

FEMALE GENITAL MUTILATION*

REPORT No. 47

**Queensland Law Reform Commission
September 1994**

* The term "female genital mutilation" is used in this Report as the term which has gained international acceptance in describing the practice. The Commission recognises that the term involves a value judgment, and but for the confusion which may result, would prefer to use the term "female circumcision" as it more accurately reflects the basis for the practice and is the term commonly used by people from countries where the procedure is a culturally accepted practice.

The short citation for this Report is Q.L.R.C.R.47.
Published by the Queensland Law Reform Commission, September 1994.
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ISBN 0 7242 6074 9

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Previous Queensland Law Reform Commission publications on this Reference:
Consent by Young People to Medical Treatment, Information Paper, May 1993.
Female Genital Mutilation, Research Paper, December 1993. (limited circulation)
Circumcision of Male Infants, Research Paper, December 1993. (limited circulation)
Female Genital Mutilation, Draft Report, July 1994.

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To: **The Hon Mr Dean Wells, M.L.A.**
Attorney General of Queensland

In accordance with the provision of section 15 of the Law Reform Commission Act 1968, I am pleased to present the Commission's Report on Female Genital Mutilation.

Yours faithfully,



The Honourable Mr Justice G N Williams (Chairman)



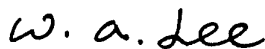
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16 September 1994

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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.¹ 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.²

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 Report concerns item (i) above.

¹ September 1990.

² 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 needed to be considered by the Commission.³ They were:

- * 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

In July 1994, a Draft Report was 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 were developed after careful consideration of all submissions and other information provided to, or gathered by, the Commission on female genital mutilation.⁴

The Commission received over 30 submissions on the recommendations and other contents of the Draft Report primarily from organisations and individuals with a particular interest or expertise in the matter. The Commission also met with and received submissions from women and men from different African, Middle Eastern and Asian countries residing in Queensland and Victoria.

The Commission is most grateful to all those who have made submissions in response to the Research Paper and Draft Report, and for the information

³ *Female Genital Mutilation* Research Paper December 1993 at 28, 29.

⁴ *Female Genital Mutilation*, Draft Report No 42, July 1994.

and opinions provided. Those submissions greatly assisted the Commission during its deliberations for this Report. A list of all respondents to the Research Paper and Draft Report is found in Appendix 1.

(d) Summary of Recommendations⁵

In this Paper, the Commission recommends -

- (i) appropriate education programs be introduced and adequate support facilities be made available to people in Queensland from countries in which female genital mutilation is practised. The education programs should have the following aspects:
 - A education of a particular group as a whole in one or more of the following ways:
 - * education through a series of sessions
 - * education through teaching at religious organisations as part of standard religious education
 - * education through the distribution of a newsletter to the group
 - * education through distribution of a videotape to the group
 - B education of girls
 - C education of new immigrants
- (ii) appropriate education programs 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 referral service be set up through which a team of professionals may provide counselling, education and advice on female genital mutilation to those in special need.

⁵ See p.64 for the detailed recommendations.

- (v) a prohibition of female genital mutilation, except for certain medical reasons, be included in a separate division of the Queensland *Criminal Code*, the commencement of which should be deferred until after the satisfactory implementation of the education programs.
- (vi) penalty for breach of the prohibition should be by way of fine and/or imprisonment. A maximum penalty of five years imprisonment should be imposed. Such matters as the type of mutilation in question, the cultural beliefs of the individual concerned and his or her knowledge of Australian law should be taken into account in determining the appropriate penalty.
- (vii) 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.
- (viii) a prohibition against denying a person medical care or services, without reasonable excuse, on the basis that the person has been the subject of female genital mutilation.
- (ix) any revised definition of children "in need of care and protection" in the *Children's Services Act 1965* be broad enough to clearly include the threat or fear of female genital mutilation, in whatever form, being performed upon a young person under the age of 17.
- (x) child protection guidelines be developed by the Department of Family Services and Aboriginal and Islander Affairs and the Queensland Police Service for use by SCAN teams in the investigation and handling of families "at risk" and families suspected of having had their daughters mutilated in Queensland.
- (xi) health or social workers who reasonably believe a child is at risk of undergoing female genital mutilation or has actually undergone 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 or other children.
- (xii) 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.

- (xiii) appropriate research into the practice of female genital mutilation and its significance in Queensland, and Australia, be commenced.
- (xiv) the Commonwealth Government be urged to co-ordinate, or be actively involved in, international educative efforts against female genital mutilation, and to provide all possible financial backing and assistance to those efforts.
- (xv) Australian embassies in countries in which female genital mutilation is practised should actively promote Australia's position in relation to female genital mutilation and should provide information regarding Australia's laws and attitude towards the practice to any person considering emigrating to Australia.

(e) Draft Legislation

The Commission's principal recommendations have been incorporated into a Bill drafted by the Office of Parliamentary Counsel. That Bill is found in Appendix 8. The Commission is most grateful for the assistance of the Office of Parliamentary Counsel.

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.⁶ 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:⁷

- * **Circumcision**⁸ involves either the scraping or simple nicking of the clitoris⁹ (which is the least intrusive form of mutilation), or the excision of the prepuce or hood of the clitoris.¹⁰
- * **Excision** includes:
 - * the excision of the clitoral prepuce; and
 - * the removal of the glans of the clitoris or removal of the whole of the clitoris itself; and
 - * the removal of all or part of the labia minora.¹¹
- * **Infibulation or pharaonic circumcision** consists of the excision of the clitoris, labia minora and parts of the labia majora.¹² 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 girl¹³

⁶ See p.17 of this Report for a list of countries where at least one form of female genital mutilation is practised.

⁷ Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation* Forward 1992 at 5 and 20.

⁸ This may also include the removal of the tip of the clitoris.

⁹ The small erectile organ of the female genitals, partially hidden by the ends of the labia minora (as defined in footnote 11 below).

¹⁰ This latter procedure is known as "sunna" in some Muslim countries.

¹¹ The inner lips bounding the vagina in the female genitals.

¹² The outer lips of the female genitals.

¹³ Female genital mutilation is usually performed on young women. See p.9 of this Report.

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

As noted at the outset of this Report, the Commission uses the term "female genital mutilation" rather than "female circumcision", notwithstanding that the Commission believes the term "female circumcision" is a more appropriate term.

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, and is of the view that the term inhibits recognition of the cultural basis for the practice. However, on balance, the Commission feels that the term "female genital mutilation" is now such a widely used term covering a range of procedures that it could be misleading to use any other term in this Report. In particular, factors which influenced the Commission to use this term included:

- * 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.
- * the term "female genital mutilation" is used by the Family Law Council in its recent Report on the matter, and has gained acceptance in national and state governments and the wider Australian press.
- * "female genital mutilation" describes all forms of mutilation; "female circumcision" is often used to describe only the first type of mutilation outlined above;

The Commission recognises that it may nevertheless still be appropriate to refer to the practice as female "circumcision" in the press and in dealing directly with the communities concerned, (as often members of those communities refer to all types of female genital mutilation as "circumcision").

The practice of female genital mutilation is almost always performed by an older woman or a traditional birth attendant in certain communities,¹⁴ although the Commission has been advised that in certain communities men

¹⁴ 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.

traditionally perform the procedure.¹⁵ Anaesthetics are rarely used.¹⁶ 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.¹⁷

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".¹⁸ 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.¹⁹

¹⁵ Submission 51.

¹⁶ 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.

¹⁷ Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 28.

¹⁸ Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 7.

¹⁹ 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 of 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.²⁰ In January 1994, the Family Law Council publicly released its Discussion Paper on female genital mutilation. A media blitz on female genital mutilation ensued.²¹ Female genital mutilation became a topic widely discussed in public as well as in State and Commonwealth Parliaments.

Fortunately, the Commission has been able to meet 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

²⁰ 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.

²¹ 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.²² The Commission has also met with and received submissions from women living in Victoria from countries in which the practice is continued and has held discussions with organisations in Victoria who work closely with those women. It is worthwhile referring in detail to the submissions of the groups with whom we have met, to gain some insight into the significance of female genital mutilation and the female genital mutilation debate for these Australian women.²³

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 women from Kenya, Egypt, Malaysia and Indonesia.

Most women from the Horn of Africa countries 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:²⁴

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

²² 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.

²³ Submission 51 and submissions DR 15, 17, 18, and 19.

²⁴ Submission 47.

Australia has been associated with the 'debate' on female circumcision.

In many 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:²⁵

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:²⁶

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:²⁷

- * 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.

²⁵ Submissions 47 and 51. This was also the reaction of some of the women with whom the Commission spoke.

²⁶ Submission 47.

²⁷ 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.²⁸

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. In the case of some women (particularly from Middle Eastern and Asian countries), this is also because the procedure carried out traditionally in their countries of origin is ritual nicking, which is the least intrusive procedure. Nicking has not been the focus of the wider debate. Some of the Queensland women are also more westernised (and thus, for example, no longer wear traditional dress.) Also, there are fewer families in Queensland who have had any experience with female genital

²⁸ Submission 47.

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 had victimised them, particularly in light of the fact that by having been mutilated they were already victims.

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

Notably, nearly all of the women and men spoken to (in Queensland and Victoria) stated that they no longer wish to have their daughters "circumcised", although some expressed a concern that some communities may still consider "sunna" acceptable.²⁹

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 immigrants. 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.

²⁹ Submissions DR 17, 18 and 19.

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.³⁰

Mummies of Egyptian females dating back to the 16th Century BC show evidence of excision.³¹ Evidence of this practice pre-dates the Islamic religion in different African regions. Hosken³² 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.³³

The practice of female genital mutilation does not stem from any religious rite. As Hosken³⁴ 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

³⁰ Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed.) at 51.

³¹ 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.

³² Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 55.

³³ *Id* at 54 and 55.

³⁴ *Id* 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."³⁵

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.³⁶

In England during the 19th Century the performance of female genital mutilation³⁷ on women, particularly from the upper class, gained medical acceptance mainly as a cure for masturbation.³⁸ 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 ..."³⁹ Female genital mutilation was also practised in Europe.⁴⁰ 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.⁴¹

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

36 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.

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

38 infibulation never gained acceptance and was discarded as a remedy in England.

39 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.

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

41 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.⁴² 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.⁴³ There are also reports that female genital mutilation is performed in Oman, South Yemen, the United Arab Emirates, Indonesia and Malaysia.⁴⁴ 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.⁴⁵

The extent to which any form of female genital mutilation is practised in Australia, if at all, is not known.⁴⁶

⁴² 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 Report.

⁴³ 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 Report.

⁴⁴ 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. See also Submission DR 19.

⁴⁵ 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.

⁴⁶ 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."⁴⁷ This protection is believed to be achieved by excising the clitoris. Others believe that men prefer their sexual partners to have undergone the procedure.⁴⁸

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

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. Whilst it has been suggested that Australian aboriginal tribes practise female genital mutilation in some regions, (Submission DR 6), the Department of Family Services and Aboriginal and Islander Affairs has advised us that this practice has never been part of Queensland aboriginal tradition or islander custom.

⁴⁷ Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 13. Note, however, that some women believe that in reducing their passion through having the procedure performed, they gain control over their husbands by remaining cool and even arrogant. See Christopher Dickey "Bride, Slave or Warrior", *The Bulletin*, 13 September 1994, 61 at 64.

⁴⁸ 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 7.

masculine element in the child.⁴⁹ Underpinning this mythology is the belief 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.⁵⁰ 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.⁵¹ 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.⁵²

(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.⁵³ These practices have been traditionally linked with the Islamic religion, even though they pre-

⁴⁹ Likewise, it is believed that the foreskin on the penis which is regarded as the female element in the male should be removed. Hosken F *The Hosken Report: Genital and Sexual Mutilation of Females* (1982 3rd ed) at 31.

⁵⁰ 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.

⁵¹ 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.

⁵² Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 13.

⁵³ See p.15 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.

date it.⁵⁴ There is no clear reference to female genital mutilation in the Koran, although some Muslims may practise this type of mutilation in the 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.⁵⁵ An oral submission to the Commission confirmed that this is also the case for some recent Australian immigrants.⁵⁶ 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.⁵⁷

(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",⁵⁸ 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.⁵⁹ 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.⁶⁰ Other groups rely on a

⁵⁴ See p.15 above.

⁵⁵ 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.

⁵⁶ Submission 51.

⁵⁷ Written submission to the Queensland Law Reform Commission by the Islamic Council of Queensland.

⁵⁸ Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 14.

⁵⁹ Submission 51.

⁶⁰ Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 14.

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 arranged by the girl's mother or other members of the girl's family as an act of love, care and protection.⁶¹

(d) Hygiene and aesthetics

Some groups consider a woman to be dirty unless her external genitals are removed.⁶² 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.⁶³

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.⁶⁴ Further assistance from the operators may be needed to permit a woman to have sexual intercourse⁶⁵ and to assist her in childbirth. Also, some women are reinfibulated after childbirth or divorce 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.⁶⁶ Naturally, many exercise their influence to maintain the ritual.

⁶¹ Submission 47, an organisation working with African women in Australia.

⁶² Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation* 1992 at 6.

⁶³ Submission 47, an organisation working with African women in Australia.

⁶⁴ 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.

⁶⁵ This assistance is in the form of cutting the infibulated opening wider so as to allow penetration.

⁶⁶ 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".⁶⁷

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 include⁶⁸ -

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

⁶⁷ Assaad MB *Female Circumcision in Egypt: Social Implications, Current Research, and Prospects for Change* (1980) *Studies in Family Planning* 3 at 11.

⁶⁸ 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, incontinence and bladder infections), anal sphincter, vaginal walls or the Bartholin glands;⁶⁹
- * a more severe form of mutilation being performed than was intended;⁷⁰
- * 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;⁷¹
- * death.⁷² 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".⁷³

(ii) Long-term complications

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

⁶⁹ This may be due to the lack of skill of the operator or the degree of resistance exerted by the child.

⁷⁰ See footnote 69.

⁷¹ Submission 51.

⁷² Submission 51 described how the respondent's cousin had died as a result of the procedure.

⁷³ 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:⁷⁴

- * chronic recurrent infections including infections of the vagina, uterus and urinary tract;
- * time taken and pain associated with urination;⁷⁵
- * keloid and severe scar formation⁷⁶ which may make walking difficult;⁷⁷
- * 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;⁷⁸
- * very painful periods;⁷⁹
- * painful sexual intercourse;

⁷⁴ 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.

⁷⁵ 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.

⁷⁶ "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."

⁷⁷ 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.

⁷⁸ 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.

⁷⁹ 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, extensive 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.⁸⁰

Besides the risks of infection and haemorrhaging, excision may result in the development of neuroma⁸¹ at the point of section of the dorsal nerve of the clitoris which makes the area permanently and unbearably sensitive to touch.⁸² Vulval abscesses may also develop. After "sunna"⁸³ circumcision, the exposed clitoris may become hypersensitive and painful to touch.⁸⁴

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.⁸⁵

⁸⁰ World Health Organisation *Maternal and Child Health and Family Planning : Current Needs and Future Orientation* Report by the Director-General January 1994 at 8.

⁸¹ "Neuroma" is defined in Butterworth's Medical Dictionary (2nd ed) as "a tumour composed of nerve cells and nerve fibres".

⁸² Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 8.

⁸³ See footnote 10 above.

⁸⁴ Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation* Forward 1992 at 6.

⁸⁵ 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), Odera 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 P6 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.⁸⁶

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.⁸⁷

⁸⁶ 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.

⁸⁷ 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.⁸⁸

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.⁸⁹

The Australian Law Reform Commission believes that there is little doubt that it would be regarded as an assault.⁹⁰ 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:⁹¹

For instance, cosmetic surgery⁹² 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

⁸⁸ See footnote 46 above.

⁸⁹ *Crimes (Female Genital Mutilation) Amendment Bill 1994* was read a second time in the New South Wales Lower House on 12 May 1994, but is yet to be passed. The Bill is set out in Appendix 2.

⁹⁰ Australian Law Reform Commission *Multiculturalism: Criminal Law* (Discussion Paper 48) 1991 at paragraph 2.35.

⁹¹ Bibbings L and Alldridge P *Sexual Expression, Body Alteration and the Defence of Consent* (1993) 20 *Journal of Law and Society* 356 at 361.

⁹² 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.⁹³ Male circumcision is considered to be lawful when performed by a medical practitioner or a religious actor as part of a ritual.⁹⁴ 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*⁹⁵ 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.⁹⁶ 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.⁹⁷

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

⁹³ 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.

⁹⁴ See Queensland Law Reform Commission, Research Paper on *Circumcision of Male Infants*, December 1993.

⁹⁵ *Adesanya* Times 16, 17 July 1974.

⁹⁶ *Children's Services Act 1965 (Qld)* s.69A prohibits tattooing of children. See also Regulations made pursuant to s.100A *Health Act 1937*.

⁹⁷ See Bibbings L and Alldridge P *Sexual Expression, Body Alteration, and the Defence of Consent* (1993) 20 *Journal of Law and Society* 356 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,⁹⁸ 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.⁹⁹ But, as Bibbings and Alldridge note:¹⁰⁰

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.¹⁰¹

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.¹⁰²

(b) Offences under the *Criminal Code*

It is considered by the Commission that, under the Queensland *Criminal*

⁹⁸ Although see pp 18 to 21 above where other origins of the practice are discussed, in particular, an attempt to ensure virginity and marriageability.

⁹⁹ 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.

¹⁰⁰ 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.

¹⁰¹ 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 Alison Boulton *Observer* 14 February 1992.

¹⁰² See also the adverse health effects of the procedure described at p.22.

Code, female genital mutilation would fall within the offences of unlawful wounding¹⁰³ and grievous bodily harm.¹⁰⁴

Although a person may consent to such a procedure, arguably consent provides no defence to these criminal offences.¹⁰⁵ 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.¹⁰⁶ To constitute a wounding the true skin of the victim must be broken.¹⁰⁷ This would be an obvious result to the child in all three forms of female genital mutilation outlined at page 7, above.

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),¹⁰⁸ disfigurement (detracting from personal appearance),¹⁰⁹ and disablement (creating a permanent disability).¹¹⁰

¹⁰³ Section 323 of the Queensland *Criminal Code*.

¹⁰⁴ Sections 317 and 320 of the Queensland *Criminal Code*.

¹⁰⁵ 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 1992* (Qld) at 199 and 200.

¹⁰⁶ Section 323 of the Queensland *Criminal Code*.

¹⁰⁷ 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.

¹⁰⁸ See *R v Woodward* [1970] QWN 30 at 76 per Douglas J: "When you do maim you ... mutilate or cripple".

¹⁰⁹ Strouds *Judicial Dictionary* (1974 4th ed).

¹¹⁰ *R v Boyce* [1824] 1 Mood 29, 168 ER 1172.

"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.¹¹¹

Grievous bodily harm without intent is also an offence which may be punishable by imprisonment for 14 years.¹¹²

(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.

(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

¹¹¹ See p.22 above. Note the Attorney-General's announcement on 21 August 1994 that female genital mutilation will be specifically included in the definition of "grievous bodily harm" in the proposed revised *Criminal Code*. See footnote 152 below.

¹¹² Section 320 of the Queensland *Criminal Code*. The Attorney-General has announced that the proposed revised *Criminal Code* will impose a maximum penalty of life imprisonment for grievous bodily harm whether or not there was intent to cause grievous bodily harm. See footnote 152 below.

and Gynaecologists regards female genital mutilation as "unethical if performed for other than genuine medical reasons".¹¹³ The College supports sympathetic measures to discourage the practice of female genital mutilation and related procedures.¹¹⁴ 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.¹¹⁵ It would also include surgery on an infibulated woman at her request to correct gynaecological problems. A gynaecologist has written:¹¹⁶

[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.¹¹⁷ 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:¹¹⁸

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

¹¹³ Letter from the College dated 12 October 1993.

¹¹⁴ Submission 40. The Australian Medical Association was of a similar view. (Submission 6A)

¹¹⁵ 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.

¹¹⁶ Bayly C *Female Circumcision and Related Practices* Royal Australian College of Obstetricians and Gynaecologists, Continuing Education Resource Unit 108 December 1993.

¹¹⁷ Fenton's procedure is "a plastic operation for enlarging the vaginal introitus [entrance]". A McIndoe procedure is for reconstruction of the urethra (Butterworth's Medical Dictionary, 2nd ed.).

¹¹⁸ Bayly C *Female Circumcision and Related Practices* Royal Australian College of Obstetricians and Gynaecologists, Continuing Education Resource Unit 108 December 1993.

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.¹¹⁹

All Queensland Regional Health Authorities responding to the Commission's Research Paper and/or Draft Report condemned the practice of female genital mutilation.¹²⁰

A gynaecologist wrote:¹²¹

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 agreed¹²² as did the Royal College of Nursing.¹²³

The Commonwealth Department of Human Services and Health also supported the prohibition of female genital mutilation.¹²⁴

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.

(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

¹¹⁹ 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.

¹²⁰ Submissions 13, 21, 23, 29 and Submissions DR 3, 4, 8 and 26.

¹²¹ Submission 1.

¹²² Submission 32.

¹²³ Submission 52.

¹²⁴ Submission 52.

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.¹²⁵

'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.

(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:¹²⁶

¹²⁵ Submission 51.

¹²⁶ *Final Report of the Criminal Code Review Committee to the Attorney-General* June 1992 at 53.

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*¹²⁷ unless "benefit" within the meaning of section 282 can be shown.

The recommendations of the Criminal Code Review Committee were considered, and endorsed at the meeting of Cabinet on 22 August 1994. Despite no reference being made to female genital mutilation in the Criminal Code Review Committee's Final Report, Cabinet announced that as part of the revised *Code*, female genital mutilation will be specifically included in the definition of grievous bodily harm and will be subject to a maximum penalty of life imprisonment. Obviously, the illegality of the procedure would not be in question if such legislation were passed.

¹²⁷

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* (Qld) 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 561 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.¹²⁸ 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 and as such, may be subject to mandatory reporting requirements, or may be the subject of an application under the *Children's Services Act 1965* (Qld).

(i) Mandatory Reporting

Sub-section 76K (1) of the *Health Act 1937* (Qld) provides that:-

"A medical practitioner who suspects on reasonable grounds the maltreatment or neglect of a child in such a manner as to subject or be likely to subject a child to unnecessary injury, suffering or danger shall, within 24 hours after first suspecting, notify by the most expeditious means available to him a person authorised by the Director-General by regulation to be so notified."

Pursuant to this section, a doctor presented with a child who the doctor suspects has recently undergone female genital mutilation, would be required to notify one of the Director-General's designated officers (who include representatives from the Department of Health, Family Services and the Queensland Police), just as for any other form of child abuse.

However, the obligation to report only relates to suspected cases of **actual** maltreatment or neglect. A doctor would therefore not be required to report a mere suspicion that children are at risk of having the procedure performed on them, on the basis of the beliefs or stated intentions of the parents or family members, at least not in the absence of

¹²⁸ Section 7 of the Queensland *Criminal Code*.

actual maltreatment or neglect. Furthermore, a doctor would not likely be required to report incidences of the least intrusive form of female genital mutilation, unless the doctor is of the view that the child has been subjected to unnecessary injury or suffering (which may not be the case in relation to a ritual "nicking" of the clitoris).

(ii) Children's Services Act 1965 (Qld)

Section 46 of the *Children's Services Act 1965* (Qld) provides, among other things, that a child¹²⁹ 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 or 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.¹³⁰

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.¹³¹ 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, and that such care and protection cannot be secured by any other order.¹³²

¹²⁹ 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.

¹³⁰ S.49 *Children's Services Act 1965*.

¹³¹ S.49(4) *Children's Services Act 1965*.

¹³² S.52(1) *Children's Services Act 1965*. (Note also s.52A which provides an appeal against such orders to the Court of Appeal).

The Court must determine such matters in the best interests of the child.¹³³

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:¹³⁴

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.

The *Children's Services Act 1965* is currently being reviewed and the Commission has been advised that any new legislation resulting from that review will be worded in such a way as to cover the threat of female genital mutilation being performed on a child. The Department of Family Services and Aboriginal and Islander Affairs has stated:

The *Children's Services Act 1965* is currently under review. One of the issues being considered in the current review is the outdated nature of the legislation. The definition of a child in need of care and protection is one area of consideration. It is likely that the definition of a child in need of protection in the child protection legislation will be broad with a view to an inclusive definition. Circumstances of female genital mutilation of a child would be appropriately considered under the legislation. It would not be appropriate for the term female genital mutilation to be specifically incorporated in the legislation. This would be likely to lead to incorporation of a range of specifically harmful behaviours to children resulting in proscriptive definition.¹³⁵

The Commission is satisfied that female genital mutilation, or the threat thereof, is a matter which would place a child in the category of "in need of care and protection" and that the Department responsible for reviewing the *Children's Services Act 1965* supports the continuation of that coverage.

¹³³ S.52(2) *Children's Services Act 1965*.

¹³⁴ Submission 18.

¹³⁵ Submission DR 28.

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.¹³⁶ 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,¹³⁷ 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.

¹³⁶ 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 (in s.64(1) *Family Law Act 1975*) the Family Court can override a decision by a *Gillick*-competent child.

¹³⁷ See pp 29 to 31.

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

*invasive, irreversible and major surgery¹³⁸

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 grave¹³⁹.

In these instances the approval of the Family Court would most likely be required.¹⁴⁰ 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).¹⁴¹ 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.¹⁴²

Parents are also prohibited from consenting to the treatment of a child which is not in the best interests of the child.¹⁴³ 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

¹³⁸ *Re Marion* (1992) 175 CLR 218 at 250.

¹³⁹ *Ibid.*

¹⁴⁰ *Re Marion* (1992) 175 CLR 218. However, the Family Court cannot consent if a procedure is made illegal, for example, under the *Criminal Code*.

¹⁴¹ *Re Jane* (1988) 85 ALR 409 at 435.

¹⁴² 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.

¹⁴³ *Re Marion* (1992) 175 CLR 218.

approval as the operation would not be regarded as being for the benefit of the child.¹⁴⁴

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 17 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.¹⁴⁵

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*¹⁴⁶ which is outside the scope of the Commission's reference.

(b) Civil liability

The principal civil actions 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.

¹⁴⁴ *Re Marion* (1992) 175 CLR 218 at 239-240.

¹⁴⁵ Submission 51.

¹⁴⁶ See pp 27 to 35 above.

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 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.¹⁴⁷ 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.¹⁴⁸

The High Court in *Rogers v Whitaker*¹⁴⁹ 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.¹⁵⁰ Registered medical practitioners are subject to the

¹⁴⁷ *Re Marion* (1992) 175 CLR 218.

¹⁴⁸ *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.

¹⁴⁹ (1992) 175 CLR 479.

¹⁵⁰ 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.

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 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. AUSTRALIAN LEGISLATION AND INITIATIVES

Female genital mutilation has received wide-spread media coverage throughout Australia over the past year and there has been a general push for the introduction of legislation specifically prohibiting the practice in Australia.

In June, the Family Law Council delivered a report on female genital mutilation to the Federal Attorney-General, making various recommendations concerning how the practice should be dealt with in Australia.¹⁵¹ The Council's primary recommendations were that immediate steps be taken to implement a national communication and education program, and that once the education program is satisfactorily established and operating, Commonwealth legislation criminalising the practice be passed.

Following the delivery of the Family Law Council's report, the Commonwealth Attorney-General announced his intention to pass Commonwealth legislation outlawing the practice, if the individual States of Australia did not do so on their own volition. However, at the meeting of the Standing Committee of Attorneys-General (SCAG) on 21 July 1994, the Attorneys-General of each State and Territory agreed to take action on a State-by-State basis.

Despite the SCAG resolution, no Australian jurisdiction has enacted legislation specifically prohibiting the practice. New South Wales and Queensland are the only States which have made proposals in this regard.

As previously noted, New South Wales has introduced legislation making it an offence under the *Crimes Act 1900* (NSW) to perform female genital mutilation and imposing a maximum penalty of 7 years imprisonment. The relevant Bill has been read a second time in the Lower House but has not been passed.

The Queensland Attorney-General has recently announced¹⁵² that the practice is to be specifically included in the definition of grievous bodily harm under a proposed revised *Criminal Code*, with a maximum penalty of life imprisonment. The Bill incorporating the revised *Criminal Code* is yet to be presented to Parliament.

Although legislation is not currently proposed in Victoria (where the number of immigrants from countries where female genital mutilation is widely practised is the highest in Australia), an education program against female

¹⁵¹ *Female Genital Mutilation - A Report to the Attorney-General prepared by the Family Law Council*, June 1994. See Appendix 7 which lists the Council's Recommendations.

¹⁵² See the Media Release of the Attorney-General *New Offences and Tougher Penalties in New Criminal Code*, dated 22 August 1994. See also *Tough stand: life in jail for rapists* Courier-Mail 22 August 1994 1.

genital mutilation has been conducted over the past year in that State by the Ecumenical Migration Centre.¹⁵³ To the Commission's knowledge, this is the only structured education program which has been implemented in Australia to date.

Over 100 women from Eritrea, Somalia and Sudan participated in the Victorian program, which was most successful in altering the women's attitudes towards the practice. The program consisted of ten sessions held over a nine month period. Approximately 40 women attended each session which were held at two different locations convenient to the women. The sessions, each of three to four hours' duration, were held on Saturday afternoons. Childcare facilities were made available. The women were provided with transport to the sessions or were reimbursed for their transport costs. The program concluded with a camp for the women and their children, held over a weekend.

The following topics were discussed at the sessions, and were either introduced by guest speakers or by way of discussion group:

- (i) The background to "female circumcision"¹⁵⁴ and details of where, when and how it is practised;
- (ii) The adverse health effects of "female circumcision";
- (iii) The psychological, social and sexual effects of "female circumcision";
- (iv) Childbirthing and associated problems;
- (v) The reasons for the practice;
- (vi) The roles of men and women in affected communities and women's morality;
- (vii) The significance of "female circumcision" in religion;

¹⁵³ The Commission is grateful to Nicki Marshall of the Ecumenical Migration Centre and the project workers, Meriem and Munira, for meeting with the Commission to discuss the program with us.

¹⁵⁴ The term "female circumcision" is used in the education sessions rather than the term "female genital mutilation". The former term is the more commonly used term in the communities involved.

- (viii) Australian and overseas legislative initiatives;
- (ix) Child protection and mandatory reporting; and
- (x) Education of the wider community.

It is proposed to hold further sessions with the women, extending the topics from the original sessions. It is also proposed to hold a series of sessions with the men from the communities attending.

The Centre is currently preparing a report on the program, which is expected to be finalised by mid-October 1994.

In Victoria, guidelines for protective workers have also been developed by Protective Services Victoria, to assist those workers in the effective and sensitive management of situations involving female genital mutilation. The guidelines, known as the Child Protection Policy,¹⁵⁵ have been carefully developed after consultation with professionals and women from the affected communities, to ensure that any intervention is no more than necessary to protect the child in question, and to avoid reporting of incidences of female genital mutilation which occurred some time ago or in the country of origin.

¹⁵⁵ Submission DR 23. The Child Protection Policy is currently awaiting the approval of the relevant Minister.

11. 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.¹⁵⁶ 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.¹⁵⁷

Many African countries¹⁵⁸ are participating in educational projects and programs aimed at eliminating the practice of female genital mutilation.

¹⁵⁶ The United Kingdom, Sweden and the United States of America (refer to footnotes 160, 169 and 176 below) have specifically prohibited or are in the process of legislating to prohibit female genital mutilation. See Appendices 3, 4 and 5.

¹⁵⁷ *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.

¹⁵⁸ These countries include Egypt, Sudan, Somalia, Kenya, Nigeria, Kenya and Burkina Faso.

Some of the programs include:¹⁵⁹

- * 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 legislation¹⁶⁰ 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

¹⁵⁹ 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 26 African countries and is currently assisting the Tanzanian Committee with its program.

¹⁶⁰ 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.¹⁶¹

The debates also highlighted the importance of education and counselling¹⁶² being made available within communities in which female genital mutilation is traditional.¹⁶³

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.¹⁶⁴

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:¹⁶⁵

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

¹⁶¹ House of Commons *Parliamentary Debates* 19 April 1985 at 586.

¹⁶² 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 pp 50 to 51.

¹⁶³ 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.

¹⁶⁴ Hedley R and Dorkenoo E *Child Protection and Female Genital Mutilation* 1992 at 8.

¹⁶⁵ 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.¹⁶⁶
- 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.¹⁶⁷

- 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.

¹⁶⁶ 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 to 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.

¹⁶⁷ Report on the *First National Conference on Female Genital Mutilation* 1989 at 3 and 4.

- v. that the wardship jurisdiction¹⁶⁸ 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.¹⁶⁹ Belgium has banned the practice.¹⁷⁰ In 1985

¹⁶⁸ A "prohibited steps order" contained in section 8 of the *Children Act 1989* now replaces 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.

¹⁶⁹ 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.¹⁷¹ Under Article 312-3 of the French *Penal Code* female genital mutilation may be prosecuted as a criminal offence.¹⁷² Prosecutions have been successful.¹⁷³

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.¹⁷⁴ 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:¹⁷⁵

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.

¹⁷⁰ Minority Rights Group International Report by Dorkenoo E and Elworthy S *Female Genital Mutilation: Proposals for Change* 1992 at 11.

¹⁷¹ *Ibid.*

¹⁷² *Ibid.* By contrast, no specific law against female genital mutilation exists in Germany despite a large African immigrant population and the belief that female genital mutilation is practised in Germany. (submission 50 from a doctor working in Hamburg).

¹⁷³ 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.

¹⁷⁴ By letter dated 31 January 1994.

¹⁷⁵ 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.¹⁷⁶ 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 Organisations

(i) World Health Organisation

In 1984 the World Health Organisation released a position statement on female genital mutilation.¹⁷⁷

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

¹⁷⁶ *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 section 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". Section 603 is set out in Appendix 4.

¹⁷⁷ 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.¹⁷⁸

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.

¹⁷⁸ *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 grassroot 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,¹⁷⁹ 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.¹⁸⁰

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*¹⁸¹ specifically refers to female genital mutilation as a form of violence against women.

Note that at the recent Cairo International Conference on Population and Development, a Program of Action was adopted which urges the prohibition of female genital mutilation.¹⁸²

¹⁷⁹ Australia ratified this Convention on 17 December 1990.

¹⁸⁰ *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 Macphee* (1982) 148 CLR 636 at 641-4; *Kioa v West* (1985) 159 CLR 550 at 570-1.

¹⁸¹ 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.

¹⁸² See "Population plan adopted with reservations", *The Australian*, 14 September 1994, 10.

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.¹⁸³ 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* as currently in force. However, the relevant existing Queensland *Criminal Code* provisions have never been tested by any Queensland court in these circumstances.¹⁸⁴

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 some form in the foreseeable future.¹⁸⁵

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

¹⁸³ See p.17 above for a list of countries where at least one form of female genital mutilation is practised.

¹⁸⁴ See p.27 above.

¹⁸⁵ 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.

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 by making every effort to prevent or eliminate the practice in Australia.

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.

Education and Research

Experience elsewhere¹⁸⁶ 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.

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 postponed until education of the relevant communities has commenced, and once introduced, should be supportive of education, understanding of the strength of cultural beliefs and traditions, clear in its intent and not sensational.

For education to be effective in completely eliminating the practice in Australia, it should be matched by educative efforts overseas in those countries in which the practice continues. The Commission therefore

¹⁸⁶ See discussion commencing at p.47 above on overseas legislation and initiatives.

believes that it is imperative that the Commonwealth Government assist in co-ordinating international efforts against the practice and give all possible financial backing and assistance to those efforts.

Several submissions were made that if on-going education is to be effective in Australia, research into the practice of female genital mutilation and its significance in Australia must be undertaken. The Commission agrees that such research is necessary, particularly due to the diversity of attitudes and experiences concerning the practice amongst immigrants in Australia, in order to provide a source of information from which effective education may be planned.

Legislative Prohibition

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 parents, 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. In its Draft Report on Female Genital Mutilation, the Commission, after appropriate consultations, considered that such would be the case if the prohibition were to be found in separate provisions of high profile legislation such as the Queensland *Criminal Code*, or in separate legislation prohibiting female genital mutilation (as exists in the United Kingdom). Other legislation, such as the *Medical Act 1939* (Qld) or the *Children's Services Act 1965* (Qld) was considered to be more appropriate.¹⁸⁷

Whilst a number of the submissions to the Draft Report supported the Commission's preliminary proposal to include a prohibition on female genital mutilation in the *Medical Act 1939* (Qld), the Department of Health, which is currently reviewing that Act, has recently advised the Commission that it would be inappropriate for provisions relating to female genital mutilation to be included in the Act. The Department is now of the view that the regulation of the medical profession under the *Medical Act 1939* (Qld), and the enforcement of the criminal law should remain separate. It has stated that:

*inclusion of the relevant provision in the Criminal Code would effectively clarify the law on this issue, whilst also maintaining the appropriate

¹⁸⁷ 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.

separation of laws regulating the medical profession and laws enforcing criminal law".¹⁸⁸

The Commission agrees that, in the light of this, the most appropriate course would be for the prohibition on female genital mutilation to be included in the *Criminal Code*. There is no other statute which appears appropriate to include such a prohibition.

A prohibition on female genital mutilation could be incorporated in the *Criminal Code*, by either specifying that it falls within the ambit of a current criminal offence, or by introducing a separate provision specifically relating to female genital mutilation.

The first option was the basis of the announcement by the Attorney-General of Queensland on 21 August 1994 that as part of the Government's proposed revision of the *Criminal Code*, female genital mutilation would be included in the definition of grievous bodily harm and would be subject to a maximum penalty of life imprisonment.

There are strong arguments against this current proposal of the Government - to include female genital mutilation in the definition of grievous bodily harm, and to impose a maximum penalty of life imprisonment.

Not all forms of female genital mutilation should be regarded as grievous bodily harm. There are varying degrees of mutilation, from a ritual nick to complete infibulation, and each type of mutilation has vastly different consequences which need to be taken into account on a case-by-case basis. Accordingly, a specific offence which takes into account all forms of mutilation and which includes a detailed definition of what is meant by the term "female genital mutilation" would be required.

Furthermore, it would be wholly inappropriate to subject persons performing female genital mutilation to life imprisonment, as is proposed. Such an approach completely disregards the variety of practices performed and ignores the reasons for the practice. Generally, the practices are not performed as acts of violence, but rather out of love and caring. The proposal also ignores the problems new immigrants will face in coming to terms with Australian attitudes and culture and stands in stark contrast to penalties imposed in overseas legislation, in which the maximum penalty is five years imprisonment.¹⁸⁹

The second option, that is, for a separate provision relating to female genital

¹⁸⁸ Submission DR 32.

¹⁸⁹ See Appendices 3, 4 and 5. The proposed New South Wales legislation imposes only seven years imprisonment as a maximum penalty.

mutilation to be included in the *Criminal Code*, would address each of the Commission's concerns with the Attorney-General's proposal. In addition, it would be less sensational than specific legislation and it would highlight the criminal nature of the proposed prohibition.

Penalties

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, the risk of unwarranted trauma being inflicted upon families is minimised by use of a penalty system which provides for the imposition of a fine as an alternative to imprisonment,¹⁹⁰ and a maximum period of imprisonment not exceeding five years.

Furthermore, 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 to, and become familiar with, the Australian approach to this issue prior to the risk of prosecution arising.

The criminal justice system could also be sympathetic to such situations by applying a penalty system 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.

Less intrusive rituals

Because female genital mutilation is considered by some communities to be a very important ritual with significant sociological, economic and self-esteem

¹⁹⁰ See *Penalties and Sentences Act 1992* (Qld), sections 44 to 46.

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:¹⁹¹

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:¹⁹²

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 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.

¹⁹¹ Liverani M *Painful Scars of Tradition* Australian 17 May 1994, 15.

¹⁹² Netherlands Government's Standpoint on Female Circumcision, undated.

Mandatory reports and referral

A suggestion has been made¹⁹³ 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. As outlined above, mandatory reporting requirements already require a doctor to report a suspicion that someone has recently undergone female genital mutilation.¹⁹⁴ However, the existing requirements arguably do not require the reporting of a suspicion that a child is "at risk" of having the procedure performed on her. In addition, they only apply to doctors.

The Commission is of the view that current mandatory reporting requirements are sufficient and should not be extended.

A mandatory reporting requirement, based on a mere suspicion that a child is at risk, could lead to unsubstantiated allegations and families could be exposed to unnecessary and intrusive investigations, simply due to their race or religion. A more effective approach where there is a suspicion that certain children may be at risk is to educate those families as to why they should not have the procedure performed on their daughters.

It has been suggested that a referral service be set up for this purpose, to which doctors and other persons (such as health workers and teachers) working with affected communities could refer families (with their consent) for education and counselling, if parents exhibit or state an intention to have their daughters "circumcised".¹⁹⁵

Advice concerning the practice could also be made available through the referral service to those persons working with the affected communities, such as health workers or teachers.

Through the use of such a service, families would receive immediate, but non-intrusive guidance concerning the procedure and its unacceptability in Australia.

Despite the existence of a referral service, in some circumstances, such as if the child is at imminent risk, a health or social worker may feel obliged to report their genuine and reasonable suspicions to child protection

¹⁹³ Submission 25.

¹⁹⁴ See p.36 above.

¹⁹⁵ Submission DR 16.

authorities. In those circumstances, the health or social worker should not be liable for breaching any duty of confidence owed to any person.

As it is the Commission's view that mandatory reporting should only relate to actual incidences of the procedure being performed, it would not appear necessary to require mandatory reporting by professionals other than doctors. Such a requirement could lead to unnecessary embarrassment of women and girls who have already suffered the rigours of genital mutilation. However, as in the case for reporting of children "at risk", if a recent mutilation was to come to the attention of a health worker, he or she should similarly receive protection for any breach of confidence resulting from the reporting of the incident.

12. RECOMMENDATIONS

(a) Education

The Commission strongly recommends that appropriate education programs be introduced and support facilities be made available on a voluntary and confidential basis to both women and men residing in Queensland from countries in which female genital mutilation is practised. The aim of such education should be to avoid or eliminate the practice of female genital mutilation in Queensland. The development and implementation of the programs should be mandated by legislation, in the terms of clause 6 of the draft Bill in Appendix 8, and the progress thereof should be the subject of an annual report to Parliament

As the educational needs of men and women may vary greatly from one community to another, any education program may need to be modified for maximum impact on each community. It may be appropriate to group several communities together for the purposes of education if they have the same educational needs.

Accordingly, communities with similar educational needs first must be identified to establish target groups for education.

The educational needs of any one community will be determined by such matters as the type of mutilation prevalent in the community, the reasons for continuation of the procedure, the religion practised by its members, the common family structure, the degree of education of its members and their attitude towards sex.¹⁹⁶

The Commission recommends that there be the following three tiers of education provided to members of any target group.

(i) Education of the group as a whole

Education of the entire group should occur in one or more of the following ways (depending upon the educational needs of the group):

¹⁹⁶ During the Commission's consultation with women from affected communities in Queensland, it was apparent that a clear distinction may be drawn between the educational needs of women from African, Asian and Middle-Eastern communities residing in Queensland. The different educational needs arose not from a difference in religion (as all the women were Muslim), but from differences in culture, education and the women's different experiences with female genital mutilation.

A. Education through a series of sessions

The format and content of these sessions, and practicalities, (such as their location and the support facilities required), should be determined in consultation with members of the relevant communities. Advice of welfare, health and other professionals with experience in dealing with such communities should also be sought. Where possible, community or religious leaders, or professionals of the same nationality should host the sessions.

The Commission recognises that it is equally important to educate men, as well as women, given the role men play in many of the affected communities. It may nevertheless be appropriate to hold separate sessions for women and men, depending upon the relationship between the sexes in the group in question. It may also be appropriate to hold separate sessions for women of different age groups, depending upon the diversity of attitudes amongst the women.

B. Education through teaching at religious organisations as part of standard religious education

Such education should focus on the apparent lack of any formal religious base for the practice and should be organised by the relevant organisation.

C. Education through the distribution of a newsletter to the group

The content of any such newsletter should be either drafted or determined with the assistance of the men and women of the target group. Existing networks for the distribution of information to new immigrants could be used for this purpose.

D. Education through distribution of a videotape to the group

The content of educative videotapes should be determined in the same way as the educative sessions, that is, in consultation with the communities and professionals.¹⁹⁷

¹⁹⁷ The use of videotapes has proven most successful in the United Kingdom. The training video 'Another Form of Abuse' produced by FORWARD outlines the necessary steps to be taken by social workers and the social service department to ensure that full protection of a child deemed to be at risk is implemented.

(ii) Education of girls

Education specifically targeting the young girls of the group, whether or not they have had the procedure performed on them, would address the special needs of those young girls and is seen as fundamental to eliminating the practice in future generations. It is the young girls who are most likely to be exposed to taunting and feelings of not belonging, by being different to those girls around them when attending school. Such young girls need to be given a sense of pride regarding their ancestry and need to understand not only the attitude in Australia concerning the practice, but the reasons for continuance of the practice in their own community.

Specific education of young girls also recognises the vital link children form in migrant families between their families and the wider Australian community upon their arrival in Australia. Children are often the first to be exposed to the Australian way of life and are first to learn our language, culture and ideas. Education of those children is therefore likely to be the most effective means of educating the wider group.

Such education could be provided either with the assistance of the community groups in question, or through schools. If education is to take place at school (which may be preferred to ensure that education is provided independently of the communities concerned, and given that a more consistent and structured education could thereby be provided than could be provided through a diverse range of community groups), educative sessions for young girls from the relevant group should be convened. Other school children should not partake in those sessions. Those sessions should be held by competent professionals trained for the purpose. It may also be appropriate, depending upon the group in question, to have a pamphlet concerning the practice available to school counsellors or school nurses for discrete distribution to young girls from the group.

(iii) Education of new immigrants

The Commission strongly recommends that new immigrants from countries in which female genital mutilation is practised, be provided with information upon their arrival in Australia concerning the Australian position regarding female genital mutilation. That information should be provided either by use of a booklet, or through educative sessions. However, the information, whether provided by way of booklet or sessions, should be provided in conjunction with information regarding other relevant laws, services and practices in Australia, with which new immigrants should become familiar. In this way, other equally important information can be provided and the practice of female genital mutilation will not be over-emphasised, which

might have the effect of alarming new immigrants.

The Commission also recommends that Australian embassies in relevant countries should actively promote Australia's position in relation to female genital mutilation and should provide information regarding Australia's laws and attitude towards the practice to anyone considering emigrating to Australia.

The Commission also strongly recommends that the Commonwealth Government be urged to co-ordinate, or be actively involved in, international educative efforts against female genital mutilation, and to give all possible financial backing and assistance to those efforts.

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, or to provide them with a better understanding of the bases for the procedure and its practical implications. In particular, such programs should aim to inform professionals of:

- (i) the cultural aspects of the procedure and of some similar practices within the Western context;
- (ii) the legal aspects of the procedure;
- (iii) the risks involved to the woman and of the practical ways of dealing with medical problems arising as a result of the procedure; and
- (iv) the special needs of women arising as a result of the procedure having been performed.

The use of videotapes or slides in conjunction with, or as an alternative to, training sessions may be useful for this purpose. Such education should also assist in dispelling any misguided rumours or myths held on the issue and about the practising communities.

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) Referral Service

The Commission also recommends that a referral service be set up through which a team of competent professionals would provide the following services as required:

- (i) Education of parents or family members who state, or exhibit an intention, to carry out female genital mutilation on their children. Such education would only be made available to willing parents by referral from a doctor, health-care worker or other professional in contact with the family.
- (ii) The provision of advice concerning the practice, its origins and implications, the background of the relevant communities and the legal position in Australia, on request by persons working with, or coming into contact with members of the affected communities.
- (iii) The provision of psychological or psycho-sexual counselling and advice for members of the affected communities if required.
- (iv) The provision of ad hoc advice or information as may be required on the issue, as special situations arise.

The establishment of the referral service should be mandated by legislation, as set out in clause 6 of the draft Bill in Appendix 8.

(c) Prohibition in *Criminal Code*

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

It would be appropriate to include a separate division within the *Criminal Code* concerning female genital mutilation. Given the range of practices which it is intended should be covered by the prohibition, and given the unique and flexible penalty provisions which we advocate for the proscribed practices, a separate division would be more appropriate than an amendment of the current assault provisions (as proposed by Cabinet on 22

August 1994).

Exceptions to the prohibition should be restricted to operations performed on a person for accepted medical reasons -

- (a) by a doctor for the person's physical or mental health, (this would include treatment to correct a gender assignment abnormality, or reconstructive surgery necessary for the physical or mental health of a person, but would not include an operation performed for purely cultural reasons); or
- (b) by a doctor, midwife or trainee doctor or trainee midwife, in connection with the birth of the person's child and during the labour or just after birth of the child.

Penalty for breach of the prohibition should be by way of fine and/or imprisonment. The maximum penalty should not exceed five years imprisonment. 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.

The prohibition should be in the terms set out in clause 4 of the draft Bill in Appendix 8.

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. The offence should be in the terms set out in clause 6 of the draft Bill in Appendix 8. It would be appropriate to include such an offence in an amendment to the *Health Act 1937* (Qld).

(d) Research

The Commission recommends that research into the practice of female genital mutilation and its significance in Australia be immediately commenced to obtain information for use in the planning, implementation and continuing evaluation of education programs throughout Australia and to assist in dealing with new immigrants and ongoing education.

As part of that research, information should be obtained on a confidential and non-identifying basis from each community in Queensland in which members have had experience with female genital mutilation to ascertain:

- (i) the nature of "circumcision" performed in the country of origin;
- (ii) the number of women in the Australian community who have been "circumcised";
- (iii) the age at which those women were "circumcised";
- (iv) the adverse health adverse effects, if any, which those women have experienced;
- (v) whether members of the community still wish to "circumcise" their children;
- (vi) if so, the reason for wishing to "circumcise" their children;
- (vii) the structure of families and the roles played in the community;
- (viii) the level of education of the members of the community; and
- (ix) the background of members of the community.

(e) 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, the Commission recommends that an offence be included in the proposed new division of the *Criminal Code*, in the terms set out in clause 4 of the draft Bill in Appendix 8, prohibiting such a procedure to be performed outside Queensland on a person under the age of 18 who is normally resident in Queensland.¹⁹⁸

Apart from a provision relating to offences committed on the high seas,¹⁹⁹ 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.²⁰⁰ The *Criminal Code Review Committee*²⁰¹ 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.

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 new Commonwealth crimes relating to child sex tourism²⁰² go so far as to make it a crime to intend to travel overseas for the purpose of paedophilia.

¹⁹⁸ 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 section 2 of the *Constitution Act 1867*.

¹⁹⁹ Section 14A *Criminal Code*.

²⁰⁰ **Note** section 14 *Criminal Code* - offences procured in Queensland to be committed out of Queensland (needs to be an offence in the other jurisdiction). Section 12 - Application of *Code* to offences wholly or partially committed in Queensland (needs to have been an act done or omission made in Queensland).

²⁰¹ *Final Report of the Criminal Code Review Committee to the Attorney-General* June 1992.

²⁰² *Crimes (Child Sex Tourism) Amendment Act 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.

The principal aim of the Commonwealth legislation is.²⁰³

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".²⁰⁴

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 Commonwealth 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 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.

(f) 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

²⁰³ Second Reading Speech, by the Hon Duncan Kerr MP, Minister for Justice, House of Representatives, May 1994. Note, the Act 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.

²⁰⁴ Second Reading Speech, by the Hon Duncan Kerr, Minister for Justice, House of Representatives, May 1994.

Affairs.²⁰⁵ The Commission recommends that any revised definition of "in need of care and protection" or equivalent phrase to be introduced by any amendment to the Act resulting from the review, be broad enough to clearly include the threat or fear of female genital mutilation in whatever form, being performed upon a young person under the age of 17 years.²⁰⁶

(g) Child protection guidelines

Female genital mutilation is very much a child protection matter. Appropriate guidelines should be developed for use by Queensland SCAN teams for the investigation and handling of families "at risk" and families suspected of having had their daughters mutilated in Queensland. The guidelines should be developed in consultation with men and women from affected communities and with professionals working with those communities, with a view to ensuring that any intervention by the protective services is no more than necessary and is sensitive to the background of the communities in question. To the extent possible, guidelines developed should be consistent with those implemented by protective services interstate.

(h) Protection of health and social workers

Although the Commission has not recommended the extension of mandatory reporting legislation, it is of the opinion that health or social workers who believe a child is at risk of undergoing, or has recently undergone 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. This immunity should be included in the *Health Act 1937*, in the terms set out in clause 6 of the draft Bill in Appendix 8.

²⁰⁵ See *Child Protection Legislation Issues Paper 1993*.

²⁰⁶ The *Children's Services Act 1965* currently defines 'child' in terms of a person under the age of 17 years.

(i) **Incitement to racial hatred**²⁰⁷

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.²⁰⁸

²⁰⁷ **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*.

²⁰⁸ 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. Note also, that the *Anti-Discrimination Act 1991* (Qld) has a provision prohibiting incitement to racial or religious hatred (section 126), but that provision is limited by the restricted ambit of the Act.

APPENDIX 1

List of Respondents to the Research Paper and Draft Report on Female Genital Mutilation

- * 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
- * Zahra Bahr
- * Dr Chris Bayly and Dr Miriam O'Connor
- * Mrs E Bennett
- * Mr R Bowles
- * Professor Branicki and Professor F Leditschke
- * Brisbane South Regional Health Authority
- * Bureau of Ethnic Affairs
- * Catholic Provincial Medico-Moral Committee for the Bishops of Queensland
- * Central Regional Health Authority
- * Central West Region - Winton Hospital
- * 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
- * Foundation for Women's Health - Research and Development (FORWARD, United Kingdom)
- * Mr J Fleming
- * Dr H Haas
- * Health and Community Services
- * Commonwealth Dept of Human Services and Health
- * International Women's Development Agencies
- * Islamic Council of Queensland
- * Fuad Jama
- * The Hon Justice Michael Kirby AC CMG
- * Dr R Lampugnani
- * Professor F Leditschke and Professor Branicki
- * Malaysian, Indonesian and Egyptian Women
- * Mrs Moira McGuinness
- * The Medical Defence Society of Queensland
- * Ms L Meyers
- * Dr David Molloy
- * Mr and Mrs Naske
- * National Children's and Youth Law Centre

- * National Council of Women of Victoria
- * National Council of Women of Australia Inc Ltd
- * Mrs Elizabeth Newman
- * Peninsula and Torres Strait Regional Health Authority
- * Reverend Les Percy
- * The Presbyterian Church of Queensland
- * The Public Policy Assessment Society Inc
- * Queensland Women's Consultative Council
- * Professor J Reid
- * The Royal Australian College of Obstetricians and Gynaecologists
- * Royal College of Nursing, Australia (Qld Chapter)
- * Royal Women's Hospital Brisbane
- * Mr M Santin
- * Mr J Shanahan
- * Social Issues Committee, Anglican Church, Brisbane Diocese
- * West Moreton Regional Health Authority
- * Dr G Williams
- * Women's Health Centre
- * Women's Policy Unit, Office of the Cabinet
- * Zonta Club of Nambour

APPENDIX 2

New South Wales Legislation

Crimes (Female Genital Mutilation) Amendment Bill 1994

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***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

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 Legislation²⁰⁹

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.

²⁰⁹ English translation kindly provided by the Swedish Embassy in Australia.

APPENDIX 6²¹⁰

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 ²¹¹	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	

²¹⁰ Reproduced with permission 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.

²¹¹ 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	
Total		114 296 900	

* 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.

APPENDIX 7

FEMALE GENITAL MUTILATION

A Report to the Attorney-General
prepared by the Family Law Council, June 1994

Summary of Recommendations

Recommendation 1 Education

Council agrees that education must be a first priority in any program for the elimination of female genital mutilation. To this end it recommends that:

- (a) A national communication and education program on female genital mutilation be developed by the Commonwealth Department of Human Services and Health, in consultation with the States and Territories and the relevant communities, and that the campaign be integrated with Australia's health advancement and child value and protection agendas;
- (b) The education program's primary focus be on members of communities coming from countries where female genital mutilation is practised and that wherever possible these education programs should be conducted by members of the communities themselves with the assistance of others, such as health workers;
- (c) It is essential that vulnerable communities be involved in planning, as well as delivering education programs, and that adequate funds be provided for education;
- (d) Other target groups for education include child protection workers, care providers (including doctors, midwives, nurses, educators, child and ethnic care workers, social workers and community workers), police and the Courts and legal profession;

- (e) The Commonwealth Department of Immigration and Ethnic Affairs cooperate in the development and delivery of an effective information program for newly arrived migrants from countries which practise female genital mutilation; and
- (f) The Commonwealth Government provide adequate funds for community education.

Recommendation 2 Commonwealth/State Legislation

Council recommends that:

- (a) In order to achieve uniform legislation without delay, the Commonwealth Parliament immediately pass legislation making it clear that the practice of female genital mutilation is a criminal offence and also that it constitutes child abuse under Australian child protection legislation;
- (b) The Commonwealth pass legislation which provides children taken out of Australia with the same protections from female genital mutilation as they would have in Australia;
- (c) The Standing Committee of Attorneys-General consider whether State/Territory legislation may also be necessary. Ultimately the matter is one for the States/Territories;
- (d) Legislation cover those matters identified in Recommendation 4 below.

Recommendation 3 Timing of Education and Legislation

Council recommends that:

- (a) Immediate steps be taken to implement an education program along the lines proposed in recommendation 1; and
- (b) Criminalising aspects of the legislation should not become operative until the education program is satisfactorily established and operating.

Recommendation 4 Content of Legislation

Council recommends that to be fully effective legislation should cover the following matters:

- (a) It should put the issue beyond doubt that female genital mutilation, in all of its forms, is a criminal offence;
- (b) It should be made clear that female genital mutilation, in all of its forms, constitutes child abuse under Australian child protection legislation;
- (c) The law should take into account the best interests, and protection, of the child in relation to imposing penalties on parents who allow this procedure to be carried out on their children. Other relevant factors should include whether the parent has offended previously, whether the parent acted in knowledge of the law and the type of procedure performed on the child;
- (d) There should be severe penalties, including imprisonment, for professionals who perform female genital mutilation;
- (e) There should be severe penalties, including imprisonment, for non-professionals (including relatives) who perform the procedure and for those who aid and abet such persons, including those who arrange for children to be genitally mutilated;
- (f) Appropriate sanctions should apply to institutions at which female genital mutilation is carried out. Officers of the institution should be liable for criminal prosecution;
- (g) Mandatory notification should apply to State/Territory child protection authorities of prospective or actual incidences of female genital mutilation. Ideally, subject to Constitutional power, the widest possible list of persons required to notify should apply;
- (h) Legislation should make it an offence to take, or to propose to take, a child outside Australia to be genitally mutilated. The legislation should be based on the Canadian model; and
- (i) The legislation should acknowledge the importance of education programs and of counselling and other forms of assistance.

Recommendation 5 Child Protection Protocols

Council recommends that the Joint Health and Community Services Ministerial Council be asked to develop protocols specifically for the purpose of dealing with instances of female genital mutilation.

Recommendation 6 Reconstructive Surgery

Council is of the view that further legislation is not necessary to enable young women to have reconstructive surgery where they so desire.

Recommendation 7 Counselling and Support Services

Council considers that provision must be made for counselling and support services for women and children, including those who reject the practice of female genital mutilation.

Recommendation 8 Jurisdiction

In Council's view there is no need for special legislation on the jurisdiction of the courts in relation to female genital mutilation. However, Council is of the view that proceedings relating to female genital mutilation should be conducted in a closed Court.

Recommendation 9 International Action

Council urges the Government to participate in international forums and by other means to take part in the international campaign against female genital mutilation.

APPENDIX 8

Queensland



D R A F T

FEMALE GENITAL MUTILATION PROHIBITION AMENDMENT BILL 1994

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*Female Genital Mutilation Prohibition
Amendment*

76S Planning, establishment and implementation of strategies 9

1994

A BILL

FOR

An Act to prevent or stop the practice of female genital mutilation

*Female Genital Mutilation Prohibition
Amendment*

The Parliament of Queensland enacts—	1
PART 1—PRELIMINARY	
Short title	3
1. This Act may be cited as the <i>Female Genital Mutilation Prohibition Amendment Act 1994</i> .	4 5
Commencement	6
2.(1) Section 6 commences on assent.	7
(2) The remaining provisions commence on a day to be fixed by proclamation.	8 9
PART 2—AMENDMENT OF CRIMINAL CODE	
Act Amended	11
3. This Part amends the Criminal Code.	12
Insertion of new Ch 32A	13
4. After section 351—	14
<i>insert—</i>	15
CHAPTER 32A—FEMALE GENITAL MUTILATION	
Crime of female genital mutilation	17
352.(1) A person must not cut, excise, infibulate or otherwise mutilate	18

*Female Genital Mutilation Prohibition
Amendment*

the whole or part of the labia majora, labia minora or clitoris of another person under 18 years.	1
	2
Maximum penalty—5 years imprisonment.	3
Crime—female genital mutilation.	4
‘(2) Subsection (1) does not prohibit a surgical operation performed on a person only for accepted medical reasons—	5
	6
(a) by a doctor for the person’s physical or mental health; or	7
(b) by a doctor or authorised professional—	8
(i) in connection with the birth of the person’s child; and	9
(ii) during the labour for the birth or just after the birth.	10
<i>Examples of paragraph (a)—</i>	11
1. Treatment of the effects, or to reverse the effects, of a previous cut, excision, infibulation or other mutilation if the treatment is for accepted medical reasons and for the person’s physical or mental health.	12
	13
	14
2. Treatment of a gender assignment abnormality if the treatment is for accepted medical reasons and for the person’s physical or mental health.	15
	16
‘(3) An offence against subsection (1) is a crime.	17
‘(4) It is not a defence that the person in relation to whom the offence was committed consented to the cut, excision, infibulation or other mutilation.	18
	19
	20
‘(5) If a person—	21
(a) at a place outside Queensland, but in Australia, does an act that would be an offence against subsection (1) if it had happened in Queensland; and	22
	23
	24
(b) the act is done to a person who ordinarily lives in Queensland;	25
the person commits an offence and is liable to be punished as if the act had happened in Queensland.	26
	27
‘(6) In this section—	28
“accepted medical reasons” see section 353.	29
“authorised professional” means an authorised midwife or a person in training to become a doctor or authorised midwife.	30
	31

*Female Genital Mutilation Prohibition
Amendment*

“authorised midwife” means a person authorised to practise midwifery by the Queensland Nursing Council, and includes, for a surgical operation performed at a place outside Queensland, a person authorised to practise midwifery under the law of the place.	1 2 3 4
“doctor” , for a surgical operation performed at a place outside Queensland, includes a person authorised to practise medicine under the law of the place.	5 6 7
“mental health” see section 353A.	8
‘When is a surgical operation performed for accepted medical reasons?’	9 10
‘353. A surgical operation is performed on a person for accepted medical reasons if the operation is—	11 12
(a) accepted as proper by a responsible body of medical opinion; and	13
(b) reasonable having regard to the person’s current physical and mental health and all the circumstances.	14 15
‘Irrelevance of custom or ritual to opinion on mental health	16
‘353A. In deciding under section 352(2)(a) whether a surgical operation is for a person’s physical or mental health, the effect on the person or someone else of a belief that the operation is necessary or desirable because of custom or ritual must not be taken into account.	17 18 19 20
‘Considerations on sentence of offender	21
‘353B.(1) In sentencing a person for the crime of female genital mutilation, a court must consider—	22 23
(a) the type of act done; and	24
(b) the offender’s cultural beliefs about the performance of that type of act in the circumstances in which it actually happened; and	25 26
(c) whether the offender was aware the act was a criminal offence.	27
‘(2) Subsection (1) does not limit the things the court may consider.’	28

*Female Genital Mutilation Prohibition
Amendment*

PART 3—AMENDMENT OF HEALTH ACT 1937	1
Act Amended	2
5. This Part amends the <i>Health Act 1937</i> .	3
Insertion of new Pt 3, Div 11C	4
6. After section 76N—	5
<i>insert—</i>	6
<i>‘Division 11C—Provisions about female genital mutilation</i>	7
<i>‘Subdivision 1—Definitions</i>	8
‘Definitions	9
‘76O. In this Division—	10
“annual report” of the department means the department’s annual report tabled in the Legislative Assembly under the <i>Financial Administration and Audit Act 1977</i> .	11 12 13
“female genital mutilation” means an act that—	14
(a) is the crime of female genital mutilation; or	15
(b) would be the crime of female genital mutilation if the person to whom it is done were under the age of 18 years.	16 17
“health care provider” means a provider within the meaning of the <i>Health Rights Commission Act 1991</i> .	18 19
<i>‘Subdivision 2—Protection and duty of health care provider</i>	20
‘Protected disclosure of information about female genital mutilation	21
‘76P.(1) A health care provider who suspects on reasonable grounds that	22
a person under 18 years is at risk of, or has recently been the victim of, the	23

*Female Genital Mutilation Prohibition
Amendment*

crime of female genital mutilation may report the suspicion to any entity that is empowered to investigate or remedy the risk or crime. 1
2

'(2) The provider is not liable, whether civilly, criminally or under administrative process, for making the report. 3
4

'(3) Without limiting subsection (2)— 5

(a) in a proceeding for defamation the provider has a defence of absolute privilege for making the report; and 6
7

(b) in making the report the provider does not contravene an Act, oath, rule of law or practice about the confidentiality of the information reported; and 8
9
10

(c) the provider is not liable to disciplinary action for making the report. 11
12

'(4) This section does not limit the protection given to the provider by another law. 13
14

'Health care providers cannot deny services 15

'76Q. A health care provider must not fail to provide a service to another person on the ground that the whole or part of the labia majora, labia minora or clitoris of the person has been cut, excised, infibulated or otherwise mutilated, unless the health care provider has a reasonable excuse for the failure. 16
17
18
19
20

Maximum penalty—100 penalty units. 21

'Subdivision 3—Relevant functions of Director-General 22

'Function to prevent or stop female genital mutilation practice 23

'76R. The Director-General has the function to take appropriate action in the community to prevent or stop the practice of female genital mutilation. 24
25

*Female Genital Mutilation Prohibition
Amendments*

Planning, establishment and implementation of strategies	1
'76S.(1) To perform the function given by this Subdivision, the Director-General must plan, establish and implement effective strategies.	2 3
'(2) The strategies must include the following—	4
(a) identifying each group within the community in which the practice is or may be followed including, for example, a group of persons from a place where the practice is known to be followed (a "relevant group");	5 6 7 8
(b) researching the extent to which the practice is or may be followed in a relevant group;	9 10
(c) using education programs and support facilities to inform individuals in a relevant group of the undesirable, unnecessary and unlawful nature of the practice;	11 12 13
(d) directing these education programs to educate—	14
(i) each relevant group as a whole; and	15
(ii) young females within each relevant group; and	16
(iii) new immigrants in each relevant group who have come from places where the practice is known to be followed;	17 18
(e) establishing a referral service with appropriately qualified staff to provide assistance and advice, including, for example, counselling services and education to—	19 20 21
(i) members of relevant groups who are adversely affected by the practice; and	22 23
(ii) members of relevant groups who are likely to support the practice; and	24 25
(iii) health care providers and other individuals who have contact with members of relevant groups.	26 27
'(3) The department's annual report must include a report on the planning, establishing and implementing of the strategies.	28 29
'(4) Subsection (3) expires on 31 December 1999.'	30 31

