nations *Convention on the Rights of the Child* provides that "state parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children". Member states of the United Nations whose communities practise the tradition of female genital mutilation should therefore take active steps to discourage and thereby eliminate this practice.

Although Australia is a party to this Convention,<sup>172</sup> ratification of an International Convention by the Australian Government does not thereby incorporate the rights and obligations contained in that Convention into Australian law. Mason CJ and McHugh J in a joint judgment in a 1992 High Court decision explained the relevant common law:<sup>173</sup>

Ratification of the ICCPR [International Convention on Civil and Political Rights] as an executive act has no direct legal effect upon domestic law; the rights and obligations contained in the ICCPR are not incorporated into Australian law unless and until specific legislation is passed implementing the provisions.

Article 2(a) of the United Nations *Declaration on the Elimination of Violence against Women*<sup>174</sup> specifically refers to female genital mutilation as a form of violence against women.

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<sup>172</sup> Australia ratified this Convention on 17 December 1990.

<sup>173</sup> *Dietrich v The Queen* (1992) 177 CLR 292 at 305. The joint judgment referred with approval to *Bradley v The Commonwealth* (1973) 128 CLR 557 at 582; *Simsek v Macphie* (1982) 148 CLR 636 at 641-4; *Kjoa v West* (1985) 159 CLR 550 at 570-1.

<sup>174</sup> Adopted by the General Assembly of the UN, December 1993. Australia was a member of a United Nations Expert Group Meeting in Vienna in 1991 which developed the Draft of this Declaration.

## 11. CONCLUSION

Female genital mutilation is a very intrusive procedure surgically performed on young women, usually under the age of eighteen years. It developed as a cultural practice over two thousand years ago in a number of countries, mainly in Africa.<sup>175</sup> The practice has spread to other countries with migrant communities within which the practice is traditional.

The practice is seen by some to be a control over a woman's sexuality, fertility, marriageability, hygiene and appearance, while others see it as an initiation into adulthood. It is also a source of income to traditional operators.

There are no known medical advantages in performing female genital mutilation on normal healthy female genitalia. On the contrary, the adverse health effects are long-term, debilitating and, in some cases, fatal.

There is a strong argument that all forms of female genital mutilation, except for recognised medical procedures, such as genital reconstruction surgery to correct a birth abnormality, would constitute an illegal act under Queensland's *Criminal Code*. However, the relevant Queensland *Criminal Code* provisions have never been tested by any Queensland court in these circumstances.<sup>176</sup>

There is also an argument that the provisions of the *Criminal Code* should remain as general as possible to cope with the myriad of circumstances that arise in the community deserving of criminal sanction and therefore should not include a specific provision prohibiting female genital mutilation.

Other legislation, such as the *Medical Act 1939* or the *Children's Services Act 1965* (Qld) might be more appropriate for provisions relating to specific medical problems.

It is apparent that, with increased migration to Australia from countries in which female genital mutilation is a strongly held and actively practised tradition, female genital mutilation, if not practised already in Australia, will most likely be practised in the foreseeable future.<sup>177</sup>

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<sup>175</sup> See page 15 for a list of countries where at least one form of female genital mutilation is practised.

<sup>176</sup> See pages 28 to 32 above.

<sup>177</sup> For Australia in 1992-1993 7.3% of the total refugee intake was from Africa (excluding North Africa); 68.8% of the total refugee intake was from South-East, North-East and Southern Asia, and 3.9% of the total refugee intake was from the Middle East and North Africa. Federal Race Discrimination Commissioner *State of the Nation A Report on People of Non-English Speaking Background 1993* at 184.



This has been the experience of other Western countries such as the United Kingdom and France.

The Commission is of the view that female genital mutilation of children is a practice totally unacceptable to the Australian community. Although Australia is a multicultural society which recognises that an individual's own cultural values should be respected to the greatest extent possible, there are some practices that are so abhorrent to the wider community that they should not be permitted. For example, Australians have never tolerated the Indian practice of women throwing themselves on their husband's funeral pyre or Chinese child footbinding. Female genital mutilation, at least of children under the age of eighteen years, is such a practice and its condemnation should be placed beyond doubt.

It is recognised that there may be adult women who, despite being fully informed about the procedure, still wish it to be performed. To prohibit those women from requesting or consenting to the procedure may be an unacceptable restriction on their freedom as individuals to consent to treatments, particularly given the tolerance in Australian society of other "body altering acts" (such as cosmetic surgery or body piercing), which are considered culturally acceptable. However, that same principle can in no way justify the performance on young girls of such a debilitating procedure, which has life long repercussions, even if those girls at the time seem capable of understanding the nature of the procedure, and of consenting to it.

Experience elsewhere<sup>178</sup> has shown that legislation prohibiting female genital mutilation, without more, is ineffective in reducing or eliminating the practice. Education of those women and men most affected by the practice in a culturally and linguistically appropriate manner is far more effective. Education of health workers, child protection officers, police and the judiciary on all aspects of female genital mutilation would also be appropriate to ensure a sensitive consideration of the issues when an instance or threat of female genital mutilation comes to light. Some legislative back-up may be required to add force to the education campaign.

Legislation highlighting female genital mutilation and stressing its criminal nature may have the detrimental effect of isolating a group of women and men in our community who simply believe that female genital mutilation is something they must have done to their daughters - it is done out of love and caring. To make these women, their daughters and the community within which they live, the focus of separate, highly emotive criminal laws seems to the Commission to be an unnecessarily harsh, potentially racist, manner of tackling the problem. Such would be the case if the prohibition were to be found in separate legislation prohibiting female genital mutilation

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<sup>178</sup> See discussion commencing at page 41 on overseas legislation and initiatives.

as exists in the United Kingdom or in separate provisions of high profile legislation such as the Queensland *Criminal Code*.

The Commission is of the view that the aim of any reform should be to stop the practice and not simply to punish the perpetrators after the event. Unless the criminal law is considered to be a totally effective deterrent it will fail to achieve that purpose. Education should be the principal focus of reform; legislative reform, if required at all, should be supportive of education, understanding of the strength of cultural beliefs and traditions, clear in its intent and not sensational.

Because female genital mutilation is considered by some communities to be 'a very important ritual with significant sociological, economic and self-esteem ramifications, it has been suggested that an alternative, less intrusive ritual might, for some people at least, be acceptable.

A recent article in the Australian newspaper quotes an Australian father from Sudan, when asked what his solution would be to the current debate on female genital mutilation, as stating:<sup>179</sup>

Let us have 'little' cuts to satisfy religious needs. Encourage change to continue through education and publicity.

However, it was pointed out that should the man's daughter go back to the Sudan for a holiday, she could not be guaranteed to be safe from more invasive ritual mutilation. By contrast, the Queensland women the Commission consulted believe that it is unlikely that their daughters would be subjected to such a procedure by family or friends against the mother's wishes. They told the Commission that it was invariably up to the mothers to decide.

The Dutch Government has considered and rejected a proposal to distinguish between "mutilating and non-mutilating" procedures. That Government has stated:<sup>180</sup>

We have ascertained that this leads to confusion as the concepts are vague ones and that to distinguish between the two forms is no simple matter.

What is more important is that the preventive value of this distinction has not been proven. Many of the recommendations have pointed out that

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<sup>179</sup> Liverani M *Painful Scars of Tradition* Australian 17 May 1994, 15.

<sup>180</sup> Netherlands Government's Standpoint on Female Circumcision, undated.

making the distinction may in fact perpetuate female circumcision as it implies toleration of the practice. We therefore feel that the distinction is impeding effective action against female circumcision ... an unambiguous policy aimed at the total elimination of all forms of female circumcision [is] necessary.

The Commission endorses these comments.

A suggestion has been made<sup>181</sup> that there should be mandatory reporting requirements for doctors, midwives, nurses and health workers in relation to girls who have recently undergone female genital mutilation or women who it is feared may have the procedure performed on their daughters. The Commission believes that such requirements could lead to unnecessary harassment of women and girls who have already suffered the rigours of genital mutilation. If health workers were aware, through proposed education programs, of the risks associated with female genital mutilation, these could be explained to the patient, particularly if there is an indication that she intends to have her daughter undergo a mutilation procedure. Mandatory reporting requirements may inhibit mothers from seeking health care for their daughters and may thereby put their daughters' health at risk.

Nevertheless, in some circumstances a health or social worker may feel obliged to report their genuine suspicions to child protection authorities. In those circumstances, the health or social worker should not be liable for breaching any duty of confidence owed to any person.

A number of submissions to the Commission expressed concern with the possibility that people who arrange or assist in the performance of female genital mutilation would be subject to severe penalties, including imprisonment. The Commission acknowledges that imprisonment of parents who have arranged for their daughter to be mutilated in accordance with the cultural dictates of their community might in fact victimise at least the daughter and the mother a second time. It is highly likely that the mother would herself have been mutilated as a child. The daughter, apart from suffering mutilation, could also lose her parents (and possibly other loved ones) if the parents are convicted of performing or organising the mutilation. The family may already have been traumatised as a result of migrating to Australia and have suffered hardship prior to departing their country of origin.

However, if the introduction of legislation and criminal penalties is deferred until after the implementation of a suitable education campaign, the communities in question would hopefully be given adequate time to adjust and become familiar with the Australian approach to this issue prior to the risk of prosecution arising. Furthermore, the criminal justice system could

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<sup>181</sup> Submission 25.

be sympathetic to such situations by applying a penalty system, whilst the education program is in its initial stages, which takes into account such matters as the type of mutilation in question, the cultural belief of the individuals concerned and their knowledge of the law in determining any penalty.

## 12. RECOMMENDATIONS

### (a) Education

The Commission strongly recommends that an appropriate education program be introduced and support facilities be made available to both women and men in communities in which female genital mutilation is practised. The Commission recognises that it is equally important to educate the men, as well as the women, given the role men play in the affected communities. Education and support programs should be developed in consultation with, and with the involvement of, women who have experienced female genital mutilation or who are experienced in the cultural aspects of the practice. Advice of professionals with experience in dealing with such women should also be sought. The education programs should be developed with the aim of eliminating and avoiding the practice of female genital mutilation in Queensland.

It would also be appropriate to develop education programs on female genital mutilation for health professionals and medical and nursing students, to make them aware of the cultural and legal aspects of the procedure, of the risks involved to the woman and of the practical ways of dealing with medical problems, or special needs arising as a result of female genital mutilation having been performed.

Information on female genital mutilation should also be made available to child protection workers, police and the Queensland judiciary in an attempt to ensure sensitive and informed handling of cases involving allegations of female genital mutilation.

### (b) Prohibition in *Medical Act 1939*

As there may be doubt that the law in Queensland prohibits all forms of female genital mutilation in all inappropriate circumstances, consideration should be given to specifically outlawing this practice except for good medical reasons. However, the introduction of any specific prohibition should await the satisfactory implementation of an education program.

An appropriate Act to include such a prohibition would be the *Medical Act 1939* (Qld) in Part VI - Prohibited Practices. The prohibition should be along the following lines:<sup>182</sup>

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<sup>182</sup> For consent requirements for lawful procedures see pp 36 to 40 above.

**Prohibition on female genital mutilation**

- (a) Except as provided in subsection (b) below, no person shall perform surgery to excise, infibulate or otherwise mutilate the whole or any part of the labia majora, or labia minora or clitoris of a person under the age of 18 years.
- (b) Subsection (a) does not prohibit the performing of a surgical operation in the following circumstances:
- (i) where the surgery is performed solely for accepted medical reasons for the physical health of the person, and is performed by a medical practitioner;
  - (ii) where the surgery is a sexual reassignment procedure and is performed by a medical practitioner;
  - (iii) where the surgery is performed on a person in labour or who has just given birth, for accepted medical reasons connected with that labour or birth, and is performed by
    - . a medical practitioner;
    - . a registered midwife; or
    - . a person in training to become a medical practitioner or registered midwife.

In determining any penalty for breach of this prohibition, such matters as the type of mutilation performed, the cultural beliefs of the individual concerned and his or her knowledge of Australian law should be taken into account whilst the education program is in its early stages. After the education program has been successfully operating for a reasonable period of time, penalties should be imposed in the usual manner, in accordance with the principles set out in the *Penalties and Sentences Act 1992* (Qld.).

It should also be an offence for medical practitioners or other health practitioners to deny a person medical care or services on the basis that the person has been the subject of female genital mutilation. Such an offence would hopefully help allay the fears that some women have, that because they or their daughters have been infibulated - possibly overseas - health care professionals in Australia may refuse to treat them for complications arising from their or their daughter's mutilation. It would be appropriate to also include such an offence in the *Medical Act 1939* (Qld).

**(c) Removal of children interstate or overseas**

The Commission is aware that some adherents to the cultural tradition of female genital mutilation may seek to take their daughters interstate or overseas to be mutilated. The Commission condemns this practice. However, it would be extremely difficult to enforce a prohibition on removing a child from Queensland for these purposes - without the possibility of interfering excessively with the privacy of individuals and families. If all jurisdictions in Australia prohibit female genital mutilation - which is likely to be the case - then no more need be done, apart from informing people of this situation, to prevent movement interstate for such purposes.

However, to cover the possibility of any form of female genital mutilation not being an offence in another Australian jurisdiction, legislation may need to be introduced to make it an offence for such a procedure to be performed outside Queensland on a person under the age of 18 who is normally resident in Queensland.<sup>183</sup>

Apart from a provision relating to offences committed on the high seas,<sup>184</sup> there is currently no provision in the *Criminal Code* to make criminal in Queensland acts or omissions performed entirely outside Queensland - when those acts or omissions would not amount to an offence in the other jurisdiction.<sup>185</sup> The *Criminal Code Review Committee*<sup>186</sup> has made no recommendations which cover the situation contemplated by the Commission.

The New South Wales Bill contains a provision which could be adopted for Queensland:

An offence is committed against this section even if one or more of the acts constituting the offence occurred outside New South Wales if the person mutilated by or because of the acts is ordinarily resident in the State.

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<sup>183</sup> The power to make such a law would be founded on the government's power to make laws for the peace, welfare and good government of Queensland founded in s.2 of the *Constitution Act 1867*.

<sup>184</sup> S.14A *Criminal Code*.

<sup>185</sup> Note s.14 *Criminal Code* - offences procured in Queensland to be committed out of Queensland (needs to be an offence in the other jurisdiction). S.12 - Application of Code to offences wholly or partially committed in Queensland (needs to have been an act done or omission made in Queensland).

<sup>186</sup> Final Report of the *Criminal Code Review Committee* to the Attorney-General June 1992.

In relation to removing children from Australia for the purposes of female genital mutilation - it would be virtually impossible to enforce a crime to intend to so remove a child - without invading individual and family privacy, and without casting possibly groundless but nevertheless damaging suspicion on families.

Not even the proposed Commonwealth crimes relating to child sex tourism<sup>187</sup> go so far as to make it a crime to intend to travel overseas for the purpose of paedophilia.

The principal aim of the Commonwealth Bill is:<sup>188</sup>

To provide a real, and enforceable, deterrent to the sexual abuse of children outside Australia by Australian citizens and residents.

The legislation was also drafted in response to a concern in relation to Australia's "unenviable reputation in the world press on this issue".<sup>189</sup>

If the Commonwealth legislation does not deter paedophiles from travelling overseas to abuse children, the only effect of the legislation will be to enable such people to be prosecuted in Australia after the event.

As female genital mutilation is such a strongly held cultural tradition for some people, it is unlikely that legislation making it criminal for an Australian citizen or resident to have the operation performed on a child overseas will be an effective deterrent. Also, prosecution after the event does not help the child at all. It is then too late for the child, who would have been mutilated before the prosecution commences.

However, if there were a deterrent value in such legislation it would be better placed in Commonwealth legislation. The provisions of such legislation would also be better enforced by Commonwealth agencies such as the Federal Police and officers of the Immigration Department rather than Queensland agencies.

The Commonwealth Government would also be in a far better position than the Queensland Government to inform refugees and other potential migrants

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<sup>187</sup> *Crimes (Child Sex Tourism) Amendment Bill 1994*. Note, also House of Representatives, Standing Committee on Legal and Constitutional Affairs *Advisory Report on Crimes (Child Sex Tourism) Amendment Bill 1994*, May 1994.

<sup>188</sup> Second Reading Speech, by the Hon Duncan Kerr MP, Minister for Justice, House of Representatives, May 1994. Note, the Bill has received widespread adverse comments because of its far-reaching implications. For example, see submissions to the *Inquiry into the Crimes (Child Sex Tourism) Amendment Bill 1994* (two volumes) conducted by the House of Representatives Standing Committee on Legal and Constitutional Affairs, May 1994.

<sup>189</sup> Second Reading Speech, by the Hon Duncan Kerr, Minister for Justice, House of Representatives, May 1994.



to Australia that the performance of female genital mutilation is an offence in all Australian jurisdictions. The Commonwealth Government would also be in the best position to deter potential migrants to Australia from having their daughters mutilated prior to emigrating to Australia.

**(d) Definition of children "in need of care and protection"**

Queensland's care and protection of children provisions are found in the *Children's Services Act 1965*. That Act is currently being comprehensively reviewed by the Department of Family Services and Aboriginal and Islander Affairs.<sup>190</sup> The Commission recommends that the definition of "in need of care and protection" or the equivalent phrase to be introduced by any amendment to the Act resulting from the review, be such as to place beyond any doubt that it includes the threat or fear of female genital mutilation in whatever form, being performed upon a young person under the age of 17 years.<sup>191</sup>

**(e) Child protection protocols**

Female genital mutilation is very much a child protection matter. Appropriate protocols should be developed by the Queensland Department of Family Services and Aboriginal and Islander Affairs and the Queensland Police Service for the investigation and handling of families "at risk" and families suspected of having had their daughters mutilated in Queensland.

**(f) Protection of health and social workers**

Although the Commission has not recommended the enactment of mandatory reporting legislation, it is of the opinion that health or social workers who believe a child is at risk of undergoing female genital mutilation, should be immune from liability for breaching a duty of confidence owed to any person in taking action to protect the child in question.

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<sup>190</sup> See *Child Protection Legislation Issues Paper 1993*.

<sup>191</sup> The *Children's Services Act 1965* currently defines 'child' in terms of a person under the age of 17 years.

(g) Incitement to racial hatred<sup>192</sup>

If incitement to racial hatred legislation were to be introduced in Queensland, an appropriate offence may relate to taunting with regard to a person's cultural beliefs and practices and to a person's bodily characteristics resulting from cultural or religious practices.<sup>193</sup>

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<sup>192</sup> Note Commonwealth Government's Intention to Introduce Incitement to racial hatred legislation - *Racists to face jail, PM warns* - Courier-Mail 30 May 1994 and *Racists may face prison terms* - Australian 30 May 1994 1. Legislation was introduced in 1992 but not proceeded with - *Racial Discrimination Amendment Act 1992*.

<sup>193</sup> The Commonwealth Government's proposed laws against incitement to racial hatred have provoked some controversy. See, for example, *Race Laws: Existing codes barrier enough* The Courier-Mail 31 May 1994 at 8, Editorial.

## APPENDIX 1

### List of Respondents to the Research Paper on Female Genital Mutilation

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- \* Aboriginals and Torres Strait Islanders Corporation for Legal Services
- \* Association of Catholic Parents
- \* Austcare
- \* Informal group of Queensland (women affected by FGM)
- \* Australian Medical Association
- \* Mrs E Bennett
- \* Mr R Bowles
- \* Professor Branicki and Professor F Leditshte
- \* Brisbane South Regional Health Authority
- \* Bureau of Ethnic Affairs
- \* Catholic Provincial Medico-Moral Committee for the Bishops of Queensland
- \* Central Regional Health Authority
- \* Professor H Charlesworth
- \* Chief Health Officer, Queensland Health
- \* Children's Interest Bureau (S.A.)
- \* Darling Downs Regional Health Authority
- \* Division of Protective Services and Juvenile Justice, Department of Family Services and Aboriginal and Islander Affairs
- \* Ecumenical Migration Centre (Victoria)
- \* Family Planning Queensland
- \* Mr J Fleming
- \* Dr H Haas
- \* Commonwealth Dept of Human Services and Health
- \* International Women's Development Agencies
- \* Islamic Council of Queensland
- \* Dr R Lampugnani
- \* Professor F Leditshte and Professor Branicki
- \* Dr D Malloy
- \* The Medical Defence Society of Queensland
- \* Ms L Meyers
- \* Mr and Mrs Naske
- \* National Children's and Youth Law Centre
- \* National Council of Women of Victoria
- \* Peninsula and Torres Strait Regional Health Authority
- \* Reverend Les Percy
- \* The Presbyterian Church of Queensland
- \* Queensland Women's Consultative Council
- \* Professor J Reid
- \* The Royal Australian College of Obstetricians and Gynaecologists
- \* Royal College of Nursing, Australia (Qld Chapter)
- \* Mr M Santin
- \* Mr J Shanahan
- \* Social Issues Committee, Anglican Church, Brisbane Diocese
- \* Dr G Williams
- \* Women's Health Centre
- \* Women's Policy Unit, Office of the Cabinet

## APPENDIX 2

### New South Wales Legislation

#### *Crimes (Female Genital Mutilation) Amendment Bill 1994*

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The Legislature of New South Wales enacts:

#### Short title

1. This Act may be cited as *Crimes (Female Genital Mutilation) Amendment Act 1994*.

#### Commencement

2. This Act commences on a day to be appointed by proclamation.

#### Amendment of *Crimes Act 1900* No 40

3. The *Crimes Act 1900* is amended by inserting after section 44 the following section:

#### Prohibition of female genital mutilation

45. (1) A person who:
  - (a) excises, infibulates or otherwise mutilates the whole or any part of the labia majora or labia minora or clitoris of another person;  
or
  - (b) aids, abets, counsels or procures a person to perform any of these acts on another person,

is liable to penal servitude for 7 years.

- (2) An offence is committed against this section even if one or more of the acts constituting the offence occurred outside New South Wales if the person mutilated by or because of the acts is ordinarily resident in the State.
- (3) It is not an offence against this section to perform a surgical operation if that operation:
  - (a) is necessary for the health of the person on whom it is performed and is performed by a medical practitioner; or
  - (b) is performed on a person in labour or who has just given birth, and for medical purposes connected with that labour or birth, by a medical practitioner or authorised professional; or
  - (c) is a sexual reassignment procedure and is performed by a medical practitioner.
- (4) In determining whether an operation is necessary for the health of a person only matters relevant to the medical welfare of the person are to be taken into account.
- (5) It is not a defence to a charge under this section that the person mutilated by or because of the acts alleged to have been committed consented to the acts.
- (6) This section applies only to acts occurring after the commencement of the section.
- (7) In this section:

**"authorised professional" means:**

- (a) a person authorised to practise midwifery under the Nurses Act 1991 or undergoing a course of training with

a view to being so authorised; or

- (b) in relation to an operation performed in a place outside New South Wales - a person authorised to practise midwifery by a body established under the law of that place having functions similar to the functions of the Nurses Registration Board, or undergoing a course of training with a view to being so authorised; or
- (c) a medical student;

**"medical practitioner"**, in relation to an operation performed in a place outside New South Wales, includes a person authorised to practise medicine by a body established under the law of that place having functions similar to the functions of the New South Wales Medical Board;

**"medical student"** means:

- (a) a registered medical student within the meaning of the Medical Practice Act 1992; or
- (b) in relation to an operation performed in a place outside New South Wales - a person undergoing a course of training with a view to being authorised to be a medical practitioner in that place;

**"sexual reassignment procedure"** means a surgical procedure to alter the genital appearance of a person to the appearance (as nearly as practicable) of the opposite sex to the sex of the person.

# APPENDIX 3

## United Kingdom Legislation

### *Prohibition of Female Circumcision Act 1985*

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#### 1985 CHAPTER 38

Be it enacted by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:-

1.-(1) Subject to section 2 below, it shall be an offence for any person-

- (a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person; or
- (b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.

(2) A person guilty of an offence under this section shall be liable-

- (a) on conviction on indictment, to a fine or to imprisonment for a term not exceeding five years or to both; or
- (b) on summary conviction, to a fine not exceeding the statutory maximum (as defined in section 74 of the Criminal Justice Act 1982) or to imprisonment for a term not exceeding six months, or to both.

2.-(1) Subsection (1)(a) of section 1 shall not render unlawful the performance of a surgical operation if that operation-

- (a) is necessary for the physical or mental health of the person on whom it is performed and is performed by a registered medical practitioner; or
- (b) is performed on a person who is in any stage of labour or has just given birth and is so performed for purposes connected with that labour or birth by-

(i) a registered medical practitioner or a registered midwife; or

(ii) a person undergoing a course of training with a view to becoming a registered medical practitioner or a registered midwife.

(2) In determining for the purposes of this section whether an operation is necessary for the mental health of a person, no account shall be taken of the effect on that person of any belief on the part of that or any other person that the operation is required as a matter of custom or ritual.

3.-(1) Offences under section 1 shall be included-

- (a) in the list of extradition crimes contained in Schedule 1 to the Extradition Act 1870; and
- (b) among the descriptions of offences set out in Schedule 1 to the Fugitive Offenders Act 1967.

(2) In paragraph 1 of the Schedule to the Visiting Forces Act 1952 (offences against the person in the case of which a member of a visiting force is in certain circumstances not liable to be tried by a United Kingdom court), at the end of paragraph (b) there shall be inserted, appropriately numbered, the following paragraph-

'( ) section 1 of the Prohibition of Female Circumcision Act 1985.'

4.-(1) This Act may be cited as the Prohibition of Female Circumcision Act 1985.

(2) This Act shall come into force at the end of the period of two months beginning with the day on which it is passed.

(3) This Act extends to Northern Ireland.

## APPENDIX 4

### Proposed United States of America Legislation

#### *Federal Prohibition of Female Genital Mutilation Act of 1993*

#### Introduced as part of Women's Health Equity Act

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##### Sec. 262 Title 18 Amendment:

- (a) IN GENERAL - Chapter 7 of title 18. United States Code, is amended by adding at the end the following new section:

##### **116. Female Genital Mutilation**

- (a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both.
- (b) A surgical operation is not a violation of this section if the operation is-
- (1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or
  - (2) performed on a person in labor or who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such a practitioner or midwife.
- (c) In applying subsection (b)(1), no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that or any other person that the operation is required as a matter of custom or ritual.
- (d) Whoever knowingly denies to any person medical care or services or otherwise discriminates against any person in the provision of medical care or services, because-
- (1) that person has undergone female circumcision, excision, or infibulation; or
  - (2) that person has requested that female circumcision, excision, or infibulation be performed on any person;



shall be fined under this title or imprisoned not more than one year, or both.\*

- (b) **CLERICAL AMENDMENT** - The table of sections at the beginning of Chapter 7 of title 18, United States Code, is amended by adding at the end the following new item:

116. Female genital mutilation.

**Sec. 263 Education and Outreach**

The Secretary of Health and Human Services shall carry out appropriate education, preventive, and outreach activities in communities that traditionally practice female circumcision, excision, or infibulation, to inform people in those communities about the health risks and emotional trauma inflicted by those practices, and to inform them and the medical community about the provisions of section 262.

**Sec. 264 Effective Dates**

Section 263 shall take effect immediately, and the Secretary of Health and Human Services shall commence carrying out not later than 90 days after the date of the enactment of this Act. Section 262 shall take effect 180 days after the date of the enactment of this Act.

## HR 3804 Minority Health Initiatives Act 1994

### Section 603 Prevention of Female Genital Mutilation

- (a) **IN GENERAL** - The Secretary of Health and Human Services shall ensure that the Deputy Assistant Secretary for Women's Health and the Deputy Assistant Secretary for Minority Health collaborate for the purpose of carrying out the following activities:

(1) Compile data on the number of females living in the United States who have been subjected to female genital mutilation (whether in the United States or in their countries of origin), including a specification of the number of girls under the age of 18 who have been subjected to such mutilation.

(2) Identify communities in the United States that practice female genital mutilation, and design and carry out outreach activities to educate individuals in the communities on the physical and psychological health effects of such practice. Such outreach activities shall be designed and implemented in collaboration with representatives of the ethnic groups practicing such mutilation and with representatives or organisations with expertise in preventing such mutilation.

(3) Develop recommendations for the education of students of schools of medicine and osteopathic medicine regarding female genital mutilation and complications arising from such mutilation. Such recommendations shall be disseminated to such schools.

- (b) **DEFINITION** - For purposes of this section, the term "female genital mutilation" means the removal or infibulation (or both) of the whole or part of the clitoris, the labia minor, or the labia major.

## New York State Legislation

AN ACT to amend the penal law, in relation to enacting the *New York State Prohibition of Female Genital Mutilation Act*

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. This act shall be known and may be cited as the *New York State Prohibition of Female Genital Mutilation Act*.

S 2. The penal law is amended by adding a new section 130.75 to read as follows:

### S 130.75 Female Genital Mutilation.

1. A person is guilty of female genital mutilation when he or she knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not reached eighteen years of age.

Female genital mutilation shall be punishable by a fine not to exceed five thousand dollars or imprisonment for not more than five years, or both such fine and imprisonment.

2. A surgical operation is not a violation of this section if the operation is:

- (a) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or

- (b) performed on a person in labor who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such a practitioner or midwife.

3. For the purposes of paragraph (a) of subdivision two of this section, no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that or any other person that the operation is required as a matter of custom or ritual.

4. Any person who knowingly denies to any person medical care or services or otherwise discriminates against any person in the provision of medical care

or services because:

- (a) that person has undergone female circumcision, excision, or infibulation; or
- (b) that person has requested that female circumcision, excision, or infibulation be performed on any person;

shall be subject to a fine to exceed one thousand dollars or imprisonment of not more than one year, or both such fine and imprisonment.

- S.3. The Commissioner of Social Services shall carry out appropriate education, preventive and outreach activities in communities that traditionally practice female circumcision, excision, or infibulation, to inform people in those communities about the health risks and emotional trauma inflicted by those practices, and to inform them and the medical community about the provisions of section 130.75 of the penal law as added by section two of this Act.
- S 4. This Act shall take effect on the first day of November next succeeding the date on which it shall have become a law; provided however, that section three of this Act shall take effect on the one hundred eightieth day after it shall have become a law; and provided further that any rule or regulation necessary for the timely implementation of this Act on its effective date shall be promulgated on or before such date.

## APPENDIX 5

### Swedish Legislation<sup>194</sup>

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#### *Act 316 of 1982 Prohibiting the Circumcision of Women*

**Section 1:** An operation may not be carried out on the outer female sexual organs with a view to mutilating them or of bringing about some other permanent change in them (circumcision), of whether consent has been given for the operation or not.

**Section 2:** Anyone committing a breach of section 1 is to be sentenced to a term of imprisonment of at most two years or - if there are mitigating circumstances - to a fine.

If the offence has caused danger to life, grievous bodily harm, a serious disease or has otherwise involved extremely ruthless conduct, it shall be regarded as being grave. For a grave offence the sentence is imprisonment of at least one year and at most ten years.

Anyone found guilty of attempting to commit the above offence is to be sentenced for liability pursuant to Chapter 23 in the Penal Code.

This Act is to enter into force on 1 July 1982.

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<sup>194</sup> English translation kindly provided by the Swedish Embassy in Australia.

## APPENDIX 6<sup>195</sup>

### Prevalence of Female Genital Mutilation (FGM)

Benin*	50%	1 200 000	
Burkina Faso*	70%	3 290 000	
Cameroon*	-	-	Information on prevalence not available.
Central African Republic*	50%	750 000	
Chad	60%	1 530 000	Prevalence based upon 1990 and 1991 studies in three regions.
Côte d'Ivoire*	60%	3 750 000	
Djibouti	98%	196 000	Infibulation almost universally practised. The Union Nationale des Femmes de Djibouti (UNFD) runs a clinic where a milder form of infibulation is performed under local anaesthesia.
Egypt	50%	13 625 000	Practised throughout the country by both Muslims and Christians. Infibulation reported in areas of south Egypt closer to Sudan.
Ethiopia and Eritrea <sup>196</sup>	90%	23 940 000	Common among Muslims and Christians and practised by Falahas (Jewish population, most of whom now live in Israel). Clitoridectomy is more common, except in areas bordering Sudan and Somalia, where infibulation seems to have spread.
Gambia*	60%	270 000	
Ghana	30%	2 325 000	A 1987 pilot survey in one community showed that 98% of interviewed women above age 47 were circumcised, while 48% of those under 20 were not.
Guinea*	50%	1 875 000	
Guinea-Bissau*	50%	250 000	

<sup>195</sup> Reproduced from Table 1 of the World Health Organisation *Maternal and Child Health and Family Planning : Traditional Practices Harmful to the Health of Women and Children*. Report by the Director-General January 1994.

<sup>196</sup> Reported jointly in the absence of separate statistics.

Kenya	50%	6 300 000	Decreasing in urban areas, but remains strong in rural areas, primarily around the Rift Valley. 1992 studies in four regions found that the age for circumcision ranged from eight to 13 years, and traditional practitioners usually operated on a group of girls at one time without much cleaning of the knife between procedures.
Liberia*	60%	810 000	
Mali	75%	3 112 500	
Mauritania*	25%	262 500	
Niger*	20%	800 000	
Nigeria	50%	30 625 000	Two national studies conducted, but not released. A study of Bendel state reported widespread clitoridectomy among all ethnic groups, including Christians, Muslims, and animists.
Senegal	20%	750 000	Predominantly in the north and south-east. Only a minority of Muslims, who constitute 95% of the population, practise FGM.
Sierra Leone	90%	1 935 000	All ethnic groups practise FGM except for Christian Krios in the western region and in the capital, Freetown.
Somalia	98%	3 773 000	FGM is general; approximately 80% of the operations are infibulation.
Sudan	89%	9 220 400	A very high prevalence, predominantly infibulation, throughout most of the northern, north-eastern and north-western regions. Along with a small overall decline in the 1980s, there is a clear shift from infibulation to clitoridectomy.
United Republic of Tanzania	10%	1 345 000	Clitoridectomy reported only among the Chagga groups near Mount Kilimanjaro.
Togo*	50%	950 000	
Uganda*	5%	467 500	
Zaire*	5%	945 000	
<b>Total</b>		<b>114 296 900</b>	

\* Anecdotal information only; no published studies. (By Donna Sullivan and Nahid Toubia for the World Conference on Human Rights, Vienna, June 1993.)

Source: Nahid Toubia, *Female Genital Mutilation: A call for global action*, 1993

Statistical estimates of FGM in Africa: Estimated prevalence rates have been developed from reviews of national surveys, small studies and country reports and from Fran Hosken, *WIN News*, Vol. 18, no. 4, Autumn 1992.