High Court of Australia Transcripts

# R v A2; R v Magennis; R v Vaziri [2019] HCATrans 16 (15 February 2019)

Last Updated: 19 February 2019

**[2019] HCATrans 016**

IN THE HIGH COURT OF AUSTRALIA

Office of the Registry

Sydney No S235 of 2018

B e t w e e n -

THE QUEEN

Applicant

and

A2

Respondent

Office of the Registry

Sydney No S236 of 2018

B e t w e e n -

THE QUEEN

Applicant

and

KUBRA MAGENNIS

Respondent

Office of the Registry

Sydney No S237 of 2018

B e t w e e n -

THE QUEEN

Applicant

and

SHABBIR MOHAMMEDBHAI VAZIRI

Respondent

Applications for special leave to appeal

BELL J

GAGELER J

EDELMAN J

TRANSCRIPT OF PROCEEDINGS

AT SYDNEY ON FRIDAY, 15 FEBRUARY 2019, AT 11.37 AM



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**MR D.T. KELL, SC:** May it please the Court, I appear with **MS E. JONES** for the applicant in the three matters. (instructed by Solicitor for Public Prosecutions (NSW))

**MR T.A. GAME, SC:** If it please, I appear for the respondent, Magennis, with **MS G.E.L. HUXLEY**. (instructed by Armstrong Legal)

**MR H.K. DHANJI, SC:** May it please the Court, I appear for the respondents, A2 and Vaziri, with **MR D.R. RANDLE**. (instructed by Armstrong Legal)

**BELL J:** Yes. Having regard to the submissions, the convenient course, as I understand it, would be, Mr Kell, for you to address the issues that are common to all three applications and, Mr Game, you will be addressing, I think, the first and second of the considerations and you, Mr Dhanji, the third and fourth. Yes, thank you, Mr Kell.

**MR KELL:** Your Honours, section 45 of the *Crimes Act* (NSW) was introduced in 1994 and enacts a prohibition on female genital mutilation. The text of the provision is at application book 697 which is volume 2. It provides that:

A person who:

(a) excises, infibulates or otherwise mutilates the whole or any part of the . . . clitoris of another person

commits an offence. The New South Wales Court of Criminal Appeal quashed the convictions of the first and second respondents of offences contrary to that provision and the conviction of the third respondent as an accessory on the basis that the provision requires the Crown to prove that the complainant's clitoris has been rendered imperfect or irreparably damaged in order to make out the offence and that is at judgment 521 and 509 of the judgment at the Court of Criminal Appeal.

**GAGELER J:** The exact error that is said to have occurred in the instructions to the jury is recorded at paragraph 522, I think, and as I read it the problem is that it allowed for a "de minimis injury" to give rise to criminal liability.

**MR KELL:** Yes. The reference there is to the inclusion of the words "to any extent" but the construction which the Court of Criminal Appeal arrived at is the one indicated at 521 which is in the preceding paragraph which is that the term:

connotes injury or damage that is more than superficial and which renders the body part in question imperfect or irreparably damaged in some fashion.

**EDELMAN J:** It really comes down, ultimately, to does "mutilates" have its ordinary meaning or does it have a meaning commonly understood in the expression "female genital mutilation".

**MR KELL:** Yes, using the term "ordinary meaning" as being common parlance about reference to statutory context and purpose.

**EDELMAN J:** Yes.

**MR KELL:** It was accepted by the Court of Criminal Appeal that there were a range of meanings for "mutilates" but that - potential meanings available so that one is in the area of constructional choice but that as a matter of common parlance that the most - or perhaps the most ordinary common parlance meaning is one which is something beyond injures and is maiming and the like.

But the question that arises here is – and what the Court of Criminal Appeal has done wrong, we say, in its constructional exercise, is that it has looked at meaning without reference initially to statutory context and purpose and looked for a common parlance meaning and then looked for reasons to depart from that and found that there are no reasons to depart from that having regard to context and like.

**BELL J:** Mr Kell, when one goes to the statement of principles as to matters of construction – could you take us to where you say the error in approach is best illustrated?

**MR KELL:** I can do it by showing the steps that the Court of Criminal Appeal has done. So it has referred to particular cases and it is – going back one step – as I have said there is a range of potential meanings that can be attributed to the word "mutilates" and the Crown contention which is "mutilates" means injures may be accepted that that is at the lesser end of the spectrum but it is within what would be a constructional choice.

Then what the court has done is, after referring to various dictionary definitions and the like, it has observed as a starting point - and this is at about judgment 489 at application book 483 - and then at 495, if I just go to that one, so at the top of page 486 of the application book, the Court of Criminal Appeal has referred to:

The text of the offence provision, in our view, particularly the use of the verb "mutilates" rather than simply "injures" or "damages", suggests that more than the causing of an injury is required –

and then again, refers to:

impairing or rendering imperfect the body part that is mutilated.

From this, as it were, starting point, the court then reasoned that, firstly in 495:

The fact that s 45(1) is concerned with sensitive body parts which may more readily be impaired or rendered imperfect does not warrant expanding the meaning of "mutilates" to encompass any injury to any extent.

What they have done in that step, and similarly when I come to 496, is that they have fastened upon a meaning which is a common parlance meaning which may be accepted as a matter of common parlance and then the error in approach here and in 496 and 497 is to look to reasons to depart from that common parlance which are reasons of context and

purpose rather than taking into account simultaneously, which is what the authorities mandate, context and purpose as a means of ascertaining meaning at the beginning.

So the language in 495, for example, is, in the second sentence, that fact which is that the object of the verb – the subject matter of the verb is a sensitive part of the female anatomy - does not warrant the expanding the meaning of "mutilates" to encompass injury to an extent. We submit, respectfully, that the subject matter of the verb in terms of ascertaining meaning must be a matter that is relevant to meaning and construction.

**BELL J:** Does not the court accept that having regard to the sensitivity of the body part it acknowledges that a "cut" or "nick", to use the expressions that were used, might amount to mutilation but what it is giving content to is the verb "mutilate" so that it is not that in its application it may not vary depending upon whether one is speaking of the sort of degree of injury required to answer the description "mutilation" with an arm as distinct from a clitoris, but the point underlying it is their Honours start with the statutory text - and "mutilate" is a strong term and it requires that consideration be given to the text. Their Honours had earlier, I think, referred to *SZTAL* and authorities dealing with approach to construction and as I understand it really you are not at odds with the respondents in that regard as to the application of the principles.

**MR KELL:** If I could put it this way, your Honour. When your Honour posits in exchange that they start with the statutory text, the difficulty is they do not appear - to a constructional exercise where purpose and context is taken into account at the stage of ascertaining meaning because – and your Honour raises, again by way of argument, the point that "mutilates" is a strong term, but the answer to that is not really when considered in context.

"Mutilates" is a term that has a particular affinity with the subject matter here which is female genital mutilation which is clear by reference to the title to the amending Act, by reference to the heading to the provision and, similarly, by reference to the extrinsic material which is relevant to ascertaining context and purpose and the mischief

**EDELMAN J:** The WHO report and the Family Law Council report both effectively contain definitions of "mutilation" in the context of female genital mutilation as in, for example, the family law report, all types of the practice where tissue damage results.

**MR KELL:** Yes.

**EDELMAN J:** So your point is really if one started holistically with all the extrinsic materials then actually you immediately have two potential definitions in front of you.

**MR KELL:** Yes. The affinity with the subject matter is shown also by the other terms. So when the surrounding terms "excises" and so on, the language of female genital mutilation, as is "mutilates" and, as your Honour rightly, with respect, indicated, the material shows – extrinsic material which again is relevant to statutory purpose and object relevant to ascertaining meaning shows that there was a clear intent that female genital mutilation as broadly understood, which includes any tissue damage, be prohibited by legislation.

**BELL J:** To the extent one looks to the extrinsic material to assist in ascertaining the mischief, one does see in the second reading speech reference to three forms of female genital mutilation and reference to the Family Law Council's report which referred to a fourth. So, on one view, it is notable that the legislature chose, to the extent that one has regard to the Minister's speech in identifying the purpose as dealing with three and not four methods, the fourth being the sort of broader notion of ritual female genital mutilation.

**MR KELL:** Can I respond to that in two ways?

**BELL J:** Yes.

**MR KELL:** Certainly that argument is raised against us. The first is that that argument can be and is drawn from one aspect of the second reading speech. The second point is this. There can be no doubt that in 1994 the discourse about female genital mutilation in this country included - the concept extended to the cutting and nicking of a clitoris as the Crown contended here and just by way of ease of reference – in the second application book we have just included at page 747 at footnote 7 - and I will just do this very quickly. Your Honours will see reference to the Queensland Law Reform Commission report of September 1994:

(describing "the scraping or simple nicking of the clitoris" as "the least intrusive form of mutilation")

So this is an area of discourse where, as at the relevant time this provision came into play, the concern here for the Crown was a recognised area of female genital mutilation as understood in this country by authoritative sources.

**EDELMAN J:** You also, I suppose, do have the preceding sentence in the second reading speech which is that:

It will be an offence for anyone to perform FGM in this State.

That is clearly talking about mutilation in the broad sense encompassing the whole of the practice.

**MR KELL:** Yes, and I respectfully endorse that comment.

**GAGELER J:** The whole of what practice?

**MR KELL:** The whole of the practice of female genital mutilation which includes damage to the tissue – general area of girls who typically prepubescent girls.

**BELL J:** The whole of the practice categorised in the Family Law Council's report in four categories.

**MR KELL:** Yes, that is right. There is no doubt, respectfully, that the Parliament intended to enact what was being recommended by the Family Law Council and it is inconceivable, with respect, that Parliament was intending to enact a provision that had such a high threshold as the construction of the Court of Criminal Appeal has resulted in where the deliberate damage the deliberate cutting to the clitoris of a prepubescent girl is not an offence because the clitoris has not been rendered imperfect or irreparably damaged in circumstances where, for obvious reasons

**BELL J:** For my part, Mr Kell, I would not read this judgment as sanctioning the deliberate cutting of the clitoris of a prepubescent girl. Their Honours are at some pains to point to the possibility that cutting or nicking may amount to mutilation; it depends on the circumstances. As Justice Gageler has pointed out all of this takes place in the context of a direction that injury to any extent would come within the concept of "otherwise mutilates" for the purpose of the attachment of criminal liability.

**MR KELL:** Yes. There was one other point I just want to come back to you on the point your Honour raised but injury, to an extent, is injury. So, it is not harm. It is not things falling less than injury to the clitoris. So, to the extent that that is a qualification, it is little. But the other point in response to what your Honour had raised about the categories is that a key point of the extrinsic material, which was touched on fleetingly by the Court of Criminal Appeal, is the explanatory memorandum.

If I could just go to application book 1, it is set out at page 65. This is the judgment of the trial judge – pages 65 to 66, so right at the bottom of 65. This is obviously the explanatory note that accompanies the Act and the offence provision to be enacted. At the top of 66 it makes clear that:

*"Procedures involving the incision –*

so the cutting:

*usually removal -*

but that is not exhaustive, so:

*"Procedures involving the incision*

relevantly:

*of part or all of the external genitalia of young females are practised by some groups . . . The practice can lead to –*

and then there are the various dangers that are listed – infection, dysuria (painful urination) – so again, a small cut is an incision, a small cut obviously can lead to infection. In our submission, it is a strong contextual indication in the explanatory memorandum accompanying the Act that what is sought to be prohibited is conduct that includes the cutting of the genitalia of a young female that can lead to infection.

**BELL J:** In that respect, the explanatory note uses the word “incision” but the legislature enacting the offence used the word “excises”.

**MR KELL:** Yes.

**BELL J:** The explanatory note - you suggest that we are to take something from the use of “incision” which does not appear in the text of the offencecreating provision.

**MR KELL:** The explanatory note refers to the incision and usually removal, so the removal will be excising. The explanatory note is indicating that the incision which is the cutting is something different from excising. It is obviously different from the infibulating which is the sewing, so it is a strong indication that “otherwise mutilates” is a term that is apt to encompass the cutting which can lead to infection.

**GAGELER J:** The Minister used the word “excision” for removal - what do we make of that – and then went on to refer to three categories. Do those three categories cover the totality of the prohibitive conduct in your submission?

**MR KELL:** Within the section itself?

**GAGELER J:** Yes.

**MR KELL:** We say no because – and this was a point that – either the term “sunna” which is understood to be something different from “otherwise mutilates” in the description within the three categories, then what that does is to leave the term – so, if it is effectively an excising then it leaves with other work to do the term “otherwise mutilates”.

**EDELMAN J:** “Sunna” itself is ambiguous. It is just Arabic for “tradition”.

**MR KELL:** Yes. That is a matter that Justice Johnson raised in the judgment at first instance or the

**BELL J:** I think when one then turns to the Family Law Council report, the term “sunna” is used to describe what the Council prefers to categorise as “clitoral circumcision” involving

the removal of the clitoral prepuce. So that if one – this is, in a sense, the difficulty of these extrinsic materials, is it not? To the extent one is looking at them for the purpose of identifying the mischief, one might think one sees indications going both ways so that at the end they may not be so helpful.

**MR KELL:** Taken as a whole we submit that they do not indicate a restrictive construction of "otherwise mutilates" as the Court of Criminal Appeal reached here and that also that what – by the Court of Criminal Appeal fastening upon the three categories that are referred to within the second reading speech, one of which is a term which itself is ambiguous, that they have given disproportionate importance to one aspect only of the second reading materials in circumstances - even of the second reading speech – in circumstances where the clear legislative intent was to prohibit female genital mutilation in all its forms, which is made clear by the Family Law Council and the second reading speech, the explanatory note.

**GAGELER J:** What is the strongest indication in the secondary material in favour of your construction?

**MR KELL:** I mean it is a dangerous question to answer. The explanatory note is powerful and, we submit, compelling material. The Family Law Council material, when read with the second reading speech, is similarly compelling because it indicates an intention to prohibit all the practices and the second reading speech itself makes clear that the intention was to prohibit all the practices as well. The second reading speech in the fifth paragraph makes clear that the policy of the provision is the protection of children. The Bill has its roots in the protection of children from a practice that is extremely painful and has no beneficial physical effects.

This is not a circumstance where one might be – one could rapidly discern that there may be a coherent legislative choice injecting an offence provision at a particular level of harm, whether it is.....or some other context. This is the protection of young children from an offence where Parliament has clearly indicated that it is abhorrent and has no beneficial, physical effects. It is inconsistent with a construction arrived at where one has to prove irreparable damage or rendering imperfect the genitalia of a young girl.

**BELL J:** Yes.

**MR KELL:** I will just quickly deal with some of the other steps which have indicated error. One is – at paragraph 496 which is at application book 486, the court similarly referred to the potential evidentiary difficulties caused by a construction which requires proof of actual impairment or imperfection as being matters that do not justify departure from the construction which is the meaning of the term in its common parlance.

Also, at paragraphs 514 and particularly 521 which is at application book 493, after referring to the second reading speech in the Family Law Council, the Court of Criminal Appeal referred to that material as informing the context of the provision but cannot change the meaning of its terms and:

do not permit a construction of “mutilates” that departs from its ordinary meaning –

So, again, the court at that stage, is not seeking to choose between a range of potential meanings as properly required by constructional choice at a starting point but is saying there is nothing here – is there anything here that – by which we need to depart from - what is, effectively, the common parlance? The problem with doing it that way, we say, is that you undervalue context and purpose you necessarily undervalue context and purpose by saying, effectively, this is the default position. Is there anything by which we should move away from that position? If it is convenient, I would move to the second of the special leave questions.

**BELL J:** Yes.

**MR KELL:** That can be dealt with briefly. The medical evidence at trial was that “clitoris” was a global term that included the clitoral hood and that the clitoral hood is part of the clitoral anatomy even though it is, in fact, on one view a different tissue or different structure and the evidence is recorded in application book 494.

**BELL J:** In terms of the importance of this second aspect of your application it really was a pleading issue, was it not - was the way the prosecution chose to put its case. There is no issue but that the prohibited conduct involves any mutilation of the labia majora or labia minora or clitoris. So it was the way the case was put.

**MR KELL:** It arose because of the form of the indictment so that was the context in which it arose but it still brings into question again the construction of terms of this important provision. We have dealt with that in the written submissions. I just see the light – could I just say this that the application raises a matter involving what we say is a profound misunderstanding of an important offence provision which would be perpetuated - it failing a grant of special leave and consideration by this Court.

It raises a novel and important question of statutory construction. It is a provision which is not in identical form but is in comparable form in other Australian States and Territories. This case is the first prosecution of its kind. The Court of Criminal Appeal decision is the first appellate consideration of the matter. Unless that judgment is corrected it is likely to be applied by trial judges in other States and Territories in dealing with the term “mutilate” or “mutilation” in their comparable provisions and the judgment

**BELL J:** It might depend very much upon the form of the provision. Some emphasis was placed in the court’s analysis on the absence in the offencecreating provision to use the expression “female genital mutilation”. I do not know, Mr Kell, but it may be that the offence is differently provided for in the legislation of other States and Territories.

**MR KELL:** It typically incorporates reference to the term “female genital mutilation”.

**EDELMAN J:** Was New South Wales first or did it follow other States?

**MR KELL:** It was the first in this country and it followed the UK legislation. It typically incorporates reference to “female genital mutilation” in the text as opposed to the heading and the title to the Act but then similarly typically defines that expression by reference to the term

“mutilates” or “mutilation” so that the question still would arise in those other States and a judgment of this Court could provide important - obviously provide important guidance.

**BELL J:** Yes, thank you.

**MR KELL:** Thank you, your Honours.

**MR GAME:** My answer to the last point was if the legislature wanted to prohibit something described as “female genital mutilation” then they could have said that in the provision and they could amend to say it in a provision. But what this case decided, if the Court pleases, is that – and the Crown tries to weigh in on what the court said in expounding meaning without facing up to the difficulty that the direction says “injury to any extent” and how they get – and including a nick or a cut – a nick, for example, one does not even normally think of that as harm. What never happens is an actual construction in the judge below - I will come to him shortly - of the actual things that are prohibited by this provision.

I will come to this as well but it is quite clear, in my submission, that the court did the very thing that is to say in context, in context of a sensitive part of the anatomy and in the context of female genital mutilation – they said that at paragraph 474 and elsewhere but I will come back to that shortly.

**EDELMAN J:** Mr Game, do you say that in future cases if a direction were given in almost verbatim terms to paragraph 521 that it would be necessary for the Crown to prove that the action or the cutting had rendered the “body part in question imperfect or irreparably damaged in some fashion” that there would be any ground to complain about such a direction?

**MR GAME:** Whether the Crown would have any ground?

**EDELMAN J:** Whether or not there would be – yes, whether the Crown would have any basis to complain about such a direction.

**MR GAME:** Well, one needs to actually be – that is an exposition of what the court was saying and, for example, they said that there were circumstances in which a small cut, for example, could cause mutilation because of tissue damage, for instance, or nerve damage or something of that kind. But “injury” or “damage” does – “mutilate” does imply something more than superficial but when it says “imperfect” you may need exposition of what that means because the court was not saying “forever imperfect”. They are clear about that. So, you would not just pick that up and read that out to a jury and the court is not saying you would just pick that up and read it out.

**EDELMAN J:** So, in every case, therefore, there needs to be medical evidence about the likely longterm consequences of a cut or nick?

**MR GAME:** Not necessarily, your Honour, but it is – there would need to be evidence that describes something that amounts to "mutilate", namely, something that creates – it does not have to actually be permanent, significant damage, or something more significant than de minimis. It is to be recalled, your Honour, two things – one, what is in question here is not whether or not something is or is not the appropriate words for a future jury direction but whether this jury direction was correct. In my submission, it is manifestly clear that and it is important

**EDELMAN J:** No, the question is whether the Court of Appeal's decision was correct.

**MR GAME:** Well, the question is whether or not the Court of Criminal Appeal was correct in saying that the direction was incorrect and that is the question. That question is – the Crown has to come back to talking up what the Court of Criminal Appeal said about what it means. There is a second part that I will come to if I have time. The Court held there was not even evidence of a nick or a cut. They did hold that for the purposes of determining the second question.

What one has to do is understand how it was that they got to – I am sorry, there are some other passages, your Honour, that set out what the Court actually concludes about the question and one does need to look at them. For example, you see at 522:

We accept that a cut or nick could, in a particular case, amount to mutilation –

There is, back at 515 - and this may answer your Honour's point - nobody is saying that there was any tissue damage in this case and tissue damage could amount in a particular case to mutilation and the court is accepting as much in paragraph 515.

I will go back to what his Honour decided but there is a fundamental problem and it is a very deepseated problem with the approach to construction and that explains why he got where he did because what his Honour did - and you can see it if you go to application book 52 - he looks at the long title "female genital mutilation" but he does not look to what was prohibited by way of female genital mutilation. He goes to a very large body of material that describes the widest possible scope of female genital mutilation. That, in fact, extends to some symbolic acts that actually are purely ritualistic.

**EDELMAN J:** Your submission is that a cut or a nick that does not amount to mutilation in the sense of – in the dictionary sense of meaning some form of imperfection, irreparable damage or something like that – that that is not female genital mutilation?

**MR GAME:** I would not put it that high. I say tissue damage could amount to mutilation and it would not be correct to leave it to the jury in that way.

**EDELMAN J:** Why is not a cut or a nick always tissue damage?

**MR GAME:** It is just superficial. This is just a superficial – I mean, we get down to what was actually talked about was scraping of skin cells but we are construing words – "excise", "infibulate", "mutilate", that is a million miles from that which is in this statute – that is a million miles from it. But what his Honour did was this and it explains why he has picked everything up because having gone through all of this material – World Health Organisation, Family Law Council, second reading speech, other material, we see a whole series of different descriptions of it and then we get to page 81, paragraph 232. Now, 232, having gone through all of that material he says:

In my view, the section may be construed appropriately as the legislature using two specific terms . . . to incorporate all other forms of FGM –

But that is not what the section says. The section says "all other forms of mutilate". So, what happens then – and that proposition at 232 is entirely circular and it goes nowhere and that is the centre of this judgment. If you then go to 243 we see his Honour speaks of an "umbrella term" and he picks up an umbrella term. Then if you go back to the definitions at 159 – paragraph 159 – 157 to 159 and then we see the reference to a catchall term, so what his Honour has done is pick - defined "otherwise mutilates" as all of those things that are caught by the definition of "female genital mutilation" in various dictionaries – not the word "mutilate". So it is all wrong. Then he says at

**EDELMAN J:** So the words "otherwise mutilates" have a different meaning from the words "female genital mutilation" in the short title?

**MR GAME:** Yes.

**EDELMAN J:** All right.

**MR GAME:** Sorry, it has a different – no, what the word is – the words are an exposition of what is prohibited and one cannot extend the offence one millimetre beyond that which sits in the provision. You are not going to get there by going to the heading of the amending legislation.

**EDELMAN J:** Or any of the extrinsic materials.

**MR GAME:** No. Well, the extrinsic material tells you a whole lot of things about female genital mutilation. It does not tell you about the definition of the word "mutilate". What "otherwise mutilates" opens up is otherwise categories of mutilation, not otherwise categories of female genital mutilation. In my submission, that point is unarguable.

Now, at paragraph 247 on page 85 we see the kind of things his Honour is trying to pick up - "ritualised circumcision". Then he picks up a whole series of things – "pricking, piercing" - so a prick would be caught by this. That is why it is such a wide thing because it describes everything that can fall within the description of what might be described as the ritualised activity.

Then you go finally at 249, that – this idea of a choice, ordinary meaning or FGM literature sets up a duality which is a false duality and the Crown's argument to you depends on a false duality, a false duality that the Court of Criminal Appeal did not engage with and their judgment does not suggest that.

So, in our submission, that judgment is completely misconceived and allowed an entire case to be put on a basis where very little, if anything, could be established. As we know, the fresh evidence shows that there is, in fact, now no damage and the Crown put the case on the basis that there may be a removal of the clitoral head – tip.

So, then if we go to the judgment. In my submission, we see that they do interpret text in context and in the light of purpose, not the reverse. I will just take your Honours to a couple of passages. If your Honours look at pages 480 to 481, we see at some point the court engages with our point about the meaning of "mutilate". But what they say is actually different. What they say - and they come back to it later at 493 - what they say at 476 is different. They say:

context in which it is used must be of relevance and the context here is excision, infibulation or otherwise mutilation of a sensitive part of the female anatomy.

That is the correct context. It is an analysis of the text. It is in context. They say the same thing at paragraph 480. They are not running with a duality that is being put by the Crown. If you go then to 485, there is a kind of vast overemphasis in the Crown's submissions about what we said about applying "mutilate" to different things, but they deal with it then at 493 and our submission has to be seen as qualified and they say:

The appellants' concession that it may be easier to mutilate a more sensitive body part is telling -

but then they go on to say that what is problematic is that his Honour was actually just looking at the definition in dictionaries and elsewhere of "female genital mutilation" as a term as a catch term, and then applying it to all of this, which is not a construction in any sense of the meaning of the words. Then at the bottom of that paragraph, critically:

The question is what is meant by "mutilates" in a statutory provision that does not use the term "female genital mutilation" as part of the description of the offence.

So, again 495 to 497 we say are quite unexceptional. As I say, a graze would not – it is difficult to see how a graze or a scratch could be described as mutilation or a prick.

**BELL J:** Or a bruise, as I understand the prosecution.

**MR GAME:** Or a bruise, yes. Or a minor bruise. So then when we come to the conclusions we see at - 513 is quite an important paragraph. The second sentence talks about the Family

Law Council recommendations:

However, that general purpose cannot extend the scope of the conduct prohibited by the actual words used in the Act.

Then, finally – it is 519, the last sentence:

The term "or otherwise mutilates" is an umbrella term –

So they are accepting the Crown's argument about opening something up, but it is an umbrella term to capture other forms of mutilation that are to be prohibited. That, in my submission, is inescapably correct and the "de minimis" "to any extent" at the top of 522 cannot be correct. So that is how we deal with that.

**GAGELER J:** Mr Game, can we just look at 521, which is the focus of the Crown's submissions?

**MR GAME:** I have missed your question, your Honour.

**GAGELER J:** Paragraph 521, can I just go back to that sentence that is criticised:

meaning connotes injury or damage that is more than superficial -

You would embrace that?

**MR GAME:** Yes.

**GAGELER J:** Is the difficulty with the remainder of the sentence?

**MR GAME:** Well, not really when you understand it in the context of the other parts of the judgment where they say they accept that a cut or nick could in a particular case amount to – you have to look at it in context and I am not – one would not just read that out in any sense when one – one would stick to the definition of the – and describe the damage. It would then be a factual question for the jury to determine whether or not that amounted to mutilate. But superficial injury would be excluded as something that could fit that description. A quibble about the words "irreparably damaged" is not a cause to grant special leave in this case, your Honour.

Now, I wanted to – so, the argument about clitoris extending to the clitoral hood, they are different structures but the case was pleaded this way. But it has to be understood in the context of the point that was being made, which was that "mutilate" involved any – because the clitoris was such a sensitive part of body, therefore any activity however minor, was mutilate.

But then because that caused a difficulty for them because they could not say it happened to the clitoris they then said well, that includes the clitoral hood and they got their account from some evidence of Dr X who actually could not describe what it was that had happened to

her. So we involved a change of case and then – but it kind of undercuts their central argument and that is why it is brought forward. But as a matter of construction what the court said is correct. It was the way the Crown ran their case.

So finally I wanted to say this, your Honours. It is on the question of the Crown quibbles with this, but the court did deal with the question on whether or not there would be a retrial on the alternative count as to whether or not there was evidence of a nick or cut that could go to the jury on the basis of damage to the clitoris or any other part of the genitalia.

Sorry, I should say also that if the Crown's submission is correct then there was no reason to say any of those things in the provision, including the identification of clitoris, labia majora, labia minora because you would just say "female genitalia" and catch everything that could possibly come within them. That specificity also can be seen as something that ties "mutilate" to those ideas because it is something – mutilates something specific, it is not mutilates something general. So then the court does - they say at 615:

We turn first to consider whether there is available evidence –

So the "assault occasioning" ended up being something that did not fit – it was a nick or cut to somewhere else. But they assess the evidence, they go through C1's evidence and then they say at 621:

The high point of the evidence –

and then 625:

The evidence of C1 –

The light has come on, but if I could just finish this little bit. C1, they are disposing of that – when they say:

she thought . . . there being no lasting pain, no blood, nor any other evidence –

They are disposing of it as they dispose of C2 and we see that at 628. That is what - I cannot go on but if you just go to 638 one can see that they engaged in a discretionary exercise about retrial but they are saying that there is – and 634 is not a qualification of that. So the most – this is many years later, there was no evidence of a nick or cut. A retrial on that question, in my submission, would be quite inappropriate and that is another powerful reason to refuse special leave.

**BELL J:** Thank you, Mr Game. Mr Dhanji.

**MR DHANJI:** Thank you, your Honour. Your Honours, we unsurprisingly adopt what has been said on behalf of Ms Magennis. But quite apart from questions as to the prospects of success, which we stress are limited, there are powerful reasons why this Court would not grant leave to the applicant to agitate the acquittals granted the respondents.

Now, it is first of all important to bear in mind what is sought here is a retrial, an order for a retrial. This is in circumstances where the respondents, A2 and Magennis, have in fact served the entirety of their sentences. Those sentences expired in September 2017. The respondent, Vaziri, served three months in custody out of an 11 month nonparole period and then was granted bail and spent a period on bail of about 13 months under conditions that were actually broadly consistent with the home detention orders that had been given to the principal offenders, Mr Vaziri being an accessory after the fact.

But more than the concern in relation to the respondents is in fact a question that arises with respect to, in reality, all the participants in this trial, most particularly the complainants themselves and as your Honours will appreciate, they were obviously young children at the time that the investigation arose.

The JIRT interview was conducted in August 2012 when the complainants were respectively just short of nine and just short of seven years of age. By the time of trial, when they were required to give evidence, they had turned 12 and 10, the trial taking place across September and October 2015. Indeed, I think they had their birthdays in the course of that time. They are now, as I calculate, aged 15 and 13 and find themselves in circumstances where proceedings remain on foot with the prospect of them, if special leave is granted, the uncertainty continuing, and if a new trial is ultimately ordered the prospect of again giving evidence in criminal proceedings, most particularly in the case of – it is the fact that that would involve giving evidence in criminal proceedings against their mother.

**BELL J:** Yes.

**MR DHANJI:** Now, that is a powerful reason to refuse special leave. But, even when one comes to issues such as the questions of general importance it should also be noted that it is not suggested that there are a raft of prosecutions in the wings turning on the fine distinction that is sought to be agitated here. That is in the context of this legislation having been enacted in 1994. The circumstance arises where there is – this was alluded to by the Court of Criminal Appeal – ample opportunity for the legislature to provide clarity if it chooses to do so, but in terms of this Court's involvement, in our submission, there is no pressing concern.

The concerns in relation to the grant of special leave go beyond those because factually it is also highly problematic. Your Honours will be aware that new evidence was admitted on the appeal in the Court of Criminal Appeal and the court's decision to admit that evidence has not been the subject of challenge. What that new evidence established is that on examination which took place subsequent to trial, the clitoral head of each of the complainants was visible. What that meant was that one of the scenarios put forward by the

Crown at trial, that is, that the clitoral head which at that time is not visible, was not visible because of excision, was no longer available.

But it goes further than that because it also goes to whether anything even less than incision could have occurred with respect to the clitoral head. Mr Game touched on this. You have areas of different sensitivity, and the clitoral head is a particularly sensitive area, so the nature of what will be required to constitute female genital mutilation in the context of the clitoral head may be different to that with respect to the prepuce.

Now, in that regard, the applicant says – your Honours do not need to turn it up but it is at application book 743 – in reply that this Court is not in a position to infer that Ms Magennis could not have retracted the clitoral hood to carry out the ceremony in the manner alleged by the Crown; in other words, they seek to put forward the idea that despite the fact that it was not visible it could still have been accessed.

Even putting to one side the difficulty that arises immediately with respect to onus and burden of proof – that is, the submission being one that the court could not infer that she could not have done something as opposed to the Crown's ability to establish that she had the capacity to do so – the evidence is such that it would not allow any such inference to be drawn. The reason for that is this, and if I can take your Honours to application book 409, your Honours will see at paragraph 227 there is an extract of some of the evidence of Dr Marks, an expert called by the Crown, and she gives the analogy of a little boy who has not been circumcised. I will not read all of that. She refers to pulling it back, and then towards the end of that paragraph she says:

So in a little girl, the structures are smaller and the head of the clitoris is smaller, but it has the – the skin that is over it is attached to it quite firmly, and can make it difficult to see and the only way then would be to forcibly pull that skin back.

Similarly, or in a similar vein, at 442 of the book again this is a reference to evidence of Dr Marks he actually says in the extract set out after paragraph 339:

to actually move the clitoral hood so as to try and see better, that would be painful, so that is not something that you can do, but [C1] was cooperative. It was possible to look at her.

**BELL J:** Mr Dhanji, accepting for the purposes of argument that the fresh evidence adduced on appeal may make the prosecution on any retrial, were that the course adopted, more difficult, I am just not quite sure where this is taking us. You have developed reasons why, in the exercise of discretion, it would be inappropriate, so you say, for an order for a retrial, but I am not quite sure how far this is taking you.

**MR DHANJI:** The point I seek to make is this. Crown evidence at the first trial, and particularly the evidence as to the sensitivity of the clitoral head and the potential for

damage as a result of interference with the clitoral head, was obviously predicated on at least the possibility that interference had actually occurred to the clitoral head. Now, that goes by the wayside and indeed that has to be seen in the context of the way the Crown brought its case. The Crown case was in fact that this process, described as khatna – it is set out at application book 354:

involves causing injury to a young girl's clitoral area by nicking or cutting the skin, and that, by damaging this area of very dense nerve tissue, the procedure is intended to suppress the development of the girl's sexuality as she attains puberty.

So the Crown case, as it was brought before the Supreme Court, was one that involved this idea that there was this intentional interference, and that aspect of the case has gone. The significance of that is it brings

**BELL J:** I think there may be some controversy. I may have misunderstood it, but I understood that the Crown does not concede that it was not possible that there could have been some interference with the clitoris as distinct from the prepuce. Now, the merits of that probably are not usefully explored on this special leave application.

**MR DHANJI:** The two aspects of the evidence that I took your Honours to were to establish that to actually retract the clitoral hood at the time when it was unexposed – and Professor Grover says something very similar – would cause pain. That is entirely inconsistent with because one needs to put that against evidence of the complainant. The complainant's most coherent account was C1's, of course. In relation to C1, her description of her experience where one had what could really only be described as transitory pain was inconsistent with there being the kind of process described by the experts that would involve this discomfort and Professor Grover says that a girl would tend to actually pull her legs together and it would actually be something of a significant interference.

All I am saying is – and that is perhaps using up a lot of my 20 minutes – that you have an account given by the complainant that is simply not consistent with that possibility. So that brings one back to this idea of could one get to mutilation by the route of what can only be, on the experts, a very superficial interference with the prepuce and that one is in different territory to the territory one would be in with respect to the clitoral head. That is that point.

When one comes to that question, could one get to "mutilate" or "otherwise mutilates" within section 45 as a result of this interference with the prepuce that of course requires the Crown construction, which is, in effect, the importing into the section of female genital mutilation as a concept. Then one goes from the definitional constructional exercise of section 45 to a construction exercise in relation to the words "female genital mutilation".

That ultimately is not, in our submission, a helpful exercise because it is a little bit like what is described with the dictionary approach, where one goes to the dictionary and one finds some words and then one goes to the dictionary in relation to those words and then you expand outwards. So ultimately what one has – and if I could just do a straight

**EDELMAN J:** Do you accept that there is a constructional choice available in relation to the section of the word “mutilates”?

**MR DHANJI:** No, your Honour.

**EDELMAN J:** No constructional choice?

**MR DHANJI:** One has to construe it depends I suppose precisely what it means. If one is simply saying a constructional choice as between construing the word “mutilates” and a constructional choice which says that it is either the word “mutilates” or the words “female genital mutilation”, then I do not accept that it is a choice

**EDELMAN J:** No, a constructional choice between what the word “mutilates” might mean in its common parlance divorced from the context of female genital mutilation, which is a much higher threshold than any ordinary injury and, on the other hand, what the word “mutilates” means in its common connotation in female genital mutilation.

**MR DHANJI:** Yes. We do not accept that there is a constructional choice, but in doing so we make the concession that we made in the Court of Criminal Appeal and that is that, in understanding the term “mutilates” in section 45, in giving it its meaning, unexpanded by some foreign or outside concept, one is nonetheless having regard to the actual subject matter and that is why we say the Court of Criminal Appeal was quite correct to say a nick or a cut to the clitoral head, for example, may amount to mutilation.

Can I put it this way? There is nothing unorthodox about an application in a criminal case of the onus and standard of proof and I think the point has been made in the submissions that insofar as that can create difficulties Parliament in other provisions has sometimes resorted to the use of deeming provisions.

Can I say this? In terms of the problem with going to the extrinsic material and in particular to the Family Law Council report – this is at application book 451 at paragraph 378 and this is where one comes to this issue of finding a meaning through another term and then trying to find the meaning of that term as it is used – what is said in the Family Law Council report, which would appear as the high point of what the applicant would seek to rely upon, is that:

Female genital mutilation ‘is the collective name given to several different traditional practices that involve the cutting of female genitals.’ It can involve any one of 4 procedures –

So it is talking about four procedures, although it goes on to say that there is perhaps concern in relation to being too precise about breaking this down. At 379, their Honours go on to note that:

the Report noted at [2.02] that the term ‘female genital mutilation’ was used in the Report as embracing “all types of the practice where tissue damage results; for example, damage manifested by bruising, contusion or incision” and that

This was raised by your Honour Justice Gageler – that in fact begs the antecedent question, all types of the practice: what are we talking about when we are talking about the practice? Insofar as they are talking about the practice, it is the four practices – and they are set out over the page, on 452 of the application book. That refers there to:

Ritualised circumcision, this being the "first, and least severe form", where the procedure may be wholly ritualised or where the clitoris is scraped or nicked -

That is a sort of summation. It might be noted at that point that the full part of that paragraph goes on to say, at application book 63 – your Honours do not need to turn it up – is that:

*This causes bleeding and may result in little mutilation or long term damage.*

But it is noteworthy that even where they are talking about the procedure, not quite wholly ritualised but just scraped or nicked, they are still talking about a procedure which causes bleeding.

**EDELMAN J:** They do open with the paragraph saying that those four categories or procedures have been described as involving a distinction that:

*is irrelevant since it depends on the sharpness of the instrument used, and the struggling of the child*

**MR DHANJI:** That is right. That is a note of caution to say there is a concern that that is going to perhaps affect the outcome, and it may well be that somebody who is trying to engage in a purely ritualised exercise will, as a result of imprecision or struggling of the child, find themselves committing an offence that actually comes within the section because it may actually result in even, as I say, a minor cut to the clitoral head.

But importantly, in the point that I want to develop is when one goes to item 2, clitoral circumcision generally called simply "circumcision" or has also been called "sunna", clitoral circumcision involves the removal of the clitoral prepuce and what is important about the way the report deals with that is it is dealing about the prepuce separately to the clitoris, which is described in

**BELL J:** Mr Dhanji, I think there has been quite a degree of overlap between the division that you and Mr Game agreed upon.

**MR DHANJI:** That is so, and I appreciate the orange light is on, so you will see the back of me, but I did just want to make that point. With respect, it was not a point made by Mr Game and it is simply to say that you have this distinction that is drawn between these first two categories in the Family Law Council report. In the second category, there is reference to the prepuce, suggesting that in the first category one is talking about the clitoris, not the prepuce and the importance of that is that that indeed would rule out what on the facts is said to have happened here.

Ultimately, what that means is that – and this is the problem I started with – you end up on this sort of constructional approach to the Family Law Council report and you are a long way removed from the actual provision. That is highly problematic, but even when you go down that path you do not inexorably arrive at the point where what happened in relation to this or what at the high point happened in this case was said to be covered by the section.

I will sit down now saying this, and this is directly an overlap, because what actually happened in this case is ultimately a situation where the medical evidence did not establish any injury, and your Honours have that at page 510 and there is a neat summary at paragraph 590, and then that sits with the evidence most coherently of C1 in the passage that Mr Game took your Honours to at 521, paragraph 625 – that is, the evidence of C1

that she thought she had been cut or pinched – is to be viewed in the context of there being no lasting pain, no blood or any other evidence of injury. I make the obvious point she did not see it and the evidence itself, when one construes it, would not support something that could possibly amount to mutilation. May it please the Court.

**BELL J:** Thank you. Anything in reply, Mr Kell?

**MR KELL:** Thank you, your Honour. First, my friend made reference again to application book 494, which is the judgment paragraph 522, which his Honour Justice Gageler referred to where there is reference to the error in the direction. If one goes to the direction of the judge to see the context, it is at volume 1 of the application book at page 100, about halfway down the page. This is the summingup, at line 32:

The word “mutilate” in the context of female genital mutilation means to injure to any extent. It is not necessary for the Crown to establish that serious injury resulted.

So the distinction there is the contention that was put to the contrary. His Honour is directing the jury that one does not need to find serious injury, so where there is reference of injury to any extent it is not a de minimus; it is that one needs to find injury but one does not need to find serious injury.

That flows on to the second point which I would put in reply, that on the question of what a future direction will be provided to juries as a consequence of this judgment if left uncorrected by this Court, there can be no doubt about it. If one looks at paragraph 586 of the judgment, it sets out what the test now is for the term “mutilates” under section 45 and the guidance that would be provided. The directions would be to the effect – and I am going to the second sentence:

that a cut or nick to the clitoris could well amount to mutilation in some circumstances -

That must be the case depending on the thrust and the savagery of the cut, but:

the medical evidence would need to establish that there had been injury or damage which rendered the clitoris imperfect or irreparably damaged in some way. We have concluded the in the absence of any medical evidence of such injury or damage, an offence contrary . . . could not be established.

That will be the direction for future juries if this Court is not persuaded to intervene.

**BELL J:** Yes.

**MR KELL:** That is what we submit will be the direction that will be resolved. My friend made reference to – that there is no evidence of a nick or cut and this is seemingly in the context of why there would not be a retrial. Therefore, your Honours would not be persuaded to grant special leave. In our submission, there is strong powerful evidence of injury. It is set out in our submissions and in the judgment. It includes evidence from C1 given to the effect that she was cut, that she saw Magennis with scissors. There is evidence of A2 in a conversation indicating that within this practice they cut – in response to a question as to whether they cut a lot or cut the whole clitoris off – "No, but they cut."

**BELL J:** Mr Kell, there are some other considerations that are said to provide powerful reasons why it would be inappropriate to grant special leave and, in the event the appeal succeeded, to contemplate a retrial, having regard to the circumstance that would involve these young girls in again being required to give evidence in a criminal proceeding against their mother in circumstances in which each of the respondents has effectively served the sentence imposed.

**MR KELL:** Yes, and we accept that those are two discretionary factors, but weighed against that is the realisation of the importance of the question of law arising. The acceptance, of course, of the sentence means that in terms of a sentence there is not going to be any greater sentence imposed but there is a profound deterrent effect of convictions for these offences on a recognition of the proper meaning of the term and those factors weigh in the balance. Of course, at this stage of the inquiry, what we need to persuade your Honours is only that a retrial is a possible order that may be made and even then, of course, a retrial is permissive.

**BELL J:** Yes.

**MR KELL:** So there are factors down the chain. But we submit that certainly there is evidence, which we have indicated in the submissions, indicating that these offences can be made out, and that there is the distinct real possibility of an order for a retrial being made; and that the discretionary factors raised against do not outweigh the importance of the matters in

**BELL J:** Yes.

**MR KELL:** We submit that it is an appropriate case for a grant of special leave.

**BELL J:** Thank you, Mr Kell. The Court will adjourn briefly to consider the future course of the matter.

**AT 12.56 PM SHORT ADJOURNMENT**

**UPON RESUMING AT 12.59 PM**:

**BELL J:** There will be a grant of special leave in each of these applications.

**MR GAME:** Your Honour, can I just say one thing?

**BELL J:** Yes.

**MR GAME:** Because it is a test case, in effect, we submit it should be conditional on paying our costs.

**BELL J:** Mr Kell?

**MR KELL:** Your Honour, we submit it is not a test case in the usual sense, it is a criminal matter; and that your Honour should not impose that condition.

**BELL J:** Yes. We are not disposed to conditioning the grant of leave on those terms, Mr Game. Mr Kell, what is the likely estimate?

**MR KELL:** It depends on the extent to which the two respondents adopt one another's arguments and contentions. I would have thought if there is that crossadoption, then it could be done within a day. If there needed to be caution because of two respondents, one to two days. But I would hope that it could be done within a day.

**BELL J:** Yes. Mr Game.

**MR GAME:** A day would be fine, we think.

**BELL J:** A day will be fine, yes, very well. Can I invite the parties to obtain the directions from the Registry, and as always, to comply with them. The Court will adjourn until 2.00 pm.

**AT 1.02 PM THE MATTERS WERE CONCLUDED**

IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY

No. S43 of 2019

No. S44 of 2019

No. S45 of 2019



BETWEEN:

**The Queen**

Appellant

and

**A2**

**Kubra Magennis**

**Shabbir Mohammedbhai Vaziri**

Respondents

## APPELLANT'S SUBMISSIONS

### Part I: Certification

1. These submissions are in a form suitable for publication on the internet.

### Part II: Statement of issues

2. These appeals raise two issues as to the proper construction of s 45(1)(a) of the *Crimes Act 1900* (NSW):
   i. Do the words "otherwise mutilates" require proof of injury or damage which renders the labia majora, labia minora or clitoris of another person imperfect or irreparably damaged in some way?
   ii. Does the word "clitoris" encompass the clitoral hood or prepuce?

### Part III: Section 78B Notice

3. The appellant does not consider that notice is required pursuant to s 78B of the *Judiciary Act 1903* (Cth).

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**Part IV: Judgment below**

4. The appellant appeals against part of the judgment of the New South Wales Court of Criminal Appeal (**CCA**) (Hoeben CJ at CL, Ward JA and Adams J) in *A2 v The Queen; Magennis v The Queen; Vaziri v The Queen* [2018] NSWCCA 174.

**Part V: Statement of facts**

5. By an indictment dated 14 September 2015, A2 and Ms Kubra Magennis (**Magennis**) were charged with having "mutilated the clitoris" of C1 and C2, contrary to s 45(1)(a) of the *Crimes Act* (Joint Core Appeal Book (**AB**) 2-3).[1] The offences against C1 were said to have occurred between 18 October 2009 and 29 August 2012. The offences against C2 were said to have occurred between 1 January 2012 and 29 August 2012. Mr Shabbir Mohammedbhai Vaziri (**Vaziri**) was charged with assisting A2 and Magennis following the commission of those offences (AB 4-5). The respondents pleaded not guilty to the charges (AB 6).

6. In a pre-trial ruling,[2] the trial judge (Johnson J) concluded that "physical injury to [any] extent to the female genital organs, which is done for non-medical reasons, can amount to mutilation for the purposes of s 45" of the *Crimes Act* (AB 41 [110], 86 [258]). His Honour also concluded that the word "clitoris" is capable of referring to the prepuce of the clitoris (AB 89 [270]). The trial proceeded on the basis that the offences could be established by proof, beyond reasonable doubt, of a cut or nick to the clitoral prepuce and the jury would be directed as such (see AB 11 [5]).

7. The evidence at trial was that A1 and A2, respectively the father and mother of C1 and C2, were members of the Dawoodi Bohra community (AB 351 [2]). Vaziri was a spiritual leader of that community (AB 354 [11]). The Crown alleged that members of the Dawoodi Bohra community observe a practice of female genital mutilation known as "khatna", which involves the cutting or nicking of the clitoris of young girls usually around the age of seven (AB 354 [14]). It was alleged that Magennis, who was trained as a nurse and midwife, performed khatna ceremonies for members of the community (AB 354 [11], 371 [75]).

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[1] Alternative charges of assault occasioning actual bodily harm, contrary to s 59(2) of the *Crimes Act*, were also included on the indictment.

[2] *R v A2; R v KM; R v Vaziri (No 2)* [2015] NSWSC 1221 (AB 8ff).

8. A2 and Magennis admitted that Magennis had performed an "examination and symbolic ceremony" on C1 and C2 at A2's request which had involved Magennis making some contact with the genital area of each girl (AB 355 [15], 394 [167]). The defence case was that this symbolic ceremony involved "no damage, injury or other physical intervention falling within the relevant statutory" language (AB 394 [166]).

Evidence of C1

9. On 29 August 2012, following an anonymous report to the Department of Family and Community Services, members of a Joint Investigation Response Team (**JIRT**) interviewed C1 and C2 at their primary school (AB 356 [19]-[20]). The recorded interviews were adduced as evidence at trial.[3]

10. In her interview, C1 said, at first, that she did not know what khatna is. She then said she "might know" because "maybe [she] heard of it" at her cultural school (AB 357 [23]). Thereafter, the following exchange occurred (AB 358 [24]):

> "Q Well I heard that it means, um, that it's something that some young girls have, and it's like a type of cutting to the private part.
> A Yeah, it is.
> Q It is. How do you know that?
> A Because it's happened to me."

11. As the CCA observed, although the interviewer introduced the idea of "cutting", C1 volunteered that it had happened to her (AB 358 [25]). C1 recalled that she was seven years old when it happened; that it happened in Wollongong; and that her mother, grandmother (A5) and great aunt (A3) were present (AB 358 [26]-[27]). She said she was "nervous about it". C1 remembered lying on a bed and being told to close her eyes and imagine she was a princess in a garden. Before she did so, she saw "all the people around" her who were there "to just calm [her] down" (AB 358-359 [28]-[29]).

12. Asked what happened when she closed her eyes, C1 said "[i]t hurt ... in the private part". Afterwards, C1 drank lemonade and had a shower. She was scared to have a shower because she thought it would hurt, but it did not (AB 359 [30]-[31]).

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[3] *Criminal Procedure Act 1986* (NSW), Part 6, Division 3.

13. C1 said they ate lunch at the house of the lady "who did it for [her]" (AB 359 [31]). She said she last saw that lady "when she had to do that thing to my sister". As the CCA noted, the disclosure that the same "thing" had happened to C2 was "unprompted" (AB 360 [34]). C1 provided details of that occasion, including that it occurred at her own home; that she thought it happened that year; that her mother and aunt (A4) were present; and that she (C1) had watched television with the lady's grandson while C2 was upstairs (AB 360 [34]).

14. Finally, C1 was asked to "explain exactly what happens" and she said "they give um, a little cut there … [i]n your private part". She said she was "not used to talking about it" because A2 told her "not to go around telling everyone" (AB 360 [35]).

15. C1 gave further evidence at trial. She added that, at the time the procedure was performed on her, she saw Magennis holding "a silver toolish thing" that looked a bit like scissors (AB 394 [168]). She also said she did not see any blood (AB 395 [169]). In cross-examination, C1 described that during the procedure she felt "a bit of pain and then a weird sort of feeling" in her private part. She said the pain was "like [she] got a pinching or a cutting". In re-examination, C1 said: "I don't really think it was a pinching, it just felt a bit like it … I'm not completely sure if it was cut, although it is most likely it was cut" (AB 395 [169]).

Evidence of C2

16. When interviewed by members of the JIRT, C2 was six years old and had been diagnosed with a mild intellectual disability (AB 361 [36]-[37]). C2 shook her head and said "no" when asked whether a lady had come to her home to do something special for her and whether she knew what khatna was. The crucial exchange was as follows (AB 362 [40], [42]):

> "Q We heard that you had had a cut on your private parts. Is that true?
> A Yes.
> Q Yeah. When was that?
> A I don't know.
> Q You don't know when it was. Where were you when that happened?
> A Home.
> …
> Q … So what did you feel when it happened?
> A Hurting.
> Q Hurting. Where did it hurt?
> A In my bottom."

17. C2 said that this did not occur on a school day; that it happened in her parents' room; and that she was lying down on cushions which she thought were white (AB 362 [41]-[42]). C2 responded to further questions by saying that she did not know or did not want to talk about it (AB 363 [43]-[44]).

18. C2 also gave oral evidence at trial, by which time she was nine years' old. That evidence was to the effect that she could not recall what happened, or that she did not "want to say" (AB 395-396 [172]-[173]).

19. The CCA concluded, contrary to the trial judge's ruling,[4] that C2 was not competent to give sworn evidence for the purposes of s 13(3) of the *Evidence Act 1995* (NSW) (AB 593 [879]-[880]), but that C2 was competent to give unsworn evidence, if informed of the matters in s 13(5) of the *Evidence Act* (AB 592-593 [877], [881]).[5]

Lawfully recorded conversations

20. On the afternoon of 29 August 2012, a conversation was recorded between A2 and her daughters. By this time, A2 had been asked to attend an interview with the JIRT (AB 364 [45]). A2 asked what C1 had spoken about with "the lady" at school. A2 said: "you told them everything ... Now we are in big trouble ... We told you my child this is [a] big secret, never tell anyone" (AB 364 [48]). Later, there was a conversation also involving A1 in which C1 referred to being "cut". A1 insisted that C1 was not cut. In response, C1 said she saw scissors. (This was the first reference to scissors.) The CCA described this conversation as giving "rise to the obvious inference that A1 was attempting to dissuade C1" from her account (AB 368 [62]-[63]).

21. On the same afternoon, A1 was recorded telephoning Vaziri. A1 said to Vaziri that C1 had told police "everything that circumcision – kharanat [sic] has happened here" (AB 365 [50]). Vaziri and A1 discussed telling police that the family had travelled to Africa and that it might have happened during that trip. This conversation was the genesis of what was described by the CCA as the "Africa checking story" (AB 365 [51]-[53]). Shortly afterwards, A1 telephoned Magennis. A1 said that he would tell police that "they did not perform circumcision ... [but that] they went to

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[4] *R v A2; R v KM; R v Vaziri (No 4)* [2015] NSWSC 1306.

[5] Consistent with authority, the differences between sworn and unsworn evidence will not necessarily impact an assessment of the reliability of that evidence: see *The Queen v GW* (2016) 258 CLR 108 at [55]-[57].

Africa where it was possibly done, so they called Magennis to check the complaints, to make sure that nothing had been done to them". Magennis said she was happy for A1 "to go that way" (AB 367 [59]).

22. A1 agreed in evidence at trial that the Africa checking story was fabricated (AB 398 [180]). A2 and Magennis variously adopted that story and the jury was instructed that a consciousness of guilt could be inferred from the advancement of such lies (AB 602 [906], 610 [932]).

23. At around 4:00pm on 29 August 2012, A1 and A2 were recorded having the following conversation in the JIRT office, while waiting to be interviewed (AB 370 [72]):

> "A1: In us do they cut skin?
> A2: um...
> A1: or do they cut the whole clitoris?
> A2: No they just do a little bit ... just little ..."

A1's evidence was that this conversation was about the practice of khatna in the Dawoodi Bohra community generally (AB 397 [176], 399 [185]).

24. On 30 August 2012, Magennis and A2 spoke about the complainants undergoing a medical examination. Magennis was asked "[i]s there any way they know about it that it happened?" and she replied "No.. Because the way I do no one knows even little bit". Magennis told A2: "No one knows even anything happened here. If they asked. You can say kids are playing on swings, they play in the garden. Graze can happen if they fall" (AB 379 [106]).

25. At various times, conversations were recorded between A1 and A2 and their family members which included references to khatna (or khatanat) and/or circumcision in relation to C1 and C2 (see AB 369 [69], 370 [70], 373 [82], 375 [91], 391 [153]).[6]

Evidence of family members

26. At trial, A1 gave evidence that A2 had explained to him that the khatna ceremony performed on his daughters involved the "placing [of] forceps in genitalia and some Koranic verses prayed" (AB 396 [175]). A3 gave evidence that she attended the ceremony performed on C1, but did not know what it involved

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[6] Evidence was given at trial by interpreters of Gujarati and Lisan-al-Dawat to the effect that "khatna" and "khatanat" refer to circumcision: AB 415-416 [252], [254]-[255].

(AB 400-401 [190], [193]). She said C1 appeared "quite calm" and there was no blood on the bed afterwards (AB 400 [191]). A5's evidence was to similar effect. She described what happened as both a "check-up" and a "symbolic procedure". But she said she did not see or know what happened (AB 401-402 [195], [197], [200], 403 [206]).

Medical evidence

27. Dr Marks examined C1 and C2 on 3 September 2012 at Westmead Children's Hospital (AB 404 [208]). Dr Marks observed that the external genitalia of C1 and C2 appeared normal: there was no evidence of scarring (AB 406-407 [218]-[219]). She noted that she could not visualise the clitoral glans or head. Dr Marks said she would expect the examination findings to be normal because cuts to the skin of the clitoral area can heal without scarring or long-term evidence (AB 405 [211]-[212], 408 [224]). Dr Marks' evidence was that there could have been "a cut to the clitoral hood that had healed and not left a scar, or … a cut to the clitoral head itself that did not result in any appreciable change" (AB 407 [223]). The examination findings neither confirmed nor disproved the allegation of cutting (AB 408-409 [224], [226], [229]).

28. Professor Jenkins, a specialist obstetrician and gynecologist, gave evidence that, in his experience of examining adult women who have undergone female genital mutilation procedures, overt changes to their anatomy are "broadly speaking, not obvious at all" (AB 410 [233]). He agreed that Dr Marks' observations neither supported nor excluded the happening of female genital mutilation in these cases (AB 411 [234]).

29. Professor Grover, a specialist in paediatric gynaecology, gave evidence that she would expect a cut to the clitoris to be painful and, usually, to bleed. She accepted that the clitoral area heals rapidly, possibly without scarring (AB 413-414 [245]-[247]).

30. Before the CCA, the respondents adduced new medical evidence to establish that, on 8 January 2016, the tip of the clitoral glans or head was visible on examination of each complaint (AB 443-444 [347]-[351]). This evidence excluded the possibility that the tip of the clitoral glans or head had been removed from C1 and/or C2 (AB 444 [352]). Dr Marks had identified this as a possible explanation for why she

could not visualise the clitoral glans or head during the examinations in 2012 (AB 442 [343]). Because one of the bases on which the offences were left to the jury was disproved by the new evidence, the CCA considered that a potential miscarriage of justice had occurred (AB 466 [358]). The appellant does not challenge that conclusion in this Court.

Evidence of Dr X

31. Evidence from Dr X was admitted at trial pursuant to s 79 of the *Evidence Act*.[7] The CCA found that Dr X's evidence as to the hierarchical structure of the Dawoodi Bohra community and the static nature of the practice of khatna in the community[8] should not have been admitted (AB 546 [713]-[714], 549-550 [724]-[725]). This conclusion is not now challenged.

Evidence of Magennis

32. Magennis gave evidence that, when living in England, she had been asked by members of the Dawoodi Bohra community to perform khatna ceremonies, which she understood to involve nicking the skin (AB 430 [304]). (It is relevant in this respect to note also that A2 stated, in her police interview, that the practice in the Dawoodi Bohra community was for "a bit of skin [to be] removed" (AB 372 [76]).) Magennis then described a symbolic form of khatna involving a "ceremony of touching the edge of the genital area of skin allowing the skin to sniff the steel" (AB 431 [305]). She said she did this to C1 and C2 using forceps. She also said that she might have touched C1 "a little harder" because her diabetes caused her hands to tremble (AB 432 [309]-[310]).

Procedural history

33. On 12 November 2015, the jury returned verdicts of guilty to the charges under s 45(1)(a) of the *Crimes Act*. Justice Johnson imposed aggregate sentences of 15 months' imprisonment, with a non-parole period of 11 months, to be served by way of home detention on A2 and Magennis.[9] Vaziri was also sentenced to

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[7] *R v A2; R v KM; R v Vaziri (No 3)* [2015] NSWSC 1264. See AB 526-528 [643]-[649].

[8] See AB 422 [275]. That the Dawoodi Bohra community is hierarchical seems not to have been disputed by the respondents: AB 354 [13]. There was also other evidence supporting this proposition: see AB 380 [111].

[9] *R v A2; R v Magennis; R v Vaziri (No 23)* [2016] NSWSC 282 at [193]-194], [200]-[201] (AB 271); *R v A2; R v Magennis; R v Vaziri (No 24)* [2016] NSWSC 737 at [122], [126] (AB 311-312).

15 months' imprisonment, with a non-parole period of 11 months. But his Honour declined to order that the sentence be served by way of home detention.[10] Each sentence commenced on 9 June 2016.

34. By notices of appeal dated 15 February 2017, the respondents appealed against their convictions on 11 grounds. Vaziri also sought leave to appeal against his sentence.

35. On 10 August 2018, the CCA quashed the respondents' convictions and entered verdicts of acquittal on all counts.

## Part VI: Argument

Meaning of "otherwise mutilates" in s 45(1)(a) of *Crimes Act*

36. The CCA reasoned that "mutilates" in "its ordinary meaning connotes injury or damage that is more than superficial and which renders the body part in question imperfect or irreparably damaged in some fashion", and there is nothing in the context of s 45(1)(a) of the *Crimes Act* to justify, warrant or permit a construction of "mutilates" that is broader than its ordinary meaning (AB 486 [495]-[497], 493 [521]). In the appellant's submission, this reasoning bespeaks the error in how the CCA approached the task of construing s 45(1)(a).

37. It is wrong to place upon contextual and purposive considerations the burden of displacing or rebutting what is otherwise thought to be the "ordinary meaning" of the statutory language. As Crennan, Kiefel and Bell JJ said in *Monis v The Queen* (2013) 249 CLR 92 at [309]:[11]

> "[t]he modern approach to interpretation, particularly in the case of general words, requires that the context be considered in the first instance and not merely later when some ambiguity is said to arise [referring to *K&S Lake City Freighters Pty Ltd v Gordon & Gotch Ltd* (1985) 157 CLR 309 at 315 per Mason J]. Such an approach was confirmed as correct in *Project Blue Sky Inc v Australian Broadcasting Authority* [(1998) 194 CLR 355 at [69] per McHugh, Gummow, Kirby and Hayne JJ]. Whilst the process of construction concerns language, it is not assisted by a focus upon the clarity of expression of a word to the exclusion of its context."

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[10] *R v A2; R v Magennis; R v Vaziri (No 23)* [2016] NSWSC 282 at [207]-[208] (AB 272); *R v A2; R v Magennis; R v Vaziri (No 24)* [2016] NSWSC 737 at [130] (AB 313).

[11] See also *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362 at [14] per Kiefel CJ, Nettle and Gordon JJ, [35]-[37], [40] per Gageler J.

38. The role of context in the modern approach to interpretation was further explained by Edelman J in *SAS Trustee Corporation v Miles* (2018) 92 ALJR 1064, where his Honour said (at [64]; emphasis in original):

> "In *Federal Commissioner of Taxation v Consolidated Media Holdings Ltd* [(2012) 250 CLR 503 at [39]], this Court said that the task of statutory construction must begin and end with the text of the statute. That statement does not mean that the text of a statute must be interpreted only according to the range of semantic meanings of the individual words. It means only that the interpretation of a statute, like any other legal instrument, is an interpretation of its words. Those words are interpreted in their context and in light of their purpose although legal rules can sometimes exclude or restrict the use of some context. In ascertaining the reasonably intended meaning of Parliament *con*text is, literally, those matters to be considered (simultaneously) together with the text."

39. The jurisprudence of this Court has made clear that, considered in context and in light of the legislative purpose, the language of a particular statutory provision may bear a meaning that differs from its literal meaning or its meaning in common parlance.[12] That does not make the meaning, ascertained by reference to context and purpose, extra-ordinary.[13] Where a statutory provision, read in context, accommodates a "range of potential meanings, some of which may be less immediately obvious or more awkward than others, but none of which is wholly ungrammatical or unnatural", the constructional choice presented "turns less on linguistic fit than on evaluation of the relative coherence of the alternatives with identified statutory objects or policies".[14]

40. Although the CCA recited some relevant statements of principle in this regard (AB 476-477 [464]-[467]), the appellant submits that the CCA's approach to construing s 45(1)(a) of the *Crimes Act* was contrary to the modern approach to interpretation described in decisions of this Court. In the result, important contextual

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[12] See *CIC Insurance Ltd v Bankstown Football Club Ltd* (1997) 187 CLR 384 at 408 per Brennan CJ, Dawson, Toohey and Gummow JJ; *Project Blue Sky* (1998) 194 CLR 355 at [78] per McHugh, Gummow, Kirby and Hayne JJ; *SZTAL* (2017) 262 CLR 362 at [14] per Kiefel CJ, Nettle and Gordon JJ, [38] per Gageler J; *SAS Trustee* (2018) 92 ALJR 1064 at [20] per Kiefel CJ, Bell and Nettle JJ. See also *Commissioner for Railways (NSW) v Agalianos* (1955) 92 CLR 390 at 397 per Dixon CJ.

[13] See *Interpretation Act 1987* (NSW), s 34(1); *Saraswati v The Queen* (1991) 172 CLR 1 at 21-22 per McHugh J (Toohey J agreeing).

[14] *Taylor v Owners – Strata Plan No 11564* (2014) 253 CLR 531 at [66] per Gageler and Keane JJ; *SZTAL* (2017) 262 CLR 362 at [38] per Gageler J; *SAS Trustee* (2018) 92 ALJR 1064 at [20] per Kiefel CJ, Bell and Nettle JJ.

considerations and the apparent legislative purpose of the provision were not brought to bear in the CCA's analysis.

*Constructional choice*

41. As the CCA accepted, there are a "range of meanings ... attributable to the verb [mutilate]" (AB 480 [476]). Dictionary definitions of the verb range from those that refer to removal or irreparable damage, thereby importing a "degree of permanence or quality of irreplaceability", to those that refer to rendering imperfect by "some act of destruction" (AB 483 [488]). Because of the "breadth of meanings there encompassed", the CCA considered that such dictionary definitions offered "limited assistance" (AB 483-484 [489]-[490]). Nonetheless, the CCA was of the view that the use of the verb "mutilates" in s 45(1)(a) of the *Crimes Act* suggests that "more than the causing of an injury is required" (AB 486 [495]). The CCA reached that view by reference to "the ordinary meaning of 'mutilates'" and/or its use in "ordinary parlance" (see AB 486 [495], [497]).[15]

42. It is undeniable that the general mischief to which s 45 of the *Crimes Act* is directed is the practice of female genital mutilation.[16] Excision and infibulation are recognised forms of female genital mutilation and the words "otherwise mutilates" are an "umbrella term" intended to capture other forms of the practice (AB 493 [519]). The notion of "mutilates" in s 45(1)(a) – referring, as it does, to an act of mutilating another person's labia majora, labia minora or clitoris – has an obvious affinity with female genital mutilation. It is necessary, then, to ask "what is meant by 'mutilation' in that context" (AB 481 [480]).

43. By the time of the enactment of s 45 of the *Crimes Act* in 1994,[17] an awareness of and discourse surrounding female genital mutilation had developed.[18] Mutilation, in

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[15] That view was consistent with the respondents' submissions: see AB 458 [400]-[401].

[16] See, for example, the heading to s 45 ("Prohibition of female genital mutilation") and the long title to the Act which introduced s 45 (*Crimes (Female Genital Mutilation) Amendment Act 1994* (NSW)): "An Act to amend the *Crimes Act 1900* to prohibit female genital mutilation."

[17] The Crimes (Female Genital Mutilation) Amendment Bill 1994 (NSW) was introduced into the Legislative Council on 4 May 1994. The Bill passed the Legislative Council on 10 May 1994 and the Legislative Assembly on 22 September 1994. It received assent on 5 October 1994 and commenced on 1 May 1995.

[18] See, for example, Australian Law Reform Commission, *Multiculturalism: Criminal Law*, Discussion Paper No 48 (May 1991) at [2.34]-[2.41]; United Nations General Assembly, Declaration on the Elimination of Violence against Women (A/Res/48/104), 20 December 1993, Art 2(a); Commonwealth House of Representatives, *Hansard*, 21 February 1994 at 891-892 (debating a motion to recognise that female genital

the context of female genital mutilation, connoted – and continues to connote[19] – injury or damage, usually involving cutting, to female genitalia inflicted intentionally and for non-medical reasons. For example, in June 1994, the Family Law Council's Report to the Commonwealth Attorney General on Female Genital Mutilation said (at [2.01]-[2.02]; citations omitted):

> "Female genital mutilation 'is the collective name given to several different traditional practices that involve the cutting of female genitals'. ... In this paper when the term 'female genital mutilation' is used it is meant to embrace all types of the practice where tissue damage results; for example, damage manifested by bruising, contusion or incision."

44. Certainly, there could be no doubt that mutilation, in the context of female genital mutilation, includes the cutting or nicking of female genitalia.[20] Both the Discussion Paper and the Report of the Family Law Council referred to anecdotal evidence "on the incidence of female genital mutilation in Australia" as including, *inter alia*, accounts that "[c]utting the clitoral hood is practised in the Malaysian community in WA".[21] A report by the Queensland Law Reform Commission on female genital mutilation, released in September 1994, also described "the scraping or simple nicking of the clitoris" as a form of female genital mutilation.[22]

45. Thus, if the word "mutilates" in s 45(1)(a) of the *Crimes Act* is to be understood in the context of female genital mutilation, the word permits of a potential meaning that extends to the infliction of injury. Relevantly for present purposes, that meaning would encompass cutting or nicking that does not render the genitalia imperfect or irreparably damaged. This gives rise to a constructional choice that requires an evaluation of the statutory objects and policies from which the intended meaning of the provision may be ascertained.

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mutilation occurs in Australia and to call for legislation to outlaw the practice); New South Wales Legislative Council, *Hansard*, 10 March 1994 at 463-465 (debating a similar motion).

[19] See, for example, World Health Organisation, *Female genital mutilation: A joint WHO/UNICEF/UNFPA statement* (1997) at 3; World Health Organisation, *Eliminating female genital mutilation: An interagency statement* (2008) at 1; World Health Organisation, *Fact Sheet: Female genital mutilation* (2018).

[20] For example, from 1979, *Black's Law Dictionary* contained a definition of "female genital mutilation" as follows: "**1.** Female circumcision. **2.** The act of cutting, or cutting off, one or more female sexual organs."

[21] Family Law Council, *Female Genital Mutilation: Discussion Paper*, 31 January 1994 at [2.30]; Family Law Council, *Report on Female Genital Mutilation*, June 1994 at [2.41].

[22] Queensland Law Reform Commission, *Female Genital Mutilation*, Report No 47 (September 1994) at 7. This Report referred to "three main types of female genital mutilation": circumcision (including the scraping or nicking of the clitoris); excision; and infibulation.

*Legislative purpose and intended meaning*

46. Section 45 of the *Crimes Act* was enacted to prohibit the practice of female genital mutilation. This is clear from the heading to s 45 ("Prohibition of female genital mutilation").[23] It is also clear from the long title to the *Crimes (Female Genital Mutilation) Amendment Act 1994* (NSW): "An Act to amend the *Crimes Act 1900* to prohibit female genital mutilation". The Second Reading Speech for the Bill which became the abovementioned Act recorded that the Bill would "make the practice of female genital mutilation a criminal offence in this State".[24] Reference was made to the World Health Organisation's recommendation that countries "adopt clear national policies to abolish the practice" and the Family Law Council's recommendation that legislation be introduced "to make clear that FGM constitutes a criminal act". It was said that the offence provision, which became s 45 of the *Crimes Act*, "aims to prevent FGM from being practised at all in this State" and to "place our condemnation of FGM beyond doubt".[25]

47. Notwithstanding the breadth of these statements of purpose, the CCA considered that "there remains some doubt as to whether the fourth form of female genital mutilation [recognised by the Family Law Council] (encompassing wholly ritualised circumcision) was intended by the legislature to be included in the legislation" (AB 491 [512]; see also AB 480 [475]). That doubt was said to arise from the following passage in the Second Reading Speech:[26]

> "It will be an offence for anyone to perform FGM in this State. The three forms of FGM in order of severity are infibulation, clitoridectomy and sunna. The bill seeks to prohibit all of these various methods of FGM."

48. By contrast, the Family Law Council stated that female genital mutilation can involve one of *four* kinds of procedures: (i) infibulation; (ii) clitoridectomy or

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[23] *Interpretation Act 1987*, ss 34(1), (2)(a), 35(5).

[24] New South Wales Legislative Council, *Hansard*, 4 May 1994 at 1859.

[25] New South Wales Legislative Council, *Hansard*, 4 May 1994 at 1859-1860

[26] New South Wales Legislative Council, *Hansard*, 4 May 1994 at 1860. Notwithstanding these comments of the Minister introducing the Bill, other members of the legislature referred to ritualised circumcision as a form of female genital mutilation in the course of debating the Bill: see New South Wales Legislative Assembly, *Hansard*, 15 September 1994 at 3129; New South Wales Legislative Assembly, *Hansard*, 22 September 1994 at 3639

excision; (iii) sunna or clitoral circumcision; and (iv) ritualised circumcision.[27] (To the extent that the CCA emphasised that this fourth category involves "wholly ritualised circumcision", it should be noted that the Family Law Council made clear that, for the purposes of its recommendations, it was referring to practices resulting in incision or tissue damage.[28]) The Family Law Council recommended that all kinds of female genital mutilation – expressly including ritualised circumcision[29] – be proscribed because "in reality the distinction between the types of circumcision ... depends on the sharpness of the instrument used, the struggling of the child and the skill and eyesight of the operator".[30] There would, therefore, be an arbitrariness to allowing one kind, and not another. For example, ritualised circumcision which involves cutting the clitoral hood could quite easily become an instance of sunna involving the excision of the clitoral hood.[31]

49. The CCA accepted that there was no indication in the Second Reading Speech of disagreement with the Family Law Council's recommendation that all forms of female genital mutilation be prohibited (AB 491 [514]). Indeed, the CCA observed that "[w]hen passing the legislation introducing s 45, the legislature clearly recognised the dangers involved in even ritualised circumcision" (AB 494 [524]). But the CCA was either not persuaded that the legislature, in fact, intended to prohibit all forms of female genital mutilation, having regard to the passage from the Second Reading Speech set out at [47] above; or, alternatively, the CCA was not persuaded that the language of s 45(1)(a) could carry such a purpose into effect, even if it were the legislature's intention (see AB 491 [513]). The first proposition, relating to legislative purpose, will be examined further below. The second proposition is erroneous for the reasons developed earlier (see [42]-[45] above) that, understood in context, the word "mutilates" in s 45(1)(a) permits of a construction that extends to the causing of injury.

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[27] Family Law Council, *Discussion Paper*, 31 January 1994 at [2.03]-[2.06]; Family Law Council, *Report*, June 1994 at [2.03]-[2.06].

[28] See Family Law Council, *Discussion Paper*, 31 January 1994 at [2.01]; Family Law Council, *Report*, June 1994 at [2.02]. Cf AB 486 [498].

[29] Family Law Council, *Discussion Paper*, 31 January 1994 at [5.22]

[30] See Family Law Council, *Discussion Paper*, 31 January 1994 at [2.02]; Family Law Council, *Report*, June 1994 at [2.01].

[31] See also Family Law Council, *Report*, June 1994 at [2.04].

50. It is possible to argue, as the respondents did below (AB 462 [415]), that the passage from the Second Reading Speech extracted in [47] above evinces a legislative intention to prohibit only infibulation, clitoridectomy and sunna; that is, to prohibit most, but not all, of the practices recognised by the Family Law Council as constituting female genital mutilation. But this understanding of the legislative purpose is very difficult to reconcile with the CCA's preferred construction of "mutilates" in s 45(1)(a). The CCA accepted that a "cut or nick could, in a particular case, amount to mutilation" for the purposes of s 45(1)(a), provided some imperfection or irreparable damage could be shown (AB 494 [521]-[522]). But a cut or nick would not, in the usual case, constitute infibulation, clitoridectomy or sunna. The CCA cannot, therefore, have considered that the legislative intention was to prohibit only those three procedures named in the Second Reading Speech. Since the CCA also recognised that its preferred construction did not accord with a legislative intention to prohibit all forms of female genital mutilation (AB 494 [523]), it is, with respect, not entirely clear what legislative purpose the CCA ascribed to s 45.[32]

51. Further, the categories of infibulation, clitoridectomy and sunna do not correspond to the language of s 45(1)(a). There is little reason to think that such categories assist in ascertaining (or confining) the intended meaning of the word "mutilates". Because "sunna" is a cultural term, its meaning can vary.[33] The Family Law Council referred to sunna in the context of procedures involving the removal of the clitoral prepuce. In the language of s 45(1)(a), such procedures would be caught by the verb "excises". The procedures named in the Second Reading Speech shed no real light on what other forms of the practice of female genital mutilation the verb "mutilates" was intended to capture.

52. In the appellant's submission, the purpose of the legislature in enacting s 45 of the *Crimes Act* was to prohibit female genital mutilation in all of its forms and thus to implement the recommendation of the Family Law Council. This submission is

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[32] By contrast, the trial judge considered that the essential difference between the appellant's and the respondents' arguments on the question of construction was the extent to which each would serve to promote the purpose or object of the provision: see AB 84 [249].

[33] See Family Law Council, *Report*, June 1994 at [2.04]. See also, generally, S Elmusharaf, N Elhadi and L Almroth, 'Reliability of self reported form of female genital mutilation and WHO classification: Cross sectional study', (2006) 333 *British Medical Journal* 124.

supported by the unconditional statements of purpose set out in [46] above. It is also supported by the Explanatory Note to the Bill, which recorded that:

> "[p]rocedures involving the incision, and usually removal, of part or all of the external genitalia of young females are practised by some groups as a matter of custom or ritual. The practice can lead to infection, haemorrhaging, dysuria (painful urination) and dysmenorrhea (painful mensuration) due to pelvic congestion and complications during labour.
>
> The object of this Bill is to amend the Crimes Act 1900 to make it an offence punishable by a maximum of 7 years imprisonment to mutilate external female genitalia".

The reference to an incision to part of the genitalia, and to complications including infection and dysuria, do not suggest a requirement of serious injury, imperfection or irreparable damage.

53. It is not coherent to accept that the legislature was concerned to prohibit all forms of female genital mutilation in New South Wales, but also intended "mutilates" in s 45(1)(a) to convey only its literal meaning. The CCA accepted that its preferred construction, based on the "ordinary meaning" of "mutilates", did not accord with a legislative intention to proscribe all forms of female genital mutilation (AB 494 [523]-[524]). Their Honours observed that:

> "[t]he potential evidentiary difficulties which might be faced in cases where, for example, there is concern as to potential nerve damage due to a cut to the clitoral glans or the clitoral hood leading to potential loss of sensitivity or hypersensitivity but no visible scarring ... if what is necessary is the demonstration to a criminal standard of proof of permanent damage or serious injury, clearly illustrate the need for legislative amendment (if our construction be correct) to make clear that the fourth category of female genital mutilation is within the terms of the offence."

54. In circumstances where female genitalia is understood to heal quickly, such that there may be no scarring visible upon inspection, and where it may be difficult to assess, or obtain evidence of, potential nerve damage (either in the nature of a loss of sensitivity or hypersensitivity) caused to the genitalia of a prepubescent girl, the construction of s 45(1)(a) preferred by the CCA – which requires proof of the genitalia being rendered imperfect or irreparably damaged – is improbable and inconvenient, and cannot be said to reflect the meaning of the provision intended by

the legislature.[34] In the appellant's submission, it is contrary to the statutory object and policy for the application of s 45 to depend, in effect, on whether, for example, a scar remains visible; whether a cut has healed; or whether a complainant is able to articulate a 'before and after' difference in sensation caused by the alleged offence. The alternative construction advanced by the appellant, of "mutilates" in s 45(1)(a) encompassing the infliction of injury, should be preferred.[35]

*Directions to jury*

55. The relevant ground of appeal upon which the respondents succeeded before the CCA complained that the trial judge erred in his directions to the jury in relation to the meaning of "otherwise mutilates" in s 45(1)(a) of the *Crimes Act* (see AB 318).

56. His Honour had directed the jury that (AB 99):

> "The word 'mutilate' in the context of female genital mutilation means to injure to any extent. It is not necessary for the Crown to establish that serious injury resulted. In the context of this trial, a nick or cut is capable of constituting mutilation for the purpose of this alleged offence.
>
> So for this offence to be proved, the Crown does not need to prove that something was cut off. If something was cut off, you may think that would demonstrate or make out a mutilation. If there is a nick or a cut, that would be sufficient in law to constitute a mutilation."

57. The CCA dealt with this ground of appeal on the basis that there were "separate complaints subsumed" within it: a complaint as to the trial judge's pre-trial ruling and a complaint as to the direction itself (AB 447 [360]). As discussed above, the CCA concluded that the trial judge misconstrued the meaning of "mutilates" in his pre-trial ruling, because "mutilates" in s 45(1)(a) bears its "ordinary meaning" of "injury or damage that is more than superficial and which renders the body part in question imperfect or irreparably damaged in some fashion" (AB 493 [521]). The error identified in the direction given to the jury was that "it included the words 'to any extent' insofar as it suggested that a *de minimis* injury would suffice" (AB 494 [522]).

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[34] See *Cooper Brookes (Wollongong) Pty Ltd v Federal Commissioner of Taxation* (1981) 147 CLR 297 at 320-321 per Mason and Wilson JJ; *CIC Insurance* (1997) 187 CLR 384 at 408 per Brennan CJ, Dawson, Toohey and Gummow JJ.

[35] *Interpretation Act 1987*, s 33; *SZTAL* (2017) 262 CLR 362 at [39] per Gageler J.

58. In the appellant's submission, it cannot follow from the CCA's reasoning on the question of construction that the simple omission from the direction given of the words "to any extent" would have resulted in the jury being properly instructed. On the question of the reasonableness of the jury's verdicts on the charges against s 45(1)(a), the CCA said (AB 509 [586]; see also AB 510 [590]):

> "although we are satisfied that a cut or nick to the clitoris could well amount to mutilation in some circumstances, the medical evidence would need to establish that there had been injury or damage which rendered the clitoris imperfect or irreparably damaged in some way. We have concluded that in the absence of any medical evidence of such injury or damage, an offence contrary to s 45(1)(a) of the *Crimes Act* could not be established."

If evidence is needed to establish injury or damage rendering the clitoris imperfect or irreparably damaged, it would seem necessary, at least in a usual case, for a trial judge to instruct the jury that they must be satisfied that injury or damage of the relevant kind is made out on the evidence.

59. In the appellant's submission, mutilation, for the purposes of s 45(1)(a) of the *Crimes Act*, can be established by proof of injury and it is not necessary for the Crown to prove serious injury. In directing the jury, the trial judge referred to injury "to any extent" to emphasise that injury less than serious injury is sufficient. His Honour did not err in directing the jury in that way.

Meaning of "clitoris" in s 45(1)(a) of the *Crimes Act*

60. The CCA concluded that the trial judge erred in ruling, and directing the jury, that the word "clitoris" in s 45(1)(a) of the *Crimes Act* "included not only the clitoral head but also the clitoral hood (or prepuce)" (AB 495 [527]). That conclusion was not supported or required by the medical evidence at trial (AB 494 [525]). Instead, it appears to have been based only on various definitions in medical dictionaries (AB 495 [526]).

61. Dr Marks' evidence at trial was that the clitoral anatomy includes both the clitoral head and the clitoral hood, because they are "closely physically related to each other", albeit separate or different tissue (AB 404 [209]). Professor Grover considered the word "clitoris" to be a "global term which included structures such as: the clitoral ridge; the clitoral hood; the shaft of the clitoris; the clitoral glans; and the prepuce" (AB 412 [240]). Professor Jenkins' evidence was that the prepuce and the

clitoral head are "separate structures" (AB 410 [231]). But, as the CCA observed, this evidence "would not detract from the proposition that together they might be viewed as forming part of the clitoris as a whole" (AB 495 [525]).

62. It is relevant also to note that the Family Law Council described the practice of removing the prepuce of the clitoris as *clitoral* circumcision.[36]

63. The clitoral prepuce exists at the fusion of the labia minora and the clitoral glans, as the two unite over the glans to create a hood. In those circumstances, and taking into account the protective purpose of the provision, the word "clitoris" should be understood in its global sense as including the clitoral hood.

64. If the hood or prepuce is not understood to form part of the clitoris, it must then form part of the labia minora. There can be no doubt that mutilation of the clitoral hood or prepuce falls within the scope of the offence contained in s 45(1)(a). As such, there is no imperative to construe the word "clitoris" narrowly or strictly, so as to avoid broadening the scope of the offence.

65. The word "clitoris" in s 45(1)(a) is naturally understood as referring to the clitoral anatomy, which, as Professor Grover attested to at trial, is made up of a number of structures, including the shaft, glans and hood. There was no error in the trial judge directing the jury that mutilation of the clitoral hood or prepuce was sufficient to make out the offence as charged (see AB 100).

## Part VII: Orders

66. The appellant submits that the Court should make the following orders in each appeal:

    i. Appeal allowed.

    ii. Set aside order 3 made by the CCA on 10 August 2018 and, in its place, order that a new trial be had.

67. This Court has jurisdiction to make such orders as the Court below should have made.[37] The Court is thus empowered by s 8(1) of the *Criminal Appeal Act 1912* (NSW) to order a new trial if satisfied that, "having regard to all the circumstances",

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[36] Family Law Council, *Report*, June 1994 at [2.04].

[37] *Judiciary Act 1903* (Cth), s 37; *State of NSW v Kable* (2013) 252 CLR 118 at [71] per Gageler J.

such miscarriage of justice as has occurred "can be more adequately remedied by an order for a new trial". In the appellant's submission, this Court would exercise the power to order a new trial because there is evidence to support the charges and the interests of justice do not require the entry of verdicts of acquittal.[38]

**Part VIII: Time Estimate**

68. The appellant estimates that 2.5 hours will be required for the presentation of its oral argument, including its submissions in reply.

10 Dated: 5 April 2019

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[38] See *Spies v The Queen* (2000) 201 CLR 603 at [104] per Gaudron, McHugh, Gummow and Hayne JJ; *The Queen v Taufahema* (2007) 228 CLR 232 at [49]-[51] per Gummow, Hayne, Heydon and Crennan JJ; *Sio v The Queen* (2016) 259 CLR 47 at [75]-[81].

IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY

No. S43 of 2019

No. S44 of 2019

No. S45 of 2019



BETWEEN:

**The Queen**

Appellant

and

10

**A2**

**Kubra Magennis**

**Shabbir Mohammedbhai Vaziri**

Respondents

## APPELLANT'S CHRONOLOGY

**Part I:**

20 The appellant certifies that this chronology is in a form suitable for publication on the internet.

**Part II:**

| | | |
|---|---|---|
| 18 October 2009 – 29 August 2012 | Offences against C1 allegedly committed | AB 2-3 |
| 1 January 2012 – 29 August 2012 | Offences against C2 allegedly committed | AB 2-4 |
| 19 July 2012 | Report received by Department of Family and Community Services that female genital mutilation had been performed on a child within the Dawoodi Bohra Community | AB 14 [12] |

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| | | |
|---|---|---|
| 29 August 2012 | C1 and C2 interviewed by members of a Joint Investigation Response Team (JIRT) | AB 356 [19]-[20] |
| | A1 and A2 interviewed by members of JIRT | AB 369 [69]<br>AB 372 [76] |
| 3 September 2012 | Medical examination of C1 and C2 at the Children's Hospital at Westmead | AB 381 [114]-[115] |
| 7 September 2012 | A1 and A2 participated in police interviews | AB 385 [129]-[132] |
| 9 September 2012 | A2 charged with offences under s 45 of the *Crimes Act 1900* (NSW) | AB 15 [21] |
| 13 September 2012 | Magennis charged with offences under s 45 of the *Crimes Act* | AB 16 [22]<br>AB 393 [161] |
| | Vaziri participated in police interview and charged with accessory offences | AB 16 [23]<br>AB 391 [156] |
| 17 June 2015 | Trial begun in Supreme Court of New South Wales before Johnson J | AB 524 [636] |
| 14 September 2015 | Indictment presented and respondents entered pleas of not guilty to all charges | AB 2<br>AB 6 |
| 12 November 2015 | Jury returned verdicts of guilty on charges under s 45 of the *Crimes Act* | AB 227 |
| 18 March 2016 | Respondents sentenced, but proceedings stood over and sentences stayed to allow for assessments as to suitability for home detention (*R v A2; R v Magennis; R v Vaziri (No 23)* [2016] NSWSC 282) | AB 353 [7]<br>AB 270-272 [192]-[213] |
| 9 June 2016 | Respondents' sentences finalised and commenced on this date (*R v A2; R v Magennis; R v Vaziri (No 24)* [2016] NSWSC 737) | AB 353 [8]<br>AB 311-313 [120]-[131] |
| 13 September 2016 | Vaziri granted bail pending his appeal | AB 353 [8] |

| | | |
|---|---|---|
| 15 February 2017 | Notices of appeal filed by respondents in the Court of Criminal Appeal | AB 315-329 |
| 23-25 October 2017 | Respondents' appeals heard by Court of Criminal Appeal | AB 353 [9] |
| 10 August 2018 | Court of Criminal Appeal made orders allowing the appeals against conviction; quashing the convictions; and entering verdicts of acquittal on all counts | AB 682-687 |
| 15 February 2019 | Special leave to appeal granted | AB 712-717 |

Dated: 5 April 2019

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IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY

No.43 of 2019
No.45 of 2019

BETWEEN: The Queen
Appellant

and

10

A2
Shabbir Mohammedbhai Vaziri
Respondents



RESPONDENTS' SUBMISSIONS

**Part I: Publication**

1. This submission is in a form suitable for publication on the internet.

20 **Part II: Statement of Issues**

2. In the phrase "excises, infibulates or otherwise mutilates" in s45(1)(a) of the *Crimes Act 1900* (NSW), does the term "otherwise mutilates" mean to injure to any extent?
3. Does the term "clitoris" in s45(1) of the *Crimes Act* include the clitoral hood/prepuce?

**Part III: Section 78B Notice**

4. The respondents do not consider that notice is required pursuant to s78B of the *Judiciary Act 1903* (Cth).

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**Part IV: Facts**

5. The respondents adopt the submissions of the co-respondent, Kubra Magennis ("MS"), in relation to the facts (MS [5]-[9]).

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6. As noted by the appellant, at Appellant's Submissions ("AS") [15]), C1 expressed some uncertainty as to what had been done to her. As the CCA observed, "[s]he did not see the procedure and was describing what it felt like" (CCA [625], see also CCA [621]-[624]) **CAB 520-521**). C2's evidence was more problematic (see AS [16]-[19] and see also CCA [626] **CAB 625**). While the appellant relied on various intercepted communications as admissions on the part of A2, ultimately, it was likely that it was only the co-respondent, Ms. Magennis, who knew with any precision what had been done in the course of the ceremony.

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7. The statement at AS [7] that, at trial, the Crown alleged that members of the Dawoodi Bohra community undertake a practice "which involves cutting or nicking of the clitoris", does not fully reflect the Crown case. The Crown case at trial also relied on the evidence of Dr. X as to the "static" nature of khatna (CCA [17], **CAB 356**). Dr. X's evidence was that the procedure in Dawoodi Bohra community involved the removal of an amount of tissue the size of a lentil from the clitoris or prepuce (CCA [265]-[266] **CAB 420**, see also CCA at [296]-[297] **CAB 427-8**; and CCA [606], **CAB 516**). As noted at MS [57], the CCA held that the evidence of Dr. X had been erroneously admitted as expert testimony (a conclusion which the
20 appellant does not here challenge).

**Part V: Argument**

8. The respondents adopt the submissions of the co-respondent, Kubra Magennis (MS [10] – [65]) and make the following additional submissions.

<u>The appellant's approach</u>

9. The appellant urges a context based approach to interpretation, primarily seeking support outside the text of the subject provision and the Act itself. In doing so the
30 appellant seeks to read the provision as prohibiting "female genital mutilation" where that expression is not used in the provision. The appellant then seeks to define that term, relying on select extrinsic material surrounding the introduction of the *Crimes (Female Genital Mutilation) Amendment Act 1994* (NSW). The result is

to supplant the language used by the legislature, substituting another term and "entering into the impermissible territory of relying on extrinsic material to provide the meaning of that ... term rather than the context and purpose of the provision in question" (CCA [514] **CAB 491**). That exercise is further undermined by an absence of clarity as to the meaning of that term in the extrinsic material.

10. As the CCA observed, the provision does not use the expression "female genital mutilation". Nor does it use terms such as "injures" or "damages" (CCA [495] **CAB 486**; see also MS at [28] in relation to other parts of the *Crimes Act* that use express statutory language proscribing acts that cause "any injury"). The provision creates an offence which has, as an element, the bringing about of a particular result, rather than merely proscribing a particular action (cf AS [48]).

11. The danger in supplanting the language of the text and seeking to define non-statutory terms has been identified in a number of decisions of this Court. In *News Ltd v South Sydney District Rugby League Football Club* (2003) 215 CLR 563, Gleeson CJ said at [19]:

> While the use of the term "boycott" may be a convenient method of exposition of some aspects of the operation of s 4D, and may be a useful means of explaining part of what it was intended to achieve, that term itself does not have a precise meaning, and there is a danger that argument might be directed towards seeking to find the meaning of "boycott" rather than the proper task, which is finding the meaning of the statutory language.

See also *Visy Paper Pty Ltd v Australian Competition and Consumer Commission* (2003) 216 CLR 1 at [23]-[26]; *Rural Press Ltd v ACCC* (2003) 216 CLR 53 at [7].

12. The appellant's submissions rely on references to "incision" in the extrinsic material to identify the purpose of the provision (see AS [52], quoting the Explanatory Memorandum; see also at AS [48]). The Explanatory Memorandum referred to "practices involving the incision, and usually removal, of part or all of the external genitalia" and potential complications from such practices. Having regard to the context in which the reference to incision was made, the Explanatory Memorandum is of limited assistance to the appellant. In any event, the CCA accepted a cut could result in scarring or nerve damage amounting to "mutilation" (CCA [522] **CAB 494**).

Authorities in relation to construction relied on by the appellant

13. The appellant relies on statements of principle in this Court concerning the proper approach to statutory construction. A review of those decisions demonstrate that the statements were made in circumstances distant from the present case, with the interpretation and use of extrinsic material generally forming a relatively minor aspect of the exercise.

10 14. The appellant seeks to draw support from this Court's decision in *Monis v The Queen* (2013) 249 CLR 92.[1] *Monis* provides limited support to the appellant. The passage from *Monis* relied upon by the appellant was expressed to apply "particularly in the case of general words", suggesting a more limited application in the context of the meaning of a word such as "mutilates". *Monis* also reinforces the significant role to be given to surrounding words within a provision (in relation to the word "offensive" when used in an offence provision in conjunction with the words "menacing" and "harassing"): see *Monis* at [310]. This is more supportive of the approach urged by the respondents.

20 15. In *CIC Insurance Ltd v Bankstown Football Club Ltd* (1997) 187 CLR 384,[2] too literal an interpretation would have required an insurer to give the insured entity notice of the upcoming expiration of a policy, even in circumstances where the insurer already considered the relevant policy to have been cancelled and had given notice to this effect. This result was avoided by reading the relevant provision in the context of other provisions of the Act. The extrinsic material was confirmatory of this result (and consonant with common sense and logic): see generally at 407 – 410.

16. Similarly, in *Project Blue Sky v Australian Broadcasting Authority* (1998) 194 CLR
30 355,[3] the conclusion that the section in question was not to be given its grammatical

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[1] AS[37], referring to *Monis* at [309]
[2] Relied on by the appellant at AS[39], footnote [12].
[3] AS[39], footnote 12

meaning was reached by reading that section together with other provisions of the Act. In doing so the section was able to be read in manner which provided consistency of operation and purpose with respect to the Act as a whole.[4]

17. In *SAS Trustee Corporation v Miles* (2018) 92 ALJR 1064[5] Kiefel CJ, Bell and Nettle JJ (at [20]), ascertained statutory context and purpose from considerations within the relevant statute. The extrinsic material provided confirmation of what those matters of statutory context and purpose revealed. This clear delineation of approach is evident from the outset of the joint judgment: "As will be explained, context and purpose favour the former [approach to construction] *and* it appears consistent with relevant extrinsic materials" (at [1], *emphasis added*). The focus of the interpretative exercise in *SAS Trustee* was the Act itself, including the interaction between provisions and the use of like statutory terms. [6]

18. In *Taylor v Owners - Strata Plan No 11564* (2014) 253 CLR 531,[7] neither the majority justices (French CJ, Crennan and Bell JJ), nor the dissentients (Gageler and Keane JJ), approached the matter through reliance on extrinsic materials in a manner comparable to the approach of the appellant here. Gageler and Keane JJ referred to the relevance of legislative history, but observed that relevant extrinsic material was "at too high a level of generality to illuminate" (at [55]). Their Honours went on to state (footnotes omitted, *emphasis* added):

> [65] Statutory construction involves attribution of legal meaning to statutory text, read in context. "Ordinarily, that meaning (the legal meaning) will correspond with the grammatical meaning ... But not always." Context sometimes favours an ungrammatical legal meaning. Ungrammatical legal meaning sometimes involves reading statutory text as containing implicit words. Implicit words are sometimes words of limitation. They are sometimes words of extension. But they are always words of explanation. *The constructional task remains throughout to expound the meaning of the statutory text, not to divine unexpressed legislative intention or to remedy perceived legislative inattention. Construction is not speculation, and it is not repair.*

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[4] See particularly at [80].
[5] AS[39], footnote 12
[6] See at [20]-[29]. With respect to the use of the extrinsic materials, their Honours said, at [33] (*emphasis* added): "Finally, *although it is not a strong point*, that construction of s 10(1A) *appears consistent* with the legislative history of the Act and the extrinsic materials."
[7] AS[39], footnote 14.

See also the reasons of French CJ, Crennan and Bell JJ at [39]), referred to at MS[36].

19. In *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362, while Kiefel CJ, Nettle and Gordon JJ observed, "[t]he starting point for the ascertainment of the meaning of a statutory provision is the text of the statute whilst, at the same time, regard is had to its context and purpose",[8] their Honours immediately noted that "[t]his is not to deny the importance of the natural and ordinary meaning of a word, namely how it is ordinarily understood in discourse, to the process of construction". In the result their Honours concluded the word in question, "intend" was to be given its "natural and ordinary meaning" (at [26]); see also per Edelman J at [68]. Gageler J, who was in dissent, commenced from the standpoint that the word in issue, "intend", did not plainly apply, or not apply to the facts, with the result that the purpose (which was readily identifiable), was determinative (at [32], [43]).

Ordinary parlance remains a powerful consideration

20. The appellant appears to accept that the proposed definition of "mutilates" represents a significant departure from *any* manner in which that word might be used in common parlance: see, for example, AS at [39]. The use (or, more accurately, possible range of uses) of a particular term in ordinary parlance is, however, a significant consideration in the constructional exercise, particularly where the legislature has not included a statutory definition of the term and the extrinsic material does not provide clarity.

21. As noted by the co-respondent (MS at [41]), the requirement of certainty is an important aspect of the rule of law. This Court (French CJ, Hayne, Crennan, Kiefel, Bell and Keane JJ) said in *Director of Public Prosecutions (Cth) v Keating* (2013) 248 CLR 459 at [48], "it is fundamental to criminal responsibility ... that the criminal law should be certain and its reach ascertainable by those who are subject to it".

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[8] *SZTAL* [14], referred at AS[39], footnote 14,

The lack of coherence in the extrinsic materials

22. The numerous aspects of the relevant extrinsic materials that support the approach adopted by the CCA in its construction of 'otherwise mutilates' are discussed at MS[18]-[24]. While the respondents find support in that material, it is to be emphasised that reliance on that material is not necessary for the acceptance of the respondents' and the CCA's construction. In contrast, the appellant is not only dependent on extrinsic materials but seeks to have select parts of those materials given determinate significance. Insofar as the appellant submits that '[t]he procedures named in the Second Reading Speech shed no real light on what other forms of the practice of female genital mutilation the verb "mutilates" was intended to capture (AS at [51]), this highlights the difficulty for the appellant, and not the respondents.

The statutory construction of 'clitoris' in s 45(1)(a) of the *Crimes Act*

23. The respondents adopt the arguments set out in the submissions of the co-respondent (MS[51]).

24. This issue is significant as a result of the manner in which the Crown case was pleaded and the evidence that the clitoral head is "more readily impaired or rendered imperfect due to the concentration of nerve tissue" while "the same may not be true of the clitoral hood (or prepuce)": CCA [497] **CAB 486.**

25. The point is underscored here, where ultimately, it was unlikely that there was any contact with the clitoral head (see MS at [56],[60]).

This Court should not order a re-trial

26. In addition to the submissions of the co-respondent, Kubra Magennis, in relation to the reasons for not ordering a retrial in the event the appellant's argument on the correctness of the trial judge's directions is accepted (MS [52]-[65]), the respondents make the following submissions.

27. The respondent, A2, served the entirety of her sentence (15 months imprisonment, with a non-parole period of 11 months, served by way of home detention), which expired on 8 September 2017: *R v A2; R v Magennis; R v Vaziri (No. 24)* [2016] NSWSC 737 at [121].

28. The respondent, Mr. Vaziri, (who also received a sentence of 15 months with a non-parole period of 11 months), served almost 6 months of his sentence in full-time imprisonment (from 18 March – 13 September 2016) prior to his release on bail pending the outcome of the appeal in the CCA: *R v Vaziri* [2016] NSWSC 1283. Mr Vaziri was subject to strict bail conditions, akin to home detention, for a period of approximately 13 ½ months, until the conclusion of the hearing of the appeal before the CCA on 25 October 2017. At the conclusion of the hearing, Mr. Vaziri's bail conditions were varied, removing the conditions akin to home detention. Nonetheless, Mr. Vaziri remained on bail for a further period of approximately 9 ½ months until the CCA gave judgment on 10 August 2018.

29. The CCA, in light of its resolution of the conviction appeal and the entry of acquittals on all counts, did not determine Mr. Vaziri's appeal against sentence. That appeal was on the ground of parity based on the fact that he received a more severe sentence as an accessory after the fact (full-time imprisonment) compared to the sentence imposed on the principals (home detention): CCA at [1189]-[1190], **CAB at 680**.

30. Whilst, as a general observation, the objective seriousness of offences under s.45 of the *Crimes Act* cannot be disputed, the absence of any evidence of serious injury or impairment, also weighs strongly against the ordering of a retrial.

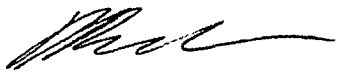
## Part VI: Cross Appeal/Notice of Contention

31. Not applicable.

**Part VII:**

32. It is estimated that the respondents' oral argument will take 30 minutes to present.

Dated 3 May 2019



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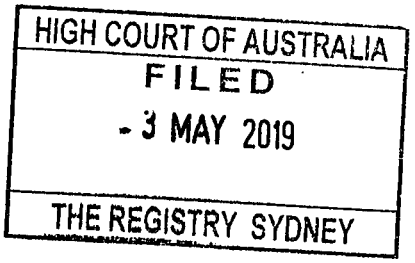
IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY No. S 44 of 2019

BETWEEN: The Queen
Appellant

and




Kubra Magennis
Respondent

RESPONDENT'S SUBMISSIONS

**Part I: Publication**

1. This submission is in a form suitable for publication on the internet.

**Part II: Statement of Issues**

2. In the phrase "excises, infibulates or otherwise mutilates" in s45(1)(a) of the *Crimes Act 1900* (NSW) does the term "otherwise mutilates" mean "to injure to any extent" as the jury were directed in this case?
3. Does the term "clitoris" in s45(1)(a) of the *Crimes Act* include the clitoral hood/prepuce?

**Part III: Section 78B Notice**

4. The respondent does not consider that notice is required pursuant to s78B of the *Judiciary Act 1903* (Cth).

**Part IV: Facts**

5. There is no significant dispute with the evidence as summarised in the Appellant's Submissions ("AS"). The summary is relevant only to the question of whether the Court should order a re-trial. The inability of the evidence to establish beyond

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reasonable doubt that there was even a nick or cut to the clitoris or genital area of C1 or C2 is addressed in further detail at the end of these submissions.

6. The appellant notes that C1 gave evidence that she saw the respondent holding a silver tool that looked like scissors (AS at [15]). The respondent gave evidence that she used forceps to touch the genitalia of C1 and C2 in the symbolic ceremony (Court of Criminal Appeal ("CCA") [306]-[310], Core Appeal Book ("CAB") **431-2**). The CCA considered that there were "obvious similarities" between C1's drawing of the "scissors" (Ex B) and the images of forceps (Ex F and 3) and noted that it was unfortunate neither Ex F nor Ex 3 was shown to C1 for comparison purposes (CCA [624] **CAB 521**).

7. The appellant's summary of C2's evidence must be considered in the context of her inability to identify the "private part" on the body sketch she was given (CCA [39] **CAB 361-2**). The sketch shows the words "tummy" and "knee" with arrows pointing to the private part (CCA [39] **CAB 361-2**). When asked if anyone had done anything to her tummy C2 said no (CCA [39] **CAB 361-2**). She shook her head when asked if anyone had done anything to her knee (CCA [39] **CAB 361-2**).

8. Only the lawfully recorded conversations involving the respondent were admissible against her (AS at [20]-[25]). The conversations referred to at AS [20], [23], and [25] were not admissible against the respondent.

9. Dr Marks' evidence regarding scarring generally was given in respect of "superficial cuts" (CCA [211] **CAB 405**; AS at [27]). Contrary to the appellant's summary at AS [28], Prof Jenkins' evidence that overt changes to a female's anatomy after having undergone female genital mutilation ("FGM") procedures were not obvious was given in respect of the specific procedure involving the cutting off the tip of the prepuce or the clitoris not FGM procedures generally (CCA 233 **CAB 410-1**). Further, Prof Jenkins' evidence was to the effect that a scar would be expected even if it was barely visible (CCA [545] **CAB 500**).

**Part V: Argument**

10. There are a significant conceptual and procedural problems with the appeal as framed and advanced by the appellant. Success on the appellant's principal ground (2.i) would not achieve the order sought (**CAB 722**). No ground of appeal directly challenges the CCA's ruling on ground 1 or the CCA's decision to order an

acquittal. Ground 2.i alleges the CCA erred in construing the term "otherwise mutilates" as requiring injury or damage that renders the body part in question imperfect or irreparably damaged (**CAB 722**). However, in order to succeed in obtaining a re-trial the appellant must also show that the CCA erred in concluding that the term connotes more than superficial injury such as the shedding of skin cells or a nick or cut that leaves no visible scarring and cannot be seen on medical examination to have caused any damage to the skin or nerve tissue (CCA [515], [521] **CAB 492, 493**). This is because the context in which the construction question arose at trial has significance for the appellant's appeal in this Court. At trial, the Crown case was that the respondent had performed a ceremony called "khatna" which involved a nick or cut to the clitoris of C1 and C2 (CCA [2] **CAB 351**). At the pre-trial hearing, the Crown contended that any physical injury to the female genitalia for non medical reasons can amount to mutilation under s45 of the *Crimes Act* (CCA [362] **CAB 447**). This construction was advanced because neither the medical evidence nor the evidence of the two complainants supported a contention that anything more serious than a nick or cut occurred. That is to say, there was no evidence that suggested something more than bare injury occurred (putting aside Dr Marks' evidence at trial concerning a possible excision which was the subject of fresh evidence on the appeal). The only case which the Crown could present on a re-trial in respect of the s45 of the *Crimes Act* is one based on a nick or cut, that is, bare injury. Success on ground 2.ii alone would not achieve an order for a re-trial.

The NSW Court of Criminal Appeal's approach to statutory construction

11. The CCA's approach to statutory construction was consistent with authority in this Court and the CCA did take into account important contextual considerations and the apparent legislative purpose (*SZTAL v Minister for Immigration* (2018) 252 CLR 362 at [14], *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355 at [69]-[71], *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue* (2009) 239 CLR 27 at [47], CCA [464]-[473] **CAB 476-9**; cf. AS at [36], [40]). The CCA construed the text of the provision in light of its context and purpose having appropriate regard to the extrinsic materials (CCA [474]-[477], [480]-[493], [497], [511]-[514], [519] **CAB 480-6, 491, 493**). The CCA took into account relevant contextual matters including that the term "otherwise mutilates"

was intended to capture other forms of mutilation that are to be prohibited and that the object of the verb was a sensitive body part (CCA [493]-[495], [519] **CAB 485-6**). The CCA also took into account that the context and purpose of the provision was to prohibit FGM (CCA [480], [510]-[514] **CAB 481, 490-2**; cf. AS at [40]).

12. The CCA considered that regard could be had to the extrinsic material to determine the context and purpose of the provision regardless of whether there was ambiguity in the provision (CCA [477] **CAB 480-1**). This accords with the statement of principle in *CIC Insurance Ltd v Bankstown Football Club Ltd* (1997) 187 CLR 384 at 408. The CCA recognised there was an argument that there was ambiguity in the word "mutilates" and consequently had regard to the extrinsic material pursuant to s34 of the *Interpretation Act 1987* (NSW) (CCA [474] **CAB 480**). The CCA disregarded various extrinsic material which was taken into account by the trial judge (CCA [499]-[509] **CAB 486-90**). The appellant does not suggest the CCA erred in doing so.

13. The CCA's conclusion that the extrinsic materials "*do not permit a construction of "mutilates" that departs from its ordinary meaning*" is simply a conclusion in respect of s34(1)(a) of the *Interpretation Act 1987* (NSW) (CCA [521] **CAB 493**). It also finds support in authority of this Court (*Alcan* at [47]). It does not bespeak error (cf. AS at [36], [37]).

14. Further, for the reasons set out in these submissions the CCA correctly concluded that the trial judge's directions were erroneous and that the term "otherwise mutilates" in s45(1)(a) of the *Crimes Act* requires some form of injury or damage that is more than superficial and which renders the body part in question imperfect or irreparably damaged in some fashion (CCA [521]-[522] **CAB 493-4**). The CCA's construction of the term "otherwise mutilates" confirms that serious or significant injury is captured by s45 of the *Crimes Act* and less serious injuries may be captured by other offences in the *Crimes Act*.

Legislative purpose

*The purpose of the provision and its significance*

15. The appellant submits that the term "mutilates" in s45(1)(a) of the *Crimes Act* extends to the infliction of injury because the context of the provision is FGM and the purpose of the legislature was to prohibit FGM in all its forms (AS at [42]-

[53]). However, properly analysed, the extrinsic material does not support the contention that the purpose of the enactment of s45 of the *Crimes Act* was to prohibit FGM in all its forms and by reference to definitions of FGM in selected reports and dictionaries (CCA at [512], [514] **CAB 491-2**; cf. AS at [43]-[52]).

16. It is not in dispute that the purpose of s45 of the *Crimes Act* was, and is, to prohibit FGM. So much is evident from the heading of the provision and the long title to the Act which introduced s45 of the *Crimes Act*. This poses the question of what is meant by the term "mutilates" in that context (CCA [480], [494] **CAB 481, 485**). The offence provision itself does not use the term FGM. Rather, what the legislature regards as FGM is that which is prohibited by the provision.

17. Neither the long title of the Act introducing s45 of the *Crimes Act* nor the Explanatory Note to the Bill stated that the object of the provision was to prohibit FGM in all its forms.

18. It is apparent from the second reading speech that the legislature was principally concerned with prohibiting the practice of FGM insofar as it involved removal of all or part of the external female genitalia. The second reading speech commenced as follows: "*This bill will make the practice of female genital mutilation a criminal offence in this State. Female genital mutilation, or FGM, is the term used to describe a number of practices involving the mutilation of female genitals for traditional or ritual reasons. The practice involves the excision or removal of parts or all of the external female genitalia.*"

19. That this was the legislature's principal concern is further supported by the later reference in the Minister's second reading speech to the three forms of FGM: infibulation, clitoridectomy and sunna. These forms of FGM all involve removal of tissue (Family Law Council Report at [2.04]-[2.06]). The Minister said "*The bill seeks to prohibit all of these various methods of FGM*". There is no reference in the second reading speech to ritualised circumcision as so described in the Family Law Council Report (CCA [512], [514] **CAB 491-2**). Nor did the second reading speech indicate that it was implementing the Family Law Council Report's recommendations (cf. AS at [52]). Further, according the Family Law Council Report, NSW had announced a legislative proposal to make the practice of FGM an offence prior to the Report being published (at [6.30]).

20. The appellant submits that it is "*undeniable that the general mischief to which s45 of the Crimes Act is directed is the practice of [FGM]*" (emphasis added, AS at [42]). The legislature did not frame the offence in terms of a particular practice. Had the legislature intended to prohibit the practice of FGM there would be no need to provide an exception for medical procedures in s45(3) of the *Crimes Act*. The legislature chose to describe the offence by reference to particular actions. This is no doubt because of the need to provide for certainty in the drafting of criminal offences and the significant difficulty in describing a practice to be prohibited. The express actions prohibited by s45 of the *Crimes Act* should be taken to have been chosen having in mind the otherwise broad application of the offence, namely to all females regardless of age and regardless of consent. As such, an expansive construction of the term "otherwise mutilates" is not justified on the basis of protection of children (cf. AS at [53], [54]). Different policy decisions regarding the female's age and consent may have been made if it was intended that the offence apply to any injury so as to avoid unintended consequences. For example, on the appellant's construction, the offence would capture a bruise or graze even if it was occasioned with an adult woman's consent.

21. The appellant relies on the fact that the term "sunna" is a cultural term and its meaning can vary (AS at [51]). However, there was no ambiguity in what the Family Law Council Report described as sunna (see at [2.04]). The procedures named in the second reading speech (infibulation, clitoridectomy and sunna) correspond to the language of s45(1)(a) of the *Crimes Act* (cf. AS at [51]). These procedures fall under "infibulates" or "excises". The appellant argues that it cannot have been the legislative intention to prohibit only these three procedures because that would leave the term "otherwise mutilates" with no work to do (AS at [50]). This reflects a finding made by the trial judge (see Judgment [248] **CAB 83-4**).

22. However, it is readily apparent from the statutory text that the phrase "otherwise mutilates" was included to ensure that the provision was not limited to practices involving excision or infibulation (see CCA [519] **CAB 493**). In fact, the appellant's construction deprives the words "excises" and "infibulates" of their meaning and significance. The second reading speech does not elucidate the purpose of including the term "otherwise mutilates" in the offence provision. Nor does the second reading speech suggest that it was intended that the meaning of that

term be extended to any injury however small. The appellant appears to accept that the procedures described in the second reading speech "shed no real light" on what other forms of FGM the provision was intended to capture (AS at [51]). It is submitted that inclusion of the term "otherwise mutilates" was to ensure the offence extended to other forms of serious or significant damage to the external female genitalia that do not involve the removal of tissue (cf. AS at [51]).

23. In support of its argument in respect of purpose the appellant relies on the Family Law Council Report using the term "FGM" to include all forms of the practice where tissue damage results (AS [43], [48]). Neither the text of the provision nor the second reading speech used this terminology. Nor was the concept of "tissue damage" endorsed by the Crown at trial. The appellant does not argue that the term "otherwise mutilates" should be construed as "tissue damage" rather the submission is that it should extend to the infliction of injury (see AS at [45], [54]).

24. The appellant places some reliance on the use of the word "incision" in the Explanatory Note, and the use of the word "cutting" in a dictionary definition of FGM (see AS at [44] [52]). In respect of references to incision and cutting, the question for the CCA was the construction of the term "otherwise mutilates" not the means by which the body part in question can be mutilated. A nick or cut to the clitoris could be capable of constituting mutilation if it results in serious damage (CCA [493], [522] **CAB 485, 494**). It would be wrong to construe the term "mutilates" by reference to the means by which that damage *might* be achieved (cf. Judgment at [161] **CAB 53-4**, see also above at [20]). Further, the reference to "incision" in the Explanatory note does not suggest, without more, that the legislature intended to extend the term "otherwise mutilates" to mean the infliction of injury to any extent.

25. The appellant incorrectly suggests that there was some ambiguity or incoherence in the CCA's findings as to the purpose of the provision (AS at [49], [50], [53]). The CCA was not satisfied that the context and purpose of the provision permitted a conclusion that "otherwise mutilates" was intended to encompass all forms of injury or any injury to any extent (CCA [514] **CAB 491-2**; cf. AS at [49], [53]). The CCA considered that there was "some doubt" as to whether ritualised circumcision was intended by the legislature to be captured by the legislation (CCA [512] **CAB 491**; cf. AS at [49], [52], [53]). The CCA did not consider that the

legislature only intended to prohibit the three forms referred to in the second reading speech (cf. AS at [50]). The CCA found that the term "otherwise mutilates" was intended to prohibit other forms of mutilation (CCA [519] **CAB 493**).

26. The CCA said that the legislature recognised the dangers of even ritualised circumcision (CCA at [524] **CAB 494**, see AS at [49]). The CCA's observations in relation to the necessity of legislative amendment was recognition of the Constitutional limits of a purposive construction (as to which see below; CCA at [523]-[524] **CAB 494**). Further, there is no reference in the second reading speech to ritualised circumcision. The Family Law Council Report did not suggest that there were there were significant physical effects in respect of ritualised circumcision. The Report noted that ritualised circumcision "*causes bleeding and may result in little mutilation or long term damage*" and that the adverse effects of ritualised circumcision, sunna and excision tend to be less severe than infibulation but there can still be considerable pain, bleeding and infections (at [2.03], [3.10]). When one compares the health hazards and physical effects described in the second reading speech to the Family Law Council Report it is apparent that the physical effects with which the legislature was concerned were those most commonly associated with infibulation, the most severe form of FGM (Family Law Council Report at [2.05], [3.06], [3.09], [3.12]-[3.14]). As such, it cannot be said that reference to the physical effects (associated with infibulation) in the Explanatory Note to the Bill support the contention that bare injury is sufficient to establish mutilates or that that was the purpose of the provision (cf. AS ta [52]).

27. The CCA's finding that the purpose of the provision did not extend to prohibiting all forms of female genital mutilation so described in the Family Law Council's Report is well grounded in the text of the provision. The purpose of a provision "*resides in its text and structure*" (*Certain Lloyd's Underwriters v Cross* 248 CLR 378 at [25], *Lacey v Attorney General (Qld)* (2011) 242 CLR 573 at [44]). Appropriate regard may be had to selected extrinsic materials (*CIC Insurance Ltd v Bankstown Football Club Ltd* at 408). However, for the reasons above, that material does not support the appellant's construction. The text of the provision is the surest guide to the legislative intention behind it (*Alcan (NT)* at [47]). This is particularly so where the extrinsic material is, at best, ambiguous as to whether it

was the legislative intention to prohibit all forms of FGM so described in the Family Law Council Report.

*Other contextual considerations*

28. A significant feature of the statutory context of s45(1)(a) of the *Crimes Act* are the words preceding "otherwise mutilates" in that provision namely, "infibulates" and "excises". These terms (including "mutilates") have a common and dominant feature – serious or significant injury. A further feature of the context of the term in s45 of the *Crimes Act* is that it appears in an offence provision (*Alcan* at [57]). The CCA was correct to place some significance on the clear legislative choice to deploy the words "otherwise mutilates" rather than "otherwise injures" or "otherwise damages" (CCA at [495]). This is in contrast with provisions that expressly prohibit the infliction of "any injury" (for example, ss315A, 322, 326, and 545B *Crimes Act*).

*Strains the language of the provision*

29. The term mutilates, itself, carries with it a strong connotation of very significant or serious injury. In the context of criminal offences, this Court has observed that the language of the provision cannot be strained. In *Grajewski v Director of Public Prosecutions (NSW)* [2019] HCA 8 at [21], "*It strains the language of the provision to interpret the words "destroys or damages" as including conduct which obstructs or renders useless without in any way altering the physical integrity of the property. If the legislature intended to criminalise obstruction of property or the rendering of it useless in s195(1), it is to be expected that it would have so provided*". Similarly, in *Milne v The Queen* (2014) 252 CLR 149 at [38] it was noted "*[p]urposive construction does not justify expanding the scope of a criminal offence beyond its textual limits*".

30. Further, as recognised in *Alcan (NT)* "*Historical considerations and extrinsic materials cannot be relied on to displace the clear meaning of the text*" (at [47], citing *Nominal Defendant v GLG Australia Pty Ltd* (2006) 228 CLR 529 at [22], *Combet v The Commonwealth* (2005) 224 CLR 494 at [135], *Northern Territory v Collins* (2008) 235 CLR 619 at [99]). In *Re Bolton; Ex parte Beane* (1987) 162 CLR 514 Mason CJ, Wilson and Dawson J said

> "*The words of a Minister must not be substituted for the text of the law. Particularly is this so when the intention stated by the Minister but unexpressed in the law is restrictive of the liberty of the individual. It is always*

*possible that through oversight or inadvertence the clear intention of the Parliament fails to be translated into the text of the law. However unfortunate it may be when that happens, the task of the court remains clear. The function of the courts is to give effect to the will of Parliament as expressed in the law.*" (see also, *Harrison v Melhem* (2008) 72 NSWLR 380 at [12]).

31. If the legislature intended that the offence cover all forms of FGM as described in the Family Law Council Report one would anticipate the offence would be described as "tissue damage". Or had the legislature intended the offence to cover any injury those words could well have been used (*Minogue v Victoria* (2016) 92 ALJR 668 at [43]). The fact that the word "mutilates" has an affinity to the term FGM is no answer to the failure to use these terms. The heading of the provision could still have signaled that the offence was concerned with FGM. It was not necessary or appropriate to use the particular word "mutilates" in the offence provision if lesser injury was intended to be covered.

32. In addition, construing the provision in the manner contended by the appellant pays insufficient regard to s34(3) of the *Interpretation Act*. This requires consideration be given to "*the desirability of persons being able to rely on the ordinary meaning conveyed by the text of the provision (taking into account its context in the Act or statutory rule and the purpose or object underlying the Act or statutory rule and, in the case of a statutory rule, the purpose or object underlying the Act under which the rule was made)*".

33. The appellant observes that ascertaining the meaning of a provision by reference to context and purpose does not make that meaning "extraordinary" relying on s34 of the *Interpretation Act* and McHugh J in *Saraswati v The Queen* (1991) 172 CLR 1 at 21-22 (AS at [39]). However, that does not permit the Court to give a term an extraordinary meaning or to strain the language of a provision. The reference to "extraordinary" meaning in *Saraswati* arose in a different way. In *Saraswati* McHugh J quoted from *Cooper (Brookes (Wollongong) Pty Ltd v Federal Commissioner of Taxation* (1981) 147 CLR 297 at 321 where Mason and Wilson JJ said "*when the judge labels the operation of the statute as 'absurd', 'extraordinary', 'capricious', 'irrational' or 'obscure' he assigns a ground for concluding that the legislature could not have intended such an operation and that an alternative interpretation must be preferred.*" The focus of that passage is not on whether the meaning ascribed to the provision following a purposive construction is extraordinary but whether the statute, when construed in accordance with its

ordinary meaning would have an extraordinary operation such that departure from the ordinary meaning is justified.

*Supplanting the language*

34. The appellant seeks to use dictionary definitions of the term "FGM" and other descriptions of that practice in selected material to inform and expand what is captured by the term "otherwise mutilates" in s45(1)(a) of the *Crimes Act* (AS at [42]-[45]). This is similar to the approach taken by the trial judge (Judgment at [145], [156]-[162], [243] **CAB 50, 53-4, 82**).

35. This does not accord with the conventional approach to statutory construction. A purposive construction does not permit reading the words "FGM" into the provision and then using extrinsic material to define those words in the broadest terms possible. Conventional statutory interpretation requires the text to be construed in context and having regard to purpose. Further, it is not logical to, on the one hand, diminish the significance of dictionary definitions of a word actually used in the offence provision and, on the other hand, favour or adopt dictionary definitions of a formulation of words that was not used in the statute (AS at [41], [43]; Judgment at [146]-[163] **CAB 50-4**). This is particularly so where the definitions relied upon were not referred to in the second reading speech. Similarly, there is no warrant for reading definitions of FGM in selected reports into the provision.

36. The construction urged by the appellant involves a rewording of the provision and gives primacy to (an asserted) purpose beyond that which is permitted by the modern approach to statutory construction. In *Taylor v Owners – Strata Plan 11564* (2014) 253 CLR 531 at [39] the plurality endorsed McHugh J in *Newcastle City Council v GIO General Ltd* (1997) 191 CLR 85 at 113, *"[i]f the legislature uses language which covers only one state of affairs, a court cannot legitimately construe the words of the section in a tortured and unrealistic manner to cover another set of circumstances."* (at [39]).

37. The limits on purposive statutory construction are grounded in the *Constitution*. In *Taylor* at [40], the plurality went on to say

> *"Lord Diplock's speech in Wentworth Securities [Wentworth Securities v Jones [1980] AC 74 at 105-106] laid emphasis on the task as construction and not judicial legislation. In Inco Europe [Inco Europe Ltd v First Choice Distribution p2000] 1 WLR 586 at 592] Lord Nicholls of Birkenhead observed that even when Lord Diplock's conditions are met, the court may be inhibited*

*from interpreting a provision in accordance with what it is satisfied was the underlying intention of Parliament: the alteration to the language of the provision in such a case may be "too far reaching". In Australian law the inhibition on the adoption of a purposive construction that departs too far from the statutory text has an added dimension because too great a departure may violate the separation of powers in the Constitution.*"

38. Similarly, in *Plaintiff S157/2002 v The Commonwealth* (2003) 211 CLR 476 at [102] the plurality it was said "*Nor could it be for a court exercising the judicial power of the Commonwealth to supply this connection in deciding litigation said to arise under that law. That would involve the court in the rewriting of the statute, the function of the Parliament, not a Ch III court.*" (at [102], see also *Zheng v Cai* (2009) 239 CLR 446 at [28] citing *NAAV v Minister for Immigration and Multicultural and Indigenous Affairs* [(2002) 123 FCR 298 at 410-12).

39. The CCA was correct to conclude that the trial judge's approach to statutory interpretation (and the appellant's approach in this Court) was wrong and impermissible (CCA [513]-[514] **CAB 491-2**). The phrase "FGM" cannot be supplanted into the term "otherwise mutilates" in s45 (CCA [513]).

40. The appellant submits that by the time s45 of the *Crimes Act* was enacted there was an awareness and discourse surrounding FGM (AS at [43]). Reference is then made to the meaning ascribed to FGM in the Family Law Council Report, the use of "cutting" in one dictionary definition of the word "FGM", references in the Family Law Council Report and discussion paper to the practice of "cutting" in the Malaysian Community in WA, and a reference in a Report of the Queensland Law Reform Commission which described FGM as including "*circumcision (including the scraping or nicking of the clitoris)*" (AS at [43]-[44]). As set out earlier, the question is the proper construction of the term "mutilates" not the means by which something can be mutilated. To the extent that there is reference to cutting, nicking or scraping in this material, little weight can be placed on it in the constructional exercise.

41. Further, an approach whereby the term "otherwise mutilates" is be understood by reference to definitions of the term "FGM" in selected reports or dictionaries (as opposed to the meaning conveyed by the term "otherwise mutilates") undermines the rule of law and the requirement for legal certainty (s34 *Interpretation Act, Director of Public Prosecutions (Cth) v Keating* (2013) 248 CLR 459 at [48]; *Director of Public Prosecutions (Cth) v Poniatowska* (2011) 244 CLR 408 at [44];

*Taikato v The Queen* (1996) 186 CLR 454 at 466; see also The Rule of Law is not a Law of Rules, Allsop CJ, Annual Quayside Oration November 2018). This is all the more so in circumstances where the legislature did not adopt such language in the second reading speech.

Constructional Choice

42. Section 33 of the *Interpretation Act* provides "*In the interpretation of a provision of an Act or statutory rule, a construction that would promote the purpose or object underlying the Act or statutory rule ... shall be preferred to a construction that would not promote that purpose or object*".

10 43. The focus of this provision is not on the construction which will "best achieve" the statute's purpose *"[r]ather, it is a limited choice between 'a construction that would promote the purpose or object [of the Act] and one 'that would not promote that purpose or object'"* (*Chugg v Pacific Dunlop Ltd* (1990) 170 CLR 249 at 262).

44. Section 33 of the *Interpretation Act* does not enable the Court to engage in a process of statutory construction whereby one asks which of the parties' constructions promotes the purpose of the provision (cf. Judgment at [249] **CAB 84**). Nor does s33 of the *Interpretation Act* permit the Court to construe a provision by reference to purpose regardless of the text or permit the Court to redraft the "*legislation nearer to an assumed desire of the legislature*" (*R v L* (1994) 49 FCR

20 534 at 538). It is not for a Court to come to a conclusion about its own idea of a desirable policy and impute that to the legislature and describe it as a statutory purpose (see *Australian Education Union v Department of Education and Children's Services* (2012) 248 CLR 1 at [28]; *Miller v Miller* (2011) 242 CLR 446 at [29], *Certain Lloyd's Underwriters v Cross* (2012) 248 CLR 378 at [26]).

45. It cannot be said that the CCA's construction given to the term "otherwise mutilates" does not promote the purpose of the provision (cf. Judgment at [249] **CAB 84**, AS at [54]). The purpose of the provision is to prohibit FGM. The CCA's construction promotes that purpose in that it prohibits the causing of serious or significant injury to the female genitalia.

30 46. The appellant states that the CCA accepted that there were a range of meanings attributable to mutilates (AS at [41]). The appellant contends that this give rise to a "constructional choice" which, after regard is had to definitions of FGM in select material, indicates that mutilates in the context of FGM extends to the infliction of

injury. However, the definitions of "mutilates" referred to by the CCA all suggested some form of serious or irreparable damage or destruction (CCA [488]-[490] **CAB 483-4**). The CCA was correct to conclude that more than the infliction of injury is required to establish mutilation (CCA [495] **CAB 486**).

47. Section 33 of the *Interpretation Act* has no work to do given that the CCA's construction promotes the purpose of the provision. Section 33 of the *Interpretation Act* does not permit purpose to be enlisted to support the framing of a term in a criminal offence in the broadest possible way. It can only operate where two constructions are otherwise properly open (*R v L* at 538).

Perceived evidentiary difficulties

48. Perceived evidentiary difficulties in proving offences under s45 of the *Crimes Act* do not support expanding the scope of the term "otherwise mutilates" to mean "any injury to any extent" (CCA [496] **CAB 486**, cf. AS at [54]). It is not an inconvenient or improbable result that a person may be acquitted of an offence under s45 of the *Crimes Act* where there is no evidence to support a finding of a result which contravenes the prohibition in s45(1)(a) (cf. AS at [54]). Parliament can, and often does, provide "deeming" provisions where there is a perceived difficulty in proof of an offence (see, for example, s29 of the *Drug Misuse and Trafficking Act 1986* (NSW)).

49. The appellant notes the difficulty in obtaining evidence of potential nerve damage as supporting its construction that any injury is sufficient to establish the offence (AS at [54]). However, the evidence adduced at the trial was not that every nick or cut to the clitoris would necessarily result in nerve damage. The CCA noted Dr Marks' evidence that a cut to the clitoral head could potentially have effects on future sexual functioning and if the nerve tissue of the clitoral head was cut that could lead to a loss of sensation, reduced sensation or altered sensation (CCA at [214] **CAB 406**). Further, the offence provision refers not only to the clitoris but also the labia majora and labia minora. As the CCA recognised, while "*the clitoral head may be more readily impaired or rendered imperfect due to the concentration of nerve tissue, the same may not be true of the clitoral hood (or prepuce), the labia majora and labia minora*" (CCA [497] **CAB 486**). The evidence of nerve disruption and possible effects of nerve disruption was given in respect of the clitoral head (not the prepuce) which, Dr Marks said, consisted of dense nerve

tissue (CCA at [213] **CAB 405**). Dr Marks, in re-examination confirmed that the clitoris is different tissue to the clitoral hood (or prepuce), which is skin (CCA [209] **CAB 404**). Dr Jenkins' evidence was that both the clitoris and the prepuce have quite a rich nerve supply, however the clitoris has a "*much more rich nerve supply than the prepuce*" (CCA [235] **CAB 411**). This is significant given that the appellant also contends that the CCA erred in finding that the term "clitoris" in s45 of the *Crimes Act* did not include the clitoral hood (or prepuce).

Directions to the jury on "mutilates"

50. The appellant contends that the trial judge's directions to the jury on the question of "mutilates" were not erroneous (AS at [55]-[59]). This submission is premised on the Court adopting the appellant's construction of the term "mutilates" which, for the reason above, should not be accepted. The appellant makes a further submission, namely that including the words "to any extent" after "injure" was not erroneous (AS at [59]). It is submitted that even if this Court is satisfied that the term "mutilates" extends to the infliction of injury the direction given by the trial judge was erroneous because it suggested de minimis injury was sufficient to establish the offence (cf. AS at [59]; CCA at [522] **CAB 494**). Describing an offence "de minimis" creates difficulties of its own (*Williams v The Queen* (1978) 10 CLR 591 at 597-598). Such a direction was particularly problematic in the respondent's case given the evidence concerning removal of skin cells (CCA [210], [490], [498] **CAB 404-5, 484 486**).

The CCA did not err in construing 'clitoris' s45(1)(a) of the *Crimes Act*

51. The CCA was correct in holding that the learned trial judge erred in construing the term '"clitoris" in s45(1)(a) of the *Crimes Act* as including the clitoral hood (prepuce). The respondent respectfully submits that the CCA's approach, in giving the term 'clitoris' in s45(1)(a) of the *Crimes Act* its anatomical meaning was correct (CCA [526] – [527] **CAB 495**). The construction adopted by the CCA is supported by medical evidence of one of the Crown witnesses at trial, Dr Marks (cf. AS at [60]; CCA [525] **CAB 494-5**). Dr Marks' evidence that the clitoral hood was not part of something else, the clitoral head and clitoral hood are closely physically related but they are different tissue and are not the same thing (CCA [209] **CAB 404**). The appellant's reliance on the perceived evidentiary difficulties concerning proving nerve damage in its argument with respect to "otherwise mutilates" makes

it particularly important to differentiate between the anatomical structures in question.

The Court should not order a re-trial

52. Even if the appellant successfully establishes that the trial judge's directions were correct (i.e. that ground 1 of the respondent's appeal in the court below should not have been upheld), it is submitted that the Court would not order a re-trial (s37 *Judiciary Act* and s8 *Criminal Appeal Act 1912* (NSW)). Not only does the evidence not support a case against the respondent on the basis that she performed a cut to the clitoris (or genital area) of C1 or C2, there are also compelling discretionary reasons as to why a retrial would not be ordered (CCA [635]-[637] **CAB 524-5**).

53. First, the evidence does not support a case against the respondent on the basis that she performed even a nick or cut to the clitoris (or genital area) of either C1 or C2. In considering whether to order a re-trial on the alternate counts of assault occasioning actual bodily harm contrary to s59 of the *Crimes Act*, the CCA considered the respondent's liability on the basis that there had been a nick or cut to the genital area, including, possibly, the clitoris (the case that would be presented on a re-trial) (CCA [614] **CAB 518**). The CCA declined to order a retrial on the alternate counts after carefully examining all of the evidence that would be available (CCA [638] **CAB525**). The appellant does not contend that this conclusion or the findings upon which it is based were erroneous. Verdicts of acquittal were entered on all counts.

54. The alleged offences came to the attention of the authorities due to an anonymous tip off (CCA [19] **CAB 356**). The evidence that there had been a cut to the private parts of C1 and C2 came about as a result of a series of leading questions (CCA at [23]-[25], [40], [626] **CAB 357-8, 362, 521-2**). The CCA considered that the high point of the evidence in support of the offence of assault occasioning actual bodily harm in relation to C1 was her evidence (CCA [621] **CAB 520**). However, the CCA concluded that C1's evidence that "*she thought she had been cut (or pinched) [was] to be viewed in the context of there being no lasting pain, no blood nor any other evidence of injury. She did not see the procedure and was describing what it felt like*" (CCA [625] **CAB 521**). Earlier, the Court observed that it was of "some

significance" that C1 was ultimately not able to describe what it was that caused her pain (CCA [621] **CAB 520**).

55. C2 was unable to identify her private parts on the body sketch (CCA [39] **CAB 361-2**). C2's account lacked any of the detail in C1's account (CCA [626] **CAB 521-2**). The CCA observed that "*[t]he evidence in her JIRT interview relevant to an allegation of actual bodily harm did not go any higher than the fact that after a number of leading questions she volunteered ... that she had "hurt" in her "bottom""*" (CCA [626] **CAB 521-2**). There were no other details in C2's account that would advance a case that actual bodily harm (on the Crown case a nick or cut) had been inflicted on her (CCA [626] **CAB 521-2**). The CCA concluded that C2's evidence, without any other evidence as to the procedure performed on her, could not support an allegation of actual bodily harm "*especially given the lack of any physical evidence of harm*" (CCA [628] **CAB 522**).

56. The medical evidence was, at best, neutral for the Crown case in relation to a nick or cut to the clitoris. The medical evidence as to whether an injury had been inflicted on the genitalia of the complainants rose no higher than a possibility. Examination of the girls revealed that the external female genitalia were normal in each girl (CCA [218]-[219] **CAB 406-7**). The prepuces of C1 and C2 were normal (CCA [218]-[220], [222] **CAB 406-7**). There was no evidence of scarring on either complainant (CCA [218]-[219] **CAB 406-7**). The medical evidence suggested that a cut to the clitoris would cause pain and be painful for a period of time after (CCA [213], [215], [235]-[236] **CAB 405-6, 411**). However, no bleeding nor significant/sustained pain was reported by the complainants (CCA [30], [31], [42], [169], [621], [625] **CAB 359, 362-3, 394-5, 520-2**).

57. Dr X's evidence was described as "important" given that neither complainant gave direct evidence that her clitoris had been cut or nicked (CCA [616] **CAB 519**). However, in assessing whether these charges could be established the CCA put Dr X's evidence regarding the static nature of khatna, the reasons the ceremony was performed and the lack of a ritualised procedure to one side because her opinions were not admissible under s79(1) of the *Evidence Act* (see CCA [616]-[618] **CAB 519**; a finding which is not now challenged). The CCA found that Dr X's remaining opinions did not advance the Crown case as to what procedure was actually performed on C1 or C2 and whether it went beyond a ritualised procedure

given the temporal and geographical limitations of her expertise (CCA [619] **CAB 520**). Further, Dr X's evidence was that the procedure involved an excision not a nick or cut (CCA [620] **CAB 520**).

58. The CCA assessed the case against the respondent in respect of C1 separately to the cases in respect of C2 (CCA [629] **CAB 522-3**). The CCA found that in the absence of the "bridging" evidence of Dr X, the evidence of each complainant did not have significant probative value as tendency or coincidence evidence in relation to the other complainant (CCA [629] **CAB 522-3**).

59. The CCA accepted that certain statements made by the respondent in intercepted telephone conversations were either exculpatory or, if not exculpatory, amenable to an explanation inconsistent with guilt (CCA [631] **CAB 523**). The evidence of A1, A3 and A5 did not advance the Crown case (CCA [633] **CAB 523**).

60. It is submitted that the evidence adduced on the appeal excluded a finding that there had been a nick/cut to the clitoral head of either complainant. At trial, Dr Marks gave evidence that a possible reason she could not clearly visualize the clitoral head on either C1 or C2 was because of the tightness of the clitoral hood, which in small girls can be due to developmental reasons (CCA [340] **CAB 442**, see also Prof Jenkins CCA [341] **CAB 442**). In order to see the clitoral head the clitoral hood has to be pulled back, sometimes quite forcibly, which can be painful (CCA [339] **CAB 442**). In her report admitted on the appeal, Professor Grover stated that "*an inability to retract the clitoral hood or prepuce does impact on what could be done to the clitoral tip/glans, as the structure is thus obscured/hidden and inaccessible to direct contact*" (p.2 Prof Grover Report 3 April 2017). In the post-trial examination, the clitoral head on both C1 and C2 could be clearly visualized and the clitoral hood could be retracted (CCA [348]-[351] **CAB 443-4**). The clear inference is that the reason the clitoral head could not be clearly visualized was due to the tightness of the clitoral hood at the time of Dr Marks' pre-trial examination in September 2012. If the clitoral hood prevented the clitoral head from being accessed on either complainant at the time of Dr Marks' examination then this same inability to access the clitoral head would have prevented the respondent from inflicting a cut or nick to the clitoral head on either complainant. Thus, the suggestion that any nick or cut to the clitoral head may be sufficient to fall within

s45(1)(a) because of the particular sensitivity and potential for damage of that area, does not advance the case for conviction on the facts here.

61. Second, the respondent was sentenced to 15 months imprisonment with a non-parole period of 11 months to be served by way of home detention. Her sentence expired on 8 September 2017.

62. Third, the complainants have been interviewed once, subjected to two medical examinations and given evidence at trial (CCA [637] **CAB 524-5**). The events the subject of the charges occurred in 2009 and 2012 (CCA [637] **CAB 524-5**). The trial occurred in late 2015. While their recorded JIRT interviews could be played under the vulnerable witness provisions in the *Criminal Procedure Act 1986* (NSW), C1 and C2 would still need to give evidence at a re-trial as provisions permitting the tender of a complainant's original evidence on any re-trial do not apply to trials of offences contrary to s45 or s59 of the *Crimes Act* (ss 3 and 306B *Criminal Procedure Act*, CCA [637] **CAB 524-5**). Any new trial would involve the complainants giving evidence at least four years after they first gave evidence, and in C1's case in the order of 10 years after the event.

63. In considering whether C1 and C2 were compellable to give evidence against their mother, A2, the trial judge accepted that there was a likelihood that psychological harm might be caused to C1 and C2 and their relationship with their mother if they were called to give evidence (*R v A2; R v KM; R v Vaziri (No 4)* [2015] NSWSC 1306 at [152]). Evidence tendered on that question indicated that such harm included emotional and psychological harm and could impact other areas of C1 and C2's development and behaviour (ibid at [148]-[151]). A re-trial would occasion further (and unnecessary) distress to the complainants in giving evidence against their mother a second time.

64. Fourth, the trial (including pre-trial arguments) and sentencing proceedings occupied a significant amount of court time and the appeal involved consideration of a voluminous amount of material (CCA [636] **CAB 524**).

65. Finally, in the event a re-trial were ordered the respondents would raise before the new trial judge certain evidentiary issues in respect of which the respondents were unsuccessful on appeal. The respondents contend that the trial judge erred in ruling C2 competent to give evidence (both at trial and at the time of the JIRT interview) (see CCA [767]-[770], [779], [784]-[785] **CAB 560-1, 564-5**). The respondents

also contend that the trial judge erred in granting leave to permit the asking of leading questions in the JIRT interview of C1 and C2 which constituted their evidence in chief, and which elicited the evidence on which the prosecution relied at trial. The respondent's further contend the trial judge erred in disallowing the defence from asking leading questions in cross-examination of C1 and C2 (CCA [810]-[811], [825]-[833] **CAB 572, 576-8**). In particular, the respondents contend that the rulings of the trial judge on this subject was contrary to the accusatorial system of justice. The respondents will also object to the evidence of Dr X if the prosecution seeks to rely on it. Dr X was not qualified to give evidence as to her opinions of the static nature of khatna (CCA [714] **CAB 546-7**). Her opinion as to the khatna procedure was based on her own experience in 1950/1951 in India and her study in 1990-1991 in India (CCA at [713] **CAB 546**). Her opinion was not capable of affecting the assessment of the probability of whether the clitorises of C1 or C2 had been nicked or cut in 2009 and 2012 in NSW.

**Part VI: Cross Appeal/Notice of Contention N/A**

**Part VII:**

66. It is estimated that the respondent's oral argument will take 1 hour to present.

Dated 2 May 2019

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IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY

No. S43 of 2019

No. S44 of 2019

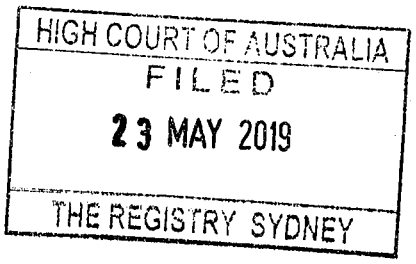
No. S45 of 2019

BETWEEN:

**The Queen**

Appellant

and




**A2**

**Kubra Magennis**

**Shabbir Mohammedbhai Vaziri**

Respondents

## APPELLANT'S REPLY

### Part I: Certification

1. These submissions are in a form suitable for publication on the internet.

### Part II: Reply

*Trial judge's direction on meaning of "otherwise mutilates" in s 45(1)(a)*

2. The trial judge's direction to the jury as to the meaning of "otherwise mutilates" in s 45(1)(a) of the *Crimes Act 1900* (NSW) was threefold: (i) injury "to any extent" was sufficient; (ii) proof of "serious injury" was not required; and, thus, (iii) a nick or cut, as had been alleged by the Crown, was "capable of constituting mutilation" (Joint Core Appeal Book (**AB**) 99). In the appellant's submission, that direction, understood in the context of the trial, appropriately emphasised that the offences against s 45(1)(a) could be made out if the jury accepted the Crown's case that the clitoris of C1 and/or C2 was cut or nicked. Proof of some more serious injury, or of a particular kind of damage, was not required (Appellant's Submissions (**AS**) [59]).

3. The Court of Criminal Appeal (**CCA**) took – and the respondents, in seeking to defend the CCA's reasoning, take – issue with steps (i) and (ii) of the trial judge's direction. The CCA concluded that "otherwise mutilates" in s 45(1)(a) does not encompass injury *simpliciter*: the extent of the injury required is that the body part in

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question be rendered imperfect or irreparably damaged (AB 492-493 [514], [521]; Submissions of Respondent Magennis (**RS Magennis**) [14]). It followed that, in circumstances where there was no medical evidence of, for example, scarring to the skin or damage to nerves, a cut or nick as alleged by the Crown was not capable of constituting mutilation (AB 509-511 [586], [590]-[591]). On that basis, acquittals were entered in respect of the counts charging offences against s 45(1)(a). By these appeals, the appellant challenges the CCA's critical conclusion as to the proper construction of s 45(1)(a) (cf RS Magennis [10]).[1]

*Legislative purpose of s 45*

10 4. The respondents accept that the purpose of s 45 of the *Crimes Act* "was, and is, to prohibit FGM" (RS Magennis [16]). But, the respondents contend, it was not intended that all recognised forms of female genital mutilation would be proscribed. In attempting to chart the boundaries of the intended scope of the provision, the respondents say of the Second Reading Speech that the "principal concern" was to prohibit female genital mutilation "insofar as it involved removal of all or part of the external female genitalia" (RS Magennis [18]-[19]). If that be right, it is a narrower legislative concern than that to which the CCA gave effect (see AS [50]). It was accepted, for example, that nerve damage could amount to mutilation for the purposes of s 45, notwithstanding that there may not, in the usual case, be any
20 removal or excision of genitalia (AB 484 [492], 492 [515]).

5. The respondents seem now to accept that the three forms of female genital mutilation expressly referred to in the Second Reading Speech ("infibulation, clitoridectomy and sunna")[2] correspond to the words "excises [and] infibulates" in s 45(1)(a), with the result that the Second Reading Speech "does not elucidate the purpose of including the term 'otherwise mutilates' in the offence provision" (RS Magennis [21]-[22]). Yet the respondents submit that the words "otherwise mutilates" were included in s 45(1)(a) "to ensure the offence extended to other forms of serious or significant damage to the external female genitalia that do not involve the removal of tissue" (RS Magennis [22]). There is no sound basis in the extrinsic material for the
30 kind of qualitative limit on the injury or damage captured by s 45 which is suggested by the respondents.

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[1] See also the articulation of Ground 1 before the CCA: AB 318, 323 (particularly Ground 1(a)), 328.
[2] New South Wales Legislative Council, *Hansard*, 4 May 1994 at 1860.

6. The respondents contend that s 33 of the *Interpretation Act 1987* (NSW) has "no work to do" in this case because "[i]t cannot be said that the CCA's construction ... does not promote the purpose of the provision" (RS Magennis [45]-[47]). This assumes the correctness of the submission that the purpose of s 45 was to prohibit only "serious or significant injury to the female genitalia" (RS Magennis [45]). Further, the *relative* coherence of potential meanings of statutory language with an identified legislative object or policy is relevant to the task of statutory construction.[3] It cannot be the case that, so long as the construction preferred by the CCA is not antithetical to some prohibition on female genital mutilation, no constructional choice arises.

7. At its highest level of abstraction, the respondents' submission seems to be that the legislative objective and policy of s 45 is entirely contained within its terms read literally: "what the legislature regards as FGM is that which is prohibited by the provision" (RS Magennis [16]). Either that contention seeks, wrongly in the appellant's submission (see AS [37]-[40]), to confine the constructional task to the four corners of the text of s 45 or the contention simply, and unhelpfully, directs attention back to the question of what is prohibited by the provision. In the context of female genital mutilation, the word "mutilates" permits of a meaning that extends to the infliction of injury to female genitalia including, relevantly, by cutting or nicking that does not render the genitalia imperfect or irreparably damaged (AS [43]-[45]). The respondents do not seem to dispute that such a meaning is open when the word "mutilates" is used in the context of female genital mutilation.

*Injury or damage that is "serious or significant"*

8. As noted, the respondents contend that s 45(1)(a) of the *Crimes Act*, on its proper construction, captures only serious or significant injury or damage to female genitalia (RS Magennis [14], [22]). It is said that "otherwise mutilates" should, in effect, be read *ejusdem generis* with the words "excises" and "infibulates" (RS Magennis [28]; Submissions of Respondents A2 and Vaziri (**RS A2/Vaziri**) [14]). This submission is misconceived for the reasons given by the CCA and the trial judge (AB 78-79 [228]-[232], 492-493 [517]-[519]). The expression "*otherwise* mutilates" (emphasis

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[3] See AS [39]; *Taylor v The Owners – Strata Plan No 11564* (2014) 253 CLR 531 at [66] per Gageler and Keane JJ; *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362 at [38] per Gageler J; *SAS Trustee Corporation v Miles* (2018) 92 ALJR 1064 at [20] per Kiefel CJ, Bell and Nettle JJ.

added) makes clear that "mutilates" is not to be understood by reference to, or as constrained by, a genus arising from the preceding words.[4] The respondents also say that the word "mutilates" carries "a strong connotation of very significant or serious injury" (RS Magennis [29]). This submission relies on the connotation of "mutilates" in common or ordinary parlance to the apparent exclusion of the meaning of "mutilates" in the context of female genital mutilation, despite the respondents seeming to accept that female genital mutilation is an important contextual matter (RS Magennis [11]). The appellant does not ask this Court to strain or supplant the language of s 45 (cf RS Magennis [29]-[41]; RS A2/Vaziri [9], [11]). The construction of s 45(1)(a) advanced by the appellant is available, when the terms of the provision are understood in context and in light of the legislative purpose, and accords with the apparent statutory object and policy.

9. The respondents are critical of the appellant for focussing on the means by which mutilation might occur – for example, cutting or nicking – rather than on the notion of mutilation (RS Magennis [24], [40]; RS A2/Vaziri [10]). But, as the respondents submit elsewhere, "mutilates" in s 45(1)(a) refers to a particular action (RS Magennis [20]). To condition the application of the offence provision on the seriousness or significance of the injury or damage that results from the action proscribed is not warranted and nor should it be thought to have been intended. The extent and permanence of injury or damage that, in fact, results from a female genital mutilation procedure in a given case can be arbitrary (see AS [48], [54]; cf RS Magennis [41]; RS A2/Vaziri [21]). That is why the legislature sought, by s 45 of the *Crimes Act*, to enact a clear prohibition on all forms of female genital mutilation (see AS [46]).

*Orders for re-trial*

10. In the appellant's submission, unless the interests of justice require the entry of acquittals or there is no evidence to support the charges, this Court should make an order for a new trial.[5] The evidence in support of the charges was described in some detail at AS [9]-[32]. At trial, there were two competing explanations of events that were, for the most part, agreed to have happened. Resolving that competition, and, in doing so, assessing the believability of each explanation in light of the available evidence, remains an appropriate matter for a jury.

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[4] See *Crowe v Graham* (1968) 121 CLR 375 at 388 per Windeyer J.
[5] See *Spies v The Queen* (2000) 201 CLR 603 at [104] per Gaudron, McHugh, Gummow and Hayne JJ.

11. The respondents submit that this Court should draw an inference adverse to the Crown from the new evidence admitted by the CCA. It is said that, because the clitoral head of each complainant was not visualised by Dr Marks in medical examinations prior to the trial, it may be inferred that it was not possible for the clitoral head to have been cut or nicked at the time of the alleged offences (RS Magennis [60]). The fallacy of this submission is that it equates an inability to visualise the clitoral head with an inability to retract the clitoral hood. Dr Marks' evidence was that she could not see the clitoral head of C1 or C2. She did not give evidence that she could not, or tried but failed to, expose the clitoral head by retracting the clitoral hood (AB 409 [227]-[228], 442 [339]-[340]). Thus, this Court is not in a position to infer that, at the time of the alleged offences, the clitoral hood of each complainant was unable to be retracted.

12. The CCA did not find that, if the appellant's construction of s 45(1)(a) of the *Crimes Act* were accepted, the evidence at trial was insufficient to found a verdict of guilty in relation to those offences.[6] The suggested "problems with the available evidence" are not of a kind that would lead this Court to disallow a new trial (AB 524 [635]).[7] In the appellant's submission, an order for a retrial is appropriate, noting that whether a retrial is, in fact, brought is matter for the judgment of the Director of Public Prosecutions.[8] The discretionary considerations identified by the respondents do not outweigh the public importance of duly prosecuting these serious offences.

Dated: 22 May 2019

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[6] Cf *Gerakiteys v The Queen* (1984) 153 CLR 317 at 321 per Gibbs CJ (Wilson J agreeing); 322 per Murphy J, 330 per Brennan J, 331 per Deane J. Whether actual bodily harm could be made out on the evidence was not fully argued before the CCA and the CCA did not express a concluded view: AB 524 [634].

[7] See *Stanoevski v The Queen* (2001) 202 CLR 115 at [61] per McHugh J; *Dyers v The Queen* (2002) 210 CLR 285 at [23] per Gaudron and Hayne JJ.

[8] See *Stanoevski* (2001) 202 CLR 115 at [51] per Gaudron, Kirby and Callinan JJ; *Dyers* (2002) 210 CLR 285 at [23] per Gaudron and Hayne JJ, [88] per Kirby J, [135] per Callinan J; *R v Taufahema* (2007) 228 CLR 232 at [144] per Kirby J.

High Court of Australia Transcripts

# R v A2; R v Magennis; R v Vaziri [2019] HCATrans 122 (12 June 2019)

Last Updated: 12 June 2019

**[2019] HCATrans 122**

IN THE HIGH COURT OF AUSTRALIA

Office of the Registry

Sydney No S43 of 2019

B e t w e e n -

THE QUEEN

Appellant

and

A2

Respondent

Office of the Registry

Sydney No S44 of 2019

B e t w e e n -

THE QUEEN

Appellant

and

KUBRA MAGENNIS

Respondent

Office of the Registry

Sydney No S45 of 2019

B e t w e e n -

THE QUEEN

Appellant

and

SHABBIR MOHAMMEDBHAI VAZIRI

Respondent

KIEFEL CJ

BELL J

GAGELER J

KEANE J

NETTLE J

GORDON J

EDELMAN J

TRANSCRIPT OF PROCEEDINGS

AT CANBERRA ON WEDNESDAY, 12 JUNE 2019, AT 10.02 AM



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**MR D.T. KELL, SC:** May it please the Court, I appear with **MS E.S. JONES** for the appellant in each of the appeals. (instructed by Solicitor for Public Prosecutions (NSW))

**MR H K DHANJI, SC:** May it please the Court, I appear with my learned friend, **MR D.R. RANDLE**, for the respondents in A2 and Vaziri. (instructed by Armstrong Legal)

**MR T.A. GAME, SC:** May it please the Court, I appear for the respondent Magennis with **MS G.E.L. HUXLEY**. (instructed by Armstrong Legal)

**KIEFEL CJ:** Yes, Mr Kell.

**MR KELL:** Thank you, your Honours. At issue in these appeals is the proper construction of section 45 of the *Crimes Act* 1900 (NSW). Section 45 was enacted in 1994 as a prohibition on female genital mutilation. It commenced operation on 1 May 1995, and the text of the provision relevantly for section 45(1) is at the joint book of authorities at page 13.

During the period in which the offences in these cases are alleged to have occurred, section 45(1) is in the terms stated at page 13 and it provides relevantly that:

> (1) A person who:
>
> (a) excises, infibulates or otherwise mutilates the whole or any part of the labia majora or labia minor or clitoris of another person

. . .

is liable to imprisonment for 7 years.

In the present cases, your Honours will be aware, from the written submissions, the first and second respondents, A2 and Ms Magennis, were charged with having mutilated the clitoris of each of the two complainants, who were identified as C1 and C2 in the materials. They are the daughters of the first respondent, A2. The present third respondent, Mr Vaziri, was charged with being an accessory to those offences. The indictment therefore links to the words within section 45(1) "otherwise mutilates". So it is mutilation of the clitoris of each of the complainants.

The question of construction of section 45 was raised by the parties as a pretrial issue. The trial judge, Justice Johnson, heard argument on that issue and delivered a judgment on 27 August 2015. That is in the core appeal book, which I refer to as "appeal book", from page 8 through to page 90. There is quite a detailed consideration of the question. His Honour in the result accepted the Crown's submission that:

> physical injury to an extent to the female genital organs, which is done for nonmedical reasons, can amount to mutilation for the purposes of section 45.

That can be seen in two references: one is at appeal book 41, at paragraph 110 of the judgment, where his Honour records the Crown's submissions as to mutilation and he refers at paragraph 111 on that same page to the joint defence submissions, to the effect that:

> a jury should be directed that the word "*mutilates* . . . means to cut off, destroy, or alter radically a part of the body –

So a quite high level of injury being posited by the defence. His Honour accepted the submissions of the Crown and rejected the submissions of the defence, and that can be seen at appeal book 86 at paragraph 257 through to 258. At 257:

I am satisfied that the construction of s.45(1) advanced by the Crown, which I accept reflects the will of Parliament.

At 258 his Honour indicates that he will direct the jury consistently with that approach. Then at the trial his Honour did direct to that effect, and that can be seen at – the summingup begins at appeal book 92 and then relevantly at appeal book 99 from about line 29 there is his Honour's directions to the jury and he relevantly starts:

The word "mutilate" in the context of female genital mutilation means to injure to any extent. It is not necessary for the Crown to establish that serious injury resulted.

That contrasts with the proposition that was being advanced by the defence:

In the context of this trial, a nick or cut is capable of constituting mutilation for the purpose of this alleged offence.

Then he continues in the next paragraph:

So for this offence to be proved, the Crown does not need to prove that something was cut off.

Et cetera, and then:

If there is a nick or a cut, that would be sufficient in law to constitute a mutilation.

That direction is consistent with the written directions that Justice Johnson gave to the jury. And just on that page at line 30, his Honour refers to – so the direction in paragraph 3, and that is a crossreference to the written directions which his Honour had given, and I will just identify where they are. In the respondent's book of further materials at page 9, your Honours will see paragraph 3, which again is consistent with the oral summingup.

The jury subsequently convicted the respondents of the offences against section 45(1). Our submission is that there was no error in the way in which his Honour Justice Johnson directed the jury, because on the proper construction of the provision and I will come to the construction of course it was necessary only for the Crown to prove injury, in the context of this case, relevantly comprising a cut or a nick. Necessarily from that, it was not necessary for the Crown to prove some high level of injury, contrary to what the Court of Criminal Appeal subsequently held.

So on the appeals against conviction, the Court of Criminal Appeal of New South Wales concluded that it was necessary for the Crown to prove more than injury simpliciter, and held that the kind of injury which the Crown was required to prove to fall within the terms of section 45 was injury rendering the body part in question, in this case the clitoris of a prepubescent girl, rendering the clitoris imperfect or irreparably damaged. That can be seen at appeal book 493, at paragraph 521. It is a joint judgment; their Honours indicate under the heading:

**Conclusion on issues** . . . **in relation to "mutilates"** –

Firstly:

that the extrinsic materials . . . do not permit a construction of "mutilates" that departs from its ordinary meaning –

and I will return to that. And the court's consideration that the:

ordinary meaning connotes injury or damage that is more than superficial and which renders the body part in question imperfect or irreparably damaged in some fashion.

As a consequence, his Honour, the appeal court said:

misconstrued the meaning of "mutilates" and hence misdirected the jury –

That can also be seen at appeal book 486, at paragraph 495, which is a paragraph leading up to the conclusion I have just taken your Honours to where their Honours indicate that:

The text of the offence provision . . . particularly the use of the verb "mutilates" rather than simply "injures" or "damages", suggests that more than the causing of an injury is required, such as impairing or rendering imperfect the body part that is mutilated.

Then there is reference to the sensitivity of the body part in question, and also references to:

One would not, in ordinary parlance, refer to a superficial graze as mutilation.

I will come back to that on the question of construction. So to succeed in relation to ground 1 of the appeal, we recognise that we need to persuade your Honours that, in effect, a person who injures the clitoris of another person is a person who mutilates the clitoris, for the purposes of section 45(1), including in circumstances such as here where the injury

comprises a nick or cut to the clitoris, deliberately inflicted, without there necessarily being evidence of any heightened or perceived permanent or lasting damage, such as the Court of Criminal Appeal required, that is, rendering something imperfect or irreparably damaged.

That arises in the context where, as your Honours would have seen from the materials, and consistent with the evidence before the Court of Criminal Appeal, this is an area of the body which is rich in blood supply and heals quickly. The medical evidence was to the effect that a cut or nicking of the clitoris of a prepubescent girl may be such that on subsequent inspection there would be no scarring or permanent disfigurement because of the nature of the body part in question and its location.

**BELL J:** Is that Dr Jenkins' evidence?

**MR KELL:** It is consistent with Dr Marks and Dr Jenkins, yes.

**BELL J:** I think there is some issue as between you and the respondent Magennis concerning Dr Jenkins' evidence on that question.

**MR KELL:** There is an issue in relation to ground 2 which I will come to, the definition of "clitoris", the meaning of "clitoris", within ground 2 but I think

**BELL J:** I may be wrong. I thought that Magennis contended that Professor Jenkins' evidence suggested that ordinarily there would upon an examination be some sign of scarring. Is that wrong?

**MR KELL:** I think that they left open the possibility that there may be, the medical evidence that there may be, and that, of course, depends in part on the savagery of the cut and the like, but it is consistent with medical evidence that there would be no rendering imperfect, there would be no lasting visible disfigurement from what would be perceived as being female genital mutilation that involves the deliberate cutting of the clitoral hood of a young girl.

**BELL J:** As I understand the appellant's position, it is that the error that the Court of Criminal Appeal made was to require in the expression "otherwise mutilates" some interference that might answer the description of "injury"; that is, the court required something more than an injury. The prosecution submits that a "mere injury" is sufficient in the context. Is that fair?

**MR KELL:** Yes, that is correct.

**BELL J:** Indeed, as I understand it, the prosecution would contend that the direction "injury to any extent" in the context of this offence was a correct direction, is that so?

**MR KELL:** Yes, and in the context of this offence in this trial.

**BELL J:** What I just want to take up with you is the question of how that fits with the concept of injury for the alternative lesser offence in light of a view that to occasion actual bodily harm requires some hurt or injury that need not be permanent but that must be more than transient.

**MR KELL:** Yes. The level of injury here – going back a step. There is no suggestion in the context of this trial that there was anything approaching de minimis injury which was being suggested, and that is clear from the directions.

**BELL J:** The direction that invites the jury to consider that the offence would be made out upon proof of an injury to any extent, you say

**MR KELL:** Yes, which was – I am sorry, your Honour – in the context of this trial was a cut or a nick to the clitoris of one of the complainants or each of the complainants. The alternative counts were clearly not the subject of findings by the jury and there was consideration of the alternative counts in the Court of Criminal Appeal, but in the context of whether there should be a retrial in connection with those alternative counts, and ultimately for reasons including discretionary reasons, their Honours decided or determined not to order a retrial on the alternative counts. But the question as to whether or not injury would constitute actual bodily harm for the purposes of assault occasioning actual bodily harm is separate from the construction of section 45(1), of course, which is the matter that we take up.

**BELL J:** I am seeking to understand the proposition that you put. The Court of Criminal Appeal considered that to mutilate within the meaning of 45(1)(a) involved the infliction of some hurt or harm that was greater than an injury to any extent, which was the way the jury was directed. You embrace "injury to any extent" in the correct construction of the offence created by section 45.

**MR KELL:** Yes.

**BELL J:** I am, at this stage, seeking to understand what the prosecution says "injury" means in this context. Is it accepted that it bears a meaning consistent with the notion of "injury" for the purposes of the offence of inflicting actual bodily harm, namely, some hurt or injury that need not be permanent but that is more than merely transient, or do you go for a, as it were, lower threshold?

**MR KELL:** I want to just check whether that question was not advanced in the Court of Criminal Appeal. I just want to check whether the precise question that your Honour raised was not the subject of a question and answer in the Court of Criminal Appeal. I do not remember it being but, subject to that – and I will just doublecheck that – as your Honours will be aware, the level of injury for actual bodily harm, putting to one side the aspects of nonphysical injury that can occur in that context, the level of injury in the context of actual bodily harm is relatively low for assault occasioning actual bodily harm.

For the purpose of section 45(1) we say "injury" is any injury. It has to be injury to the genitals. Beyond that, one moves to the context of what happened in this case, which is the alleged nick or cut. But we do not posit a higher – and we do not need to and we should not consistent with the construction that I will come to, we do not suggest a higher level of injury than the need to prove injury simpliciter.

**BELL J:** It is a question of what "injury simpliciter" in this context means.

**MR KELL:** Yes, it is, and it is a context where, on the Crown case, there was deliberate cutting of the clitoris of each of these girls for nonmedical reasons and, in our submission, that would clearly amount to injury.

The contrast was the case advanced by the defence and relevantly now the holding of the Court of Criminal Appeal which was to place the level of injury at a much much higher level, that is to say that the clitoris needs to be irreparably damaged or rendered imperfect – and I will come back to this later – which we say is inconsistent with a legislative intention and that also the result of such a construction is to undermine the legislative purpose, which is to protect – I will come to the materials – vulnerable female children from a practice which is regarded as abhorrent and of no perceivable benefit for the child.

This is not an area of discourse where there may be balancing of – combat sports or the like where there may be perceived balancing of policy considerations allowing persons to engage in particular activities that may or may not cause harm. This is a provision which was directed to protect vulnerable children.

The construction arrived at by the Court of Criminal Appeal, we say respectfully, it is inconceivable that Parliament could have intended that this provision be construed in such a way that the only way in which an offence would be made out in connection with such conduct against a child is to prove that the clitoris is irreparably damaged or rendered imperfect. It is just inconsistent with the legislative purpose of the provision and the perceived parliamentary intent. I will come to that in further detail, if I may.

**NETTLE J:** You do accept that level of injury necessary to sustain an offence under section 45 need not necessarily be as much as the level of injury required to sustain an offence of assault occasioning actual bodily injury.

**MR KELL:** I do, subject to the comment that I recognise of course, that particularly with evolving cases of *Donovan, Miller* and the like, from memory, that the concept of actual bodily harm itself is quite a low threshold.

**NETTLE J:** Yes.

**EDELMAN J:** Your point, as I understand section 45, is that there are other facts other than any actual harm that make section 45 the more serious offence.

**MR KELL:** Yes. I will come to that with some of the materials shortly. Can I say this as well

**KIEFEL CJ:** Mr Kell, in relation to your approach to construction, am I correct in thinking that it has two principal limbs? The first is that which was put before the Court of Criminal Appeal, that for some time the term “female genital mutilation” has been accepted as a collective term which refers to all practices that inflict injury. And the second is that you take a purposive approach to construction because you say section 45 is a provision, the purpose of which is the protection of children.

**MR KELL:** Yes.

**KIEFEL CJ:** Are they your two principal approaches?

**MR KELL:** They are, with nuances, but yes.

**KIEFEL CJ:** In relation to the first, the Court of Criminal Appeal effectively said, I think at paragraph 494, the notion of it being a collective term was irrelevant because the statute does not use the collective term in its substantive part, in the definition of the offence.

**MR KELL:** Yes.

**KIEFEL CJ:** I am not sure whether the Court of Criminal Appeal actually dealt with a purposive approach expressly. Was that dealt with expressly by the – was that

**MR KELL:** What their Honours recognised was that the construction that they had arrived at appeared to be at odds with the legislative purpose, if it was as contended by the Crown, which is what we say is the case, and that is really at appeal book 494, at paragraphs 523 and 524.

**KIEFEL CJ:** I think again at paragraph 513. Is that the essential approach of the Court of Criminal Appeal that it is the ordinary meaning of the word "mutilates" as distinct from any developed meaning of the term "female genital mutilation", which conveys something else about the term "mutilation"?

**MR KELL:** Yes. Certainly we say that the Court of Criminal Appeal anchored its analysis to the ordinary meaning of "mutilates" and we say, properly viewed, that was the meaning as a matter of ordinary parlance. One can accept, perhaps, that "mutilates" in common ordinary parlance suggests a higher level of injury.

Just going back to your Honour's question about the first step; we say, as a first step in the analysis, that this is an area where it is not a question of looking and seeing that the term "female genital mutilation" is not expressly referred to in the language of section 45, putting to one side the heading and the long title of the Act and so on.

Our step one is that we demonstrate, including from context, that there is a constructional choice arising. That is to say that this is a case where "mutilates" has various meanings, and relevantly here there are perhaps two meanings. One is the ordinary common parlance meaning, so to mutilate some accounting records or the like.

The other, we say, which arises as a constructional choice, is the meaning of "mutilates" which is shown as deriving in a context which is female genital mutilation and I will come to that but that is not to incorporate all the nuances or practices of female genital mutilation which has a cultural context and the like.

**KIEFEL CJ:** Is it your submission that the term "female genital mutilation" refers to all practices?

**MR KELL:** Yes.

**KIEFEL CJ:** Including the generally defined four which appear in the Family Law Council report?

**MR KELL:** Yes, your Honour.

**KIEFEL CJ:** There is a lot written about the terminology and its origins and how it changed from a reference to female circumcision to female genital mutilation by the time of the Family Law Council discussion paper which is based on this and the reasons for the selection of the term “mutilation” not “circumcision”.

**MR KELL:** Yes. I respectfully agree with and adopt what your Honour said. Just going back to the issue or recognition that the term “female genital mutilation”, that compound concept, is not within the language of 45(1) expressly; we say that of course that is right but it does not prevent the argument that we adopt of the constructional choice and will come to and expand that.

The other aspect is that, if one looks at the language of section 45(1), there is an obvious affinity to the concept of female genital mutilation from the words that are used within the section itself. The section itself uses the language of “excises, infibulates or otherwise mutilates”. In addition to that, the subject matter of the offence is very particular. It is far removed from assault provisions and the like. It is dealing with female genitals.

**EDELMAN J:** Does that not suggest that the contrast is not really between ordinary parlance and some special meaning? In ordinary parlance, context is always relevant, and context in ordinary parlance might require one to consider whether words such as “excises” or “infibulates” were used in the context of the use of the word “mutilation” in ordinary parlance.

**MR KELL:** Yes. When I say “ordinary parlance”, I am referring to ordinary parlance, which is a criticism here ordinary parlance without particular context.

**EDELMAN J:** No parlance ever occurs without any context.

**MR KELL:** That may be right but what we say here is that ultimately the construction for which we contend is a construction which is, when one has regard to context and purpose, properly viewed in that sense as the ordinary meaning that one ends up with.

**GAGELER J:** Do you offer a precise definition of the words “excises” and “infibulates” and, if so, where can we see it written somewhere?

**MR KELL:** Is your Honour asking whether it is in the materials generally? I will take your Honours to the categories of female genital mutilation from which those two concepts are drawn, but clearly what was in issue in these proceedings was what was referred to as the umbrella term, the “otherwise mutilates”.

**GAGELER J:** It is just possible that the umbrella term is informed to some extent by the content of the earlier expressions, at least on one rather orthodox approach to statutory interpretation.

**MR KELL:** The answer to that, respectfully, is it is and it is not. It is informed in the sense that it is making that those terms which have an obvious affinity like “mutilates” with the concept of female genital mutilation, which I will come to, so that is relevant. Beyond that, we submit that it is not a ejusdem generistype case, and that was made

**GORDON J:** Are not those terms, that is, those words – excision, infibulation, and otherwise mutilates – reflecting what the Chief Justice put to you before, categories that appear both in the discussion paper from the Family Law Council, and then ultimately the Family Law report?

**MR KELL:** We say yes.

**GORDON J:** I mean, they are the words that are used. When one looks at them in terms of the way in which they have been described, one is infibulation, one is excision

**MR KELL:** Yes.

**GORDON J:** So there is an explanation as to what it was intended that those particular things might cover, and between them there are degrees.

**MR KELL:** Yes, and that they cover the field, as it were, of those four categories which are the least extreme to the most extreme of female genital mutilation, and I will come to them, but just one the

**GORDON J:** Do they not, picking up both the question you were asked by Justice Gageler and also what was put to you by Justice Edelman, give you the context? The words were not just plucked out of the air. They were chosen for a particular purpose.

**MR KELL:** Yes, we say they do assist with context, yes. Can I just, because I did refer to ejusdem generis, so at appeal book 492 at paragraph 518 – or from appeal book 492 from paragraph 516 the Court of Criminal Appeal noted that the appellants raised ejusdem generis as a means of seeking to argue that "otherwise mutilates" – that the first two terms, being the very extreme forms of female genital mutilation, "infibulates" and "excises", so "excises" is the cutting off completely of, for example, the clitoris and "infibulates" includes the removal and sewing and the like, that somehow "otherwise mutilates" should be understood as within a similar genus of very significant injury, and that was rightly rejected, we say, by the Court of Criminal Appeal, paragraphs 516 through to 519.

At 518 at the top of page 493 the court indicated – or referred to the Crown's submission that the expression "otherwise mutilates" and the term "mutilates" is an umbrella term. At 519 the Court of Criminal Appeal rightly made findings upholding those Crown submissions, including a finding that:

The term "or otherwise mutilates" is an umbrella term intended also to capture other forms of mutilation that are to be prohibited

and is not to be understood in an ejusdem generis sense. Can I turn to some of the material in the first step which is the step that we say assists in indicating that there is a constructional choice. That is material beyond the context that arises from the straight reading of the provision which I have been taking your Honours to now.

We say that the word "mutilates" is to be construed in the context of a provision dealing with female genital mutilation. I will come to the question of what that context means for the

ultimate construction but we say that to mutilate in the context of female genital mutilation connotes all forms of injury which will often involve cutting to the female genitals which is deliberately inflicted.

If I can go the Family Law Council's report, which is in the joint bundle of authorities at 646, I have touched on some of these aspects already. The Family Law Council report starts at page 631. It is a report dated June 1994.

**KIEFEL CJ:** This had not been published at the time of the second reading speech, which was May 1994.

**MR KELL:** Yes.

**KIEFEL CJ:** Was it in the same form as the discussion paper?

**MR KELL:** For relevant purposes, the matters to which I will draw attention, yes, there is no relevant distinction. The discussion paper is at 585. Some of the intentions in the discussion paper were put forward as necessarily the preliminary view of the council because it was a discussion paper and then those preliminary views about prohibiting female genital mutilation included views in the discussion but your Honour is right. The discussion paper is dated 31 January 1994, so before the second reading speech and the like. I will give your Honours, where I can, references to both, but we say there is no relevant difference on the points being advanced.

**KIEFEL CJ:** There is no issue but that the reference in the second reading speech to the report of the Family Law Council is a reference to the discussion paper.

**MR KELL:** Yes.

**KIEFEL CJ:** There is no dispute about that?

**MR KELL:** No. If your Honours go to appeal book 646, at paragraph 2.01, at about line 21, it is made clear by the Family Law Council that:

Female genital mutilation "is the collective name given to several different traditional practices that involve the cutting of female genitals."

So reference to the cutting and then at 2.02 at about line 35:

In this paper –

having referred to there being four procedures and the like:

when the term "female genital mutilation" is used it is meant to embrace all types of the practice where tissue damage results; for example, damage manifested by bruising,

contusion or incision.

Then at 2.03, there are the four categories referred to, and I will just come back to that. But a matter that we say is important is that both the discussion paper and the Family Law Council report refer to what was accounts and reports at the time, referred to as being anecdotal evidence of the occurrence of female genital mutilation in Australia and perhaps if I go to the discussion paper which is before the second reading speech at appeal book 598. At paragraph 2.30

**KIEFEL CJ:** I think you meant the joint book of authorities.

**MR KELL:** Sorry, yes, I apologise. The joint book of authorities at page 598.

**KIEFEL CJ:** Is this anecdotal evidence particularly helpful for construction? Is it not really the terms of the Family Law Council report or discussion paper about what female genital mutilation comprehends more important?

**MR KELL:** It is part of the material that was before the Family Law Council in making the recommendations that it did. But when it is referred to as anecdotal, it is information gained by DIEA – so that is the Department of Immigration and Ethnic Affairs and then the third bullet point down, that the material that was being reported by the Department of Immigration and Ethnic Affairs was that the practice included cutting the clitoral hood, being practiced in the Malaysian community in Western Australia.

So that was part of the material, and that can be found similarly in the report at page 654 of the joint bundle of materials. Just in the discussion paper as well, at page 591, at paragraph 2.01, at about line 17 on the page, there is reference to:

In this paper when the term “female genital mutilation” is used it is meant to embrace all types of circumcision, other than mere ritual, when an incision is made in the girl’s genital area.

So the context concerning the recommendations that were to be made by the Family Law Council included female genital mutilation across four categories, which I will come to, with the concern being, relevantly, an incision – that is to say, cutting of the girl’s genital areas.

**EDELMAN J:** Dr Kell, is there any reference in the discussion paper that is equivalent to the sentence which follows that which you took us to in the Family Law Council report that refers to Armstrong?

**GORDON J:** The next paragraph.

**MR KELL:** Yes.

**EDELMAN J:** And Armstrong’s suggestion about the different types of circumcision?

**MR KELL:** Yes. The references to Sue Armstrong are in paragraphs 2.02 of the discussion paper at 591. For the transcript I will give the reference. Sue Armstrong is referred to at page 646 of the joint book of authorities in the context of the report.

**KIEFEL CJ:** Is the reference in 2.02 of the report to the two sentences, which are the third and fourth:

Those who oppose the practice call it “genital mutilation”.

I think you have taken us to this sentence:

In this paper when the term “female genital mutilation” is used it is meant to embrace all types of the practice –

**MR KELL:** Yes. I will just identify the four categories which are referred to. On that page, at 646, at 2.03 there is:

The first, and least severe form, is called ritualised circumcision. In this case the procedure may be wholly ritualised . . . In other forms of ritualised circumcision the clitoris is scraped or nicked.

So a nick or cutting. The Council then put to one side the ritualised form of circumcision, that not being a subject of recommendations for prohibition, of course.

**BELL J:** Did that involve some rejection of the point that Ms Armstrong was making, that a practice involving even ritualised circumcision or mutilation, or however you wish to describe it, carries its risks of the accidental injury to the child’s genital area?

**MR KELL:** We say not, but perhaps in part Professor Armstrong was referring to the sharpness of an instrument. It is conceivable that wholly ritualised circumcision:

(e.g. where there is cleaning and/or application of substances around the clitoris)

may not raise directly the same concerns that Professor Armstrong identified. One thing we say is relevant and can be taken from the Family Law Council’s recording of the Armstrong concerns is that it is consistent with an intention by the Council, and subsequently an intention by Parliament, that one would not be looking at prohibiting by reference to categories or prohibiting by reference to the second, third and fourth categories – I will deal with the second reading speech later – in part because the Council put an important caveat on the categories themselves, which is the reference to Ms Armstrong’s report that there is an inherent even with the least severe form of ritualised circumcision involving cutting there is an inherent risk to the child.

One factor, as Ms Armstrong indicated, is that, depending on the skill of the circumciser – we are not talking generally about medical procedures in a hospital – and the struggling of a child, one can readily foresee circumstances where what started what was intended to be a ritualised cutting became, unfortunately, a cuttingoff, for example, of a clitoral hood or the like.

**BELL J:** Or a ritualised ceremony involving no intention to cut, but where, as I understand it, the respondents submit was the intention here – a touching of the genitals of a young child with an instrument such as forceps.

**MR KELL:** Yes, yes.

**BELL J:** As I understand Professor Armstrong, if it were possible to frame an offence that captured that conduct, that would have an important public value too, because of the high risk of a ritual circumcision.

**MR KELL:** Yes.

**BELL J:** My point is, on one view, the Family Law Council itself recognised a difficulty with criminalising ritualised circumcision to the extent that it did not involve cutting.

**MR KELL:** Yes, that is right, and we say that clearly the offence requires proof of the verb "to mutilate", and that relevantly in this case includes – or is the cutting, the cutting of the clitoris. Just on that, I said that one of the aspects was the Armstrong caveat about the practical utility of some of these categories. The second matter, just on that topic, and I will just draw attention to it, is the explanatory note. I am doing this slightly out of order, but at page 721 of the joint book of authorities, there is the explanatory note to the 1994 Bill. The first paragraph of the explanatory note refers to "cutting". So:

Procedures involving the incision –

Just pausing there, so the cutting, rather than excising:

Procedures involving the incision, and usually removal –

Pausing there, but not invariably or inevitably so the incision:

of part or all of the external genitalia of young females are practised by some groups as a matter of custom or ritual. The practice can lead to infection, haemorrhaging, dysuria (painful urination) –

and the like. So there was again a recognition that what would be the cutting of the clitoris, such as was the Crown case here, which may be viewed as the first of those four categories of female genital mutilation, presents the Armstrong risk. But it also presents the risk that the legislature perceived, which was that the cutting of the clitoris of a prepubescent girl can lead to infection, which obviously may have serious longterm consequences, but simply the dysuria, the painful urination, and that those were matters that were the subject of legislative concern.

Can I just take your Honours as well to the Queensland Law Reform Commission report, which is at 806?

**KIEFEL CJ:** It postdates the legislation, does it not?

**MR KELL:** Yes, barely, but yes.

**KIEFEL CJ:** So how do you make it, as an extrinsic material, relevant to the legislation?

**MR KELL:** We say it is consistent with what is in the Family Law Council report and within the area that as at the time of – as at 1994 that the area of discourse for female genital mutilation included

**KIEFEL CJ:** There were a number of reports and the Family Law Council obviously had regard to them. I think they mentioned some – the World Health Organisation had been looking into this, the United Nations; other agencies had been.

**MR KELL:** Yes. So it is consistent with that material – and I will mention it just in passing – which shows that the nicking of the clitoris is a form of what was recognised as female genital mutilation, but in one sense it is consistent with and does not take it further than the Family Law Council material.

**BELL J:** Is there a distinction between a cut and a nick for the purposes of this argument?

**MR KELL:** I think both

**BELL J:** Perhaps you could tell us what the distinction is, if there is one.

**MR KELL:** They may be descriptions of more or less the same thing. A nick, at least on one view, may be a form of – a cut of less severity than perhaps – so one may put a savage cut into a person which would not similarly be necessarily described as a nick or a savage nick, but it is both

**BELL J:** Just to come back to your position as to the error that the court below made, the court below accepted that either a cut or a nick could amount to mutilation. The error that they saw in the primary judge's reasons was the inclusion of the words "to any extent" which suggested that a de minimis injury would suffice, and I just want to be clear about this. You accept for the purposes of the offence created by 45(1) that a de minimis injury is within the expression "otherwise mutilates"?

**MR KELL:** We say that there needs to be – it depends what one means by "de minimis". We say that there needs to be proof of injury. If I could just go to where I was on the summingup and the like, just by reference to the directions; I was at appeal book 99. There is a question of characterisation of what one means by "de minimis injury", particularly where the context is here the deliberate – by definition, it is the deliberate infliction for nonmedical reasons of injury to the clitoris relevantly of a prepubescent girl. That is the context.

**NETTLE J:** In that context, you say any cut, no matter how small, is sufficient.

**MR KELL:** Yes, we do. At appeal book 99, his Honour refers to:

The word "mutilate" in the context of female genital mutilation means to injure to any extent.

So there has to be an injury. His Honour is not there using the language of de minimis but he is saying that you must find injury to any extent but:

In the context of this trial, a nick or cut is capable of constituting mutilation

So that is what we advance, which is that a cut or nick to the genitals of the female girl will constitute mutilation, particularly having regard to context and purpose.

**BELL J:** I think, Mr Kell, it is perhaps uncontroversial that to direct injury to any extent embraces an injury that would, in ordinary legal parlance, be a de minimis injury.

**MR KELL:** Yes. It needs to be injury is what we say.

**EDELMAN J:** Was there an issue at trial as to whether the injury might have been de minimis?

**MR KELL:** No. The question was, by reference to paragraph 99, the Crown case was a nick or cut and relevantly it was either – it was put in different ways but it was a cut to the clitoral hood, the clitoral head, and a third possibility which was that there may have been removal of part of the clitoral head or the clitoris, and that of course was put to one side after the new evidence that emerged from the Court of Criminal Appeal. In the context of this trial, the question that arose is really what I have drawn attention to on page 99 of the appeal book.

**BELL J:** Just to understand how the Crown case was put at trial, there was I think an issue about the relationship between the principal count and the alternative lesser account and that was resolved by saying that the lesser account might be available if the jury were not satisfied that there had been any injury to the clitoris particularised in the primary count but found that there had been an injury amounting to actual bodily harm to some other part of the labia. Is that how it was put?

**MR KELL:** Yes, it was some other part of the female genitals.

**BELL J:** So does that carry with it that in relation to the principal count the Crown submits the trial judge was right to say injury to any extent sufficed but in relation to the alternative lesser account it was necessary to make clear that the injury had to be of a kind that was not merely transient or trifling, to refer to Justice Swift's definition of assault occasioning actual bodily harm in *Donovan*?

**MR KELL:** Yes.

**BELL J:** You accept that that is how the Crown case was to be understood?

**MR KELL:** Yes. I will just try and see if we can give your Honours the reference in the summingup to where his Honour – page 101, at the top, and then at the bottom of the prior page, at page 100, your Honours will see the definition à la *Donovan* of actual bodily harm. In paragraph 15 there, at page 100 at line 49, there will be a reference back to the written directions which I have taken your Honours to.

**GORDON J:** I know you have been asked this a number of times, Mr Kell, but can I just deal with this question of what is sufficient for injury for section 45.

**MR KELL:** Yes.

**GORDON J:** There has been a lot of focusing on nicking and cutting, because that was what was the issue at trial here.

**MR KELL:** Yes.

**GORDON J:** In the final Family Law Council report, it seemed to suggest that for the purposes of the damage that was done, it would extend to include bruising – it uses that word in paragraph 2.02. In other words, it identifies as a matter of language that incision is one of the things but it also identifies that there can be other damage, other injury.

**MR KELL:** Yes.

**GORDON J:** Do you accept that that is right? In other words, I understand the issues here were cutting or nicking.

**MR KELL:** Yes, we do. With respect, yes, we do. We do not say that injury which is deliberately inflicted manifesting in bruising would not be within the scope of the offence and your Honours can see reference to "scraping". So, for example, on that same page that your Honour took me to at 646 of the joint book of authorities, there is reference to – in contrast to the nicking of the clitoris or the cutting, the scraping – which similarly does not entail, you know, a wounding, a cutting of the skin or the whole skin and that would be consistent with deliberately inflicted conduct that can lead to bruising of the genitals.

It is again difficult to perceive any parliamentary intent as to why what might be perceived to be a lesser form of injury would not be within the scope of the offence in context. Obviously matters become relevant to sentence decisions to prosecute, perhaps, and the like but in terms of the ambit of the offence, yes, we say it would be within it.

So what I hope to have drawn from the material that I have taken your Honours to is to make clear that in the context of female genital mutilation, that to mutilate does not require injury of a high order of the type that was found by the Court of Criminal Appeal and that an available meaning of the term "to mutilate", as was the case here, includes to cut or nick to cut the genitals of a female child. I have referred to the affinity of the language, and the terms within the provision of section 45, that they have on their face an obvious affinity with the concept of female genital mutilation.

So we say that the available meaning does give rise to a constructional choice as to whether within section 45 the term "mutilates" should be understood as conveying injury simpliciter rather than if it is perceived, as the Court of Criminal Appeal appeared to conceive by reference to ordinary meaning or common parlance, a higher level of injury, that the construction for which we contend is an available construction.

The second and next step following on from that is to establish that female genital mutilation, the concept is so centrally relevant as a matter of context to section 45 that the meaning of

"mutilates" in that context, i.e. female genital mutilation, which is the meaning consistent with the meaning the Crown has propounded, was the intended meaning of "mutilates" in section 45.

In this context we submit that there is identified a clear legislative purpose of section 45 which was to enact a clear and emphatic prohibition on all female genital mutilation procedures which involved tissue damage, cutting and the like. We rely on a number of features of statutory context and extrinsic material to make good these submissions, so I will quickly take your Honours through those.

The first I have referred to, which is the language of the provision itself, that the terms "excises" and "infibulates" are squarely in the context of female genital mutilation, and I take your Honours to the Family Law Council report, the third and fourth categories which are on page 647 of the joint book of authorities. The third category is that of excision or clitoridectomy, and fourth is infibulation the most severe form being infibulation. Those terms, "excises" and "infibulates", are two of the verbs which are picked up in the offence provision again, the words being used instead of other generictype words that might be used such as "wounds" or the like.

The second point of context is that the heading to section 45 – I will just go back to volume 1 of the joint book of authorities at page 13. The heading for the section is "Prohibition of female genital mutilation". We recognise that the headings to sections are not part of the Act. Including by reference to section 35(5) of the *Interpretation Act* they may be considered as extrinsic material that assists in interpretation.

The third factor is the long title to the Act, and if one goes to the joint book of authorities at page 26, the long title is set out at about line 38 on that page. So the amending Act was:

An Act to amend the Crimes Act 1900 to prohibit female genital mutilation.

The fourth important matter of context was the explanatory note. I will just identify that again quickly at the joint book of authorities, volume 2, at page 721, and I have referred to the reference there to:

Procedures involving the incision –

i.e. cutting of part of the external genitalia, and also the risks of the practice leading to infection or painful urination. The fifth matter of context which we say indicates there was a clear intention to prohibit all forms of female genital mutilation causing injury is the discussion paper of the Family Law Council, and its report, and I have taken your Honours to part of that. That is referred to in the second reading speech.

I will first just quickly go to the reports themselves again and then I will come back to the second reading speech. So the report of the Family Law Council is at page 631. I have taken your Honours to the four categories. In terms of the recommendations and the emphatic

statements of the Family Law Council, and this is in terms of the recommendations, at page 636 at about line 18

**BELL J:** Is there a paragraph number?

**MR KELL:** No, it is just recommendations relating to paragraph 5.23.

**BELL J:** Thank you.

**MR KELL:** So under the heading:

**The practice of female genital mutilation in Australia**

Council considers . . . and has concluded that female genital mutilation is a practice which should not be accepted in Australia.

Then just jumping to page 637, at about line 29, under the heading:

**The need for legislation** –

With a crossreference into paragraph 6.41, there is a recommendation at about line 28:

there should be special legislation which makes it clear that female genital mutilation is an offence in Australia.

Then at page 638, so the next page, at about line 38, under the subheading:

**Recommendation 4 (para 6.80) Content of legislation**

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

And then relevantly (a):

**It should put the issue beyond doubt that female genital mutilation, in all of its forms, is a criminal offence** –

**BELL J:** That would include the purely ritual form of the practice.

**MR KELL:** Except that the Family Law Council had made clear in its discussion

**BELL J:** That they were confining its meaning to something more than purely ritual.

**MR KELL:** Exactly, that effectively requires injury.

**GORDON J:** That is that passage I took you to at 2.02 where they talk about reference to female mutilation in this paper extends to and includes bruising.

**MR KELL:** Yes, quite right.

**KIEFEL CJ:** In relation to recommendation 4 are you referring to 4(b) as well?

**MR KELL:** Yes, thank you. In similarly emphatic language it should be made clear that female genital mutilation, in all of its forms, constitutes child abuse under Australian child protection legislation.

**GAGELER J:** Did that occur?

**MR KELL:** Whether there was corresponding legislation under child protection legislation, I am not certain, your Honour.

**KIEFEL CJ:** Is the Family Law Council speaking, though, of whether it constitutes child abuse under existing child protection legislation rather than creating more

**MR KELL:** Yes.

**KIEFEL CJ:** It refers to it as "child abuse" at a number of points.

**MR KELL:** Yes. Can I just give your Honours the reference at page 678 that is paragraph 5.23, which was drawn from the recommendations. As I indicated, the discussion paper had recommendations to similar form, although necessarily stated, because it was a discussion paper. I will give your Honours references to those at pages 612 and 613 in the boxes, with the heading "*Council's preliminary conclusion*".

**KIEFEL CJ:** Mr Kell, that might be a convenient time for the Court's morning break.

**MR KELL:** Thank you.

**AT 11.16 AM SHORT ADJOURNMENT**

**UPON RESUMING AT 11.31 AM:**

**KIEFEL CJ:** Yes, Mr Kell.

**MR KELL:** Thank you, your Honours. Could I take your Honours to the second reading speech in the joint book of authorities at page 762.

**GORDON J:** What tab number is that, please?

**MR KELL:** This is at tab 24.

**GORDON J:** Thank you.

**MR KELL:** The first point is that the Minister made references in a number of points to the Family Law Council and its report and that can be seen on page 762 at about line 45. Then the next paragraph where it said:

It was noted that the evidence relating to the incidence of FGM in Australia –

et cetera; the "It was noted" is the Family Law Council report or discussion paper. Then again at page 763 on the last paragraph of that page at about 46, again reference to the Family Law Council. There were also indications when one reads the second reading speech of effectively an endorsement of the position taken by the Family Law Council in the sense of there being an emphatic statement made about the practice and that can be seen similarly borrowing the language or the message in the Family Law Council. So at page 763 at about line 15:

However, the Government is of the view that a clear message should be sent to the community that the practice is not acceptable in this State.

Similarly, at 762 at about line 29 the intention that:

This bill will make the practice of female genital mutilation a criminal offence in this State.

At 764

**KIEFEL CJ:** What do you say about this statement on page 763 which was the focus of the Court of Criminal Appeal's reasons, the reference to there being "three forms of FGM"?

**MR KELL:** Yes, we say that that statement does not – it is obviously something that we need to deal with and it was referred to in the Court of Criminal Appeal. We say that the fact that there is reference to only three forms of FGM in the second reading speech does not meaningfully assist in construing the words "otherwise mutilates", in part because it is clear, returning to the language of the section, that one has "infibulation" and "excises" taking up two of the recognised forms of female genital mutilation and "sunna", which was the third one, can be picked up by those two verbs.

So that if the legislature was intending to proscribe only those procedures falling within the first three forms of FGM, then the term "otherwise mutilates", on that view, would have been surplusage, we say, and that is a most unlikely outcome. It is intended clearly that the words have work to do.

**BELL J:** To the extent that you draw on the second reading speech for its references to the Family Law Council's report, the report sets out four types of female genital mutilation and ranks them in order of severity and one sees the Minister saying that what is proscribed are three forms of female genital mutilation in order of severity, picking up the very concepts that one finds in the Family Law Council's report and notably not including that which was covered by the least severe, namely, ritual circumcision or ritual female mutilation.

**MR KELL:** It is apparent that the Minister does not refer in terms to that fourth category, that is correct, but it is also apparent from reading the second reading speech as a whole that there is no suggestion other than that reference to what can be sought to be drawn from

reference to those three categories, there is no suggestion of a disagreement with the views of the Family Law Council and its recommendations.

**KIEFEL CJ:** Well, you have referred to – the submission which you made earlier really is that the second reading speech is based in large part on the Family Law Council report.

**MR KELL:** Yes.

**KIEFEL CJ:** It says there are four forms, so when the second reading speech says there are three, is that accurate?

**MR KELL:** Are the Minister's words accurate?

**KIEFEL CJ:** Yes.

**MR KELL:** No.

**KIEFEL CJ:** The second reading speech says "The three forms of FGM in order of severity". It does not say the three more severe forms of FGM.

**MR KELL:** Yes.

**KIEFEL CJ:** Do you understand the distinction I am referring to?

**MR KELL:** Yes.

**GORDON J:** It is odd, is it not, because you have the questions on notice before the Bill is put in which refer to the four forms, covers all practices.

**MR KELL:** Yes.

**GORDON J:** You have what appears in the Legislative Assembly, from the materials in that extract, recognition it is dealing or intending to deal with the four categories, and then you have this hiccup in the middle.

**MR KELL:** That is right, and when I say is it accurate, it is accurately recorded.

**KIEFEL CJ:** In the sense of reflecting the Family Law Council report.

**MR KELL:** Yes, that is right. It is not and also nowhere in all the materials is there any suggestion that there are other than the four categories of reports.

**KIEFEL CJ:** In your reference you took us to various points in the second reading speech which refers to "the practice". I understood you to say that that was intended to encapsulate all forms.

**MR KELL:** Yes, that is right.

**GAGELER J:** There is a reference at page 762 to the World Health Organisation having condemned the practice at an international level.

**MR KELL:** Yes.

**GAGELER J:** Where do we find that condemnation in the materials?

**MR KELL:** We have included in our submissions a footnote to the WHO material. Sorry, I will just give your Honours a reference.

**KIEFEL CJ:** Is the WHO material amongst the materials before the Court?

**MR KELL:** No, it is not.

**KIEFEL CJ:** So we find it ourselves, do we?

**MR KELL:** We were in part concerned about putting overseas material, and adding to the – we will see if we can find something over the lunch break.

**KIEFEL CJ:** Is it the WHO material that the Family Law Council referred to?

**MR KELL:** Yes, and we will see if we can

**KIEFEL CJ:** Is that one of the interagency statements that looked at the practice in Africa in particular?

**MR KELL:** Yes. And as I understand – and, your Honours, I was looking at, for example, footnote 19 of the appellant's submissions at page 12 but those dates are later in time, so that is 1997.

**KIEFEL CJ:** What is the WHO report – can you refer us to where the Family Law Council refers to a WHO report? I think it was only one that the Council refers to.

**GORDON J:** I think it is paragraph 3.06, and it is dealing with an overview of the effects of female genital mutilation.

**MR KELL:** Thank you, your Honour.

**GORDON J:** If that is the WHO report that is being referred to by the second reading speech.

**KIEFEL CJ:** Yes, that is a journal article.

**MR KELL:** That equates to footnote 31

**GORDON J:** Footnote 27, I think. Footnote 27 refers to an article published by the World Health Organisation on female circumcision.

**MR KELL:** Yes.

**GORDON J:** Then the resolution is dealt with at paragraph 4.09.

**MR KELL:** Yes. So I think I was at crosspurposes. Yes, at the discussion paper it is footnote 27 at page 601. And for later in the report, it is at page 662, at footnote 31 – but the same article, the 1992 World Health Organisation article.

**GORDON J:** The point being made though is they did not have the report at the time the legislation was being debated, did they? So they had to be working off the discussion paper.

**MR KELL:** Yes, I think that is right, for the Legislative Assembly, the report had been published by that time, but certainly for the Legislative Council, that was the case.

**GAGELER J:** So will you at some stage identify precisely the World Health Organisation document or documents being referred to?

**MR KELL:** Yes, we will, your Honour, and we will see if over the lunch hour we can obtain and provide your Honours with a copy of it.

**EDELMAN J:** Is there any precise definition anywhere of exactly what sunna is?

**MR KELL:** There are references to it being an uncertain term that has different meanings in different contexts and in the discussion paper itself there is reference to the term at the top of page 592 as being an alternative phrase that was being used for the particular category.

**EDELMAN J:** At 662, paragraph 3.10, it seems to be equated to a form of ritualised circumcision.

**MR KELL:** Yes. In part I had intended to refer – so in the context of the report at 646 at about line 50 that:

The word "sunna" in Arabic means "tradition", but it also means "tradition of Prophet Muhammad" which indeed is a serious misnomer –

and the like. The trial judge himself referred to uncertainty surrounding the meaning of "sunna" and at pages 646 to 647 within the context of the Family Law Council report there is reference to:

Use of the term "sunna" can lead to the incorrect linking of clitoral circumcision with the Islamic religion –

and the like. So it seems to have been a term that is subject to some criticism because of its uncertainty of meaning or its variability of meaning. Just on the second reading speech, I was at page 763 and a further reference is a bit further than halfway down the page at about line 35, there is a paragraph beginning:

This provision will also apply

and the third sentence:

The provision thus aims to prevent FGM from being practised at all in this State.

I think I indicated quickly that there is no indication in the second reading speech of the legislature disagreeing with the Family Law Council's recommendations and that was

recognised also by the Court of Criminal Appeal. I will give your Honours the reference without necessarily taking your Honours to it.

At appeal book 491 in paragraph 514, Court of Criminal Appeal seem to recognise that there was an apparent intention of the legislature to adopt all the recommendations of the Family Law Council report, including prohibition of ritualised circumcision, but one is left with an uncertainty as to what the Court of Criminal Appeal was identifying, if anything, in terms of the legislative purpose, which is part of the criticism that we make – that there is no purposive interpretation which is developed in advance by the Court of Criminal Appeal.

**BELL J:** The Court of Criminal Appeal appears to have accepted the evident purpose of the provision was to criminalise female genital mutilation. In issue is what the Parliament intended to be covered by that portmanteau term in terms of the offence that it provided.

**MR KELL:** Perhaps I should just illustrate part of our criticism of the context. In the Court of Criminal Appeal judgment at appeal book 480 at paragraph 475 there is that reference in the context of the meaning of "mutilates":

the disparity between an apparent intention of the legislature to adopt all the recommendations of the Family Law Council Report

So there seems to be acceptance and we endorse that, and there is nothing to the contrary, putting to one side what might be said to be the statement of the Minister about the three forms, the disparity in the statement by the Minister. So there is that statement or recognition by the Court of Criminal Appeal. Then at page 491, at paragraph 514, at about line 50 and following, again there is recognition by the Court of Criminal Appeal that:

there was no indication in the speech of any disagreement with the Family Law Council's recommendation that all forms of female genital mutilation be prohibited, ultimately, the Family Law Council Report . . . while shedding light on the context and purpose . . . do not in our view permit the conclusion that "otherwise mutilates" was intended to encompass all forms of injury

Again, we say no analysis about why what is recognised seemingly to be a legislative purpose is not given effect to, or given greater recognition, and then that can be seen particularly at appeal book 494, at paragraphs 523 and 524. Paragraph 523, "if," and we say it clearly was:

if the intention of the legislature . . . was to encompass all forms of female genital mutilation, then in our opinion, legislative amendment is necessary in order expressly to incorporate the fourth classification of female genital mutilation –

And then similarly in paragraph 524, a recognition that:

the legislature clearly recognised the dangers involved in even ritualised circumcision.

Then there is a reference to "potential evidentiary difficulties" and a suggestion about legislative reform. We say that there is no purposive interpretation that is adopted or advanced, given recognition to, in the judgment of the Court of Criminal Appeal.

There is a recognition of what the legislative purpose was, but simply a suggestion ultimately that, well, amendment might need to be made – and partly because, it seems, "mutilates", no matter the context, does not extend further than what the Court of Criminal Appeal referred to as the ordinary meaning, and I will come to that very quickly.

**KIEFEL CJ:** Mr Kell, you have taken us just a moment ago to paragraph 475 of the Court of Criminal Appeal. Their Honours seem to be saying that the ambiguity does not arise from the text or context, but from the extrinsic materials themselves. What do you say about that approach to construction?

**MR KELL:** I am just trying to find 475.

**KIEFEL CJ:** Their Honours appear to be saying that the ambiguity does not arise from the statute, in which case you look to the extrinsic materials.

**MR KELL:** Yes.

**KIEFEL CJ:** Their Honours seem to be saying that the ambiguity arises from the second reading speech, which is to say the extrinsic materials themselves and you interpret the statute by reference to the ambiguity arising in the extrinsic materials.

**MR KELL:** Yes. We say that, consistent with the approach that we adopt, the correct step one is to look to whether there is a constructional choice available – what is the meaning of the term "mutilates" and I have taken your Honours through that step. One does not need to search for ambiguity by reference to extrinsic material in the way that is referred to there, that our construction and the construction advanced by the Crown is orthodox.

Can I just, just on the point that I was raising, just make this clear too – I seek to make this clear. In paragraphs 523 and 524, where there is reference to if Parliament intended the fourth category of FGM to be included within section 45, then amendment would be necessary. The construction that the Court of Criminal Appeal has arrived at and the result, that is to say the test that – and I have taken your Honours to that before, but the test in paragraph 521, at the bottom of 493 which is that effectively there must be medical evidence to the effect that the body part be rendered:

imperfect or irreparably damaged –

**KIEFEL CJ:** So I think what you are saying is that in paragraph 475 their Honours are saying there is no ambiguity because the word "mutilates" in its ordinary meaning is clear.

**MR KELL:** Yes.

**KIEFEL CJ:** I should have added to my inquiry of you, but on your argument the word "mutilates" read under the umbrella term "female genital mutilation" itself creates no ambiguity. There is no need to resort to the extrinsic material. Do you go that far? You say there is constructional choice, so you say there is some ambiguity.

**MR KELL:** We accept that there is a possible alternative argument, which was the argument advanced by the defence and

**KIEFEL CJ:** Do you say there is ambiguity, or not? Are you saying that there was such an accepted understanding of what female genital mutilation means as seen by the Family Law Council report as covering all practices that "mutilates" simply is understood contextually and there is no ambiguity and therefore no need to resort to the extrinsic materials or do you say you do need to resort to the second reading speech and the other extrinsic material?

**MR KELL:** We accept that it is appropriate to have recourse to the extrinsic material – the second reading speech. So there is not ambiguity in the sense of the *Interpretation Act* requirement, if that be so, to demonstrate ambiguity. We accept that our construction is the appropriate and the attractive construction that arises in part from just looking at the text and words of the provision as they were, but we do not suggest that your Honours cannot have regard to the second reading speech and the like, including to make clear what is the context and purpose of this term.

**KIEFEL CJ:** You do not need ambiguity, is what you are saying? You can look at the extrinsic materials in any event?

**MR KELL:** Yes.

**GORDON J:** As I understand your argument, it is the first limb of your *Interpretation Act*, is it not, and that is you say as a matter of context we have got an Act dealing with, as I understand your argument, a prohibition on female genital mutilation. One sees that by the provisions you have taken us to, including the long title of the Act and all of those things, and the other words that are in the section. Then do you not, as I understand it, use the *Family Law Act* to confirm that that construction that you have put forward, consistent with 34(1)(a) – I always get your provisions mixed up.

**MR KELL:** Yes.

**GORDON J:** So you do not need ambiguity. You use it for confirmation of the construction you have put forward. Is that the way you put it?

**MR KELL:** Yes, it is, and (1)(a) is looking at what is the meaning of words having regard to the context and purpose and, from memory, (1)(b) one of the subparagraphs is referring to ambiguity. So we say that we come in within (1)(a) of our *Interpretation Act*.

**EDELMAN J:** It is not really a question of constructional choice or a stepped approach. The short point is you say your submission is contextual and you say that the respondent's submission is not contextual.

**MR KELL:** Yes. I just make the point, to finish the point which I was making, which was in connection with paragraph 521 and the three versus four categories of FGM, that the holding of the Court of Criminal Appeal itself, which is to require the body part to be irreparably damaged or rendered imperfect, is not itself within what would be the categories 1, 2 and 3, or not necessarily within categories 1, 2 and 3.

So the very holding of the Court of Criminal Appeal in terms of the test is seemingly recognising that what we say would be the fourth category is part of

**BELL J:** Is it doing that or is it looking to the text of the offence that the legislature has created and seeing that in addition to the particular forms of injury that might be done this offence covers some broader field under the rubric "otherwise mutilates"? What I am putting to you, Mr Kell, is that the Court of Criminal Appeal's attention is directed to the terms of the provision, accepting that it is within a context including the intention to proscribe a practice known as female genital mutilation and it then looks at, accepting that is what might be described as the broad purpose, what is it the legislature has in fact proscribed.

**MR KELL:** Yes.

**BELL J:** Your argument seeks to draw comfort from the second reading speech, albeit, as I understand it, you contend that the second reading speech has the difficulty that it contains an error as to the content of the Family Law Council's report. So one is looking to confirm the meaning for which you contend by explaining away an error in the second reading speech.

**MR KELL:** Except that what the Court of Criminal Appeal is doing at 523 and 524 is seemingly indicating that, if the intention of the legislature was to bring in this fourth category of FGM, then legislative amendment would be needed. So on the one hand the Court is saying that and we say without reference really to legislative purpose but on the other hand it is curious and, in one sense, inconsistent with that that the holding of the court is itself a finding or putting a level of injury that is required that would in many cases be within the fourth category, unless it is excised of part of the clitoris. So, it is troubling and an indication, we say, that there is not a purposive construction that is given and

**BELL J:** There are limits to purposive constructions and is not the Court of Criminal Appeal saying, in paragraphs 523 and 524, if the intention were to catch de minimis injury of any kind, then the legislature has missed the mark, and it might be appropriate for it to consider amendment.

**MR KELL:** Well, no. We say that part of the difficulty arising from the interpretation of the Court of Criminal Appeal is to – and we have set this out in the written submissions – to look to what is referred to as – to start, effectively, with what is the meaning of "mutilates" in its ordinary parlance and then to look to whether there is reason to depart from what it regards as the ordinary meaning.

We say that is inconsistent with the approach taken by this Court to determining the meaning of words such as "to injure". I will just deal with these quickly, at paragraph 495,

which is at 486. So the Court of Criminal Appeal's conclusion that "mutilates" requires more than the causing of injury – and I have taken your Honours to that at paragraph 49 previously – appears to be based only on substantially on the ordinary meaning of "mutilates" and in 495 there is reference to:

One would not, in ordinary parlance, refer to a superficial graze as mutilation.

**GORDON J:** Then the positive side of that seems to be at 515. You took us so that is what is excluded on the Court of Appeal's analysis and then what is included, that is, what is the minimum, some form of more serious injury than, say, a superficial shedding of the skin cells, or a nick or cut that leaves no visible scarring, and cannot be seen on medical examination to have caused any damage to the skin or nerve tissue. That is the bit that I do not understand at the moment, about the way in which the Court of Appeal puts it, because it seems to suggest that any damage to the skin or nerve tissue has to be serious injury, has to be more than any damage.

**MR KELL:** Yes, and which is consistent with what we say about the test being pitched, or being stated at a very high level of injury. Then at appeal book 493 at 521 there is reference in the conclusion:

For the reasons set out above, we have concluded, on balance, that the extrinsic materials relied on by his Honour do not permit a construction of "mutilates" that departs from its ordinary meaning and we consider that its ordinary meaning connotes –

Then there is reference to irreparably damaging the clitoris. The articulation of the "ordinary meaning" there relates back to what I had taken your Honours to in 493, which is the textual meaning identified there, and we submit, and we have set out the various linking paragraphs in writing, that what the Court of Criminal Appeal has identified as an ordinary meaning the court has then looked to extrinsic materials and other aspects, including what is suggested as context, as a reason to displace or rebut the ordinary meaning and concluded in 521 that the ordinary meaning has prevailed.

We say that that is an error of principle, that of course the correct approach is to determine the meaning of the provision to take into account issues of context and purpose simultaneously and at the same time to then arrive at a conclusion as to meaning, and that 521 indicates an error of principle here and explains why as a result the Court of Criminal Appeal has ended up with what we say is a very high level test of injury that we respectfully submit could never have been the intention of the legislature in the context of the protection of vulnerable children.

**KIEFEL CJ:** Are you moving to the second ground shortly, Mr Kell?

**MR KELL:** Yes, if I could turn to that now and I will deal with that quickly. So the second ground of appeal is that the Court of Criminal Appeal erred in excluding from the meaning of "clitoris" in section 45 the clitoral hood. This was an issue that arose because the indictment

specified the clitoris of C1 and C2 as the subject of the mutilation giving rise to the offence or the offences.

The medical evidence at trial was to the effect that the clitoris is a global term – or "clitoris" is a global term which includes the clitoral hood and that the clitoral hood is part of the clitoral anatomy, even though it is in fact different tissue, and this aspect was accepted by the Court of Criminal Appeal as being the thrust of Dr Marks' evidence. I will just give your Honours the references without taking your Honours to it at appeal book 494 to 495 at paragraph 525 and their Honours indicate that Professor Jenkins' evidence would not detract from that. Dr Marks' evidence was that the clitoral anatomy includes both the clitoral head and the clitoral hood:

"because they are closely physically related to each other.

That is at paragraph 209 at appeal book 404. Professor Grover considered the term "clitoris" to be a global term that included:

the clitoral ridge; the clitoral hood –

being relevant here:

the shaft of the clitoris; the clitoral glans

Professor Grover - the reference is at paragraph 240 at appeal book 412. Professor Jenkins' evidence was to the effect - or he gave evidence that the clitoral head and the clitoral hood were separate structures, but the Court of Criminal Appeal commented - and we would respectfully adopt that comment - that such a proposition did not preclude the two structures from being encompassed within the word "clitoris", and that is at paragraph 525.

We would also note that the Family Law Council in its report – I will not take your Honours to the page but I will just give your Honours the reference – the Family Law Council report in the joint bundle of authorities at page 646, paragraph 2.04, describes acts of excision in relation to the clitoral hood as being "clitoral circumcision". Standing back from the evidence, there can be no doubt that the clitoral hood exists at the fusion of the labia minora and the clitoral glans and the two unite over the glans to create a hood. So mutilation of the clitoral hood clearly falls within the scope of the offence and we say that, putting to one side the pleading point, there is no imperative to construe the word "clitoris" narrowly or strictly so as to avoid broadening offence provision.

There is no doubt, we would submit, that the clitoral hood is covered by the offence provision and we submit that, taking into account the medical evidence – and we have detailed that in the written submissions – that the Court of Criminal Appeal erred in finding that that trial judge was wrong to conclude that the clitoris should be understood in its global sense to include the clitoral hood.

Your Honours, we deal in the written submissions also on questions relating to a retrial. If it is content for the Court, I can deal with those in reply and to the extent that they need to be raised unless your Honours have particular aspects that I should deal with now.

**KIEFEL CJ:** Why would you want to deal with them in reply? You have to justify the orders that you seek.

**MR KELL:** Certainly. So we say that the appeal should be allowed, that the orders made by the Court entering verdicts of an acquittal should be set aside. The question then arises, if we succeed, as to whether this Court would make an order for a retrial. We say that there is evidence to support the charges of the complaints in respect of both C1 and C2, that there is evidence of cutting, and we set that out in our written submissions. We also so in respect of discretionary factors arising that these are serious charges and that there is a strong public importance in the offences being duly prosecuted and this is on the assumption that we succeed in the appeal being allowed.

**EDELMAN J:** Do you accept that the effect of a retrial upon C1 and C2 is a relevant factor to consider?

**MR KELL:** Yes, we accept that that is a factor to take into account. We note - and we have referred to this in the written submissions - that when his Honour Justice Johnson had regard to a ruling about the giving of evidence, that it was noted that the children would be giving evidence on a discrete point, and partly by reference to recorded interviews and the like, so the extent of the harm to the

**EDELMAN J:** Against their mother.

**MR KELL:** Against their mother. The extent of the harm was clearly a factor to have regard to, but was not outweighed by other considerations. We say similarly here that there is a profound public interest, assuming we are right on construction, in a conviction being recorded for offences such as these involving the deliberate cutting of genitals of prepubescent children, and of course the order for a retrial is permissible. Whether evidentiary or other considerations, discretionary factors come into play, at least in part is a matter for the Director in terms of the bringing of a new trial. But we say that there are profound discretionary considerations that justify the order of a new trial here.

**BELL J:** Do I take it that you accept that on a new trial, it would not be open to frame an indictment containing the alternative counts which were the subject of the orders of acquittal entered by the Court of Criminal Appeal that are not challenged by your appeal?

**MR KELL:** Yes, I think that must be right, yes.

**BELL J:** And is the rationale to explain what might otherwise appear inconsistent in that result, that an assault occasioning actual bodily harm requires an injury that is more than merely transient or trifling and, on your submission, the injury, in the case of a 45(1) offence, can be a transient or trifling injury? Is that the reason that one can see the appropriateness in terms of consistency of an order for a new trial on the principal count, recognising that it is not open to direct a new trial in relation to the alternative, lesser count?

**MR KELL:** Yes, at page 687 of the appeal book were the orders. So the verdict of acquittal was entered in respect of all counts, which includes

obviously the assault occasioning actual bodily harm, and we seek that order being set aside.

If our construction is right on section 45, in the manner in which the case was advanced – well, we certainly principally would seek a new trial for the purpose of the section 45 offences. Whether that extends to the alternative counts – and the reason we are hesitating is not because of the point that your Honour raised, because if we are right about construction then the question of damage, we say, will be satisfied here. But I have in mind the exchange between your Honour and I about if the jury were to find that the place of damage was not the clitoris but some other part of the female genitals. I just want to be careful about not making a statement there. So it might be that your Honours just would order a new trial on the counts.

**BELL J:** On all counts?

**MR KELL:** On all counts.

**BELL J:** But what part of your notice of appeal challenges the acquittals on the assault occasioning counts?

**MR KELL:** I think that the notice of appeal is more general. So it is to set aside order 3, and then in its place order that a new trial be had. Order 3 is the verdict of acquittal. Could I just

**BELL J:** But how do we get there from the grounds of your appeal to setting aside the orders of acquittal in relation to the assault occasioning counts, particularly given the argument that you have addressed today, which does embrace that a lesser level of injury might support a conviction for the principal offence than under the alternative offence?

**MR KELL:** Yes, I hear your Honour. Could I just clarify the position over lunch, your Honour? I just want to confirm my instructions on that.

**KIEFEL CJ:** Perhaps you could deal with that in reply, and you might consider how this was dealt with in the court below.

**MR KELL:** Yes, I will. I will deal with it quickly. I just do not want to take up further time on it at the moment.

**KIEFEL CJ:** Yes. Thank you, Mr Kell. Mr Game, are you arguing first?

**MR GAME:** I will come to the second reading speech in due course, but it might be noted that this legislation actually comes from UK legislation passed in 1983 or 1984.

**NETTLE J:** In 1985.

**MR GAME:** In 1985, I am sorry, your Honour. I will come to that in due course. The second reading speech is explicit about that and that is quite an important aspect of this.

But where I wanted to start, if I can take your Honours to our outline, and I am starting at paragraph 3 - so the question in this case is not about how high one can pitch the idea of "mutilate"; the question is how low one can pitch it. It is not correct to say that this case was not conducted on a de minimis basis.

Significantly, if your Honours have the document that is the written directions, which is in the book of further materials at page 9 one sees in paragraph 3:

The word *"mutilate"* . . . means to injure to any extent.

Now, that is important, and it informs the nick or cut because it is not a cut with any bleeding or any lasting effect and a nick is less than a cut, and I will take you to what the evidence was in a moment. So the actual question becomes whether or not the words "otherwise mutilate" mean "otherwise injure to any extent" and we say that textually is not available.

Now, I will just say a little bit more about the de minimis – sorry, just looking at these written directions, it is important also to note that at paragraph 15 and this is duplicated for the other defendants, accused we see, yes, they have all been acquitted of the alternative counts, and those acquittals are important, if one got to the question of retrial or not because the court it is provisional to a degree, but the unsatisfactory nature of the evidence to get to actual bodily harm features very high in the court's decision not to order a retrial. That is to say, there was not a case, and I will take you to some paragraphs in a moment. But in respect of the idea of injure to – so we see in 15:

merely transient or trifling.

There was no evidence in this case of anything that could possibly be described as more than transient. In terms of the evidence, I will just take your Honours to two passages in the Court of Criminal Appeal's judgment. First to page 404, paragraph 210. So it says:

Dr Marks' evidence was that any cut or nick . . . would cause injury to and loss of skin cells at the site of the cut. (The appellants point out that in Dr Marks' evidence she noted that loss of skin cells could result from scratching one's arm –

Now, the Court ultimately, at paragraph 498, because of the approach they took to injury having to be more serious than trivial, did not need to deal with this, but at paragraph 498 they said why they did not need to deal with what flowed from that submission, so the aspect of it that refers to shedding of skin cells. If one looks at a couple of passages in evidence, paragraph 31 of the Court of Criminal Appeal's judgment – sorry, paragraph 31 first.

**GORDON J:** Sorry, where are we, Mr Game? I am just lost.

**MR GAME:** I am lost too, your Honour. I am lost, I am sorry. Paragraph 31 of the Court of Criminal Appeal's judgment, which is at page 359 – I apologise:

C1 said . . . she was scared of going into the shower because she thought it would hurt her but "then I found out it didn't hurt at all" –

So that is C1. And then C2 there is a short passage at paragraph 42, she said it hurt in her bottom. Then in the Court of Criminal Appeal's judgment at paragraph 625, one sees bringing together what flows – this is all in the context about whether to order a retrial on assault occasioning but because of the common nature of the – sorry, and extended to the prospect that assault occasioning could be to the parts of the genitalia that were described in the principal count, that is to say, not the way it was run at trial, but generally. So at 625, that is dealing with C1:

no lasting pain, no blood, nor any other evidence of injury.

Then at 628, it ends up:

without any other evidence as to the procedure performed on her, could support an allegation of actual bodily harm

So yes, this case is de minimis in respect of the

**GORDON J:** Sorry, I am a bit lost. That was C2, was it?

**MR GAME:** That is C2, yes.

**GORDON J:** Difference in relation to C1.

**MR GAME:** C2 is a little different but the evidence was stronger in C1 than in C2. The evidence is, in our submission, de minimis that a nick could be a very very minor thing

**EDELMAN J:** Mr Game, might it depend on what is meant by "de minimis"? If by "de minimis" it is meant a shedding of skin cells, then that was not part of the case, but if by "de minimis" it is meant some nick or cut, then that would be part of the case.

**MR GAME:** Yes, a nick that does not draw blood, a nick that has no lasting pain, a nick that is

**EDELMAN J:** But necessarily is more than the mere shedding of skin cells.

**MR GAME:** Yes, your Honour, but still it is a nick, that is just a nick, because there is no blood, no lasting pain, and there is no evidence of that. So it could be a nick like I have just done to my hand.

**NETTLE J:** A nick exposes blood necessarily, does it not?

**MR GAME:** No, there is no evidence of blood in this case.

**NETTLE J:** I understand there is no evidence of bleeding out but a nick is, by definition, something which exposes blood to some extent, albeit minimal surely.

**MR GAME:** Not necessarily, and it was not put on the basis in this case that there had to be any blood. That was not embraced.

**EDELMAN J:** Then it is a shedding of skin cells.

**NETTLE J:** It has not broken the skin, it is not a nick.

**MR GAME:** A nick is something less than a cut. A nick is a scratch that removes skin cells.

**NETTLE J:** It is a small cut. It is what you do shaving. It is a small cut.

**MR GAME:** Yes, but it may not bleed. There is no evidence in this case of any bleeding – in either case.

**NETTLE J:** All there is there is no evidence that there was not sufficient blood for it to be seen at the time.

**MR GAME:** Your Honour, I would put that the other way, which is there is no evidence in this case of any bleeding. There is no evidence. One cannot positively assert that there was bleeding in this case.

**NETTLE J:** Yes, I follow.

**MR GAME:** One can assert that there was something that caused pain for a period of time; that is it. Part of the problem is it was posited on the basis of Dr X's evidence about what the practice was and that evidence was rejected, so that the evidence about something occurring in respect of the prepuce by Dr X went out of the trial, on the appeal. So one was not left with a solid basis to say that there was a cut of the kind that was described

**GORDON J:** It was described by C1.

**MR GAME:** It was described by C1, but C1 said she thought there was a cut, but that was left up in the air. She did not actually conclude – you could not conclude that there was a cut to C1 and that is what the Court of Criminal Appeal held.

**KIEFEL CJ:** There was evidence that forceps were used.

**MR GAME:** There was evidence that something like forceps was used, yes, and there could have been a pinching

**KIEFEL CJ:** Did your client accept that?

**MR GAME:** I beg your pardon?

**KIEFEL CJ:** Did your client admit that?

**MR GAME:** Yes, that is what she said.

**KIEFEL CJ:** So to take up a matter that Justice Gordon raised earlier, that we could be in the area of contusions or bruising, you say that was not part of the Crown case.

**MR GAME:** It could be in the area of bruises but there is no evidence of a bruise in this case.

**KIEFEL CJ:** Except what one would infer from the use of forceps on the skin.

**MR GAME:** You could, but yes, but my point is a little bit different, which is that if you talk about a nick or a cut, that nick is a very, very minor thing because that nick is informed by the words "to any extent". So it is a mistake, and it is a big mistake, to talk about this case as if it involves cutting. It does not.

**GORDON J:** Why is that, Mr Game?

**MR GAME:** Because ultimately it was put on a lesser basis than that.

**GORDON J:** What lesser basis? It was put on the basis that it was a nick or a cut.

**MR GAME:** Yes, but, your Honour, one has to go to the lowest thing to see if it is sustainable, not some higher

**EDELMAN J:** That is not quite what the Court of Appeal found. The Court of Appeal said at 498:

There was debate in the course or oral argument as to the proposition that something more must be required than just the "shedding" of skin cells, which can occur without any form of cutting –

Then they say:

It is not necessary to decide that issue –

Presumably, it is not necessary to decide that issue because they think that a nick includes a cut or a cut includes a nick.

**MR GAME:** They thought it was not necessary to decide the issue in this case because they had come to a different conclusion about the correctness of the directions.

**EDELMAN J:** They say:

in circumstances where what occurred, on the Crown case, was the nicking or cutting of the clitoris.

That is why it is not necessary to determine whether something that can occur without any form of cutting might fall within the definition.

**MR GAME:** Your Honour, it is ultimately put to one side because of the way in which they dealt with the appeal. But here, as I said before, one cannot save the thing by referring to "cutting". One cannot save the thing by reference to "cutting" having some imagined outcome because it is all informed by the words that are driving the thing, which is "to any extent" and that is unmistakably de minimis and that is how it was put.

**KIEFEL CJ:** Well, putting aside questions of retrial, if one is focusing just on the construction of the statute, are you saying that, even if one construes "mutilates" as "injure" you cannot add to it "injury to any extent"?

**MR GAME:** I do say that, your Honour, yes. I also say that if one examines the text of the provision carefully the idea that the words "otherwise mutilates" can mean "injure to any extent" is not reasonably open and that comes from a textual analysis.

I will take you to the second reading speech in due course, but we say the second reading speech needs to be read in a different way than it has been put. There are statutes around Australia that prohibit female genital mutilation. They include the words "female genital mutilation" and they define the conduct and they define the conduct by reference to some of the things that this case concerns and by reference to others more expansively. There is legislation all around Australia that now deals with this in terms of the language of female genital mutilation but not this legislation.

**EDELMAN J:** Some of the legislation defines "female genital mutilation" as including "mutilation".

**MR GAME:** That is true. I think that is the Northern Territory legislation. The most exhaustive, I think, is the ACT legislation. Anyway, what I am saying is it varies so it is quite a simple matter to actually define "genital mutilation". "Genital mutilation" is not defined in this and it does not appear in it and it is not part of the Act and it is not permissible to refer to it as part of the Act.

If one looks at this offence, one starts with the proposition that this is a crime, and it is a crime in which ordinary principles of statutory construction would say that recklessness was a sufficient mental state. So that means if you do a thing that excises or infibulates or otherwise mutilates, even though the thing you do is done with a lesser intention, you may excise, infibulate or otherwise mutilate, even though it was not your intention if you were reckless about it. That is because offences relating to actual bodily harm and the like in the context, the only exception really is when one gets to offences like murder.

Recklessness is treated as a mental state of crimes that do not have an identified mental state in this field. In terms of the argument that has been put, that one did something, one set out to do A but actually the knife slipped or something and one got B, that does not work because "recklessness" would pick that situation up.

The words "excises" and "infibulates" are strong words. "Excise" is removal of the clitoris, essentially. "Infibulate" is to remove everything. So they are radically strong terms. If one went from them to "otherwise mutilates", that is to say they are mutilations, and we are now talking about other forms of mutilations. It does not matter about ejusdem generis, it is just textual, that we are talking about three very strong words. One has to then look at other mutilations. There was no textual analysis by the trial judge and there has been no textual analysis, in our submission, by the Crown.

Now, if one comes to the words if one reads into the “injures to any extent”, maybe there is room for – it is definitely a fallback position but the words “injures to any extent” then why would one say “whole or any part”? Because if you injure to any extent, it is completely unnecessary to talk about “whole or any part” because one is all of it, and the part of it is any part of it. That, in our submission, is a nonsense.

Now, then the labia majora or labia minora and the clitoris do not make up all of the structures of the female genitalia and there was an argument in this case about the prepuce and whether that was to be included. So we have identified aspects of the female genitalia that are specified.

Why would you do that, if you were talking about an umbrella term, “female genital mutilation”? In our submission, it does not make sense to do so. You would say “So injures, or injures to any extent”, so why would you say “whole or any part”? Why would you say “labia major” or “labia minora” or “clitoris”? There is no explanation for that.

What it means is this: the legislature has decided to prohibit identified conduct, and that is a standard method of the creation of crimes. It has not set out to create an umbrella term. If you look at the other legislation that is created about female genital mutilation, it goes on to define what you mean by female genital mutilation.

If in this you pick up all categories of female genital mutilation, the umbrella term, then you have to go somewhere else to construe what this statute means and that is antithetical to our ideas about the construction of statutes. One needs to be able to look at a statute and see what it means, not to go to extensive secondary sources to work that out. Nowhere do the words “injury”, “damage”, “any injury” – none of those words appear. Then there is a reference in the aiding and abetting offence to those acts and those acts we see in subsection (2):

if the person mutilated –

So it is a moving thing; it is something that involves identified conduct which is the conduct that brings about “excision, infibulation or otherwise mutilate”. So the words the acts themselves have meaning in this context as well, as does the appearance of the word “if the person mutilated”.

Now, subsection (3) talks about surgical operation. Now, surgical operation, it is difficult to see why surgical operation would be necessary if one was talking about female genital mutilation, which is mutilation for nonmedical purposes because it is a practice. That is to say, surgical operation has to be brought in in this context and it comes also directly from the UK provision of 1985. It has to be brought in because otherwise the physical acts identified in (1)(a) could amount to – a surgical operation could satisfy the descriptions of the acts prohibited in subsection(1)(a).

**KIEFEL CJ:** I am sorry, I do not quite follow that, Mr Game. The medical procedures referred to in subsection (3) one could accept would take account of procedures which would mitigate the effects of the practices referred to in subsection (1), in particular, infibulation. What is the point you are making?

**MR GAME:** So, the point is that the physical act which is the surgical operation could satisfy the provisions of (1)(a), but if one defined this thing just in terms of the umbrella idea of "female genital mutilation", female genital mutilation is conduct done for other than surgical purposes.

**KIEFEL CJ:** That is creating an exception – subsection (3) is creating the exception, is it not, on that view?

**MR GAME:** Yes, but only by reference to the specified conduct in (1)(a).

**BELL J:** Your point is

**EDELMAN J:** The subsection

**MR GAME:** What I am saying is not pointless, in my submission.

**BELL J:** Your point is that the offence created in subsection (1)(a) is not created by reference to the concept of a practice

**MR GAME:** That is right.

**BELL J:** of female genital mutilation.

**MR GAME:** Yes, yes.

**BELL J:** If it were possible to define an offence in that way, it would necessarily be an offence done for nonmedical purposes

**MR GAME:** That is exactly right.

**BELL J:** and one would not need the statutory exception.

**MR GAME:** Exactly.

**EDELMAN J:** Except, one might read subsection (3) as not being an exception but a clarification that commences with the words "It is not an offence".

**MR GAME:** True, but it is identifying – it is all about physical – the doing of physical acts. Then if one goes on, one sees:

It is not a defence to a charge . . . that the person –

Again, the word "mutilated" appears:

consented –

So, what one would have here is no age restriction, no defence of consent, so that any conduct on any female person that involved any injury to any extent, whether consensual or not, other than the exception in subsection (3) would be an offence of female genital mutilation. That is the construction that is being put by the Crown and it does not make sense.

The word "mutilate" has to be given – the words "otherwise mutilate" – they have to be given the sense that they carry. They cannot be extended to any de minimis circumstance that fits within any description in other material about the extent which the umbrella term, "female genital mutilation" might catch. If that were the case, as I have just said, you will create an offence on any woman, any age, consent or otherwise, involving any injury to any extent and that is a crime now carrying 25 years' imprisonment.

So, that is what we say in the paragraphs that appear from paragraphs 4 through to 10. We make the point about context in paragraphs 11 and 12. That is a small point but it is in a particular part of the legislation and that is a relevant matter.

I would like to then go – in paragraph 15 – I am moving on a bit – but in paragraph 15, we deal with the extrinsic material. Most of it, we submit – sorry – most of it was put aside, and correctly so, by the Court of Criminal Appeal. That included the material which is set out in paragraph 15, particularly extending to dictionary definitions of "female genital mutilation" which is not the term in the community education material, the AttorneyGeneral's Department and the subsequent amending legislation, all of which were given weight. So then one comes to the second reading speech which I will take your Honours to now.

**KIEFEL CJ:** Would that be a convenient time to break?

**MR GAME:** Yes, certainly, your Honour.

**KIEFEL CJ:** The Court will adjourn until 2.15 pm.

**AT 12:45 PM LUNCHEON ADJOURNMENT**

**UPON RESUMING AT 2.16 PM:**

**KIEFEL CJ:** Yes, Mr Game.

**MR GAME:** If the Court pleases. I am about to come to the second reading speech and what I have to say about it but, by way of a preliminary observation, the question of how the appellant relies on the extraneous material was raised in argument this morning.

We say in our argument that not only does the appellant, to get from "otherwise mutilates" to "otherwise injures to any extent", have to take you out of the statute and its text in the immediate context but to the second reading speech, and then out of the second reading

speech, because they say it is wrong, to the Family Law Council report, and I will say something more about that.

Then they say, effectively, that for one to not only understand the provision but to construe it one has to refer to that material. We say that that is impermissible but it does not stand in the way in which these words “ordinary” and “mutilate” actually read. We say that one can refer to the extraneous material but it does no more than confirm that the ordinary meaning is to be given to those words, and they are strong words.

I wanted to take your Honours to the second reading speech, which is at page 762. There is the explanatory memorandum, which you have been referred to, but that does not take the matter a great deal further. But if you go to page 762, what is being referred to at line 30 on 762 are when it says, “The practice involves”, so it talks about FGM, it talks about a number of practices. Then it says:

The practice involves the excision or removal of parts or all of the external female genitalia.

Then at the bottom of the page there is a reference to the Family Law Council, about which I will say more in a moment. At the second paragraph on that page they talk about the “most severe form” and so forth, but when one comes to that which is being spoken about on 763, “the practice” on about line 3 and line 8, that is the practice that they have been referring to back at line 30 on page 762. So that when one comes to the critical bit at:

I turn to the provisions of the bill . . . The three forms of FGM in order of severity are –

And then:

The bill seeks to prohibits all of these various methods –

That is not a mistake. There is no reference at all anywhere here to – nowhere to ritualised circumcision. What is being referred to throughout is the practice in the invasive, destructive sense that the second reading speech began with.

**KIEFEL CJ:** Would “infibulation” fall within “excision” or “removal”?

**MR GAME:** Yes, your Honour. “Infibulation” is the most severe form. It is removal of

**KIEFEL CJ:** It involves more.

**MR GAME:** It involves more, yes. It involves removal and then potentially sewing up. The critical thing here is that (a) nowhere is it said that they were adopting the Family Law Council recommendations; (b) there is no mention at all here of ritualised circumcision; and, (c) when we get to the forms, we are talking about the invasive things – I say “the invasive things” – the terribly invasive things that we saw in the Family Law Council report. Then it says:

The bill seeks to prohibit all of these various methods of FGM.

When you get to line 24, it says:

The bill follows legislation in place in the United Kingdom and the United States –

What we see at line 20 we say is not an anomaly. What we see then at line 25 is "The bill follows legislation in place". If one then goes back to an annexure to the Family Law Council report, page 710, there we have the UK legislation.

**EDELMAN J:** Do we have the US legislation?

**MR GAME:** I do not have the US, your Honour. I have not looked at either, I apologise. I might add that the UK second reading speech is not exactly a scintillating read but the point of it is, though, that they have taken their lead from the UK legislation and they have picked up the ideas pretty much holus bolus – "excise, infibulate or otherwise mutilate" and there is the exception for medical purposes.

So it would be a mistake to think that from this, this discloses an intention to pick up what were described as all of the forms of female genital mutilation under the umbrella idea of female genital mutilation, and then transpose that into the definition of "mutilate" in the provision. We say this second reading speech, insofar as it throws light on it, very much points away from the position put by the appellant. Just a couple of other points about the report. It says at the bottom of page 762 – they talk about "released a detailed report".

**GORDON J:** Sorry, where are we now, Mr Game?

**MR GAME:** Page 762, about line 45, your Honour. So what we say about that is this, that probably the best understanding one can have is that they probably had an advance copy of the report. The other thing is a discussion paper. The discussion paper and the report, as we have seen, are not entirely the same. We saw in the discussion paper

**KIEFEL CJ:** The final report of the Family Law Council is only a month later, so it is quite possible that they had an advance copy.

**MR GAME:** Yes, that is the most likely, so that one would look to the final report. But the thing is that some of the things have dropped out of the discussion paper, so that what one sees at 613, paragraph 522, that does not appear to be in the final report. What appears at 591 in 2.01, that does not appear to appear in the final report either.

So what one does have is that we have seen the recommendation that all forms be made unlawful. That is at page 793, but when we go back to 746 and 747, we see what patently are four different things, ritualised and so forth, excision, infibulation.

Now, it is tolerably clear, in our submission, that when you read that with the second reading speech they are not picking up ritualised circumcision and that is the only fair way, in our submission, that you would read all of this material.

**KIEFEL CJ:** You can read it in a couple of ways really, can you not?

**MR GAME:** You can.

**KIEFEL CJ:** You could say that the reference at 763, line 21, is to the three most serious forms of FGM. You would assume that when they have read the Family Law Council report, they understand that there are actually four.

**MR GAME:** Yes, your Honour, exactly. They may be saying the three forms that we want to prohibit.

**KIEFEL CJ:** Or no, the three most severe.

**MR GAME:** That is true.

**KIEFEL CJ:** That more accords with their language.

**MR GAME:** Your Honour, in our submission, it is not going to get one to the point that one can swing in ritualised circumcision into the statutory provision because there is no indication that that was the intention to do so.

**KIEFEL CJ:** The difficulty, though, Mr Game, is having read the Family Law Council report, it was obviously influential. It is very recent. They are saying it is accepted that it should criminalise what is a form of child abuse. Why would they leave out an area – it is called ritualisation, but in part can be physically damaging. Why would we assume that the legislative intention would be to put that to one side when there is nothing in the language of the second reading speech which suggests that up to a point it is an acceptable practice?

**MR GAME:** Your Honour, it is not to say that it is an acceptable practice but if one goes back to 763, line 4 – sorry, the other thing is it has not been left out completely if other mutilations somehow are caught. So it is a question of construing other mutilations, not construing what sits inside ritualised circumcision in the report.

**GORDON J:** That is why I wonder why you are focused on that contention. It is not that the question is what “otherwise mutilates” picks up and it may very well pick up, given its context, some things which some people may view as ritualised circumcision, others may not.

The whole reason for not adopting the category is because of the debate and confusion, sometimes debate within the community about what falls within each of the categories. So the language is “otherwise mutilates” and one has to work out whether or not a cut of a prepubescent’s clitoris is within “otherwise mutilates”, regardless of whether it is sunna or in what you have described as ritualised circumcision.

**MR GAME:** I accept that, your Honour, but what I am saying is that if you construe the statute as it stands, you are construing the words “otherwise mutilates” without trying to swing in these categories and that when one does that, “otherwise mutilates” in context

**GORDON J:** I think that was my point, Mr Game.

**MR GAME:** Yes, I accept that, your Honour – sorry. What I am saying is that the text, by its very nature, contemplates – the very idea of mutilate is an injury or an insult of some

significance and we do not accept

**GORDON J:** The question is whether or not a cut to a clitoris for a prepubescent child which is the size of a lentil is something which falls within that category.

**MR GAME:** Your Honour, that case fell away. That case fell away because Dr X's evidence fell away. That case did not survive because Dr X

**GORDON J:** That was a case left to the jury.

**MR GAME:** Sorry, on appeal, that case fell away, but there is by no means any satisfaction that the jury were satisfied about that because that witness was giving evidence about something that happened 30 or 40 years ago in India.

**GORDON J:** We have two questions here. One is construction of the statute, which is what I thought we were directed at at the moment, and we were trying to work out what "otherwise mutilates" means, and the second is its application to the facts.

**MR GAME:** Yes, your Honour, but I do not accept that it is just a question of asking whether or not a cut satisfies the description of "mutilate", and in some circumstances a cut might. The reason for that is that what has been said about the meaning of the word "mutilate" is that it does catch events that are de minimis, and that is because of the idea of injury to any extent. What else could it – and potentially things that are transient that do not cause pain even a little while later.

What is put is that, by going to this material, you will get to ritualised circumcision because you will get to ritualised circumcision, any insult of any kind, however small, will satisfy the question. The point I am making is that it is our opponents that have to get to this material. We do not have to get to this material at all. In fact we say that all the material shows up is a confirmation that one has to determine what the ordinary meaning of "mutilates" means and that it has a connotation of an impact of some significance.

**KIEFEL CJ:** You might be right that on either view you may not get to the second reading speech, but on either view you do get to the Family Law Council report, I would have thought.

**MR GAME:** You can get to the Family Law Council but there is very limited that you can draw from it for the reasons that I have given in terms of what is said about it.

**KIEFEL CJ:** Except that the terminology chosen by the statute is to pick up terminology of the report. It is not "female circumcision" as in the British statute in 1985; it is "female genital mutilation", which has, and had in the 1990s, a received meaning which was reflected in the Family Law Council report, which gives a different view to what "mutilation" means, not the least because, as I think is referred to in the Family Law Council report, the term "mutilation" was chosen by those who are the protagonists of making it a criminal offence and to try to overcome these practices. They chose a word which was condemnatory.

**MR GAME:** Quite, your Honour, but they chose a word in the context of three words: "excises, infibulates or otherwise mutilates". That word "mutilates" does not sit there in the

umbrella of the words “female genital mutilation”, which has taken on a meaning of its own. But one does not get the meaning of the word “mutilates” by going to a statutory definition of female genital mutilation.

**EDELMAN J:** One also does not get the meaning of the word “mutilate” from some socalled ordinary meaning that is divorced from “female genital mutilation”. The whole context is female genital mutilation.

**MR GAME:** Yes, but it is being used in a different way here, which is that what is being done is driving into the word “mutilate” all of the different things that have been used to describe the practice of female genital mutilation, and that is a completely different thing than just construing the word “mutilate” against a background that this is an offence dealing with female genital mutilation. The reason for that is this. We had this offence of prohibiting female genital mutilation and then we go on to describe what is the conduct with the result.

One does not build that up by going back elsewhere to ask about the reason just why the thing is being prohibited because now you are being told what the conduct is that is prohibited. You have been told that, as I went through before lunch, with a good deal of specificity about each aspect of it, whole or part, the particular circumstances relating to it and so forth. So that you have to look at that body of words together, your Honour.

**EDELMAN J:** If that submission is right, and if you are right, and I understand that sometimes a cut might fall within and sometimes it might not, does that mean that it would be necessary on an application of the provision to adopt a wait and see approach? If not, how else would one tell?

**MR GAME:** You could do. You might have to. You might have to say, “On that account, such and such could amount,” so you may have to give the jury some specific directions about but that is at the margins, which are not the margins that we are talking about in this case. They are not the de minimis margins, they are the margins about whether or not

**EDELMAN J:** I am just asking about the construction point.

**MR GAME:** Yes. You may, in a particular case, have to wait and see, yes.

**NETTLE J:** Before you could charge?

**MR GAME:** Sorry, I thought you meant wait and see how the evidence flowed out. Do you mean you wait and see in terms of what happened with the injury?

**EDELMAN J:** Wait, because you may not know at the outset whether the cut is going to be one that causes permanent injury.

**NETTLE J:** Whether it is permanent.

**MR GAME:** You may not know, yes, your Honour. So you may not know. I was thinking of something else, your Honour, which is this – it is not a settled thing in jury directions. For example, in *Peters*, two of the dissenting judges said you might direct the jury that on that account, that amounts to dishonesty, and others did not accept that.

In a particular case, you might say to a jury, “On that account, if there were X, Y and Z, then I direct you that that could amount to mutilation,” so that there is no reason why that sort of direction could not be given. I thought you meant wait and see, sorry, but I accept the first – now understanding what your Honour has said, I accept that may be the case in a particular instance.

I also say that the margins of what amount to mutilate in extremis are not really what this case is about. This is about the margins in minimis, about what this offence is about. So that there is a passage, and I will come to this in due course, but we do say that the Court of Criminal Appeal fully considered both the meaning of the words in context, they did not give them excessive the dictionary or anything excessive weight.

They did understand context, and they were conducting an orderly exercise, having regard to purpose, when they come to their conclusion about what the ordinary words mean. So that there is nothing, we say, in the Court of Criminal Appeal’s reasons that is capable of criticism but there is one very small proviso, which is this. I will go back in a minute, but at paragraph 521, page 493, we say that that passage is no more than an orderly application of section 34(1)(a), having considered purpose, but it does not mean something different.

They have had full regard to the extrinsic material and if you go back to paragraphs 512 to 514, one can see how they have done it. The critical thing from our perspective is 515, that:

some form of more serious injury than, say a superficial shedding of the skin cells or a nick or cut that leaves no visible scarring and cannot be seen on medical examination –

that is correct, in our submission. One does not have to come – another way of saying what I was saying, you do not have to come to a definitive, ultimate definition of “mutilate” because it applies to different circumstances, but it must be something of some significance in terms of an injury.

**BELL J:** So, in terms of supporting the judgment below, rather than paragraph 521, you point to 522, the acceptance that a nick or a cut in a particular case may amount to mutilation and the error being, as you have put it, a direction that invited the jury to consider that a de minimis injury could support the conviction?

**MR GAME:** Yes, and we say it is a mistake to shift all of this case to focus on the word “cut”. You have to actually look at that bundle of words. If one goes back a little, the actual consideration of the words in our submission, we see at paragraph 484 the words in dictionary context and so forth. That is orderly statutory construction. It is giving dictionaries no more than their proper weight. Then when one gets to 494 at page 485, that is correct. In our submission, one does not get to the meaning of the word “mutilate” by particularly since those definitions of “female genital mutilation” mostly came after this statute and offences.

**GORDON J:** Can I just ask in that context about 492?

**MR GAME:** Certainly, your Honour.

**GORDON J:** The way you have just put it, for my part there are a number of passages through this Court of Appeal's decision which, on their face, seem in some respects to be inconsistent. Is it the way you have just put it consistent with what is put out at 492?

**MR GAME:** Yes, but you would have to ask yourself – this would not be dressed with any injury to any extent. It would be a significant injury and a cut to the clitoris might in particular circumstances, depending on its depth and scarring and so forth or whether or not there was any impact on nerves, that might well amount to a sufficiently serious injury, to answer the description of "mutilate".

**GORDON J:** Well, it is not put under serious injury. The way they put it is – as they read it, it says "any cut", because a cut is nerve damage.

**MR GAME:** I am sorry, your Honour, you will probably be annoyed by me being distracting, but it ultimately ended up not being the clitoris, but the prepuce, which is a different piece of

**GORDON J:** I am trying to deal with the question of construction.

**MR GAME:** That is true, but what they are saying here does not undermine what they are saying because the injury is to a different part. Yes, there is some tension but, your Honour, again one cannot just take that word "cut" and then build the argument around that.

**GORDON J:** I am doing the opposite; I am trying to take the passage and put it into context in relation to the other paragraphs. I am trying to work out on your view what is, as you would put it, the minimum, what is the thing that otherwise mutilates.

**MR GAME:** Your Honour, I think one would have to go to 493 and say what is being said is that there may be a circumstance in which nicking or cutting itself amounts to an act of destruction. So it does say "any" but, when you read that with 493, they are really saying something of some significance.

In addition, your Honour, when one reads what is said later at 515 and 522, there is a flow of logical meaning to it, in our submission. The passage I wanted to take your Honours to is at 514. Sorry, at 513 there is an important point there in our submission which is we say this case is a case like *Milne* or a case like *Grajewski* where one is looking elsewhere not to determine the scope of a provision but to extend it.

That is an extension of jurisdiction in the sense of *Kirk* and we say that one should be quite vigilant to not engage in an exercise which extends crimes beyond their effective and natural meaning. Now, 514 is a significant passage because what is being criticised there is using the idea of female genital mutilation to supplant the idea of the word "mutilate" which leads to the conclusion at that top of 492. That is what I wanted to say about that.

There was one remaining point about the – there was an answer that I was giving to your Honour Justice Kiefel about a question about the second reading speech that I wanted to come back to.

**GAGELER J:** I want to ask you a question about that as well, Mr Game.

**MR GAME:** Certainly, your Honour.

**GAGELER J:** You do your bit and then I will ask my question.

**MR GAME:** I will just say this. Your Honour the Chief Justice asked me about particular things that might not fall within the description of "mutilate" and whether that created a difficulty for my argument. On page 763 – and we do say this is a significant point – on line 4, it is said that:

FGM could constitute an offence against the general assault and wounding provisions of the Crimes Act.

The point about it is that things that are at the margin can be dealt with under other penal provisions and it is not an insignificant observation in the second reading speech. That is all I wanted to say about that.

**GAGELER J:** I have two questions. One arises from page 762 and it is really the question I asked Mr Kell.

**MR GAME:** Yes.

**GAGELER J:** The second paragraph of the second reading speech contains the sentence:

The practice has been condemned at an international level. The World Health Organisation has recommended that governments adopt clear national policies to abolish the practice.

Now, as at 4 May 1994, what is it that the World Health Organisation had recommended?

**MR GAME:** I do not know the answer to that question, I apologise. If Mr Kell does not have an answer, we could send a note and we can ascertain that material.

**GAGELER J:** The second question relates to the second paragraph at page 763, the reference again to the United Kingdom Act. I think you intimated that there is nothing in the second reading speech for the United Kingdom Act that sheds any light on it. Is there anything

**MR GAME:** It is worth reading but it is – we actually have copies of it – we have one, sorry. I cannot give you the

**GAGELER J:** Mr Game, my question is: is there anything in the context of the identically worded United Kingdom statute that might shed light on the meaning of the words or how the words are to be read? Secondly, is there any commentary on the United Kingdom provision that we should be aware of?

**MR GAME:** I am not certain about commentary but there is a judgment that is referred to in Justice Johnson's judgment.

**KIEFEL CJ:** Is this the judgment of the Family Law Division?

**MR GAME:** Yes, your Honour.

**KIEFEL CJ:** It is not heavily reasoned.

**MR GAME:** That is correct, your Honour. There is the judgment referred to at page 54 of the first appeal book. It is a decision of Sir James Munby. The legislation is a later piece of legislation, 2003, but the critical words you will see at page 57 are close to identical.

**KIEFEL CJ:** Could I interrupt you just for a point of clarification, Mr Game. The 1985 UK Act was entitled *Prohibition of Female Circumcision Act* 1985, and the later Act you were talking about, which was the subject of this decision, was then called the *Female Genital Mutilation Act* 2003. I do not know what to make of that.

**MR GAME:** Yes, there is something in the context because they talk about it in the second reading speech.

**KIEFEL CJ:** Yes, thank you. I interrupted you. You were talking about *Re B and G (Children (No 2))* [2015] EWFC 3.

**MR GAME:** If one follows it through, there are said to be four different types. It is said, if one looks, for example, at page 55, a reference to the World Health Organisation 2008, a reference to four different types. There is a type IV referred to there, and again there is a reference at paragraph 8 to four types. Then again there is another reference to UNICEF in 2013. Then there is the 2003 legislation. His Honour in his decision accepts that it brings within types I, II and III but:

Type IV comes within the ambit of the criminal law only if it involves ‘mutilation’.

Mutilation” is not further elaborated. He refers to dictionary definitions and then he goes on to say something else. So, it is a very limited consideration, but it leaves up in the air what one has to say about the fourth category.

**KIEFEL CJ:** I think it would be found at paragraph 70 of the judgment of the Family Court in that case that his Honour the President determines the question of whether a particular case of type IV4 FGM involves mutilation is not a matter for determination by that court.

**MR GAME:** Yes.

**KIEFEL CJ:** I do not think there is any other – there is no other case that deals with the UK provision.

**MR GAME:** No, your Honour. So I am leaving that subject now, so I wanted to now say something briefly about the ground relating to the definition of “clitoris”. Now, the indictment referred to “clitoris”, the legislation refers to “clitoris”, and the alternative counts were based on things not occurring to either “clitoris” or “labia majora” or “minora”. One ended up in the

position that it was said that the clitoris extended the structure extended to the prepuce. We actually saw a diagram that was of some assistance in the discussion paper.

Now, if one goes to the Court of Criminal Appeal's judgment on this at paragraphs 526 to 527, and our submissions, in our submission, there is some significance in – it did make a difference, also, in terms of the kind of injury that might be required, because it was said that the clitoris itself was specially sensitive.

What was ultimately put was that if there was injury, it was to the clitoral head or prepuce. Now, the court accepts there, and we say correctly, that they are different anatomical structures, and that was the effect of the evidence and we have set out what Dr Marks had to say about the subject, by reference to the judgment, paragraph 209 of the judgment at page 404, so it did have significance. The passage at 209 page 404, paragraph 209:

Dr Marks' evidence was that the hood over the clitoral head is not part of something else – it is the clitoral hood.

So, in our submission, the court came to the correct conclusion about that subject and it did matter in terms of both the indictment and how the alternative was put. Now, this brings me then to how the appeal would be resolved if the appellant succeeded in sustaining an argument that the directions given on ground 1 were correct.

So, as we have said there, the Court of Criminal Appeal explicitly rejected that the offence applied to minor or de minimis injuries and we have set out the passages there. So, that issue was firmly seized by the Court of Criminal Appeal and that is the first significant issue on the appeal. If the appellant succeeds, there are additional reasons – and they are significant ones – for dismissing the appeal and, if not dismissing the appeal, making no order for a retrial. So, there are two aspects to that. To understand this proposition, one needs to go to how ground 2 of appeal was dealt with and that is at appeal book page 495, paragraphs 529, and following.

What the Court decided was that after – so there is a discussion from paragraph 587. At 590, what is happening there is that, on the court's construction of "mutilation" – that is to say, something more than any injury to any extent, there was no proper basis to convict and, accordingly, acquittals had to be entered. That, then, took the court to the alternative counts. The alternative counts, of course, related to the same conduct that if the same conduct occurred somewhere else than in the identified place, the clitoris, including the prepuce. So, we have already seen that the elements of the offence in one respect, at least as put, involve potentially a nontransitory injury in respect of assault occasioning.

If we go then to paragraphs 613 and 614, in order to address this question, properly, namely, whether to acquit or order a retrial on assault occasioning, the court asked itself a different question. The court asked itself the question whether or not there was adequate evidence to convict on the basis that the nick or cut, or whatever it was said to be, occurred to the clitoris itself. So, they are not just considering the assault occasioning, as it was put, they were looking at the question on a wider basis, and they come to the conclusion. So then we see

some passages I took you to before – the consideration of C1's evidence at 621 and 622 and a sort of conclusion at 625, and then C2 at 628.

So, the discussion continues. And then, at 634, in effect – one sees at 632, is there evidence to satisfy:

beyond reasonable doubt that there were assaults occasioning actual bodily harm . . . on the basis of a nick or cut to the clitoris

Then, they say at line 30, they say:

Although we are prepared to accept that a nick or cut to the genital area could amount to actual bodily harm, the question is whether there is sufficient basis –

That ultimate question is left as one has seen it. So, a very real – a lack of conviction in the Crown case on that but not an ultimate firm decision, it would seem but then they add in some other discretionary factors. At 636, the amount of time the case took, the fact of C1 and C2 already having – what has already occurred to them, they are now teenage girls, they would be giving evidence against their mother again so many years later. Then, so we get to 638:

Having carefully examined all of the evidence that would be available on a trial confined to allegations of assault occasioning . . . we do not propose to order a new trial –

Now, then one sees at 618, convictions are quashed, so effectively there is an order of acquittal in relation to the assault occasioning counts. Now, in New South Wales it has become very rare, if not unheard of, for a court not to order a retrial, but at the same time not order an acquittal. There are decisions of this Court from I think perhaps 20, 30 years ago when orders were not made for retrials, even though acquittals were not entered. But normally, if an order for a retrial is not made, then normally an acquittal is entered. But it is open to the Court to quash the decision of the Court of Appeal and not order a retrial without ordering an acquittal. The Court has power to do so.

**EDELMAN J:** Are you making that submission on the basis of potential inconsistency between verdicts?

**MR GAME:** Yes.

**EDELMAN J:** You do not have a notice of contention to that effect.

**MR GAME:** No, no, I am making that submission on the basis of the weakness of the evidence in relation to C1 and C2, your Honour. I mean, the appellant has not advanced an

argument attacking the acquittals, but we have not put on an incontrovertibility ground, if that is the question your Honour is asking me. I am trying to point to the deeper problems that reside in here with the evidence and what I am encouraging your Honours to do so is that even if your Honours accepted the appellants' substantive argument, there are still the fundamental problems with their evidence and then there are these discretionary factors.

So point 1 is, we say, at least the Court would not order a retrial but point 2 antecedent to that, we say that one would enter an acquittal, having regard to these features of the evidence.

**EDELMAN J:** Is there any authority in this Court where the Court has entered an acquittal in circumstances in which it is also held that there may be evidence sufficient to sustain a conviction?

**MR GAME:** I cannot think of a case.

**EDELMAN J:** I do not know of any.

**MR GAME:** I do not think of a case that actually deals with that problem but you will see plenty of decisions 30, 40 years ago where convictions are quashed, they do not enter an order of acquittal, but they do not order a retrial. That is not a practice that I am familiar with in the – I could not say definitively about here but in the Court of Criminal Appeal, for a long time now, the court has not made orders just quashing a conviction and not ordering a retrial.

My argument here is this. It is not an incontrovertibility point. My point is, the point is when you look at all of these factors that the Court of Criminal Appeal took into account, this is an appropriate case not just not to order a retrial, but it is an appropriate case for one to order an acquittal.

Or if one looks at that another way, say the court at paragraph 634 – and presumably for discretionary reasons they decided they did not have to go further – they had said that any verdict on that would be unsafe, which is pretty much what they do say.

There is no decision of this Court in which a verdict has been found to be unsafe and ordered a retrial except for the circumstance in which a verdict cannot be sustained on – where a verdict is sought, say, on murder on two separate bases, and it is unsafe; say it is unsafe on felony murder, but not on extended joint criminal enterprise you could conclude the verdict was unsafe, but order a retrial limited to extended joint criminal enterprise but that is the only exception.

There is actually no decision – there is a case called *Abbas* that got special leave on this but the appeal was resolved but there is no case that deals with it. So what I am saying is at paragraph 634 they came as close to holding that the verdict was not safe for me put the submission

**NETTLE J:** Close but no cigar. It does not say that.

**MR GAME:** Yes, I accept that, your Honour, but when you look at all of the things that have been said leading up to that, they are pointing to the very unsatisfactory features of the evidence of those

**BELL J:** Mr Game, you are here talking of the acquittals on the alternative counts?

**MR GAME:** No, all I am saying is this, your Honours. That argument about alternative counts holds good for the principal counts because the court considered a nick or cut anywhere that it occurred. Since it is anywhere that it has occurred, it takes up all the subject matter of the principal counts.

**BELL J:** I understand that, but as I understand the prosecution argument, it is that in relation to the principal counts, that was upon a view that an injury that was transient would not be within the provision. If that is wrong, then

**MR GAME:** That is true, except for the fact that the Court of Criminal Appeal was not focusing on the word “transient” in their determination of this question. They just accepted that a cut or nick could amount to assault occasioning. Once you have got the cut or nick to the parts that are said to be caught by section 45, when you get to this discussion that I have gone through you have a deliberative decision about the strength of the evidence on the principal counts. That is the point I am trying to make.

I accept what your Honour Justice Nettle put to me, but all of the discussion before is weighing up what is the strength of that evidence towards a view that it has very unsatisfactory features. That is what we see at the very end when it is said “all of the evidence that would be available” referred to in paragraph 638. So they did not have to come to that conclusion because they were making a discretionary decision about what to do with the balance of the case, your Honours.

**EDELMAN J:** We would effectively have to reach a conclusion that the evidence could not sustain a conviction before we were to enter an acquittal, as opposed to make no order for a retrial.

**MR GAME:** That is a point that I am partly trying to challenge because I am saying that you could have regard to discretionary factors in that determination.

**EDELMAN J:** How then would the law not be hopelessly contradicting itself by saying, on the one hand, there is evidence to sustain a conviction and yet, on the other hand, an acquittal is directed?

**MR GAME:** If one looks at, say, section 8 of the *Criminal Appeal Act*, there are plenty of cases at intermediate level where the court determines that, having regard to all of the circumstances including the unsatisfactory nature of the evidence, the court will not order a retrial but they will also order an acquittal. It is not heresy to say that. But you are picking up a variety of discretionary factors, including – I can think of one case in particular, but you are not deciding the thing under section 6 of the *Criminal Appeal Act*; you are deciding what to do with the case under section 8. So that is really

**BELL J:** In that context a somewhat striking example might be *Anderson's Case*, in which the Court of Criminal Appeal, allowing the appeal, found that the evidence was sufficient to support a verdict, albeit not strong, but for discretionary reasons declined to order a retrial, entered acquittal in relation to the offences known as the Hilton bombing.

**MR GAME:** Yes, your Honour. Another example is *JB*, an unsuccessful special leave application, where an admission allegedly made to a support person, the support person was in fact the police informer. The court did not go on to determine whether or not the verdict was unsafe. They looked at the significance given to that admission and they ordered an acquittal, without determining that the verdict was unsafe. It happens, and it happens often enough. I mean, it is not much of an argument but it is a practice that happens, and I say for principled reasons. But obviously if one gets to the end of this, my concern is that there would be no retrial is obviously

**BELL J:** Mr Game, do you accept that, if it be the case that the prosecution accepts that it makes no challenge to the acquittals on the alternative counts, nonetheless, having regard to the argument that it mounts, there would not be an inconsistency in a retrial on the principal counts, notwithstanding the acquittals on the alternative?

**MR GAME:** Your Honour, they may potentially, but that is not to say that the accused could not bring forward their acquittals, for what they were worth, on the question of what the Crown could or could not put.

**BELL J:** In the way the matter was left though, am I right in understanding that it was in case the jury were not satisfied that the injury occurred to that part of the body that was the subject of particularisation in the indictment?

**MR GAME:** Yes, it would have to be that.

**KIEFEL CJ:** Yes, thank you, Mr Game. Mr Dhanji.

**MR DHANJI:** Your Honours, much of what I would put has been said already. Your Honours perhaps appreciate that from the outline that we have provided. We do not seek to avoid the secondary materials. We have, in our written submissions and in our outline, indicated what we make of those but, like the respondent *Magennis*, we would start with the provision and we would draw from the provision matters similar to those raised by Mr Game, and that is starting with section 45(1)(a). In our submission, one does take something from the expression "excises, infibulates or otherwise mutilates", the first two words informing the third concept as a concept of harm of some seriousness.

**NETTLE J:** Is that to say that it requires at least a cut because of the flavour of "excision" and "infibulation"?

**MR DHANJI:** At least.

**NETTLE J:** Anything more though?

**MR DHANJI:** It is going to depend upon the nature of the cut. So a cut to skin, for example – and skin only may not be within the idea. A cut that penetrates the skin and can be seen to

have resulted in some damage that would fit within the idea of mutilation may. The concession that we made and continue in this Court to make at all stages was that when one is looking at the word “mutilates”, it is not divorced from the subject matter.

The contention we put in the Court of Criminal Appeal was, of course, that it does not change its meaning because of the subject matter, but the way one would get to “mutilates” will vary because of the subject matter. That is to say that because you are dealing with a very sensitive part of the anatomy, it is going to be a lot easier to mutilate that part of the anatomy than it might be, say, an arm or a leg. But it is going to require one to actually examine the harm occasioned on the particular occasion to determine whether it fits within the idea of “mutilates”.

At the end of the day, in our submission, this is a criminal offence provision that is not particularly unusual by way of criminal offence provisions in that it provides for an act and it provides for a result. As Mr Game has pointed out, you see the result stated very clearly. In our submission, you see it in section 45(1)(a), but you certainly see it in sections 45(2) and 45(5), where those subsections speak of the person mutilated. So what one requires by way of contravention of this provision is some act committed – and again, we would say, an act committed intentionally or recklessly. It is not clear on the appellant’s argument how - their formulation is an intentional act for nonmedical purposes, but it is not clear how the recklessness is written out because it is a standard part of criminal offences within this part.

The provision itself, as I say, does speak of “act” and “result”, and when one is looking – and I appreciate that this point has been made by Mr Game but I will just underscore it. When one is looking at, for example, 45(1)(b):

aids, abets, counsels or procures a person to perform any of those acts on another person

what that is speaking of are the acts, of course, in subsection (1); that is:

excises, infibulates or otherwise mutilates –

What we take from that is that, in speaking of those acts in subsection (1), there is an acknowledgement that subsection (1) is not speaking of some unitary concept of female genital mutilation; it is speaking of these separate acts - “excises, infibulates or otherwise mutilates”.

I will come to the second reading speech in a moment, but there is some correspondence there with the second reading speech. Ultimately what we would put is that, when one looks at an umbrella term such as “otherwise mutilates”, it is not unusual because Parliament is forever enacting provisions in circumstances where it cannot and acknowledges – it cannot foresee a full range of matters that it might seek to capture; it cannot foresee the type of factual scenarios that it wants to catch. But what one does see in the second reading speech and in this provision is the desire to catch actions that result in particular harm.

There is nothing in our submission that one could draw from either the provision or the second reading speech that would suggest that this provision could pick up the type of matters embraced by the appellant which, in our submission, would amount to the mere transitory.

**EDELMAN J:** Mr Dhanji, section 345(1)(a), which is copied almost verbatim or perhaps verbatim from the UK legislation, contains the phrase in triplicate, but does the UK legislation repeat the umbrella term in the way that it is repeated in subsection (2) and subsection (5) – "mutilated" in the broad sense in (2) and (5)?

**MR DHANJI:** Certainly in the primary provision, as your Honour indicates, there is no - at least at 710 of the joint book of authorities, the 1985 version shows nothing equivalent to the kind of reference to a person mutilated. There is the subsection (b), which is similar, and there is the penalty provision. There is then a reference to section 2 of the Act in relation to surgical operations. The 2003 provision does not have any equivalence in relation to subsections (2) and (5).

Your Honours, we too would take up the point in relation to not just subsection (3) but subsection (3) and subsection (4) in relation to the exclusion of surgical operation within paragraphs (a), (b) and (c), and your Honour Justice Bell I think made that point most clearly in relation to that aspect.

But further, whether this be by way of clarification or exclusion, it is again noteworthy that there is no equivalent for, for example, the genital piercing case, or the cosmetic procedure case - and one can imagine various cosmetic procedures, and we have referred to waxing in the written outline, where one could well say that there is an intentional act that results in at least a level of injury that would, on the Crown version, on the appellant's version, come within the provision that would be occasioned at least recklessly because one might well foresee

**EDELMAN J:** I am not sure that was the – as I understood the Crown's submission, "mutilates" takes its meaning from the notion of female genital mutilation, which I am not sure anyone has ever suggested included waxing or piercing.

**MR DHANJI:** But that is the difficulty with subsection (3), because subsection (3) and (4) speak against that. You would not need subsection (3) and subsection (4)

**KIEFEL CJ:** Would you have a difficulty of the kind you are referring to, though, if you understood "mutilate" in the context of female genital mutilation to refer to a practice, rather than any act carried out, such as those chosen by people who think it makes their body more beautiful?

**MR DHANJI:** Your Honour, the difficulty, with respect – I appreciate that that is an argument that is available. But the section, in our submission, is not speaking of a practice; it is speaking of an act and a result, and that is why I started with that proposition.

**KIEFEL CJ:** I understand that. It is just that the word "practice" appears on about six occasions in the second reading speech.

**MR DHANJI:** That is so.

**KIEFEL CJ:** And that is what the Family Law Council report is directed to.

**MR DHANJI:** That is so. However, there is a difficulty in adopting "practice" to use in that type of context, particularly a nonlegislative context, that is, secondary context, because of course "practice" can pick up, in a sense, a particular act with a particular result. But when one comes to the legislative context, what one sees here is what we say is a typical criminal provision, which is defined by act and by result.

**KIEFEL CJ:** I understand what you are saying. It is just that the Crown case -the contrary view is that female genital mutilation is a practice, and if you understand subsection (3) in that way, I think it may overcome at least some of the circumstances you were referring to.

**MR DHANJI:** That is so. But then, of course, one turns immediately to what we say is the difficulty in relation to that, and that is that one is in the territory of then, rather than trying to lend a definition or provide a definition for the expression "otherwise mutilates" in the context of

**KIEFEL CJ:** I understand that.

**MR DHANJI:** Yes. One is searching for the definition of the practice, or the practice of female genital mutilation. I appreciate, as has been pointed out, that there has certainly been a good deal of discussion in various papers and Parliament can be taken to be aware that there was a good deal of discussion in various forums about the practice.

**KIEFEL CJ:** Can we infer that Parliament may be taken to understand that female genital mutilation has an accepted meaning at 1994?

**MR DHANJI:** No, with respect, your Honour, because the bounds – and, particularly – I mean, obviously, a case like this is throwing up issues in relation to the bounds of injury or noninjury, or de minimis injury, or whether it is a nick or a cut. But, even when one goes to the Family Law Council report – and there is the discussion paper – if I can take your Honours to the joint book of authorities, volume 2, tab 20, and at page 591, what one sees there at 2.01:

*Female genital mutilation* –

refers to:

Circumcision of young girls is a traditional cultural practice –

It goes on:

Those who oppose the practice call it “genital mutilation”. In this paper when the term “female genital mutilation” is used it is meant to embrace all types of circumcision, other than mere ritual, where an incision is made in the girl’s genital area.

Again, one gets to the – just pausing there – the idea of an incision again throws up all sorts of questions about quite what that means, in our submission.

**NETTLE J:** It means a cut – to incise – a cut.

**MR DHANJI:** Yes. But, it has been said – I think it was Justice Callinan in *Banditt v The Queen*, that there are no true synonyms in the English language. So, you are still – whilst it means to cut – and I do not dispute that – but there is a connotation that goes with it. An incision has more of a quality to cut into. And, I suppose it all depends upon, again, context but it is likely to mean more than a nick or a cut in those circumstances. But the point that I am really trying to make is that when one goes to the report – and this is at page 646 – at 2.01, there is reference to:

*Female genital mutilation.*

At 2.02, there is a very similar sentence. It is the third sentence in:

Those who oppose the practice call it “genital mutilation”. In this paper when the term “female genital mutilation” is used it is meant to embrace all types of the practice where tissue damage results; for example, damage manifested by bruising, contusion or incision.

**GORDON J:** That follows on from the opening line of 2.01 which mirrors the part you just took us to, does it not, in the discussion paper?

**MR DHANJI:** Except, with respect, that there is a reference there, in 2.01, to traditional practices that involve the cutting. But, the statement at 2.02 appears to be broader because it is picking up all types of the practice where tissue damage results but it is talking about – it is including damage manifested by bruising, for example, contusion, which seems to be somewhat broader than simply cutting. That is the definition that is adopted for the purpose of the paper. But, even if one was to, in a sense, dwell on this definition, and say we can take this definition, that one is immediately in the territory of trying to determine what tissue damage is and I think you have been taken to evidence already but very minor actions are going to result in the removal of skin cells which is part of the tissue of the skin.

Clearly enough, when one reads this, where it speaks at 2.03 of ritualised circumcision, what is stated there is:

The first, and least severe form, is called ritualised circumcision. In this case the procedure may be wholly ritualised (e.g. where there is cleaning and/or application of substances around the clitoris). In other forms of ritualised circumcision the clitoris is scraped or nicked. This causes bleeding and may result in little mutilation or long term damage.

The first part in terms of ritualised circumcision would appear perhaps unclear as to whether that is regarded as being within the definition that has been provided at 2.02. But certainly on one view even that type of process, “cleaning and/or application of substances”, cleaning could result in removal of skin cells. I appreciate that I am at a very fine level of detail here, but the point that I am seeking to demonstrate is that once one goes down this path and starts looking at these definitions and is trying to get clarity, there is not sufficient clarity there that one is going to be able to say we can arrive at a kind of received understanding of what is meant by “mutilation” in this

**KEANE J:** We can get an understanding that all these practices are disapproved of. There is no suggestion that some of them are regarded as legitimate. There is no suggestion that the cultural sensitivities that are being exhibited in the second reading speech are reflecting an appreciation that some of these activities may continue rather than that they should all be prohibited. It is a prohibition on the practices. It is not a regulation of them.

**MR DHANJI:** I apprehend your Honour is speaking about the second reading speech at page 764.

**KEANE J:** Insofar as it adopts this terminology.

**MR DHANJI:** Yes, but if I could just turn that up, at 764, the paragraph beginning at line 19, the concluding paragraph:

It is important to stress that in passing a law against FGM the Government is not seeking to attack the values of any particular group in the community. Cultural diversity has always been recognised and supported in New South Wales. However, the wider community should not tolerate a practice which results in detrimental and unfortunate longterm physical effects.

So there are two things that we would draw from that, and that is there is reference – the reference to cultural diversity is acknowledging that there is a sort of balancing in a sense to be done between values of

**KEANE J:** That is where I have difficulty with your submission, because there is not any balancing – there is no notion of balancing in these materials. The practice described as FGM or the various practices encompassed under that description are all regarded as illegitimate. There is no balancing about it.

**MR DHANJI:** I am sorry, "balancing" might have been the wrong word. What I am trying to say is that what one takes from that reference is an acknowledgement that there is a tradeoff or a price to pay, however one might put it. But when one comes to the next sentence, what is being spoken of in the context of that acknowledgment that there is at least some price to pay is that the:

community should not tolerate a practice which results in detrimental and unfortunate longterm physical effects.

**KIEFEL CJ:** More generally after saying – it does at about six points I think in the second reading speech that you are talking really about a practice which involves children of tender age. It goes on:

As responsible members of the community, we should place our condemnation of FGM beyond doubt.

**MR DHANJI:** Yes.

**KIEFEL CJ:** Not some of the practices, FGM, in fact the umbrella to the wider term.

**MR DHANJI:** I understand that.

**KIEFEL CJ:** That is a sweeping statement.

**MR DHANJI:** But the difficulty with that, with respect, is that if one were to embrace that as picking up all the practices, one is then in a territory of reading section 45(1)(a) as including what is described at 2.03 of the report on page 646 of the ritualised circumcision. The first and least severe form is called ritualised circumcision.

In this case the procedure may be wholly ritualised – for example, where there is cleaning and/or application of substances around the clitoris. That, in my submission, is difficult to reconcile with the idea of a practice which results in detrimental and unfortunate long–term physical effects.

**EDELMAN J:** Except that it goes on to say when it is talking about other circumstances, in particular the scrape or the nick, that this causes bleeding that results in little mutilation or long–term damage.

**MR DHANJI:** Yes.

**EDELMAN J:** Now, it would be hard to read the word "mutilation" as permitting a little mutilation, in the legislation.

**MR DHANJI:** I understand your Honour's point and what is being spoken of here is the idea of less mutilation – obviously there can be degrees. It would be unusual to speak of little mutilation in ordinary parlance but the problem here again – and this is the kind of platform

from which we jump off – is that one is in a detailed debate in relation to construing expressions in a report that was not even expressly adopted. It was referred to and there is no suggestion of disagreement with it but one is in the territory of a report.

To put it another way, what we have here is a report that is a long way from, for example, a Law Reform Commission report with a set of recommendations and a statement in the Parliament that it is the intention of the Parliament to enact legislation according to the recommendations and the model provisions provided in a particular Law Reform Commission report. It is some distance from that. Indeed, we accept that whilst it is dated June 1994, it is probably the report which was in the mind of the relevant Minister by way of some sort of advance paper but to an extent we are not even certain of that.

So, really, all of this underscores the point that the respondents make, and that is that what one is doing by going down this path is in effect reading the concept of female genital mutilation into the provision and then embarking on an exercise of construing that. The point that we make is that, firstly, you fail at both steps, in a sense. You fail at the first step. You cannot just read “female genital mutilation” - the Court of Criminal Appeal asked itself the right question: what is meant by a provision that uses the words that it does, but does not use the words “female genital mutilation”?

**GAGELER J:** Mr Dhanji, in defining the offence as being constituted by an act and a result, what is the result for which you contend? Does it differ from the result referred to by the Court of Criminal Appeal at paragraph 521? That is, in terms of leaving the body part in question imperfect or irreparably damaged?

**MR DHANJI:** Your Honour, again, we take that same approach, and that is to say in terms of construing the provision, the Court of Criminal Appeal at 521 has provided a formulation. In terms of determining the appeal, 515 is obviously critical in terms of deciding what it is not. In our submission, it is sufficient for us to say, well, the Court of Criminal Appeal was correct, at 515, in defining or in making a statement as to what it is not. At 521 there is a positive statement which we would accept as capturing quality of mutilation. Whether in a given case something less might suffice is another question. But certainly it is not, as the Court of Criminal Appeal said at 515:

a superficial shedding of the skin cells –

**GAGELER J:** In the passage in the secondreading speech to which you drew our attention, at page 764 there is a reference to:

detrimental and unfortunate longterm physical effects.

**MR DHANJI:** Yes.

**GAGELER J:** Is that a sufficient formulation for your purpose?

**MR DHANJI:** An act which had the result of producing detrimental, longterm physical effects would, in our submission, amount to mutilation. We would accept that.

**GORDON J:** Is that the minimum for you?

**MR DHANJI:** There is a difficulty – ultimately, I think the question is that it is probably not for me, with respect. It is going to be for the jury. Presumably, a jury is going to want some guidance on this question.

**GORDON J:** The reason why I ask the question is, if you assume for the moment that, as I understand your submission, you accept in certain circumstances that a cut can be sufficient to satisfy the "otherwise mutilates"?

**MR DHANJI:** Yes.

**GORDON J:** And, as I understood the questions which were put to Mr Game, in a sense, have to be put to you as well, that the cutting does not come to light until some years later when someone complains, for example, so that you have got a question about the delay. If you pick up this detrimental, longterm physical effect and the body has healed, for example, or it is otherwise not visible by means of scarring or some other evidence that can be adduced, is the offence still made out or capable of being made out?

**MR DHANJI:** It would depend upon what the evidence was, but one could imagine a situation where a complainant might say, for example, "I was in quite severe pain across a period of two to three weeks," and you might have medical evidence that went in conjunction with that to say that there was significant pain across a period of two to three weeks that would require a level of cut that went beyond the skin and certainly interfered with the wellbeing of the complainant, and that may well be sufficient. One is going to have at the very least the account of the complainant and in a given case you might raise matters in relation to levels of pain, levels of discomfort, the sighting of blood. These are all matters which were ultimately not explored. At 544

**GORDON J:** Not explored?

**MR DHANJI:** In this trial. At 544 the Court of Criminal Appeal

**KIEFEL CJ:** I am sorry, which paragraph was that?

**MR DHANJI:** Paragraph 544, your Honour, at page 499.

**KIEFEL CJ:** Thank you.

**MR DHANJI:** It is just picking up submissions that were made about the limitations on the complainants' evidence. C1 had not excluded pinching. But the particular part, referencing the last sentence:

The appellants note that a number of areas of the complainants' evidence were not explored by the Crown; for example, what exactly was felt, the nature of the pain, the length the pain

lasted, whether they felt dabbing of blood or whether they felt pain urinating in the days that followed.

I am simply making the point that one can well imagine a case – and it might be well after the event – whereupon a person might give evidence of those various things that might be explored that either on its own or in conjunction with other relevant expert evidence would be sufficient to prove mutilation. So it is certainly not an insurmountable problem, and in the context of what typically happens in the prosecution of criminal offences it would barely be described as a problem at all. Indeed, it would be an entirely orthodox style of prosecution in that sense.

Really I have gone a little bit off track but ultimately what we put is that, looking at the various textual considerations, that is, the grouping of words, the position of the particular provision within the Act; that is, Division 6 of Part 3, "Acts causing danger to life or bodily harm", in that regard it is to be noted that it is in a different division to "assault occasioning actual bodily harm" which itself is in Division 8, "Assaults". So it is actually rated - or put in an area grouped with offences involving a higher degree of seriousness in relation to danger or bodily harm than assault occasioning actual bodily harm, the context provided by the various subsections that surround subsection (1) and ultimately the fact that one has a maximum penalty, then seven years, now 21 years.

Now, in terms of the secondary material, I think I have said what I wanted to say, somewhat out of turn, in relation to the various reports. We are, in a sense, in our submission – and I appreciate Mr Game has made this point – we would say we are very much in *Milne*-type territory. That is, even if one could find it to be open, or this alternative use, when one looks at the statutory text, it just cannot bear the meaning on which the Crown would place on it.

Clearly enough we have made reference to a number of authorities with respect to statutory construction. Your Honours will appreciate we have performed the exercise of obviously not just picking out the various statements of principle, but in our written submissions we have performed the exercise of attempting to elucidate in very brief form how they actually applied in the particular cases in which they were applied. What one sees through that exercise, in our submission, is no use of those types of constructional principles that would take one as far as we say the Crown needs to go, or the appellant needs to go, in relation to this case. Your Honours, in relation to ground 2, I adopt what has been said by Mr Game, and similarly in relation to the issue of retrial.

**BELL J:** Just in relation to that lastmentioned issue, if one accepts for present purposes that it would be open to the Court not to order a retrial, notwithstanding it was of the view that there were some evidence capable of sustaining a verdict on the first count, in circumstances in which there is no suggestion of a misstep by the Crown, what would be the basis for not leaving the discretionary considerations on which you rely to the Director?

**MR DHANJI:** Your Honour, can I first of all make this submission in relation to the premise of the question, and that is, we do not accept that there was no misstep by the Crown. The Crown led the evidence of Dr X over objection. Dr X was not able to give evidence of the

opinions which Dr X gave. Dr X's evidence was described by the prosecutor to the jury in closing address as - I think the word was critical or very important bridging evidence. So it was actually linking - it was actually trying to deal with, if I can put it this way, the difficulties raised with the evidence of the complainants – and Mr Game has taken you to that and I think I just – at 544 and the following passage.

**BELL J:** Yes.

**MR DHANJI:** You have got this problem with - C1 is the best and C1 cannot exclude, for example, pinching. You have got this problem that is at the centre of this case, and that is that really, with the exception of Mr Game's client, no one is actually able to say quite what the level of contact was.

So you have got a real paucity of evidence there. You have, we accept, various intercepted conversations, but they are all seen in the context of, as I say, no one other than perhaps Mr Game's client knowing - and perhaps not even her - knowing quite what the level of contact was.

**KIEFEL CJ:** What about the conversation between A1 and A2 about what was involved in the practice?

**MR DHANJI:** Well, there are two points to be made in relation to that. That was firstly whether they were speaking more generally, as opposed to what necessarily happened here, and there was no general practice case as opposed to a coincidence case between the two complainants.

Secondly, the point that I make in relation to that is, at best you are still only getting to A2's understanding in relation to obviously something which happened very quickly, in a location that was presumably not easily observed by a person other than the person performing the actual procedure. So even A2 could not be taken to have known precisely what it was that occurred.

It is not just the problems with the evidence and it is not just the problems created by the conduct of the prosecution. I appreciate that raised against us is what was said in *Taufahema*, but *Taufahema* of course was a very different case that involved a murder of a police officer. I will not take your Honours to it, but what happened in *Taufahema* was in fact the Court, in discussing these issues distinguished Anderson, a matter raised by your Honour Justice Bell, and set out at paragraph 55 a whole lot of factors, most of which did not apply in the case of *Taufahema*. But when one looks at them, most of them apply here.

So you have got the unusual factor that the respondents have received a verdict of acquittal, and there was an appeal to this Court against the acquittal. You have got the fact that we are talking about now events that occurred in 2012. They were investigated – well, the first event was

probably sometime before that, but at the latest, 2012. Investigation and charging - charging was in September of 2012, followed by a trial in 2015. If there was to be a further trial in the

matter, that trial was going to take place, one would have thought, at best in 2020, so five years after the original trial, and eight years after the investigation and charging, all in circumstances where A2 and Mr Game's client has served their sentences.

Mr Vaziri served three months of his 11month nonparole period, but then spent a period longer than the nonparole period on a form of bail equivalent to home detention, and that is why we have put the bail decision and the conditions that applied in the additional appeal book. Again, this is all in circumstances where you have complainants born in 2003 and 2005, engaged in a JIRT interview on 29 August 2012, when the younger one was just short of seven and the older one was just short of nine. They are 10 and 12 by the time of trial. By 2020, they would be either 14 and 16 or possibly 15 and 17.

So, you are talking about having these events continue in these young girls' lives – that is the prosecution and giving of evidence against their mother – going on, in the case of C1, from the age of eight to the age of 16 and, in the case of C2, from the age of six to the age of 14. So, to answer your Honour's question, in a sense it is difficult to imagine a case that would be, in a sense, more compelling with respect to discretionary considerations that would militate against the ordering of a retrial. That is what I would say in relation to that. Those are my submissions, your Honour.

**KIEFEL CJ:** Thank you. Reply, Mr Kell?

**MR KELL:** Yes, thank you, your Honour. There are just four points that I wanted to touch on. The first was in response to the question, just before lunch, about the World Health Organisation. What the material – and I will just deal with the starting point – so, in the second reading speech, there is reference at page 762 of the appeal book, at about line 38. It is not particularly precise, what was stated in the second reading speech, but it says that:

The practice has been condemned at an international level. The World Health Organisation has recommended that governments adopt clear national policies to abolish the practice.

What we have been able to find

**KIEFEL CJ:** That is obviously a reference to what is in the Family Law Council report, is it?

**MR KELL:** It is a reference to the World Health Organisation at that stage. The Family Law Council report was an article in 1992.

**KIEFEL CJ:** That is right.

**MR KELL:** Yes, but if one looks at page 852 of the same book – joint book of authorities – which is within the Queensland Law Reform Commission report of September 1994 there are three references to note. At page 852, there is reference and then a quote from – sorry. First, there is a reference to the World Health Organisation having released a position paper

on female genital mutilation and then there is a quote from it which refers to the:

Khartoum Seminar of 1979 –

Then, that:

WHO support the recommendations . . . These were that governments should adopt clear national policies to abolish female circumcision –

and the like. We have

**KIEFEL CJ:** We cannot be sure that this is the World Health Organisation recommendation that is referred to in the second reading speech.

**MR KELL:** We cannot be certain because

**KIEFEL CJ:** The other thing is that quite a bit moved on.

**MR KELL:** Yes. As recorded by the Queensland Law Reform Commission report, the next matter to note is on page 853. There is a similar recommendation by the World Health Assembly which is part of the World Health Organisation, I understand. I will come to the date of it in a minute. But, paragraph 2 of that is in similar terms. So, the World Health Assembly urged all Member States, relevantly, to abolish female genital mutilation. The date that is given there is 10 May 1994 – sorry, is May 1994. From our research over the lunch break, we seem to date that for 10 May 1994 which would come a few days after the second reading speech. But, again, we are left with – the second reading speech itself does not give precision as to

**KIEFEL CJ:** Perhaps you could undertake some further research as to whether there was a World Health Organisation recommendation in existence at May 1994 or prior and if you wish to make any comment upon it add that to a note within seven days.

**MR KELL:** Yes.

**KIEFEL CJ:** If the respondents would then wish to comment upon any comment that you make, to respond to it, and they respond within another seven days.

**GORDON J:** Can I just suggest that in chapter 4 of the Family Law Council report there is a whole wealth of material about women's rights, including World Health Organisation reports done in combination with UNICEF and the like which may very well be the papers referred to.

**BELL J:** Indeed, on the page that you have taken us to in the book of authorities at 853, footnote 178 refers to the World Health Organisation publication of January 1994, in which it

would seem such a recommendation was made.

**MR KELL:** Yes, although partly that is quoted in the passage at the last paragraph at the bottom of 853 and continuing over, which does not seem to have the terms there.

**KIEFEL CJ:** Perhaps if you could further refer to it. I think the Court would be assisted by a note from you, making comment upon the recommendation.

**MR KELL:** Yes.

**KIEFEL CJ:** The respondents, of course, are entitled to respond in the time that I have indicated.

**MR KELL:** Certainly. We will attach to it, as long as it is not too lengthy, copies of the WHO publications that we have found that relate to that. The second point is – I had just wanted to confirm this over lunchtime and I do so – to make clear that a retrial is not sought on the alternative counts. It was just something I wanted to confirm.

The third point is that both respondents made reference, although not in their written submissions, to the position of the offence in Part 3, Division 6 of the *Crimes Act*. That was referred to in Mr Game's summary that was handed up today, I think at paragraphs 11 and 12. We would just say briefly that Part 3, Division 6 of the *Crimes Act* is entitled:

Acts causing danger to life or bodily harm

Its position in that division and part does not suggest that section 45 must contemplate a higher or a high level of injury and a number of offences in that division contemplate injury or an intent to injure at a level of actual bodily harm or less. I will just give your Honours the references, so sections 35A(2), 41, 41A, 51A(1) and 53. They are a miscellaneous group of offences, but they do not – so there is nothing relevantly that assists from considering the context.

The fourth point is, going back to the question of retrial and the various matters that were raised against us, we point first to the fact that in the CCA judgment, there was no finding made about – and this was accepted, I think, by Mr Game – that there was no finding made about the evidence that would be – what the evidence could establish on the alternative counts. There are some negative comments, but there is no finding and then there are two paragraphs where discretionary considerations are referred to.

That was at appeal book 524 to 525, from paragraph 635 and onwards. We say two things. The discretionary considerations here are more powerful and favour the position of the Crown, given that what we submit are more serious offences, and there is a heightened public and community interest in the prosecution of these particular offences, contrasting to the alternative counts.

The further final point is that there is substantial evidence that supports the charges, we say, and we have referred to it in our written submissions. My friend touched on a couple of points, but when one looks at the material, there is evidence in connection with the cutting of

C1 who says, “It happened to me,” that is, that she was subject to a type of cutting to her private parts.

She recalls being told – at appeal book 358, the judgment, 24 to 25, she recalls being told to close her eyes and to imagine that she was a princess in a garden. So she does not at the time have her eyes on whether there are drops of blood and the like from a procedure that is being done.

She gives evidence at appeal book 359 that it did hurt a little bit and when asked where she says, “In the private part”. She also says at 360 that, “it’s part of our culture” and “has to happen to every girl”. Then at 360 they give a little cut and she is asked where. She says, “In your private part”.

Then, in her evidence at trial, she refers to having seen a silverlooking thing, not that it was forceps but that it looked like scissors, which was consistent with cutting. And at appeal book 395, says:

most likely it was cut

And the evidence of C2 is similar – sorry, is not as strong. But in combination with both of those pieces of evidence, which the Court has touched on briefly, that there is, at least insofar as A2 there are, in a separate conversation where A2 and A1 refer to the cutting, and A2 tells her husband, in response to a question as to whether they cut the whole clitoris, she says, they do, i.e. cutting the skin a little bit, just a little, and that a little bit of skin is to be removed, which applies to both C1 and C2.

We say that there is material that would justify a retrial and that your Honours should, with respect, make an order for retrial having regard to the material. Thank you, your Honours.

**KIEFEL CJ:** Thank you. The Court reserves its decision in this matter and adjourns to 9.45 am tomorrow.

**AT 3.59 PM THE MATTER WAS ADJOURNED**

IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY

No. S43 of 2019
No. S44 of 2019
No. S45 of 2019

BETWEEN:



**The Queen**
Appellant

and

**A2**
**Kubra Magennis**
**Shabbir Mohammedbhai Vaziri**
Respondents

APPELLANT'S OUTLINE OF ORAL ARGUMENT

**Part I:**

1. The appellant certifies that this outline is in a form suitable for publication on the internet.

**Part II:**

*What meaning does "mutilates" convey in the context of female genital mutilation?*

2. This is the relevant question for the purposes of construing s 45 of the *Crimes Act 1900* (NSW): see AB 481 [480]; 493 [519]; AS [42]; RS Magennis [16].

3. In the context of female genital mutilation, "to mutilate" connotes the infliction of injury to female genitalia, intentionally and for non-medical reasons: AS [43]-[45]. Thus, mutilation in the context of female genital mutilation includes the cutting or nicking of female genitalia. See, for example:

   i. Family Law Council, *Report on Female Genital Mutilation*, June 1994 ("Report") at [2.01]-[2.02], [2.41] (JBA 646, 654).

   ii. Family Law Council, *Female Genital Mutilation: Discussion Paper*, 31 January 1994 ("Discussion Paper") at [2.01], [2.30] (JBA 591, 598).

iii. Queensland Law Reform Commission, *Female Genital Mutilation*, Report No 47, September 1994 at 7 (JBA 806).

*What was the intended meaning of "otherwise mutilates" in s 45 of the Crimes Act?*

4. Female genital mutilation is so centrally relevant, as a matter of context, to s 45 of the *Crimes Act* that the intended meaning of "otherwise mutilates" must be the meaning that those words convey in the context of female genital mutilation.

5. Section 45 of the *Crimes Act* was enacted to prohibit the practice of female genital mutilation. This is clear from:

   i. The language of s 45 and the references to specific practices of female genital mutilation ("excises" and "infibulates") (see AB 493 [519]; JBA 13);

   ii. The heading to s 45 (JBA 13);

   iii. The long title to the *Crimes (Female Genital Mutilation) Amendment Act 1994* (NSW) ("1994 Act") (JBA 26); and

   iv. The Explanatory Note to the 1994 Act (JBA 721).

6. The practices proscribed by s 45 were intended to extend to all forms of female genital mutilation, including injury by cutting or nicking:

   i. The Discussion Paper and Report of the Family Law Council recommended that all forms of female genital mutilation, including ritualised circumcision, be prohibited by legislation. The need for clarity and putting the illegality of the practice "beyond doubt" was emphasised: see Discussion Paper at [5.17], [5.22], [527] (JBA 612-614); Report at [6.41], [6.80] (JBA 692, 703).

   ii. The Second Reading Speech for the 1994 Act evinces an intention to enact a clear prohibition on female genital mutilation: see JBA 762 (line 29). 763 (line 5), 764 (line 24). It refers to a number of recommendations for clear law reform "to abolish the practice" and to "make clear that FGM constitutes a criminal act": JBA 762 (lines 38, 45).

7. The proposition that the legislature intended to enact only a partial prohibition on recognised practices of female genital mutilation is not supported by the extrinsic material. That "infibulation, clitoridectomy and sunna" are referred to in the Second Reading Speech as the "three forms of FGM" does not meaningfully assist the task

of construing the words "otherwise mutilates" in s 45: see JBA 763 (line 20); AS [50]-[51]; RS Magennis [22].

8. Given the contextual and purposive matters outlined, it was erroneous for the Court of Criminal Appeal to prefer, for the purposes of s 45 of the *Crimes Act*, the literal meaning of "mutilates" (that is, its common or most usual meaning in ordinary parlance) to the meaning of "mutilates" in the context of female genital mutilation: AB 486 [495], 491 [514], 493 [521]; see also *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362 at [14], [38] (JBA 459, 466); *SAS Trustee Corporation v Miles* (2018) 92 ALJR 1064 at [20], [64] (JBA 418, 425).

9. If "mutilates" in s 45 is construed to mean the infliction of injury *simpliciter*, there was no error in the directions given to the jury by the trial judge: see AB 99. Those directions conveyed that it was necessary for the Crown to prove only injury by cutting or nicking: AS [59]; Reply [2]-[3].

*Meaning of "clitoris" in s 45 of the Crimes Act*

10. The word "clitoris" in s 45 is a global term referring to the clitoral anatomy, which includes the clitoral ridge; clitoral hood; clitoral shaft; clitoral glans; and prepuce (or clitoral hood): see AB 404 [209], 412 [240].

*Orders if appeals succeed*

11. If the appeals succeed, orders for a new trial of the respondents are appropriate in the circumstances. There is evidence to support the charges: see AS [9]-[32]. There is also a significant public interest in the due prosecution of the offences under consideration: *R v Taufahema* (2007) 228 CLR 232 at [49], [51] (JBA 545-546). Noting that orders for a new trial are permissive, the interests of justice do not require the entry of verdicts of acquittal in these cases: *Dyers v The Queen* (2002) 210 CLR 285 at [23] (JBA 149).

Dated: 12 June 2019

**David Kell SC**
Crown Advocate of New South Wales
Solicitor General & Crown Advocate

**Eleanor Jones**
Counsel Assisting the New South Wales
Solicitor General & Crown Advocate

IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY

No.43 of 2019
No.45 of 2019

BETWEEN:


The Queen
Appellant

and

A2
Shabbir Mohammedbhai Vaziri
Respondents

**RESPONDENTS' OUTLINE OF ORAL ARGUMENT**

**Part I:** This outline is in a form suitable for publication on the internet.

**Part II: Outline of propositions in oral argument**

1. An offence against s45(1)(a) is committed by doing something which "excises, infibulates or otherwise mutilates" the relevant part of another person (Joint Book of Authorities '**JBA**' 21). That is, the offence is constituted by an act and a result. Consistently with this s45(2) refers to "the person mutilated". See also s45(5). Section 45(1)(b) in referring to *acts* in s45(1)(a) is inconsistent with a reading of "excises, infibulates or otherwise mutilates" as a unitary concept (of female genital mutilation).
2. Conformably with the above, the respondent, A2 was charged that she "mutilated the clitoris of" C1 and C2 (Core Appeal Book ('**AB'**) 2).
3. The text does not support a construction prohibiting an act of engaging in "female genital mutilation". To read s45(1) as prohibiting engagement in a religious or cultural practice of "female genital mutilation" renders s45(3) otiose. (The difficulty of defining "female genital mutilation", a term not used by the legislature, is a separate issue.)
4. The word "mutilates" is found in an expression "excises, infibulates or otherwise mutilates" and suggests a serious level of injury. Section 45 itself is found in Division 6, "Acts causing danger to life or bodily harm" of Part 3, "Offences against the person".
5. Textual indicators strongly support a construction inconsistent with that of the appellant. To read s45(1) as referring to "injury to any extent" would criminalise acts consented to by an adult woman which result in a graze or bruising to the genitalia (where unintended but the possibility of injury to any extent was foreseen (Magennis Submissions ('**MS**') [20]), or potentially foreseen, such as by genital piercing or waxing.
6. While the starting point is the text of the statute "at the same time regard is [to] be had to its context and purpose" - *SZTAL v Minister for Immigration and Border Protection*

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(2017) 262 CLR 362 at [14] (JBA 459, RS [19]), A2 and Vaziri Submissions ('**RS**') [19]). As the CCA correctly observed, "[t]he question is what is meant by "mutilates in a statutory provision that does not use the term "female genital mutilation" as part of the description of the offence (CCA [494]; AB485). The long title to the amending Act and the heading to the offence provision set the "context as being that of female genital mutilation" but this "begs the question of what is meant by "mutilation in that context" (CCA [480] AB 481). The second reading speech describes "FGM" as "a number of practices involving the mutilation of female genitals for traditional or ritual reasons" (JBA 762.29). The minister, having observed that it will "be an offence for anyone to perform FGM in this State, said "[t]he three forms of FGM in order of severity are infibulation, clitoridectomy and sunna" (JBA 763.20). See also JBA 764.20. Sunna, in this context, is the removal of the clitoral prepuce. The Family Law Council did not suggest there was any doubt as to this (cf Appellant's Submissions ('**AS**') [51], JBA 646).

7. The appellant submits "the procedures named in the second reading speech shed no real light on what other forms of the practice of female genital mutilation the verb "mutilates" was intended to capture" (AWS [51]). This leads to the conclusion (supported by the text) that the legislature chose to define what is prohibited by reference to the result (rather than prohibiting a practice by reference to an expression of uncertain reach, "female genital mutilation"). At the least it demonstrates the extrinsic materials point in different directions.

8. The second reading speech, while noting the Family Law Council's recommendations, did not suggest that the form of the provision was based on that report or indicate an intention adopt the report's recommendations (see at JBA 762.45; cf AS [49],[52]; cf Johnson J at [199], AB 69, [207], AB 73). Nor does the Explanatory Note evince such an intention (JBA 721). The reference there to "incision" in the context of "[p]rocedures involving the incision, and usually removal" of part or all of the external genitalia" suggests more than transient interference. In any event "incision" was not used in the provision itself. While that paragraph makes reference to practices, the following paragraph confirms (consistently with the terms of the provision) the object of the Bill was to criminalise acts with a particular result. Neither the second reading speech nor the Explanatory Note suggest parliament was intent on (or even considered) proscribing conduct resulting in transient effects. Rather they suggest a concern with injury of a qualitatively different kind to that here. (See JBA at 764.21, JBA 721.33)

9. The Family Law Council report, in contrast to the second reading speech, speaks of four kinds of practice but acknowledges there may be others (JBA 646-648). However, even when referring to "ritualised circumcision" the distinction is drawn between a procedure which is "wholly ritualised" and one which involves scraping or nicking to clitoris which causes bleeding (JBA 646). Here no injury to the clitoris was established. There was no evidence bleeding or any lasting pain: CCA [30], [31], [42], [169], **[621]**, **[625]**, AB 359, 362-3, 394-5, **520-2**; as referred to at MS [56].

10. Nor can the respondents' construction be said to "not promote the purpose or object of the legislation" (s33 of the *Interpretation Act 1987*, JBA 36; cf AS [50]). This is particularly so having regard to the fact that the act alleged here was "on any view" an assault (CCA [524], AB 494). In any event, as was said in *Milne v The Queen* (2014) 252 CLR 149 at [38], a "[p]urposive construction does not justify expanding the scope of a criminal offence beyond its textual limits" (Magennis WS [29]).

11. The construction exercise "begins, as it ends, with the statutory text", acknowledging the text "from beginning to end is construed in context": *SZTAL v Minister for Immigration* (2017) 262 CLR 662 at [37], JBA 465. Even if it could be said a potential range of meanings are available, the clearer the natural meaning the more difficult it is to depart from it: *SAS Trustee Corporation v Miles* (2018) 92 ALJR 1064 at [64]; JBA 425. "Construction is not speculation and it is not repair": *Taylor v Owners of Strata Plan 11564* (2014) 253 CLR 531 at [65] JBA 519. Having regard to the text, to adopt a meaning of "mutilates" based on selected secondary materials undermines the requirement of legal certainty, and ultimately the rule of law (MS [41]).

12. It is not sufficient for the appellant to succeed on Ground 2.1. The trial judge's directions were in error based on the CCA's conclusion at [515], [522] (AB 492, 494).

13. Further, the appellant undertook to prove mutilation to the clitorises of the complainants. The CCA was correct in its interpretation. The new evidence established that there was no injury to the clitoris (cf Appellant's Reply at [11]). The evidence was that in order to see the clitoral head the clitoral hood has to be retracted, which "would be painful" (CCA [339], AB 442).

14. Finally, even if the appellant were to make out either ground of appeal, a retrial would not be ordered (RS, [26] – [30] and MS [52] – [65])

Dated: 12 June 2019

.....
Hament Dhanji

.....
David Randle

IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY No. S45 of 2019

BETWEEN: The Queen

Appellant

and


Magennis

Respondent

RESPONDENT'S OUTLINE OF ORAL ARGUMENT

**Part I:**

1. This outline is in a form suitable for publication on the internet.

**Part II: Construction of "otherwise mutilates" in s45(1)(a) of the *Crimes Act***

2. Statutory construction requires a Court to construe the text of a provision in light of its context and purpose having appropriate regard to extrinsic materials (*SZTAL v Minister for Immigration* (2018) 252 CLR 362 at [14] Joint Book of Authorities ("**JBA**") **459**; *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue* (2009) 239 CLR 27 at [47] **JBA 60-1**).

How the case was left and ground 1 of the appeal

3. The jury were directed that "mutilates" means "to injure to any extent" and this could include a nick or cut (Core Appeal Book ("**CAB**") **99**, Respondent's Further Materials ("**RFM**") **9**). Ground 1 of the appeal in the Court of Criminal Appeal ("CCA") alleged this direction was erroneous and the CCA held that it was (CCA [528] **CAB 495**).

Text and immediate context of s45(1)(a) of the *Crimes Act*

4. The offence proscribes conduct with an identifiable result (**JBA 13**, Respondent's Submissions ("RS") [20], [24]; cf. Appellant's Submissions ("AS") [42], [44], Appellant's Reply ("AR") [9]). It does not describe a practice.
5. Specific defining and limiting terms are used (RS [28]). Specific conduct is prohibited. Specific parts of the female genitalia are described.
6. "Excises, infibulates or otherwise mutilates" all connote serious or significant injury (RS [28]; cf. AR [8]). The term "otherwise mutilates" extends the offence to other forms of mutilation (RS [22]; cf. AR [5], [8]).

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7. The exception in s45(3) for identified surgical procedures would not be necessary if the provision proscribed "female genital mutilation" ("FGM") because FGM is a cultural practice for non medical purposes (RS [20]).
8. The offence applies regardless of age (s45(1)(a)) and consent (s45(5) RS [20]).
9. Subsections (2) and (5) refer to a "person mutilated by or because of the acts".
10. On the appellant's construction the offence would extend to very minor events, including consensual ones, done to adult women (such as bruising or piercing). This is clearly not part of the discourse of "FGM".

Context

11. Section 45 appears in Division 6 "Acts causing danger to life or bodily harm", Part 3 "Offences against the person" of the *Crimes Act* (s35(1) *Interpretation Act 1987* (NSW) **JBA 39**).
12. The heading of the provision and the long title of the amending Act are not part of the Act; however they can be considered as extrinsic aids (ss34(2)(a), 35(2) *Interpretation Act* **JBA 37-9**; CCA [480] **CAB 481**; Judgment [142]-[145] **CAB 50**; RS [16]-[17]).

Purpose and other aids to interpretation

13. The provision is to be construed "in accordance with its terms rather than according to preconceptions about underlying policy" (*SAS Trustee Corporation v Miles* (2018) 92 ALJR 1064 at [32] **JBA 421**). To construe "otherwise mutilates" as "to injure to any extent" extends the offence beyond its textual limits (*Milne v The Queen* (2014) 252 CLR 149 at [38], *Grajewski v DPP (NSW)* (2019) 93 ALJR 405 at [21], RS [29]-[33]; CCA [513] **CAB 491**).
14. No constructional choice arises under s33 *Interpretation Act* (RS [42]-[47]; *Chugg v Pacific Dunlop Ltd* (1990) 170 CLR 249 at 262; cf. s15AA *Acts Interpretation Act 1901* (Cth)). The trial judge's approach was erroneous (Judgment [249] **CAB 84**).
15. Extrinsic materials provide little support for the appellant's construction and the trial judge's approach (RS [15], [27]). The CCA correctly rejected or placed very little weight on most of the extrinsic material relied on by the trial judge: including, dictionary definitions of "FGM" (CCA [494] **CAB 485**); the FGM community education program material (CCA [501] **CAB 487**); the Attorney General's Department 2013 review of Australia's FGM legal framework (CCA [502] **CAB 487-8**); the subsequent amending legislation (CCA [503]-[509] **CAB 488-490**).
16. The Explanatory Note suggests serious or significant injury is required (**JBA 721** RS [17], [24]).

17. The principal concern of the legislature was to prohibit excision (clitoridectomy and sunna) and infibulation (Second Reading Speech **JBA 762-763**; Family Law Council Report **JBA 646-7**; RS [18]-[19], [21]-[23], [26]; cf. AS [46]-[53], AR [4]-[5]). It was not implementing the Family Law Council Report recommendations. The provision enacted was derived from the UK provision introduced in 1985 (**JBA 710**).

18. The CCA placed some (appropriately qualified) weight on the dictionary definitions of "mutilates" (CCA [484]-[489], [521] **CAB 482-4, 493**; Judgment [152]-[155] **CAB 51-2**). More than mere injury was required (CCA [495]-[496], [513]-[515], [521]-[522] **CAB 486, 491-4**).

10 19. The trial judge erroneously supplanted the term "FGM" into the provision and construed that term (Judgment [243] **CAB 82**, see also [151]-[161] **CAB 52-3**; CCA [513]-[514] **CAB 491**; RS [34]-[41]).

20. The trial judge's construction involved the Court assuming jurisdiction beyond the reach of legislation (RS [34]-[39]; CCA [523]-[524] **CAB 494**).

**Clitoris**

21. It was erroneous for the trial judge to direct the jury that the clitoris included the prepuce (SU 9 **CAB 100**; CCA [527] **CAB 495**; RS [51]; cf. AS [60]-[65]). Medical dictionaries differentiate between the anatomical structures (CCA [526] **CAB 495**). As Dr Marks made clear, they are made up of different tissue (CCA [209] **CAB 404**). The distinction
20 had real significance given the alternative counts (CCA [614] **CAB 518**).

**Orders sought by the appellant**

22. To obtain a re-trial the appellant must first show that the trial judge's directions on the subject of ground 1 were correct (RS [10]). In upholding ground 1 the CCA explicitly rejected that the offence applied to minor injuries (CCA [495], [515] **CAB 486, 492**).

23. Secondly, the appellant would need to establish that the CCA's reasons for not ordering a re-trial on the alternative counts under s59 of the *Crimes Act* were erroneous. The CCA addressed that issue by reference to a nick/cut to any part of the female genitalia (including the clitoris) and on the assumption that a nick or cut could amount to actual bodily harm (CCA [613]-[634], [638] **CAB 518-25**; **RFM 43**; RS [53]-[60]).

30 24. There are significant discretionary considerations under s8 of the *Criminal Appeal Act* (see CCA [636]-[637] **CAB 524-5**; RS [61]-[65]; s37 *Judiciary Act*).

Dated: 12 June 2019

Tim Game

Georgia Huxley

IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY

No. S43 of 2019
No. S44 of 2019
No. S45 of 2019

BETWEEN:

**The Queen**
Appellant

and

**A2**
**Kubra Magennis**
**Shabbir Mohammedbhai Vaziri**
Respondents



# APPELLANT'S NOTE ON WORLD HEALTH ORGANISATION'S RECOMMENDATIONS

## Part I:

1. The appellant certifies that this note is in a form suitable for publication on the internet.

## Part II:

2. On 4 May 1994, the Minister reading the Crimes (Female Genital Mutilation) Amendment Bill 1994 (NSW) ("the Bill") for a second time in the New South Wales Legislative Council said:[1]

> "The practice has been condemned at an international level. The World Health Organisation has recommended that governments adopt clear national policies to abolish the practice."

3. At the hearing of these appeals on 12 June 2019, the appellant was granted leave to file a note outlining the relevant recommendations of the World Health Organisation in existence at the time of the Second Reading Speech for the Bill in 1994.

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[1] Legislative Council, *Hansard*, 4 May 1994 at 1859 (Joint Book of Authorities (**JBA**) 762).

*Actions of World Health Organisation in relation to female genital mutilation*

4. In 1979, a seminar on "Traditional Practices Affecting the Health of Women and Children" was held in Khartoum in association with the World Health Organization Regional Office for the Eastern Mediterranean. The topic of "female circumcision" was discussed.[2] Two papers that were presented described types of female circumcision.[3] The first, regarding the practice of female circumcision in Egypt, is recorded as saying:

> "from field work done recently, three types of circumcision could be delineated:
>
> 1. Sunna type in which the clitoris is snipped.
> 2. Second type in which the labia minora and part of clitoris are removed.
> 3. Total removal of clitoris and labia."

5. The second paper, delivered by a "WHO Temporary Adviser" from the Ministry of Health in Somalia "cited the different forms of circumcision as":

> "1. Mild Sunna
> 2. Modified Sunna
> 3. Partial or total clitoridectomy
> 4. Infibulation (Pharaonic female circumcision)."

6. The seminar resulted in the following recommendations:[4]

> "(i) Adoption of clear national policies for the abolition of female circumcision.
>
> (ii) Establishment of national commissions to coordinate and follow up the activities of the bodies involved including, where appropriate, the enactment of legislation prohibiting female circumcision.
>
> (iii) Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of female circumcision.
>
> (iv) Intensification of education programmes for traditional birth attendants, midwives, healers and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision

[2] The terminology of "female genital mutilation" (as opposed to "female circumcision") became prevalent in the 1980s. The Inter African Committee on Traditional Practices Affecting the Health of Women and Children proposed the change in terminology in 1990: see World Health Organisation, *Female genital mutilation: An overview*, 1998 at 2-3, 60-61. Relevant portions of the document are available at: https://apps.who.int/iris/handle/10665/42042

[3] World Health Organization, Regional Office for the Eastern Mediterranean, "Seminar on Traditional Practices Affecting the Health of Women and Children", Khartoum, 10-15 February 1979 at 10, 14. Document available from World Health Organisation at: https://apps.who.int/iris/handle/10665/254379

[4] Ibid at 24-25.

with a view to enlisting their support along with general efforts to abolish this practice."

7. It appears that these recommendations were endorsed by the World Health Organisation in public statements during the 1980s. A publication of the World Health Organisation in 1998 ('*Female genital mutilation: An overview*'), records, in its discussion of "WHO policies and activities", that:[5]

> "In August 1982, WHO made a formal statement of its position to the United Nations Commission on Human Rights, endorsing the recommendations of the Khartoum seminar. WHO's main points were:
>
> - that governments should adopt clear national policies to abolish the practice of female genital mutilation, and to inform and educate the public about its harmfulness; ..."

The Queensland Law Reform Commission extracted, in its report, part of a similar "position statement" from 1984.[6] The appellant has been unable to locate copies of the 1982 or 1984 statement referred to.

8. In January 1994, the Director-General of the World Health Organisation provided to the Executive Board of the World Health Organisation a report entitled "Maternal and child health and family planning: Current needs and future orientation".[7] The World Health Assembly in 1993 had requested that the Director-General submit such a report to the Executive Board.[8] In the report, the Director-General invited the Executive Board to consider a draft resolution calling for, *inter alia*, the establishment of "national policies and programmes that will effectively abolish female genital mutilation".

9. On 25 January 1994, the Executive Board of the World Health Organisation resolved (EB93.R10), in terms substantially consistent with those suggested by the Director-General:[9]

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[5] World Health Organisation, *Female genital mutilation: An overview*, 1998 at 59-60.
[6] Queensland Law Reform Commission, *Female Genital Mutilation*, Report No. 47 (September 1994) at 53-54 (JBA 852-853).
[7] Document available at: https://apps.who.int/iris/handle/10665/171782
[8] Forty-Sixth World Health Assembly, Resolution WHA46/18 (12 May 1993). The material from the Family Law Council set out the 1993 recommendation that the Director-General report on these issues, but seems not to refer to the material from 1994 in connection with that report, as submitted, and the response of the Executive Board: see Discussion Paper at [4.09]-[4.10] (JBA 608); Report at [4.09]-[4.10] (JBA 669-670).
[9] Resolution available at: https://apps.who.int/iris/handle/10665/172016

"The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

...

3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

...

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 251 of 1992 on traditional practices affecting the health of women and children;

Recognizing that although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early marriage and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

...

2. URGES 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, marriage and childbearing before biological and social maturity, and other harmful practices affecting the health of women and children; ..."

10. The Forty-Seventh World Health Assembly, in turn, adopted the resolution recommended by the Executive Board on 10 May 1994 (WHA47.10).[10]

11. In the appellant's submission, the matters set out above reflect the World Health Organisation's position on female genital mutilation, to which reference was made in the Second Reading Speech. That position emerged following the recommendation in 1979 that "clear national policies" be adopted "for the abolition of female circumcision". The expression of the World Health Organisation's position that was most temporally proximate to the Second Reading Speech was the resolution of the Executive Board of the World Health Organisation in January 1994 that member

[10] Resolution available at: https://apps.who.int/iris/handle/10665/177378

states be urged "to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation".

Dated: 19 June 2019

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**Eleanor Jones**
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Solicitor General & Crown Advocate

IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY

No. S43 of 2019

No. S44 of 2019

No. S45 of 2019

BETWEEN:

The Queen

Appellant

and

A2

Kubra Magennis

Shabbir Mohammedbhai Vaziri

Respondents



**RESPONDENTS' JOINT NOTE ON WORLD HEALTH ORGANISATION RECOMMENDATIONS**

**Part I:**

1. This Note is in a form suitable for publication on the internet.

**Part II:**

2. This Note addresses the World Health Organisation's ("WHO") recommendations in existence at the time the Crimes (Female Genital Mutilation) Amendment Bill 1994 (NSW) ("the Bill") was introduced as referred to in the second reading speech. In particular, this Note addresses the definitions of female circumcision/female genital mutilation used by the WHO at certain points in time including leading up to the introduction of the Bill. An appreciation of the definitions of the term used by the WHO is necessary to understand the recommendations made by it. The material referred to in this Note is annexed to it.

3. In the second reading speech, the Minister referred to the WHO's recommendation that governments adopt clear national policies to abolish the practice (Joint Book of

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Authorities ("JBA") 762). It appears such a recommendation was made by the WHO first in 1979 and, in substantially the same terms, again in 1982, 1984 and 1994 (see Appellant's Note ("AN") at [4]-[9]).

4. In 1979 the WHO held a seminar in Khartoum on Traditional Practices Affecting the Health of Women and Children (WHO Seminar on Traditional Practices Affecting the Health of Women and Children, Khartoum 1979, Annexure A). One paper presented at that seminar described the three types of circumcision as: (1) sunna type where the clitoris is snipped; (2) second type in which the labia minora and part of the clitoris are removed; (3) total removal of clitoris and labia (Annexure A p.10). Another paper presented described four types of circumcision: (1) mild sunna; (2) modified sunna; (3) total or partial clitoridectomy; (4) infibulation (pharaonic female circumcision) (Annexure A p.14). The respondents have been unable to locate the papers presented and cannot identify any further description of these types of circumcision.

5. The recommendations from the 1979 Khartoum Seminar in relation to female circumcision included intensification of education efforts (to both the public and traditional midwives/healers/birth attendants) to demonstrate the dangers and harmful effects of female circumcision (Annexure A p.25).

6. In 1992 the WHO published an article "Female Circumcision" in the *European Journal of Obstetrics & Gynecology and Reproductive Biology* 45 (1992) 153-154 (Annexure B). The same article was published in the *International Journal of Obstetrics and Gynecology* in 1992 (Annexure B, footnote 2). The Family Law Council Discussion Paper and subsequent Report refer to this article (see JBA 593, 601, 649, 662). In the article, the WHO stated:

> "Female circumcision in any of its three forms, is a painful fact of life…
>
> In its mildest form, female circumcision involves only the removal of the foreskin of the clitoris. But in the majority of cases the clitoris itself is removed, together with all or part of the labia minora and in the most severe form the labia majora." (Annexure B p.153).

7. The article then discussed the "lifelong physical and psychological debilities resulting from female genital mutilations" (Annexure B p.153).

8. In his January 1994 Report "Maternal and child health and family planning: Current needs and future orientation" the Director General of the WHO invited the Executive Board of the WHO to consider a draft resolution calling for the establishment of "national policies and programmes that will effectively abolish female genital mutilation" (Annexure C). The resolution was ultimately adopted by the Executive Board on 25 January 1994 (Annexure D) and adopted by the World Health Assembly on 10 May 1994 (6 days after the second reading speech) (Annexure E). In his report, the Director General said (emphasis added):

> "Female genital mutilation is a collective name given to a series of traditional surgical operations performed on female genitals in several countries in the world.... Its physical and psychological effects on girls and women, particularly on normal sexual function, affect their reproductive health in a way which lasts all their lives, since none of the procedures are reversible. In all types of female circumcision part or the whole of the clitoris is removed. More severe forms, such as excision and infibulation, remove larger parts of the genitals and close off the vagina, leaving areas of tough scar tissue, permanent damage and dysfunction." (Annexure B at [21]).

9. The available WHO material in existence at the time the Bill was introduced indicates that the WHO considered that female circumcision/female genital mutilation involved the removal of tissue and was concerned with the irreversibility of such procedures.

10. The resolution of the Executive Board of the WHO in January 1994 appears to be the most proximate in time to the introduction of the Bill (AN at [11]). The resolution refers to the harmful practices that "cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children" and the abolition of "other harmful practices affecting the health of women and children" (see extract at AN [9]; see also the Khartoum 1979 recommendations above at [5]). This suggests that the WHO was concerned with procedures with enduring adverse effects.

11. It was not until 1997 that the WHO adopted a specific definition of female genital mutilation along with four classifications of the types of female genital mutilation including the broader Type IV category. This followed after recommendations made

in 1995 by the WHO Technical Working Group on Female Genital Mutilation (WHO, *Female Genital Mutilation: An Overview* (1998) Annexure F p.6, 62). The WHO adoption of this definition of female genital mutilation and the four classifications post-dated the second reading speech and introduction of s45 of the *Crimes Act*. This suggests that as at 1994 there was no generally accepted meaning of the term female genital mutilation that included the broader Type IV category.

12. The change in terminology from "female circumcision" to "female genital mutilation" was proposed in 1990 by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (Annexure F p.60). This appears to have been adopted by the WHO in 1992 and the World Health Assembly in 1993 (Annexure E p.61). In the WHO Report of 1998 it was observed that "It is because of the severity and irreversibility of the damage inflicted on the girl's body that the procedure has been termed "female genital mutilation"" (p.3).

13. The four categories of female genital mutilation referred to in the Family Law Council Discussion Paper and Report do not appear to have come from the WHO material. It is noted that where the four categories are discussed, there is reference to an article in New Scientist authored by Sue Armstrong, a freelance journalist in South Africa, (Annexure G). Ms Armstrong makes limited reference to the WHO's involvement in abolishing female genital mutilation. She makes no reference to ritualised circumcision. Her description of female circumcision accords with the description of the term by the WHO as at 1994 (p1.5):

> "... female operation nearly always involves the removal of healthy (and highly sensitive ) organs ...
>
> ... The mildest form – known to Muslims as 'sunna' and the least common – involves the removal of the prepuce or hood of the clitoris. It is the only operation analogous to male circumcision. Excision involves the removal of the clitoris and labia minora; while infibulation, the most drastic form ... involves the removal of all the external genitalia and the stitching up of the two sides of the vulva..."

14. The passage cited by the Family Law Council stated "In reality the distinction between the types of circumcision is often irrelevant since it depends on the sharpness of the instrument used, the struggling of the child, and the skill and

eyesight of the operator". The reference is to the distinction between the types of circumcision Ms Armstrong refers to in her article, not risks associated with ritualised circumcision.

15. It is apparent that other countries acted consistently with the WHO's recommendations to abolish female circumcision/female genital mutilation prior to 1994. For example, in the United States, federal legislation introduced in 1993, made it an offence where a person "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" (extracted at JBA 881, see also definition of "female genital mutilation" at JBA 882). The New York State legislation was in similar terms (extracted at JBA 883). The Swedish legislation provided that an operation must 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" (extracted at JBA 885). The second reading speech refers to the legislation from these countries (JBA 762).

16. As noted at the oral hearing, the legislation was derived from the UK legislation, enacted in 1985 (over 10 years before the WHO adopted a definition of female genital mutilation and the four classifications). The UK second reading speech does not refer to the WHO recommendations.

Dated: 26 June 2019

**Tim Game**

**Hament Dhanji**

**Georgia Huxley**
Counsel for Magennis

**David Randle**
Counsel for A2 and Vaziri

IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY

No. S43 of 2019

No. S44 of 2019

No. S45 of 2019

BETWEEN:

The Queen

Appellant

and

A2

Kubra Magennis

Shabbir Mohammedbhai Vaziri

Respondents

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ORGANISATION MONDIALE DE LA SANTÉ

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March 1979

# SEMINAR ON TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN

KHARTOUM, 10 - 15 February 1979

The views expressed in this Report do not necessarily reflect the official policy of the World Health Organization.

The Seminar was inaugrated by H.E. Sayed Khalid Hassan Abbas, Minister of Health, Sudan, at the Friendship Hall. (Annex I).

Dr R.A. Khan, WHO Programme Coordinator welcomed the participants on behalf of WHO and Dr T.A. Baasher, WHO Regional Adviser on Mental Health and Secretary of the Seminar, read the message of Dr A.H. Taba, WHO Director, Eastern Mediterranean Region. (Annex II).

The following Seminar Officers were elected:

- Dr Hamid Rushwan, Associate Professor, Gynaecology and Obstetrics Department, Faculty of Medicine, University of Khartoum and Chairman of the National Preparatory Committee for the Seminar, was elected Chairman of the Seminar.
- Dr (Mrs) B.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital Yaba, Nigeria, and
- Dr Afaf Attia Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, were elected Vice Chairpersons.
- Dr Yahia Ownallah Younis, University of Khartoum, Department of Community Medicine, Sudan, was elected as General Rapporteur for the Seminar.
- Mrs Awatif Osman, Director, College of Nursing, Ministry of Education, Khartoum, and representing the International Confederation of Midwives, was elected as Rapporteur for the first session.

It was agreed that for each day's sessions a rapporteur would be elected.

The Seminar was welcomed by Dr Rushwan, who introduced the speakers.

Following the election of Officers, members moved to the adoption of the Agenda which was presented by the Chairman. Dr B.C.A. Johnson suggested the addition of Menopause to the Agenda. This was given consideration. The Agenda was then adopted by the members. Dr Baasher introduced the programme and the presentation scheduled for each session under items IV to VIII to be discussed during the five days meeting, hoping that the participants would be able to cover most of the topics on the Agenda. Dr Baasher also asked contributors to hand in their working papers and written suggestions and recommendations to be given to the Secretariat or Chairman of the Seminar. He also pointed out that before the closing session, a summary report will be given on the scientific contributions and the deliberations including the recommendations which will come out of the meeting. Twenty minutes (approximately) was the time given for the presentation of each paper.

Dr R.H.O. Bannerman, Programme Manager, Trditional Medicine, WHO Central Office, Geneva, suggested his willingness to present the paper on "Traditional Practices on Confinement and After Childbirth (in the Chinese culture)" by Dr B.L.K. Pillsbury who could not attend the meeting and this was accepted by the members.

The first topic "Nutritional Taboos and Traditional Practices in Pregnancy and Lactation Including Breast-feeding Practice" was then introduced by the Chairman and the first speaker Dr Hafiz El Shazali, Senior Paediatrician, Ministry of Health, Sudan, presented his paper on "Breast and Supplementary Feeding during Early Childhood".

Dr El Shazali pointed out that his main emphasis is on the child. He highlighted the nutritional taboos and traditional practices in pregnancy and lactation in the Sudan. Dr El Shazali classified traditional practices in three categories: harmful, harmless and useful.

Among the harmful practices he listed:

- restriction of food intake during pregnancy;
- failure to remove dirt from the house (infections);
- breast-feeding while lying down (colic);
- using only one breast in nursing (decreases milk formation);
- weaning done suddenly;
- cauterization of children with a big hot needle for diarrhoea, cough, fever, etc.;
- stopping breast-feeding during diarrhoea;
- supplementary foods introduced too late;
- boys should not be fed at sunset or by mother with head uncovered;
- wearing beads and scented necklace to prevent vomiting.

Among good practices were listed:

- neighbours bringing food to nursing mothers;
- breast-feeding for a long period;
- during last month of pregnancy, eating raw liver.

"Dietary Practice and Aversions during Pregnancy and Lactation Among Sudanese Women" was presented by Dr Ali Karrar Osman, Director of Nutrition Division, Ministry of Health, Sudan. Dr Karrar indicated that his paper was more concerned with the child.

Low birth weight is a problem affecting some 20 million newborn infants annually, mainly among the low socio-economic groups of the population.

A survey in MCH centres in Khartoum Province to investigate the nutritional knowledge, attitudes and practices among pregnant women showed that pregnant women of the low socio-economic class are not aware of the importance of the consumption of a balanced diet during pregnancy (67%). This situation is aggravated by vomiting during early pregnancy and by dietary aversions, since 57.4% of the respondants dislike meat, fish and poultry. The effect of under-nutrition, especially low protein intake, is discussed in the light of the results of global research results demonstrating the effect of this on the mental and physical development of the foetus.

93% of the respondants believe that diet should be changed during post-partum while 45% believe this should take place during lactation. High-protein, high-energy diets are consumed. The reasons cited for this change were: to regain strength, to compensate for loss during delivery and to increase milk production. This represents sound nutrition knowledge, attitudes and dietary practices. One food item which is consumed by all respondants is the fenugreek Nasha (Fenugreek + Milk + Ghee + Sugar). This is a high energy recipe and fenugreek is shown to contain a lactogenic factor.

The next paper was on "Traditional Feeding Practices in Pregnancy" - Mrs A.N. Mikhail, Director of Nursing Services, Alexandria Health Directorate, Egypt.

Urban sector and rural sector habits for housewives were examined, showing that economic aspects and education had a major influence as to whether or not the diet was balanced. During puerperium the majority of housewives preferred protein-rich food regardless of income. Reasons given for food consumption patterns showed lack of awareness about nutrition. Breast-feeding was shorter and supplementary feeding better among educated housewives. In the rural areas and among poorly educated mothers, prolonged breast-feeding is customary in the belief that it protects against pregnancy.

Discussion:

A number of important issues emerging from the papers were discussed, as follows:

- morning sickness;
- prevalence of breast-feeding in the rural areas more than in urban areas;

contraceptive tablets and mothers' complaints of reduced milk output;

- how to deal with harmful practices, e.g. cauterization of children;
- mass media;
- advertisement of powdered milk and advice given to mothers in reference to breast-feeding of babies suffering from diarrhoea, especially within the first 24 hours;
- traditional medicine with reference to puerperal psychosis and its effect on the nutritional condition of the lactating mother and child;
- the emphasis on health education and assistance of mass-media in nutritional health education;
- native drugs during puerperium;
- breast-feeding on demand;
- overweight during lactation;
- traditional cultural ways of thinking in using red-ribbons, shells and beads to protect the child from the evil eye, infection, etc.;
- the practices of excision of the uvula, canines and cauterization of the epiglottis and the micro-organisms in reference to coughing, talking and certain diseases;
- nurseries and breast-feeding problems of working mothers, etc.

On 11 February the meeting opened with a presentation on: "Nutritional Taboos and Traditional Practices in Pregnancy and Lactation Including Breast-feeding Practices" by Dr L.J. Ghulam, Senior Public Health Officer, Ministry of Health, Muscat, Oman.

Two communities of Oman were studied. It was found that most women change their diet during pregnancy and lactation. The reason for diet changes are varied but the most important is the misunderstanding of the proper location of the unborn child. It is believed that the child is located in the stomach and as it grows, the size of the stomach is reduced.

Women eat less fish because they believe that the bones and scales of fish will harden the bones of the foetus and lead to a difficult delivery. A large number of women eat more during breast-feeding to increase their milk and to have better health.

The study shows some bad habits such as women abstaining from cold food such as rice, stew, citrus fruit, salted and fried fish, lamb, veal and sweet potatoes. In both communities some foods were recommended more than other kinds of food.

Breast-feeding Practices

The pattern of demand feeding continues from infancy until weaning. 90% of the children are breast-fed up to two years of age. Early weaning is against customs and religious beliefs. Breast-feeding is practised to avoid pregnancy; however, even when the mother is pregnant she continues to feed the baby until the fifth month of her pregnancy.

"Traditional Practices on Confinement and After Childbirth" by Dr B.L.K. Pillsbury, Medical Anthropologist, Bureau for Programme and Policy, Washington, USA, was presented on her behalf by Dr R.H.O. Bannerman, Programme Manager, Traditional Medicine, WHO Central Office, Geneva.

The paper is based on Dr Pillsbury's study in China. The woman is confined to the house for one month after delivery. She is said to be "doing the month". During this period she is expected to refrain from certain practices e.g. washing, domestic work. Regarding diet, she is expected to have a "hot" liberal diet with abundance of protein. At the end of the resting month relatives are invited to drink the full moon wine. In rural China deliveries are undertaken in the home by a midwife. 90% of the obstetricians and gynaecologists are women.

A very interesting discussion followed the presentation of the paper. Similarities between the Chinese experience and various African countries in traditional practices related to confinement were noted, e.g. length of period of confinement after delivery, washing practices, dietary habits etc.

The next paper was on the subject of: "Traditional Practices in Relation to Childbirth in Kenya" presented by Miss Margaret Njoki, Psychiatric Nurse, Nairobi.

Practices vary from one part of Kenya to another, but in essence they are similar. A woman who does not do work is thought of as a lazy person, so even during pregnancy women continue to do hard work with the risk of miscarriage and ill health. Traditional midwives have harmful practices which may lead to infection in both the mother and her child. Some of the useful practices include the good nutrition secured for the mother during confinement and after delivery, and the domestic help offered by neighbours.

Dr O. Modawi presented the next paper on: "Traditional Practices in Child health in Sudan" .

Dr Modawi gave a historical review of the cultural heritage in the Sudan which is a mixture of African, Eastern, Ancient Egyptian and religious cultures - both Islamic and Christian. The common elements forming the traditional practices were discussed. These included spirits and myths, the cultural heritage, the religious background and the supernatural powers represented by the river, the sun, the moon, colours, etc. He explained that the type of food eaten by the pregnant women is determined by social practices and beliefs. He presented a cultural description of food as prestige food, celebration food, food for special groups - especially pregnant women - and religiously defined food. Traditionally, infertility is attributed to various causative factors depending on the part of the country e.g. spirits, religious reasons, witchcraft and the evil eye and the Mushara. Traditional practices in the treatment of infertility were discussed. Dr Modawi explained the different traditional contraceptive methods, described the various positions in labour, the practices during confinement and after delivery and the beliefs about multiple pregnancies and births. Slides were shown.

The topic of the following paper was "Traditional Practices in Pregnancy and Childbirth in Ethiopia" presented by Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa, Ethiopia.

Traditional practices during pregnancy, labour and post-natal periods were described, e.g. good practices such as taking nutritious food and being at home for long periods during puerperium, and harmful ones such as carrying heavy things during pregnancy. Also practices concerning the newborn and children were described, such as cutting the cord with an unclean razor and cutting eyelids to treat conjunctivitis and avoiding sunshine for fear of the evil eye.

"Traditional Practices Affecting the Health of Women in Pregnancy and Childbirth" was the topic of the next paper presented by Dr (Mrs) M.O. Aromasodu, Assistant Director, Public Health Services, Federal Ministry of Health and Social Welfare, Nigeria.

Traditional care of the pregnant women in Nigeria is described. The traditional healer, through means of certain rituals, claims to be able to forecast the outcome of

a pregnancy. If there is going to be difficulty, he can consult the "gods" through his oracle to find out what sacrifices are to be performed. He also claims to have the means by which he "ties down" the pregnancy and thus ensures that it is carried to full term.

The traditional healer, apart from consulting the "gods", through his oracle, also treats the pregnant woman with herbs. In addition, there are certain taboos which the pregnant woman must observe or else all efforts will be useless. Thus she must not go out at night or at midday to avoid meeting evil spirits, she must also not eat snails or bananas so that her baby will be healthy with no congenital abnormality.

When the woman is in labour, the pregnancy which was "tied down" is released. If it is not vertex presentation, the baby is turned round by supernatural means. Vertex delivery is preferable, although at times breech delivery is undertaken. The woman is delivered on her knees. After delivery the placenta is carefully buried because it is a bad omen for the baby if its placenta is eaten by any animal especially a dog.

After childbirth, the woman is kept indoors for 40 days. During this period, she is massaged every morning with very hot herb water to aid uterine contractions and expulsion of all remaining "bad blood" in the uterus. Sitting on top of a pot with hot herb water also has the same effect.

Twins and other multiple births are said to be a bad omen which is accepted as being the fault of the woman as well as any congenital abnormality.

In order to improve the standard of obstetric practice, traditional healers and birth attendants are now trained. During training emphasis is laid on identifying any deviation from normal and prompt referral to health institutions where patients will be taken over. With intensified health education, even the community now prefers to use non-traditional healers and birth attendants who have been trained by the experts from the Ministry of Health.

Mrs D.V. Kuteyi, Principal Nursing Officer, PH, Federal Ministry of Health and Social Welfare, Lagos, Nigeria, continued where Dr Aromasodu left off by describing

the naming ceremonies for girls and boys. The mother is kept indoors for 40 days after delivery. The naming ceremony traditionally includes tribal remarking, shaving of head and circumcision.

The baby is forcefully fed immediately after delivery with a special herbal concoction which is continued sometimes for one year and is the only food given besides mother's milk. The baby is fed with bap after sixth or seventh month (millet and corn).

Twins: If a mother has twins she must go in the street and sing and dance as well as beg for alms in order that the twins survive.

The diet of the pregnant woman is without eggs or meat and no beans or milk are given. Protein intake is lacking.

Dr S. Coleman, Staff Research Associate, Johns Hopkins Population Information Programme, Baltimore, USA, presented the next paper on: "Tobacco and Reproductive Health: Practices and Implications in Traditional and Modern Societies".

Few women in many developing countries smoke, but the tendency is for an increase; the tobacco market is growing and increased use follows increased income and spending power. Cigarettes are being promoted by tobacco corporations in developing countries, where the prospects for market expansion are greatest and where there are rarely restrictions on advertising and no antismoking educational campaigns. With increasing urbanization and emancipation, more women will soon be smoking in many countries.

Tobacco use during pregnancy lowers birth weight. This has been proven in more than forty-five studies examining over half a million births, in a number of countries. The infant's reduced weight is independent of maternal weight gain during pregnancy, and is not due to reduced length of gestation. More women who smoke, however, give birth before the full gestation period than do non-smokers. The reduced weight of smokers' infants may be due to an attempt to adapt to lack of oxygen. Carbon monoxide and nicotine are two agents in tobacco smoke that may be affecting birth weight. Increased intake of calories during pregnancy cannot counteract their effects.

The woman who smokes during pregnancy is in the greatest danger of losing her newborn infant or having a stillbirth:

- if she has experienced perinatal loss previously;
- if she is older in age;
- if she has had many previous births (high parity);
- if she is anaemic.

The more any woman smokes, the greater is the risk of perinatal mortality. Tobacco use also increases the risk of pregnancy complications. Antepartum bleeding, placental abruptions, placenta previa and premature rupture of membranes have all been found in increased frequency among smokers. Thus, the life of the woman as well as that of her offspring may be threatened, especially if medical facilities are not immediately available.

The third session was devoted to the discussion of female circumcision.

The Chairman introduced the first speaker in this session, Miss F. Hosken, Editor, Women's International Network, Lexington, USA and WHO Temporary Adviser on "Female Circumcision in the World of Today: A Global Review".

Information about genital operations performed on female children, mostly at an age too young to be able to make any decisions on their own, have been concealed for more than 2000 years. As a result these practices have spread all over Africa and are now also practised in the modern sector.

In other parts of the world genital mutilations no longer exist though they have been reported also in the medical literature (Shandall, Verzin, Mustafa, Sequeira and others) up to the present time though no clinical observations are available. In Australia genital mutilations among the indigenous population have been abandoned decades ago. In South America no clinical evidence has ever been available and the few cases reported in the ethnographic literature go back more than 100 years with no medical evidence. All the reports of genital operations on females go back to 1885 (first edition of Ploss Das Weib = Woman).

There is no present day clinical evidence that any form of genital operations are practised anywhere except in Africa and among the Moslem population of Malaysia and Indonesia, where the mildest form of circumcision is reported.

Leading Moslem gynaecologists in Malaysia and Indonesia have offered to make studies concerning any health damage.

In Africa and the Middle East a survey of 36 countries has provided the beginning of a systematic collection of data which should be continued and amplified as more information becomes available. Due to population growth more female children are operated on now than ever before. The operations are performed at a younger age because parents are afraid their daughters will refuse to submit to them when they are able to decide for themselves.

A cost analysis of genital mutilations is supplied showing that the economic costs of doing nothing about these operations are going to increase rapidly and will become a major drain for governments. Prevention campaigns could obviate many expenditures as well as improve the health of females.

This "expenditure" or cost may be listed as follows:

1. The costs due to loss of life.
2. The costs due to making childbirth more hazardous including many added services needed.
3. Costs of work time lost, health insurance and social security.
4. Costs of operations performed in hospitals.

Relevant recommendations include the education of traditional midwives, which should be undertaken on the national scale, keeping the traditional system in place but re-educating the practitioners.

Following the presentation and discussion of Miss Hosken's paper several country reports were presented. Dr Afaf Attia Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, presented a paper on "The Practice of Circumcision in Egypt". She said the practice of female circumcision is illegal in Egypt and so there are no confirmed data, but from field work done recently, three types of circumcision could be delineated:

1. Sunna type in which the clitoris is snipped.
2. Second type in which the labia minora and part of clitoris are removed.
3. Total removal of clitoris and labia.

The first type is done in both urban and rural areas and the third one mostly in Upper Egypt. Dr Salem also cited the various complications that may follow the operation.

A second presentation from Egypt on "Mental Aspects of Circumcision" was made by Dr A.S. El Hakim, Head of Mental Health Department, Ministry of Health, Cairo. Dr El Hakim indicated that sex before marriage is taboo and the female's virginity before marriage is identified with the dignity of the family. Circumcision is believed to ensure the girl's chastity, hence the man's concern with the circumcision of the female. But the operation leaves a psychological scar in the woman. It is thought that circumcision causes delayed sexual arousal in the female, but there are no direct data on this matter, only indirect information from opium addicts who claim that they resorted to the drug after frustrations from delayed sexual arousal in their circumcised wives.

A third presentation from Egypt was given by Mrs Marie B. Assaad, Senior Research Assistant, The American University, Cairo, who is also representing UNICEF. Mrs Assaad presented a very voluminous document on "Female Circumcision in Egypt". She attempted in her paper to give a critical review of written and oral information on female circumcision in Egypt and to suggest areas where systematic study is needed. Also, she summarized a pilot study which she carried out recently in Egypt with the objective of testing a set of questions and to have insight into the present extent of the practice and how, where and by whom it is done.

Circumcision in Egypt is practised by both Moslem and Christians and there is no religious basis for the practice. It fits into the people's value system about virginity and family honour. The practice existed in Egypt long before Christianity and Islam. The pilot study showed that women of low socio-economic class submit their daughters to the same fate which they themselves underwent when circumcised. Interestingly, the study does not show any correlation between excision and sexual dissatisfaction.

Mrs Assaad concluded by stating that concerted effort is needed now to accomplish the following:

- Multi-disciplinary action - research should be undertaken by psychologists, gynaecologists and social scientists - men and women - with the purpose of defining what information will be persuasive to men and women in eradicating the practice.

- health practitioners, social workers, nurses, family planning workers, feminists engaged in education and outreach programmes, and educated people in general should form the first audience of instruction. They should be informed about the practice, its extent, reasons for its perpetuation, and how traditional and erroneous beliefs of women on women's health and sexuality can be modified. It is important to engage this group first because of their prospective leadership role.
- We need to be creative and imaginative, finding ways to convince the daya (traditional birth attendent) to work with us and not against us. In view of her influential role as a traditional leader we need to exert special efforts to involve her in the new concerns, whether in relation to female circumcision or family planning. We must care for her as a person and guarantee for her other sources of livelihood and importance.
- We should begin now with the knowledge that is already available and experiment with it for educational programmes in family planning centres and health services.

Ongoing evaluations of different approaches will be useful in finding out what is feasible and effective within service constraints.

Then followed a paper from Ethiopia on "Female Circumcision In Ethiopia" presented by Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa. Sister Beddada presented a short report and said that female circumcision is mainly done at home by a traditional midwife and never in a hospital. The main reason given to rationalize the operation is that circumcision lessens the sexual desire in the female and so protects the young girl from any promiscuity.

A report from Kenya on "Female Circumcision in Kenya" was presented by Miss N. Njoki, Psychiatric Nurse, Nairobi. Miss Njoki said she would add an intimate personal experience to the report. The operation is done by a traditional healer and usually done in groups in warm weather, about August. Reasons given for the practice are: to reduce sexual desire in the girl and to initiate the young girl into womanhood. The operation is usually performed on the girl between the ages of 7 and 10 years. Though the practice is still being carried out by some groups of people, it is certainly dying out.

A report from Nigeria on Female Circumcision in Nigeria was presented by Dr (Mrs) B.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital, Yaba. Dr Johnson said that there is no official attitude to the practice and there are no reliable data. The practice is dying out. When it is done it is done as early as the seventh day after birth and as late as just before marriage. It gives a sense of belonging to the girl, being thus initiated into adulthood. Dr Johnson also cited many of the physical and psychological complications that follow the operation.

A paper was then presented by Ms Raqiya Haji Dualeh, Representative of Somali Women's Democratic Organization on "Female Circumcision in Somalia".

Women are victims of outdated customs and attitudes and male prejudice. This results in negative attitudes by women about themselves.

There are many forms of sexual oppression. These are rooted in the family, society and religion.

In the space of nine years the Somali Revolution has achieved a great deal by building a new generation free of traditional prejudice against women's rights and needs.

Infibulation (Pharaonic circumcision) is still widely practised. It is a horrible practice, fraught with ordeal and danger and is in fact the result of the inability of women to find other ways of establishing virginity.

Children are the centre of life of the Somali family and the whole community. Somali society does everything possible to make sure that a bride is a virgin because of payment of the bride price. Families do not put a stop to the custom, out of fear of the older generation and fanatic religious leaders. The custom can only be abolished through education.

A National Committee coordinated by the Somali Women's Democratic Organization composed of representatives of various Ministries, Unions, Youth Organizations, doctors, etc. has been formed. The Committee is now developing a nationwide campaign.

A report was submitted on "Female Circumcision - Physical and Mental Complications" by Mrs Edna A. Ismail, WHO Temporary Adviser and Director, Department of Training, Ministry of Health, Somalia. Mrs Ismail cited the different forms of circumcision as:

- Mild Sunna
- Modified Sunna
- Partial or total clitoridectomy
- Infibulation (Pharaonic female circumcision).

The operation is carried out by a woman who earns her living by the performance of such operations or it may be done by paramedical personnel or by the traditional birth woman - the operated girls are between the ages of 5 and 8. After the operation the child is bound from the waist to her toes and is made to lie still on a mat. The child's diet is restricted and after the seventh day the thorns used to hold the wound together are removed. After the nineteenth day the child may begin to take some steps with a stick.

The physical and mental complications are delineated. The physical complications include the immediate shock from pain and haemorrhage; lacerations due to the struggling of the child, sepsis, retention of urine, closing of the urethra and failure of the infibulation. Usually in this case another operation is done on the child and sometimes a third. Also at the time of marriage more lacerations are inflicted on the woman by her husband and additional cuts have to be made at the time of childbirth.

Mental complications begin to affect the female child from an early age and begin with her throughout her life. Well before the child is circumcised she sees others who have been recently circumcised or hears tales of horror relating to the act of infibulation. At the same time girls who themselves have been circumcised taunt others with insults and call them unclean.

Each stage of her older life will only add further to her mental injuries: the onset of the menarche with its accompanying discomfort and odors; marriage, the opening up of the infibulation and the agony of intercourse; the birth of the first child and the knowledge that subsequent deliveries are not going to be any easier on her scar-riddled vulva.

A survey was made in 1978 by 3 male medical students including interviews of 290 women in hospitals and among university students.

The report also has tables giving the result of the survey which shows the reasons given, the age of the girls, the complications, the hospital records of complications and much more.

The Histological Study of Normal Vulval tissue (Clitoris, labia majora and labia minora) removed at circumcision from 13 children, showed abundance of nerve fibres and touch organs especially in the clitoris.

Fibrous scar tissue of circumcised vulvae of 10 adult women removed at gynaecological repair operations showed very few nerve endings which were trapped in abundance of fibrous tissue.

Circumcision and infibulation (Pharaonic circumcision) results in destruction of the nerve supply of the vulva, thus rendering it into a sheet of fibrous tissue with minimum function.

This paper will present the normal anatomical layout with special reference to innervation and its loss following circumcision and infibulation.

In the fourth session, Dr Suleiman Modawi, Ministry of Health, Khartoum, gave the first presentation under the country profiles of the Sudanese experience. In his paper "The Obstetrical and Gynaecological Aspects of Female Circumcision" Dr Modawi presented the Sudan profile of female circumcision. He reviewed the world history, the entry of circumcision into Sudan and its distribution and then made a critical review of the social impact of socio-economic factors and the changing aspects of circumcision.

Dr S. Mirghany El Sayed (Sudan) from the Centre Hospitalier de Villeneuve, Saint Georges, Villeneuve Saint Georges, France, presented a paper on female circumcision. The paper was read in French. It is part of an M.D. thesis submitted to the Faculty of Medicine in Paris. The material was collected over two years and the aim of the study was to find out the reasons and motives for female circumcision. These were discussed.

After the paper was read, a film was shown. The film was photographed in Central Africa and it shows how the operation is performed and the ceremonies and celebrations which are performed for the occasion.

A very lively discussion followed the presentation of the first two papers.

1. Mrs Amal Arbab, Ministry of Social Affairs, Sudan, took up the point about the effectiveness of the law in abolishing female circumcision and said that probably the law was not effective earlier because those who introduced it did not take into consideration the social circumstances and did not provide alternatives, but if legislation is passed with due consideration to these factors, then they will help in reducing the harmful consequences of the practice.

2. Dr R.A. Khan, WHO Programme Coordinator in Sudan said that Moslems in the world number about 600 million, while female circumcision is only practised by about one fifth of them, so if it had any religious basis it would have been practised by a larger proportion. He suggested that it is probable that those who would like to perpetuate the practise give it a religious quality.

3. Dr R.H.O. Bannerman, Programme Manager, Traditional Medicine, WHO Geneva, said that the pattern of circumcision in all country reports was similar and the reasons for it were multiple. He stated that it is clear that our aim here is to abolish the practice; so he suggested that it might be more useful if the participants would dwell a little more on what to do to abolish the practice. He said it may be worthwhile to look into the experience gained in the field of family planning and try to make use of it here.

Dr Mohammed Shaalan, Assistant Professor and Chairman, Department of Neuropsychiatry, Faculty of Medicine, Al-Azhar University, Cairo, Egypt, then presented his paper "Clitoris Envy: A Psychodynamic Construct Instrumental in Female Circumcision". Dr Shaalan said that the prevalence of the practice of circumcision over so many centuries and in so many areas, indicates that it is no accidental occurrence. Yet its lack of ubiquity and its declining prevalence indicate that the hypothetical belief on which it was based is uncertain and/or that it is ceasing to be verified.

On the basis of clinical psychotherapeutic experience and other sources, this hypothesis may be speculated to be as follows:

Sexuality was associated with reproduction; reproduction required surplus male labour to provide for the offspring; surplus male labour was provided in exchange for female chastity and fidelity; reduction of female sexual desire and excitability was conducive to chastity and fidelity; this reduction was achieved by excision of erogenous genital areas (essentially the clitoris) or circumcision.

With present social changes reproduction is losing primacy in favour of relation and recreational sexuality. Female chastity and fidelity are declining as exclusively female virtues and circumcision is becoming redundant.

Conscious evolution coupled with rapid social change necessitate active intervention to limit circumcision.

Dr T.A. Baasher, WHO Regional Adviser on Mental Health, then presented his paper: "Psycho-Social Aspects of Female Circumcision". Dr Baasher gave a general introduction on psycho-social aspects of female circumcision. He spoke about the psycholinguistics in female circumcision, the meaning and psychological background of the practice, the psychiatric problems of it and its political associations. He said that words to describe female genitalia in our culture are few and they mainly describe the shape of them. Studying the linguistics will help in understanding the psychology of female circumcision. He said that psychological reactions depend on many factors e.g. defence mechanisms, personality factors, past experience, psychological and social support during and after the operation, and described the psychiatric disturbances resulting from the inflicted psychological trauma or manifesting as a sequelae to the physical complication. He further added that there is paucity of prospective studies about psycho-social disorders following female circumcision and the findings are conflicting. Dr Baasher gave two examples from Kenya and Sudan in relation to politics and female circumcision, where the early efforts to abolish the practice were met with resistance from nationals who thought that the colonizers wanted to destroy the code of modesty and national solidarity when they interfere with such practices.

Dr Malik Badri, Dean, Faculty of Education, University of Khartoum, Sudan, in his paper "Sudanese Children's Concepts About Female Circumcision" stated that any wide range programme to effectively change deep rooted customs and children's

attitudes should be studied. Bearing this in mind a pilot study was made with two groups of girls who were also asked to make some drawings. The two groups of 24 and 19 girls respectively had definite concepts of circumcision as their drawings also indicated. The children expressed a variety of reactions including fear of surgical instruments.

"Opinions about female Circumcision" was a paper delivered by Dr Gasim Badri, Ahfad University College, Omdurman, Sudan. The study group consisted of 60 Sudanese gynaecologists, 24 midwives and 190 female college students. A questionnaire including questions about complications of circumcision, attitudes towards the practice, methods suggested for its eradication, if any, was distributed to all participating in the study group. There was a good response. All gynaecologists who responded said that circumcision has bad physical and psychological complications. They said that the factors perpetuating the practice are multiple. 10% of the midwives thought that circumcision is a good practice. 152 of the 190 female college students said that they will not circumcise their daughters. All of them said that they do not think their grand-daughters are going to be circumcised.

Dr Asma Abdel Rahim El Dareer, Project Director, Department of Community Medicine, Faculty of Medicine, Khartoum, presented a preliminary report on "A Study on Prevalence and Epidemiology of Female Circumcision in Sudan Today" particularly in the White Nile province. This is a part of a broad study, assisted by WHO, on female circumcision. The objectives of the study are to determine the extent of the practice, people's attitudes towards it, health problems encountered, impact of socio-economic factors and possible ways of dealing with the problem. 90% of women interviewed were illiterate and of the lower socio-econocmic class. There are 3 types of circumcision: pharaonic - 84%, intermediate - 4% and sunna 1%. 4% do not practise circumcision and they belong to the Falata tribe. 81% of husbands approved the practice and 14% of them said it is prohibited by religion. Health education seems to be the most effective method to stop the practice.

Ms Rachel Mayanja - Special Assistant Secretary General for Social Development and Humanitarian Affairs, United Nations, New York, USA, stated that the question of women's health is a very important one, and the United Nations is interested in co-operating with WHO to ensure that this matter is given adequate attention. With regard

to female circumcision she urged the participants to consider whether or not this is a desirable practice. She stressed the need for the participants to make concrete proposals with a view to either abolishing it or providing it under better conditions. She appealed to the media when presenting the views expressed to the public at large to report accurately placing this sensitive topic in its proper context.

The first morning session was devoted to the discussion of the previous day's papers.

Dr B.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital, Yaba, Nigeria, chaired this session. At the start she welcomed to the meeting Mrs Alice Tiendregeogon, President, Federation of Women of Upper Volta and Representative of the International Alliance of Women, Ouagadougou, Upper Volta, who arrived the previous day. Then she invited the previous day's speakers to give brief summaries of their presentations to refresh the memories of the participants before starting the discussion. After that was done, the Chairman opened the floor for discussions. At the end of the discussion the Chairman invited Mrs Triendregeogon to give her country report. Mrs Triendregeogon addressed the meeting in French.

Commencing with the background of her country Mrs Triendregeogon stated that the Mossi, the largest ethnic groups, have a patriarohal culture, while other population groups have a matriarohal system where the children belong to the mother's family. About 30% of the population is Moslem, 20% Catholic and the rest animist: all groups practise excision, without infibulation. The operation is done when the girls are 10 - 12 years old and are isolated for four weeks afterwards and taught about their adult responsibilities.

Cultural customs are beginning to disappear, however, excision continues also in the cities and is performed under very bad hygienic conditions. The Voltaic Women's Organization started a campaign against excision through a radio broadcast, after asking women why they practised the operation. Most of the women responded "because it is the custom". The women who oppose the excision are the educated ones. Although the Women's Organization dealt only with health problems, the campaign caused an adverse reaction from men as well as women. Therefore the campaign was stopped. This campaign was in 1975; since 1979 is the International Year of the Child abolition of the practice is necessary.

Various points were raised in the discussions; finally it was agreed that a Sub-Committee be formed to draw up resolutions and recommendations in the light of the presentation on female circumcision and the discussion that followed. The following were elected for the Sub-Committee: Dr S. Modawi (Sudan); Dr Afaf A. Salem (Egypt); Sister B. Beddada (Ethiopia); Miss Grace Mbevi (Kenya) and Ms Raqiya Haji Dualeh (Somalia). They were assisted by Dr R.H.O. Bannerman (WHO Central Office, Geneva) and Ms Rachel Mayanja (United Nations, New York).

In the late morning session Dr Afaf A. Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, took the chair.

Dr Salem introduced the first speaker, Mrs Mehani Saleh, Maternal and Child Health Supervisor, Ministry of Health, Aden, who presented her statement on "Traditional Practices during Pregnancy - Female Circumcision and Child Marriage in Yemen Democratic Republic". Mrs Saleh gave a general introduction about the country and an account of traditional practices during pregnancy and labour. She said that during the post-natal period the nursing mother does not take cold drinks and she is not allowed to take certain food like fish and beans because it is thought that this will pass with the mother's milk and cause abdominal pain in the child. The duration of confinement after delivery is 40 days. She said that circumcision is usually done by the traditional midwife and can take place as early as the seventh day after birth. She also stated that the marriage age for the female is between 15 and 16 years.

Mrs Saleh suggested some measures - such as general education, health education - be taken to abolish practices dangerous for women's health. She made a plea for women's organizations to take a leading role.

Then Dr L.J. Ghulam, Senior Public Health Officer, Ministry of Health, Oman, presented her paper on "Early Teenage Childbirth and its Consequences for both Mother and Child". Dr Ghulam indicated that in Oman both sexes, especially females, get married when very young, and as a result the infant mortality rate is very high. She presented a summary of a study conducted in Nizwa and Soher communities in Oman regarding early teenage childbirth. 27% of women interviewed in Nizwas were married at the age of 11 and 86% were married by the age of 15. In Soher 9% were married by

the age of 11 and 80% by the age of 15. There is a trend towards marrying at a later age in Soher. Dr Ghulam then listed the complications that result from early marriage, e.g. risk of operative delivery, low birth weight. She ended by recommending a design of a health education programme and passing some legislation to stop the practice.

The third speaker was Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa and she gave a brief communication on child marriage in Ethiopia. She stated that the marriage age for the female is between 12 - 15 years. The main reason for that in the mind of the people is to prevent pre-marriage pregnancy.

Miss Grace Mbevi, Public Health Nurse, Kenya, presented a paper on "Child Marriage and Early Teenage Childbirth". As mentioned in the past, children were counted as wealth. This was because,for the female children, a brideprice was paid (dowry) and this was a source of income to the family. Child-marriage was also a custom; the main function of a woman was to bear children, hence the custom of early marriage, but this practice is dying out in Kenya. The Government and religious leaders are playing a very significant role on this issue. Miss Mbevi explained how the child is exposed to early responsibility which is difficult to cope with and this leads to mental stress and many other complications. Due to early marriage the female child is deprived of education and this is essential for the developing countries since, as everyone knows, to educate women is to educate the nation.

The fifth paper was presented by Dr M. Warsame, Director, Benadir Hospital, Mogadishu, on "Early Marriage and Teenage Deliveries in Somalia". Dr Warsame stated that the country is divided into 3 economic groups: the nomadic (about 70%), the agricultural (about 15%) and the urban who are the minor component. He said in the nomadic areas a man is not considered mature before the age of 20 years and in these areas marriage is decided by the elder male relatives. Polygamy is practised in this nomadic sector. The nomadic prefer to have children at intervals of 2 years.

In agricultural communities early marriages occur usually at the age of 15. In these communities there is no spacing of pregnancies and the birth rate is very high.

In the urban community only a few still practise child marriage, sometimes at the age of 12, and in this community polygamy is very rare. The average age of marriage is 20 years.

The Chairman expressed her regret for the absence of Dr Haddad O. Karoun, Head, Department of Obstetrics and Gynaecology, Faculty of Medicine, Khartoum, who was expected to present a paper on "Adolescent Pregnancy and Childbirth". She then introduced Dr O. Modawi, Senior Gynaecologist and Obstetrician, Ministry of Health, Sudan, who made a brief comment on teenage pregnancy. Dr Modawi said that generally early marriage is the mode in many parts of the country. Several factors play their role here e.g. tradition, religion, few chances for education. He said that there are no social difficulties as a result of this early marriage, but mainly health problems to the young primigravidae. He also said that, except for very few tribes in the Southern part of the country, early teenage pregnancy in the unmarried is a stigma and is unwanted.

After the presentations, the floor was open for discussion and valuable comments were made.

Mrs Edna Adan Ismail, WHO Temporary Adivser and Director of Department of Training, Ministry of Health, Somalia, presented a paper on "Child Marriage and Early Teenage Childbirth". Mrs Ismail stated that although child marriages sometimes take place among nomadic and agricultural communities, the practice is very rare now in Somalia. No accurate statistics can be obtained since these communities conduct their marriages and deliveries themselves. Statistics on deliveries at the Mogadishu Maternity Hospital during the last six months show that there have been no deliveries of females under the age of fourteen years. It is not known if the practice was reduced because of the law which was passed on 11 January 1975 which makes it illegal for a female below the age of 16 to be married and a male below the age of 18, or whether the practice is dying out because of economic reasons. In any case, the practice of child marriage no longer presents problems in Somalia.

## RECOMMENDATIONS

Three categories of traditional practices - useful, harmless and harmful - were discussed by the participants in the Seminar. The following recommendations were proposed in support of useful practices and to abolish harmful ones. Special recommendations were made to correct harmful practices and to replace them with positive actions to promote better health.

National policies should be formulated to promote useful practices and to abolish harmful ones.

### Useful practices

- Governments should recognize the need for adequate breast-feeding for the health of the child, which reflects on the total well-being of the family and the nation.
- Feeding of expectant mothers should be promoted.
- Day nurseries and crêches for working mothers should be a matter of priority.
- More part-time professional as well as non-skilled jobs should be available for women.
- Intensive nutrition education programmes should be launched by all those involved in the health of mothers and children.
- Nutrition education for women through MCH centres, schools and rural health units should be encouraged.
- Nutrition education should be propagated by the mass media with the widest possible coverage.

In summary, traditional breast-feeding patterns should be supported by giving women the opportunity to continue breast-feeding and by providing them with information on healthful feeding patterns for themselves as well as for their children.

### Harmless practices

A variety of harmless practices were discussed, such as fumigation and certain charms, amulets etc. to ward off evil spirits. It is envisaged that with health education and socio-economic changes, such practices will disappear and the community will make appropriate use of available modern medical technology.

Harmful practices

(a) Harmful practices, customs and traditions, for example restrictive feeding patterns during pregnancy or abrupt weaning, should be exposed; special educational programmes should be designed concerning the harmfulness of such practices; and positive attitudes towards nutrition, involving useful, locally available foods, should be promoted.

(b) Other harmful practices, for example the restriction of high-protein diets including fish, chicken, eggs and camel meat in certain communities, should be discouraged because of their ill effects.

(c) It is the belief among some communities that the milk of pregnant mothers is harmful to the child she is nursing and consequently breast-feeding is abruptly stopped, with ill effects on the child. Hence, special educational programmes for pregnant women and mothers should be developed and promoted to stop these harmful practices.

(d) Special attention should be focused on the insufficiency of appropriate nutritional ingredients of supplementary foods for infants, the tendency to feed low protein-calorie diets to babies, the ill effects of the promotion of artificial and manufactured milk and food substitutes for babies.

(e) Other harmful practices and remedies were discussed,e.g. cautery (the application of hot iron sticks to certain parts of the body as a curative and preventive measure for diarrhoeal diseases and respiratory infections; cautery of children's gums at the time of teething, etc.).

(f) Noting the harmful effects associated with the use of tobacco, khat, alcohol, etc. in some countries on pregnancy, it is recommended that concerted efforts be made for the prevention of the use of these toxic agents.

Female circumcision

The following recommendations were made:

(i) Adoption of clear national policies for the abolition of female circumcision.

(ii) Establishment of national commissions to coordinate and follow up the activities of the bodies involved including, where appropriate, the enactment of legislation prohibiting female circumcision.

(iii) Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of female circumcision.

(iv) Intensification of education programmes for traditional birth attendants, midwives, healers and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision, with a view to enlisting their support along with general efforts to abolish this practice.

Childhood marriage and early teenage childbirth

It was recommended to:

- Conduct further research concerning child marriage and early teenage childbirth in all its aspects, i.e. medical, social, psychological, etc., to find out the possible complications.
- Design health education programmes in order to discourage childhood marriage.
- Introduce legislation to stop childhood marriage when and where appropriate.

ANNEX I

ADDRESS OF HIS EXCELLENCY SAYED KHALID HASSAN ABBAS, MINISTER OF HEALTH, SUDAN, TO THE SEMINAR ON TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN HELD IN THE FRIENDSHIP HALL, KHARTOUM FROM 10-15 FEBRUARY 1979

Distinguished participants, Ladies and Gentlemen,

Greetings of our eternal and "God Given" victorious revolution. I bring you greetings from our brother President Gaafar Mohammed Numeiry wishing to express our extreme happiness that you have chosen the Sudan as the venue of this important Seminar. I wish to thank the participating brothers and sisters and I greet the institutions and the international, regional and local organizations who have participated in this Seminar, especially the World Health Organization and United Nations Development Programme and their representatives in Alexandria and the Sudan.

Women constitute half the society, carrying the burden of building the family and the society. It is therefore imperative for governments and organizations to protect her in order to ensure development. For this reason it has been our policy in the national health programme to give priority to maternal and child health within the preventive and medical services, thus following what has already been provided for in the Constitution towards the protection of women. Since the mother is the very foundation of the family, to protect her means to provide happiness and peace to the whole family and to the ideal society for which we aim. Despite our ambitions and dreams to provide the best for her, we find that our resources are limited and we, therefore, seek for help from the international organizations in order that they may assist us in achieving our goals and ambitions.

We, as a country with its own history, customs and traditions, originating from the environment must give these customs and traditions much attention. We must also study them to benefit from them. At the same time must study the harmful practices in order that we may avoid them and try and eradicate them and, protect the health and happiness of the women and the family.

The cadres working in the health fields, and especially midwives and dayas, are accepted and respected by mothers. We, therefore, train them and prepare them in the fields of health education in order that they may carry out this role. We hope that the Women's Associations will carry out their active and effective roles in spreading health knowledge.

We, therefore, hope that this Seminar will collect the necessary information concerning the traditional practices, especially in the case of circumcision, traditional nutritional practices, early marriage and traditional practices in the field of pregnancy and child bearing, in order to find the best ways and means to develop and spread the beneficial practices and to eradicate the harmful ones.

We have made many previous efforts to eradicate some of these harmful practices through the legal system, but many of these methods have failed. We must, therefore, turn to health education as the means of spreading health knowledge hoping that we may thus influence the people and make them want to act in a correct and healthy way. These new trials and approaches have shown some hopeful results and we are convinced that health education will be our means to change these harmful traditions to better and beneficial customs.

I wish all success to your Seminar in order that you may reach effective decisions and recommendations and we, in the Ministry of Health, will give your recommendations all our support and will see that they are carried out, and together we hope to reach our aim in building our modern society without forgetting our good and beneficial traditions which may help assist us in growth and development.

ANNEX II

MESSAGE FROM DR A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION
TO THE
SEMINAR ON TRADITIONAL PRACTICES
AFFECTING THE HEALTH OF WOMEN
Khartoum, 10-15 February 1979

Dear Colleagues, Ladies and Gentlemen,

It gives me particular pleasure, and indeed happiness, to welcome you all, on behalf of WHO, to this important Seminar on Traditional Practices Affecting the Health of Women. Much as I would have liked to be in person with you, due to other official commitments this was not possible. However, I wish your meeting fruitful deliberations and successful discussions.

I am particularly grateful to the Government of the Democratic Republic of the Sudan for hosting this Seminar, and to the Ministry of Health, under the leadership of H.E. Sayed Khalid Hassan Abbas, Minister of Health, for unfailing support and excellent collaboration in the preparation of this meeting.

Furthermore, I am appreciative of the keenness and interest shown by various countries and by a number of UN agencies, non-governmental organizations, institutions and the mass media. This interest is not new nor surprising for, as you are aware, the UN and its Member States have been increasingly concerned with the promotion of the status of women and their role in economic and social development. This was formally acknowledged by declaring 1975 International Women's Year, and by proclaiming the ensuing decade the United Nations Decade for Women. Similarly, the World Health Assembly in 1975 passed a resolution urging governments to widen the range of opportunities for women in all aspects of health and to ensure the further integration of women in health activities.

Furthermore, special attention was given to traditional practices and their effects on the health of women, with the primary objective of fostering a realistic approach to promote useful and proven practices and do away with harmful ones.

In this respect, I am pleased to point out that concerted efforts have recently been made by the WHO Eastern Mediterranean Regional Office to systematically collect information and stimulate interest in this subject. It has also been advocated that the consequences of traditional practices, be they healthy or adverse, be highlighted, wherever appropriate, in training programmes and scientific meetings.

At the international level, it is important to recall that in 1976 the Director-General of WHO drew the attention of the World Health Assembly to the need to "combat taboos, superstitions and practices that are detrimental to the health of women and children, such as female circumcision and infibulation". It has also been considered appropriate to include the latter topic as well as others among the agenda items of this Seminar.

It is obvious that the topics with which you will be dealing are intricately culture-bound and deeply enmeshed in the customs and beliefs of the people and have, therefore, to be appropriately studied within their local contexts and social perspectives.

I feel confident that the distinguished participants in this Seminar, with their multi-disciplinary professional backgrounds and wide experience, will competently contribute to its success and I will, therefore, be looking forward to the recommendations emanating from you, which I sincerely hope will be helpful in the promotion of the health of women and in the proper care of children.

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ANNEX III

LIST OF PARTICIPANTS

Eastern Mediterranean Region

| | |
|---|---|
| DEMOCRATIC YEMEN | Mrs Mehani Saleh<br>Maternal and Child Health Supervisor<br>Ministry of Health<br>Aden |
| DJIBOUTI | Dr Said Salah Youssouf<br>Médecin Chef du Centre médical de Brousse<br>Tadjourah |
| | Dr Alain David<br>Médecin Chef du Centre médical de Brousse<br>Ali-Sabieh |
| EGYPT | Dr Afaf Attia Salem<br>Director<br>General Directorate Maternity and Child Health<br>Ministry of Health<br>Cairo |
| | Dr Ahmed Saad El Dine El Hakim<br>Director<br>Mental Health Department<br>Ministry of Health<br>Cairo |
| | Mrs Angèle Naguib Mikhail<br>Director of Nursing Services<br>Alexandria Health Directorate<br>Alexandria |
| OMAN | Dr Layla Jassim Ghulam<br>Senior Public Health Officer<br>Maternal and Child Health Section<br>Ministry of Health<br>Muscat |

SOMALIA

Dr Mohamed Warsame
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Benadir Hospital
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Dr Suliman Modawi
Gynaecologist Obstetrician
Ministry of Health
Khartoum

Dr Hassab El Rasoul Suleiman
Director-General
Mental Health Department
Khartoum

Mrs Amal Sayed Arbab
Sudan Family Planning Association
Ministry of Social Affairs
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ANNEX IV

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*European Journal of Obstetrics & Gynecology and Reproductive Biology*, 45 (1992) 153–154



# Female circumcision

## Female genital mutilation [1,2]

WORLD HEALTH ORGANIZATION

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO)

Female circumcision in any of its three forms, is a painful fact of life for about 80 million girls and women in over 30 countries of Africa, the Middle East and South East Asia where its practice is widespread.

Although a traditional practice, female circumcision is also a health issue because it potentially affects the physical and mental well being of every woman and girl who undergoes the surgical procedure.

In its mildest form, female circumcision involves only the removal of the foreskin of the clitoris. But in the majority of cases the clitoris itself is removed, together with all or part of the labia minora and in the most severe form the labia majora.

Initial circumcision is carried out before a girl reaches puberty sometime between 1 week and 14 years, and in some societies where infibulation is practiced, women are commonly re-infibulated after each delivery, after divorce and on the death of their husband.

Because the operation is usually preformed by traditional midwives, with unsterilized knives, razors or pieces of glass and without any anesthesia, it carried many health risks.

The immediate physical effects — acute infection, tetanus, bleeding of adjacent organs, shock resulting from violent pain, and hemorrhage — can even cause death. In fact, many such deaths have occurred in continue to occur as a result of this tradional practice.

The lifelong physical and psychological debilities resulting from female genital mutilations, are manifold: chronic pelvic infections, keloids (scar tissue), vulval abscesses, sterility, incontinence, depression, anxiety and even psychosis, sexual dysfunction and marital disharmony, and obstetric complications, with risk to both the infant or fetus and the mother. Female circumcision also carries with it the possibility of AIDS infection. Finally, there is profound impairment of women's potential for development as a result of trauma and chronic suffering.

Female circumcision is significantly associated with proverty, illiteracy and low status of women, with communities in which people face hunger, ill health overwork and lack of clean water. In these settings, the woman who is not circumcised is stigmatized, ostracized and not sought in marriage. Regardless of her personal feelings, a woman who wants to remain with her own community cannot afford to rebel against or even question this tradition which remains profoundly entrenched in powerful taboos and is protected by secrecy and moral codes. If she loses her community social acceptance and support, it may mean the difference between life and death. Hence the paradox — the victims of the practice are also its strongest proponents.

Because of the difficulty and delicacy of eradicating a practice based on cultural and traditional patterns that have been traced back for over 2000 years, the issue can only be addressed effectively by promoting awareness through education of the

[1] Issued by the joint WHO/FIGO Task Force. For further information contact FIGO Secretariat, 27 Sussex Place, Regents Park, London, NW1 4RG, UK.

[2] This article appeared in the International Journal of Obstetrics and Gynecology 1992; 37: 19.

public, of health workers and of trained practitioners. It requires the active involvement of local communities, their leaders, women groups and organizations rather than emotional statements by outsiders, however well intentioned they may be. Experience shows that when the practice of female circumcision has been condemned by outsiders or outlawed by governments in isolation from the complex psychosocial, cultural process of which it is but one part, it has led to the exacerbation of the problem. The practice has simply been done with greater secrecy and those suffering from complications have been inhibited from seeking help.

In any effort to change prevailing attitudes towards this custom, the education of men is as critical as the wider efforts to improve the status of women including that of their reproductive health as a whole. In settings where femal circumcision represents one among many other serious problems facing women, it is these women themselves who must set their priorities and initiate the steps towards the abolition of this practice in line with the religious and cultural sensitivities surrounding this subject. National and local women's organizations, governmental or not, have been distinctly identified as the most appropriate mechanism for influencing the process of change in attitudes and practice of this age old custom. Such national and local initiatives can be greatly helped by outside support to accelerate this pace of change.

Together with UNICEF, UNFPA, WHO and FIGO continue to support national efforts against femal circumcision and to collaborate in research and in the dissemination of information. WHO also collaborates with the Inter-African Committee, a regional NGO which works through its affiliates in 22 African countries.

WHO believes that integrating information on female circumcision in programs of primary health care and safe motherhood will have a far reaching effect.

World Health Organization
Organisation mondiale de la Santé

EXECUTIVE BOARD
Ninety-third Session

Provisional agenda item 8

EB93/18
12 January 1994

# Maternal and child health and family planning: Current needs and future orientation[1]

## Report by the Director-General

This report reviews the health situation of women and children 15 years after the introduction of primary health care and 18 years after the sixth meeting of the Expert Committee on Maternal and Child Health. Major advances in policies and programmes have occurred since then. While many of the recommendations of the Expert Committee have been implemented at a policy level and are reflected in the strategy for health for all through primary health care, there have been notable gaps between policy and programme implementation in a number of areas. Integration of the elements of maternal and child health and family planning and sustainability of programmes elude many countries, particularly the least developed, with their weak infrastructures and dependence on external support for specific components of care.

Nearly all countries have adopted policies recognizing the importance of family planning, and direct or indirect support to programmes is found in 144 countries. However, a great continuing need for the spacing and limiting of births is noted in many countries, and facilities for family planning are often limited to the maternal and child health services.

Immunization coverage shows substantial increases in all regions of the world and infant mortality rates continue to decline. New problems have emerged, and many have been reflected in policies and programmes.

Maternal health has become a high priority in most countries, underlined by the tragic figure of over 500 000 maternal deaths each year. The health of the newborn is inseparable from the health of the mother. Despite progress, significant differences in maternal and child health and family planning coverage continue to exist between countries, and differences between groups within countries may even be on the rise. Analysis of the patterns of coverage and accessibility reveals major gaps in the quality of care provided in services.

Approaches appropriate to both developed and developing countries are described in the final sections. The Executive Board is invited to consider resolutions on traditional practices that are harmful to the health and development of women and children and on quality of care in maternal and child health and family planning.

[1] For a tabular summary the reader is referred to document EB93/INF.DOC./3.

## CONTENTS

## INTRODUCTION

1. At its ninety-first session the Executive Board requested that a report on progress in maternal and child health and family planning be prepared for the ninety-third session. Subsequently, the Health Assembly in resolution WHA46.18, *inter alia*, requested the Director-General to give particular attention in his report to traditional practices affecting the health of women and children. The last comprehensive review of maternal and child health was made at the sixth meeting of the WHO Expert Committee on Maternal and Child Health in 1975.[1] In 1978 the Thirty-first and in 1979 the Thirty-second World Health Assembly, considering the report of the Expert Committee and on the occasion of the International Year of the Child (1979), requested the Director-General *inter alia* to report on progress in maternal and child health and family planning to a future Health Assembly.[2] While progress in specific programme areas relevant to maternal and child health and family planning have been reviewed by subsequent Health Assemblies,[3] this report is the first review of progress in nearly 15 years. The recommendations of the sixth meeting of the Expert Committee have been taken as the point of departure for this report.[4] Since then the world has undergone monumental social, political and economic changes. The information revolution and rapid advances in technology have affected the health of women and children in nearly all countries and communities. Problems of maternal health, HIV/AIDS and the large numbers of refugees and people displaced by natural and man-made disasters, unnoticed or unimagined in 1975, came to the fore in 1993. Violence affecting women, children and adolescents is being recognized as a public health problem. Newer evaluation techniques have provided better insight into such issues as the content and quality of care, adequacy of skills and the organization of services as district systems. The new emerging needs are summarized in document EB93/INF.DOC./3.

2. This report deals with major developments in maternal and child health and family planning as they relate to the overall provision of services. Recent reports of the Director-General and reports of Technical Discussions at the Health Assembly have dealt with the Expanded Programme on Immunization, "Women, health and development", "The health of youth", "Health of the newborn", "Women and AIDS", and "Control of diarrhoeal disease". While there have been references by the Board and Health Assembly to maternal health and safe motherhood, family planning, and the need for an integrated approach to maternal and child health and family planning, the Board has not explicitly examined the needs and experience of countries with respect to these problems. Information for this review has been forthcoming from: the monitoring of the global strategy for health for all; the development of monitoring and evaluation methods within specific programmes; the data from Demographic Health Surveys; reports of regional committees; preparatory work for the International Summit for Children; the development of readily accessible databases relevant to the health of women and children; and the documents and background papers for the seventh meeting of the Expert Committee on Maternal and Child Health in December 1993.

## POLICIES AND INTERNATIONAL INSTRUMENTS

3. As noted in document EB93/INF.DOC./3, there has been no dearth of policy responses to most of the matters raised by the sixth meeting of the Expert Committee on Maternal and Child Health, or to a

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[1] *New trends and approaches in the delivery of maternal and child care in health services.* WHO Technical Report Series, No. 600, 1976.

[2] Resolutions WHA31.55 and WHA32.42.

[3] Relevant Health Assembly resolutions on maternal health; women, health and development; infant and young child feeding; Expanded Programme on Immunization; diarrhoeal diseases; human reproduction research, etc. are noted in document EB93/INF.DOC./3.

[4] Although the Expert Committee's report included recommendations on research, the subject will not be covered in this report since an earlier meeting of the Advisory Committee on Health Research dealt with this subject and because space is limited.

number of those that have arisen subsequently. Alma-Ata at the time of the International Conference on Primary Health Care represented a sea of change for policy and programme development in maternal and child health and family planning. The Declaration, *inter alia*, affirmed that family planning as part of maternal and child health was an essential element of primary health care, and that equity and participation of communities were essential in health development. Many of the goals set to meet the needs of women and children are common to WHO, UNICEF, UNFPA and UNDP. They have been reiterated and expanded upon in: the WHO/UNICEF Common Goals for the Fourth United Nations Development Decade; a series of joint policy statements by WHO and UNICEF on such subjects as immunization, control of diarrhoeal and respiratory diseases, breast-feeding, and maternal and neonatal care, and - with UNFPA - on reproductive health of adolescents, traditional birth attendants, breast-feeding and family planning, and HIV/AIDS and maternal and child health and family planning (the latter also with UNDP). The Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, *inter alia*, establish legal frameworks for action by national authorities to give effect to many of the health goals and targets adopted by the Health Assembly and other international bodies. Target-setting as a means for guiding and providing a stimulus for national and international action has been introduced since the sixth meeting of the Expert Committee on Maternal and Child Health.

## PROGRESS IN THE HEALTH STATUS OF WOMEN, CHILDREN AND FAMILIES

4. The greatest strides in this domain in the last two decades have been made in child health and family planning. Life expectancy at birth increased from 51 to 64 years between 1960 and 1990. From estimated global childhood immunization coverage of about 5% in 1975, coverage reached about 80% in 1991 (see document EB93/INF.DOC./3). Infant mortality declined from 76 per 1000 live births in 1985[1] to 68 per 1000 in 1991. Emphasis on breast-feeding and the introduction of oral rehydration therapy in the management of diarrhoeal disease have resulted in sharp declines in the case-fatality rate for this disease. For nearly all areas of the world stunting - an indicator of long-term malnutrition - declined from 40% to 34% between 1975 and 1990.

5. There is much evidence that family planning affects the health and well-being of women in many ways. Among the most significant benefits are: improvement in health status, self-esteem and educational and employment opportunities. More specifically, the possibility to avoid an unwanted pregnancy and to space out or limit childbearing enables women better to exercise their rights as women in their productive and reproductive lives. Currently 144 countries provide direct or indirect support to family planning programmes. The total number of contraceptive users in developing countries is estimated to have risen from 31 million in 1960-1965 to 381 million in 1985-1990. Progress in and unmet needs for family planning (by United Nations regions) is presented in document EB93/INF.DOC./3. To meet these needs, taking into account the United Nations projection for medium population growth, the current estimated "contraceptive prevalence" (51% of people protected) will have to increase to 59% by the year 2000.

6. Little notice was accorded to maternal health until WHO, UNFPA, UNDP and the World Bank focused world attention, at the International Conference on Safe Motherhood in 1987 in Nairobi, on the tragic figure of 500 000 maternal deaths each year. Awareness and policy commitment are widespread but progress has been slow. The negative indicators of women's health - maternal mortality, anaemia, unsafe abortion, low birth weight and perinatal mortality - remain high, and where data on trends are available they show only slow improvement or none - even a deterioration, particularly in the least developed countries or disadvantaged communities. WHO estimates that in the period from 1983 to 1988 numbers of maternal deaths remained the same but in some areas of Africa maternal mortality rates increased by 3% to 9%. The declines over that period in Asia and Latin America were in large part attributable to declining fertility. While earlier data suggested that countries with at least 70% coverage by trained birth

[1] *Implementation of the Global Strategy for Health for All by the Year 2000, Eighth report on the world health situation, Vol. 1.* Geneva, World Health Organization (1993).

attendants do not appear to have maternal mortality rates higher than 150 per 100 000 live births, more recent data from a few urban centres in Africa and Asia have shown rates ranging from 200 to 500 per 100 000. These rates are much higher than expected in areas where the coverage by prenatal care and trained attendants in childbirth were thought to be adequate. It is apparent that the content and quality of care must be assured simultaneously if maternal health is to benefit. Low birth weight and anaemia during pregnancy, two other negative indicators of newborn and maternal health, have not shown any improvement for the world as a whole in the decade from 1980 to 1990. The current global rate for low birth weight is 17%, while the rate of anaemia among pregnant women is 51%.

7. Despite the emphasis on lowering infant mortality there is only limited direct activity in countries to reduce neonatal mortality, which accounts for half of infant mortality, and to combat low birth weight, another major factor. The causes of the 4.2 million deaths in newborn infants each year are linked to complications of pregnancy and/or birth: neonatal tetanus, low birth weight and pre-term births, asphyxia/hypoxia, birth trauma and infections. The millions of newborn infants who survive the consequences of maternal ill health, poor nutrition and poor quality of care are left with poor health, increased risk of death or life-long morbidity. Infants with low birth weight or born prematurely are more likely to suffer the effects of birth trauma and asphyxia, with permanent and severe damage from seizure disorders, retardation or learning disabilities. Yet, most of the conditions that result in neonatal death and severe morbidity can be prevented or treated without resorting to sophisticated and expensive technology. The health needs of newborn infants, inseparable from those of the mother, are mistakenly thought to involve high technology and sophisticated services.

## EMERGING HEALTH NEEDS FOR WOMEN, CHILDREN AND FAMILIES

8. Children and women are particularly vulnerable to the effects of poverty, disaster and displacement. Even in natural disasters they bear a disproportionate share of the morbidity and mortality. In most catastrophic situations - war, famine, refugee movements, natural disasters - children are separated from their families. Studies of children's response to extreme violence, death of those around them, abuse and hunger indicate that they are able to resist emotional stress and physical hardship as long as they remain with their parents and families; emergencies become significant in this sense as soon as separations occur and the child's primary attachments are disrupted. Sexual violence against women and sexual exploitation are all too common in mass conflicts. Mental illness is a much neglected but serious consequence of violence, social disruption, refugee situations or displacement. The behavioural implications, in adulthood, for children exposed to widespread senseless violence and death - as such events become banal - and to disruption of the social fabric, are serious. Studies of ghetto children have shown that violent conditions at home and in the environment tend to breed violence.

9. Child labour and the phenomenon of street children persist as economic crisis deepens. The International Labour Organisation conservatively estimates that over 18% of children between 10 and 14 years of age in developing countries are working: at least 7% in Latin America, 18% in Asia and 25% in Africa. Hazards to health include malnutrition (as energy for growth is diverted to work), exposure to toxic substances, and occupational illness and injury, and they can be fatal.

10. Families, and especially the women members, have been seen as the "under-utilized" resource for care. Yet, the family needs internal support if it is to function, providing for the basic requirements of its members. Very little information is available on family functioning and the health of families. The burden of maintaining a family as a functioning entity is on women in much of the world, and often they have limited decision-making authority. There are few indicators of the health of families.

(Emerging needs related to HIV/AIDS must not be forgotten. They have been and must continue to be considered by the Board in another context - see provisional agenda item 9.)

## PROVISION OF CARE: ACCESSIBILITY, COVERAGE AND QUALITY OF CARE

11. Adequate coverage is the aim of programmes, and it is often used as an unofficial indicator for the effect of care; however, it is imprecise and of limited use managerially. For example, low levels of coverage could be attributed to inaccessibility (in terms of delays, or distance from services), or to lack of motivation to use services, a more complex factor with economic and cultural aspects, perception of need and belief that the services will meet the need, as well as the acceptability of the services and those providing them. Even when coverage is reported to be high, the system may not be working according to expectations because of lack of equipment or supplies, or health workers may fail to perform tasks correctly.

12. Accessibility of care has not been considered methodologically except in isolated studies and in recent Demographic and Health Surveys (DHS) in a limited number of countries. A wide discrepancy between the population considered to have access to services and those actually using services provides programme managers with an indicator of problems in terms of communities' knowledge, perceived needs or motivation. An analysis of the accessibility of different components of maternal and child health and family planning care provides a measure of the degree to which services are functionally integrated within a community. Data from the DHS during the period 1988-1991 showed a wide variation in accessibility and degree of integration of the different components of maternal and child health and family planning; the widest discrepancy between accessibility and use concerned family planning activities and the use of oral rehydration salts. There is also a wide gap between rates of diphtheria/pertussis/tetanus (three doses) in children and tetanus toxoid vaccination (two doses) for women at risk. An analysis of the use of services in relation to distance from the services provides a useful measure of the importance of the latter. Among 10 countries in which this was examined in DHS studies, distance was not a factor in five while in two it was a severe constraint, and in three a lesser constraint.

13. Significant improvement in maternal health is not possible in the absence of the essential obstetric care generally found at the level of a district or small rural hospital. Yet even in developing countries with well developed health infrastructures, only a minority of the rural population has access to such facilities. As noted in the WHO/World Bank analysis for the 1993 World Development Report, many of the essential obstetric functions could be provided at the level of the health centre where staff had the necessary midwifery skills and supplies and equipment to deal with emergency treatment of haemorrhage, infection, etc. The DHS comparative analysis indicated that in most countries the majority of rural women live within eight kilometres of a health centre.

14. Access to services does not ensure the availability of service or the necessary quality of care. Evaluations of the performance of the maternal and child health and family planning services in several countries have confirmed that essential tasks, such as testing for anaemia or measuring blood pressure, cannot be performed because equipment and supplies are not available or are out of order. Even when they are available, they may be misused; in one evaluation 40% of the health workers did not perform their tasks correctly or did not perform them at all. Thus, while countries may report reasonably high levels of maternal and child health and family planning coverage, *effective* coverage should be the criterion by which to judge progress. Less effective coverage may account for the contradictory data on the effect of antenatal care on pregnancy outcome, as it is also likely to explain the very wide discrepancy between claimed numbers of trained delivery attendants and high rates of maternal mortality. Some countries with maternal mortality rates of 500 per 100 000 live births, or higher, reported that 50% to 70% of birth attendants were trained. Similar discrepancies are observed in data from at least two African urban settings. Before extending maternal and child health and family planning services, the content and quality of care provided remain among the highest priorities.

15. A critical method for the evaluation of quality is maternal and perinatal death audit. In one recent national study, failure in diagnosis or incorrect case management by the obstetrician was noted in over 40% of the instances where the mother died, shortcomings in the facilities were noted in over 10% of the instances and "self-neglect" when women failed to seek care was noted in over 50%. Only 7% of the deaths

were considered unavoidable, and over 50% of the problems could have been detected during antenatal care.

16. In many countries, particularly those with weak infrastructures, new maternal and child health and family planning programme components, such as the Expanded Programme on Immunization and diarrhoeal disease control, were introduced with their own structures and procedures for planning, management, training, information and evaluation. Often they were strongly supported by external resources in contrast to other aspects of maternal and child health care. By 1990 immunization programmes had made spectacular progress, but - in Africa at least - there was a 10% decline in immunization coverage between 1990 and 1991; countries with the best overall maternal and child health coverage maintained high levels.[1]

17. The deployment of maternal and child health personnel is inequitable; midwifery is the backbone of maternal and child health and family planning services; many countries have enough trained midwives in theory but most are located in the urban areas, some in private practice. Rural clinics are often not provided with the equipment and skills to handle the common complications of pregnancy. Rural areas have to make do with traditional birth attendants who, while a useful adjunct to the modern midwife, are not an adequate substitute alone and without the supervision or referral services essential to prevent maternal mortality.[2] Some countries have no alternative but to train traditional birth attendants. In some countries in Africa and Latin America maternity waiting homes have been established close to the referral hospital. Malawi, Mozambique and Zaire are among countries that have upgraded the obstetric and surgical skills of medical assistants and midwives to provide essential obstetric care.

## TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN

18. All societies have evolved norms of care, feeding and related behaviour with variations according to age and sex. These "norms", often referred to as traditional practices, have social or cultural origins or are based on empirical observation of individuals or society and their well-being. The health effects of traditional practices may be beneficial, harmful or benign. Many of the traditional practices of childbirth are beneficial, including delivery in an upright position, the presence of a companion during labour and delivery, and measures to ensure a warm, draught-free environment.

19. While many traditional practices have no health rationale they may have a profound health effect, particularly those relating to female children, relations between males and females, including marriage, and sexuality. The socially disadvantaged position of women and girls is manifested in feeding patterns, health care, work, play and schooling. The effects are often cumulative, the most severe consequence being death in childbirth. The last to be fed, the least educated, in many societies the girl child is kept indoors, out of the sun and without other sources of vitamin D, and her pelvic bones are apt to become deformed. Because of menses and later pregnancies and lactation, the adolescent girl requires, but rarely gets, 18% more iron per kg body weight than male adolescents. Globally, 37% of women, and 51% of pregnant women, suffer from anaemia. In developing countries, up to 7% of pregnant women suffer from severe anaemia (below 7 gm% haemoglobin). The common practice of drinking tea with meals interferes with the biological availability of whatever quantity of limited iron may be present in the diet. The practice of eating less or doing without certain nutritious foods during pregnancy is widely described but poorly documented (ACC Subcommittee on Nutrition, 1988). It is presumably thought to guarantee a small infant, thus reducing the chance of obstructed labour due to cephalopelvic disproportion. No published research results confirm or disprove the concern that food supplementation before and during pregnancy might increase such risks while reducing the risk of low birth weight of the baby and malnutrition of the mother.

[1] UNICEF, *Progress of Nations*, 1993.

[2] World Bank, *Better Health in Africa*, 1993; Joint WHO/UNFPA/UNICEF Statement, 1992.

20. Child marriage persists in many communities. With marriage comes the pressure to bear a child, preferably a son. Unfortunately for the girl, the capacity for reproduction is attained about three years before full growth and, more importantly, before the pelvic bones reach adult dimensions. Pregnancy, without nutritional supplementation, before completion of growth will retard or stop further growth, leaving the girl-cum-woman at high risk of obstructed labour, vesiculo- or ano-vaginal fistula, infection and death. In Ethiopia, for example, the maternal mortality rate in the age group 15-19 years is three times higher than that in the age group 20-24 years. In northern Nigeria, in the absence of antenatal care, 5% to 7% of girls under 17 years may die. When such "children bearing children" survive and are still fertile, they face the prospect of repeated complications in future childbearing. If the girls have had the misfortune to undergo one or another form of genital mutilation, and have survived, they are doubly endangered.

21. Female genital mutilation is a collective name given to a series of traditional surgical operations performed on female genitals in several countries in the world. It is a cultural practice and not a disease. Its physical and psychological effects on girls and women, particularly on normal sexual function, affect their reproductive health in a way which lasts all their lives, since none of the procedures are reversible. In all types of female circumcision part or the whole of the clitoris is removed. More severe forms, such as excision and infibulation, remove larger parts of the genitals and close off the vagina, leaving areas of tough scar tissue, permanent damage and dysfunction.

22. 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. At present, it is estimated that between 85 million and 114 million girls and women in the world are genitally mutilated (Table 1). Most of them live in 26 African countries, a few in Asian countries and increasing numbers in Europe, Australia, Canada and the United States of America. It is estimated that at least two million girls every year are at risk of genital mutilation. The information on total prevalence and rates by type of operation is incomplete (Toubia, 1993). It is estimated, for example, that more than 80% of women in Somalia, Djibouti and North and Central Sudan have undergone the more severe procedure, infibulation. Most of the studies and reports contain inadequate or biased samples and use unclear or faulty methods of data collection. The only country with nationwide data is Sudan, where three countrywide surveys included questions on female genital mutilation.[1]

23. The immediate and long-term consequences will vary depending on the procedure performed. The immediate consequences may include: haemorrhage, tetanus or sepsis, vesiculo-vaginal fistula and most recently, HIV transmission from the performer of the operation or when the procedure is part of a group ritual among older girls. Other consequences include cysts and abscesses, keloid and severe scar formation, difficulty voiding and during menstruation, bladder and urinary tract infection, etc. For the most severe form, infibulation, difficulties in intercourse may lead to the cutting open of the vagina, which usually becomes necessary in any event in the course of delivery. Though no data exist, it is likely that the risk of maternal death and a stillbirth is greatly increased by these factors, particularly in the absence of skilled personnel and appropriate facilities. During childbirth the risk of haemorrhage and infection is certainly greatly increased, and long-term morbidity becomes cumulative and chronic.

24. 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

[1] University of Khartoum Survey 1979, World Fertility Survey [WFS] 1979/80, and Demographic and Health Survey [DHS], 1990. Comparison of WFS and DHS data shows an overall decline of about 6%-8% and a shift from infibulation to clitoridectomy affecting 12% of those mutilated.

far as possible the skills and experience of those whose work is among villagers, such as teachers, social workers and health personnel.

25. 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.

## WHO RESPONSE TO THE PERSISTING PROBLEMS AND NEW CHALLENGES

26. The health of women and children is among the highest priorities for all regions of the Organization. The governing bodies at global and regional levels have discussed the majority of previously identified and emerging needs in maternal and child health and family planning, although they have yet to respond to some of the critical problems of management and performance in programmes. At all levels WHO has attempted to maintain its leadership in supporting Member States in the development of policy and of technical programmes. However, too often, its presence and coordinating role in many countries is limited by material and human resources; resources, and not reason, often have the greater influence on health development priorities. The Organization's development and application of a number of methods for "empowerment" to improve the quality of care, programme performance and training, have been effective in pinpointing many of the questions raised in this report.

27. Regional and global programmes have asserted policy and technical leadership in support of Member States to tackle the most glaring manifestation of inequity and years of neglect for women's health, namely maternal mortality. With the support of a number of major agencies, a global programme on maternal health and safe motherhood has been launched. Activities are focused on national programme development and the global support necessary for that process. Particular attention has been given to the role of health centres, midwifery skills and essential obstetric care in the programme's strategy. A "mother-baby package" of measures to be implemented in any country within the context of national health development has been prepared.

## CONCLUSIONS: OLD NEEDS UNMET, EMERGING NEEDS WITH NEW CHALLENGES

28. WHO has been increasingly successful in monitoring the health situation of women and children, documenting global and regional progress and spotting situations requiring urgent attention. The strategies and tools for improving maternal and newborn health have been found. The urgency with which the Organization has taken the lead in this field has in large part been matched by the commitment of many, if not most, countries. Many more countries must take the next step of adapting the global and regional policies, strategies and technology for national programmes. Maternal and newborn health and family planning require even higher commitment of the donor community, governments and WHO. Strengthening of country coordination, and cooperation with nongovernmental organizations, together with rapid exchange of country experience, will facilitate the attainment of the global target of reducing by half the 1990 level of maternal mortality by the year 2000.

29. Considering the analysis reflected in this report and recognizing that the goals of health for all and the Child Summit will not be realized without sustained support for the health of women, children and adolescents, a concerted effort must be made:

- to improve the quality of care and programme performance as a prerequisite for any major investment in extending the coverage of services for maternal and child health and family planning;

- to strengthen the understanding, training and commitment of staff of the entire health system regarding the importance of family planning and their contribution to related services;

- to ensure the functional integration of all the elements of maternal and child health and family planning services, their planning, management and evaluation, to serve not only women and children but young people and families, and including activities for the prevention of sexually transmitted diseases and HIV/AIDS;

- to focus on and plan the elimination of harmful traditional practices affecting the health and development of women and children, in close cooperation with governments and nongovernmental organizations, and stress the public health implications of violence and abuse of women and children, and the need for action to prevent them;

- to increase sustainability of maternal and child health and family planning programmes through decentralization and integration of services and appropriate delegation of responsibility for care within the community, relying on people's involvement and participation, and improve the quality of care.

## ACTION BY THE EXECUTIVE BOARD

30. After reviewing this report, submitted in accordance with resolution WHA46.18, and the complementary document EB93/INF.DOC./3, and noting the action of WHO in response to country needs, the Board may wish:

(a) to recommend that the programme's financing should be allocated distinctly within WHO's overall accounts in order to give the necessary attention to the activities and the need for increased external funding, and approve the establishment of a Special Account for the Maternal Health and Safe Motherhood Programme within the Voluntary Fund for Health Promotion as from 1 January 1994;

(b) to consider the following two draft resolutions:

### (1) Traditional practices harmful to the health of women and children

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;

2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;

3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 251 of 1992 on traditional practices affecting the health of women and children;

Recognizing that although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early marriage and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES 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 abolish female genital mutilation, marriage and 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;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

## (2) Quality of care in maternal and child health and family planning

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;

2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;

3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA32.30 on primary health care and monitoring health for all; and WHA46.18 on maternal and child health and family planning for health;

Noting that the Organization has successfully developed and adapted a number of management and evaluation methods that involve the participation of all levels of the health system and community, that can be rapidly applied to a wide range of service delivery problems, and that may provide guidance on action needed to improve the functioning and performance of maternal and child health and family planning services;

Recognizing that enormous progress has been made in many aspects of maternal and child health, as evidenced by the great increase in immunization coverage, accessibility and use of family planning services and numbers of trained attendants at childbirth;

Concerned nonetheless that in many countries such increases in coverage are not having the expected effect because of poor quality of care and performance of health systems;

Emphasizing that rapid progress in the health of mothers and the newborn and in family planning can be assured by improving the quality of care and the performance of the existing services and staff,

1. URGES all Member States:

(1) to give priority to assessing and improving the quality of care for women and children in district-based health systems;

(2) to adapt and apply standard protocols for the diagnosis and clinical management of the common problems encountered in services for the health of mothers, infants and children;

(3) to strengthen health centres so as to ensure a high level of midwifery care, and to provide regular supervisory, managerial and logistic support to peripheral health posts, community health workers and trained traditional birth attendants applying local strategies for the health of mothers and the newborn;

(4) to reorient training curricula to community-based and problem-solving approaches, and to ensure that health workers are made aware of the attitudes and needs of women and other members of the community;

2. REQUESTS the Director-General:

(1) to continue to provide technical support and guidance to Member States in the further development, adaptation and application of indicators of quality of care in maternal and child health and family planning and other aspects of primary health care;

(2) to continue to prepare guidelines and training material and devise approaches that improve the quality of care through standardized case definition, diagnosis and case management for the major health problems affecting mothers, the newborn, infants and children, and providing the necessary supervisory support;

(3) to ensure that the components of maternal and child health care and family planning are promoted and provided to Member States in a coherent and integrated manner, and that they correspond to national priorities and demand.

## TABLE 1. 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[1] | 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 97% 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 | |
| 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.)

[1] Reported jointly in the absence of separate statistics.

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世界衛生組織執行委員會 決議 قرار المجلس التنفيذي لمنظمة الصحة العالمية
RESOLUTION OF THE EXECUTIVE BOARD OF THE WHO
RÉSOLUTION DU CONSEIL EXÉCUTIF DE L'OMS
РЕЗОЛЮЦИЯ ИСПОЛНИТЕЛЬНОГО КОМИТЕТА ВОЗ
RESOLUCION DEL CONSEJO EJECUTIVO DE LA OMS

Ninety-third Session EB93.R10

Agenda item 8 25 January 1994

# Maternal and child health and family planning: Current needs and future orientation

## Traditional practices harmful to the health of women and children

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;

2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;

3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 251 of 1992 on traditional practices affecting the health of women and children;

Recognizing that although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early marriage and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES 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, marriage and 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;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

Thirteenth meeting, 25 January 1994
EB93/SR/13

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世界衛生大會 決議 قرار جمعية الصحة العالمية
RESOLUTION OF THE WORLD HEALTH ASSEMBLY
RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ
РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ
RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

**FORTY-SEVENTH WORLD HEALTH ASSEMBLY** **WHA47.10**

Agenda item 19 10 May 1994

# Maternal and child health and family planning: traditional practices harmful to the health of women and children

The Forty-seventh World Health Assembly,

Noting the report by the Director-General on maternal and child health and family planning: current needs and future orientation;

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 1992/251 on traditional practices affecting the health of women and children;

Recognizing that, although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early sexual relations and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

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(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;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

Twelfth plenary meeting, 10 May 1994
A47/VR/12

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# Female genital mutilation

*An overview*

World Health Organization
Geneva
1998

The World Health Organization was established in 1948 as a specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health, a responsibility that it fulfils in part through its extensive programme of publications.

The Organization seeks through its publications to support national health strategies and address the most pressing public health concerns of populations around the world. To respond to the needs of Member States at all levels of development, WHO publishes practical manuals, handbooks and training material for specific categories of health workers; internationally applicable guidelines and standards; reviews and analyses of health policies, programmes and research; and state-of-the-art consensus reports that offer technical advice and recommendations for decision-makers. These books are closely tied to the Organization's priority activities, encompassing disease prevention and control, the development of equitable health systems based on primary health care, and health promotion for individuals and communities. Progress towards better health for all also demands the global dissemination and exchange of information that draws on the knowledge and experience of all WHO's Member countries and the collaboration of world leaders in public health and the biomedical sciences.

To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures the broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease throughout the world, WHO's books contribute to achieving the Organization's principal objective – the attainment by all people of the highest possible level of health.

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# Contents

# Foreword

Female genital mutilation, a traditional practice that can have serious health consequences, is of great concern to the World Health Organization (WHO). In addition to causing pain and suffering, it is a violation of internationally accepted human rights.

In the last few years, WHO's governing bodies have adopted a number of resolutions urging Member States to establish clear national policies to end traditional practices that are harmful to the health of women and children and requesting WHO to strengthen its technical support and other assistance to the countries directly concerned. Activities are being carried out to combat this practice as part of WHO's broader programmes on women's and children's health.

WHO has consistently and unequivocally advised that female genital mutilation, in any of its forms, should not be practised by any health professionals in any setting — including hospitals or other health establishments. While recognizing that female genital mutilation is an important reproductive health issue, it is also a sensitive topic. The issue must be approached with an understanding of the context of the cultural practice and its meaning for communities that practise it.

Much has already been achieved in the last decade in lifting the veil of secrecy from female genital mutilation and developing a strategy to bring about changes. However, there are still major gaps in understanding the extent of the problem, its health impact and the kinds of interventions that can be successful in eliminating it.

Lack of information hampers work in this area. This is why WHO is focusing on increasing knowledge and promoting technically sound policies and approaches to eliminate female genital mutilation.

This review, which includes an assessment of the epidemiological status and health complications of female genital mutilation and past and present policies at international, regional and national levels, aims to assist government agencies and nongovernmental organizations that are working to eliminate this practice. We hope that the book will help to turn this challenge into an opportunity for change in the lives of women.

**Dr Tomris Türmen**
*Executive Director*
*Family and Reproductive Health*
*World Health Organization*

# Acknowledgements

This publication has been prepared by N. Toubia and S. Izett of RAINB♀ Research, Action and Information Network for Bodily Integrity of Women.

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# Introduction

The traditional practice of female genital mutilation, sometimes referred to as female circumcision, has attracted increasing international attention in the past 20 years. Activists and nongovernmental organizations (NGOs) have used the opportunity provided by world conferences organized by the United Nations,[1] together with associated nongovernmental forums, to establish a strong global consensus against this practice and to consolidate the will and resources of national, regional and international institutions to stop it. WHO has been the leading United Nations specialized agency to take a position against female genital mutilation, starting in the 1960s. It is coordinating action in this area with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). In April 1997, WHO, UNICEF and UNFPA issued a joint statement expressing their common purpose in supporting the efforts of governments and communities to promote and strengthen action for the elimination of female genital mutilation. In recent years, increasing recognition of the human rights of women and children has brought additional calls for the practice to be stopped.

This book is intended primarily to document the medical and health facts about female genital mutilation together with related information as it appeared in the published literature, both formally in peer-reviewed journals and informally in country reports and publications resulting from workshops and conferences over the years. The book also considers legislation, human rights declarations and other action relevant to efforts to combat this practice. A special effort has been made to review past research in order to identify gaps in knowledge and make recommendations for future research priorities.

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[1] World Conferences on Women, Copenhagen, 1980, Nairobi, 1985, Beijing, 1995; World Conference on Human Rights, Vienna, 1993; International Conference on Population and Development, Cairo, 1994; World Summit for Social Development, Copenhagen, 1995.

This is not a comprehensive review of all aspects of female genital mutilation. Many organizations and countries have developed projects to educate communities or to change attitudes and behaviours towards this practice. These projects are not adequately documented and any attempt to list them would be an arduous task. Evaluation of the success or failure of these efforts is also extremely difficult at this stage. However, the walls of silence surrounding the practice have been broken. There is more willingness by all concerned to face the problem. This is the first step towards creating conditions conducive to behavioural change with regard to female genital mutilation and is a major breakthrough. Although more work needs to be done, this achievement should be acknowledged. Some communities known to practise female genital mutilation have migrated to other countries. However, little is known about the numbers of girls who have undergone female genital mutilation or who are at risk of female genital mutilation in the new communities. Although several countries have passed laws against the practice, many now recognize that laws alone are not effective and are increasingly supporting preventive education programmes within the communities directly concerned. The increasing involvement of WHO and other technical agencies in this complex area of women's health will not only add to the visibility of the issue but will strengthen work that has already begun.

This book is intended primarily to address many of the scientific and medical questions related to female genital mutilation. It is hoped that it will prove useful not only to health professionals as they consider their role in relation to this practice but also to other individuals and groups active in combating female genital mutilation or in a position to develop policies and take action to stop it. Readers may not find all the answers to their questions or concerns here. However, the list of references gives direction for further investigations.

The review has been prepared by Nahid Toubia and Susan Izett of RAINB♀ — Research and Information Network for Bodily Integrity of Women. This nongovernmental body is well known for its commitment to the protection and promotion of the health of women and girls, and in particular to the elimination of female genital mutilation.

# 1.

# Definitions and classifications

## Background

Both traditional and modern genital surgery is performed in different societies for a variety of medical, cosmetic, psychological or social reasons. The surgical procedures included in the definition of female genital mutilation used in this book are limited to cutting rituals performed exclusively for cultural and traditional reasons on girls or young women, often without their approval or full understanding of the consequences of the procedures.[1] The procedures are outlined in the current WHO definition and classification of female genital mutilation which is reproduced on page 6. Surgeries described in the medical literature as circumcision for treatment of sexual disorders[2] and sex-determining surgeries for hermaphroditism[3] are

[1] The issue of consent by an individual of majority age (adult) to non-therapeutic surgery or any physical or psychological act by another, which may be perceived by some as a violation, is a widely debated and controversial issue which is not considered in depth in this review. The authority and limitation of parents and guardians to consent or withhold consent on behalf of a minor for treatment or surgery, whether medical or ritualistic, is a subject that requires more comprehensive discussion in the future. For further reading on these issues see, for example, Katz, 1984 *(1)* and Anderson, 1993 *(2)*. Also refer to principles established in the World Medical Association Declarations of Geneva (1948), Helsinki (1964) and Tokyo (1975) *(3-5)*.

[2] Medically prescribed "circumcisions" allegedly treat women for decreased sexual response or "frigidity". These operations usually involve the removal of the prepuce or foreskin from around the glans clitoris of adult women to increase exposure of the sensitive area. This procedure may be categorized as plastic surgery and is therefore beyond the scope of discussion of this review. Other genital cosmetic surgeries, involving trimming of the labia or repositioning of the clitoris, are reported in parts of Europe and North America (*6*, p.107). Such operations were performed in Norway in the recent past on women with wide inner lips colloquially termed "bat lips". The law against female genital mutilation which was passed in Norway in 1995 also outlawed this operation. Apart from this one exception, such operations are legal in most countries on the basis that, like all cosmetic surgeries, they are requested by adult women legally capable of consent. The question of the nature of consent when culture is a major determining factor in women's choices is an important one but is also beyond the scope of this work.

[3] In sex-determining surgeries for hermaphroditism, one set of gonads is removed and there is some form of plastic reconstruction of the external genitals, which may involve amputation of some parts. One of the objections to such procedures is that they are performed on non-consenting children.

excluded. However, the limitations set for the purposes of this book should not preclude future discussions and appropriate scientific debate to expand or limit criteria for what constitutes female genital mutilation.

Female genital mutilation is mostly performed as a rite of passage from childhood to adulthood and is undertaken in most communities between the ages of four and 14 years. However, the age varies from area to area. For example, in southern Nigeria female genital mutilation is performed on babies in the first few months of life while in Uganda it is performed on young adult women. It is difficult to summarize the cultural significance of the practice in a few sentences because the cultures in which it occurs are very diverse. The reasons and meaning mostly revolve around social definitions of femininity and attitudes towards women's sexuality. A common feature is the social conditioning of women to accept female genital mutilation within social definitions of womanhood and identity. This leads them to perpetuate and defend the practice. Although many of these societies acknowledge the dampening effect of genital mutilation on women's sexual pleasure, preservation of chastity is not always the goal. In Egypt, Somalia and Sudan, for example, extramarital sex is completely unacceptable and female genital mutilation is used to ensure that it does not occur. In Kenya, Uganda and west African countries such as Sierra Leone, a girl may have a child out of wedlock to prove her fertility, then undergo genital mutilation and be married afterwards. For a mother in a society where there is little economic viability for women outside marriage, ensuring that a daughter undergoes genital mutilation as a child or teenager is a loving act to make certain of her marriageability. Because of the very private nature of the practice, the operation is performed at the request of the family and condoned by society as part of its cultural identity. The roots of the practice run deep into the individual's psychology, sense of loyalty to family and belief in a value system. These aspects are discussed further in section 3.

Controversy continues over the use of the terms "female circumcision" and "female genital mutilation" to describe the procedures employed. "Female circumcision" appeared in the reports of explorers and missionaries in Africa as early as the late nineteenth century and continued to be used until the 1980s. The term "female genital mutilation", used in the 1980s mostly by western writers (*7*), was endorsed by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) during its regional meeting in 1989 (unpublished report).

The most common argument over the term "female circumcision" relates to whether or not the procedure is analogous to male circumcision. In the medical literature, "circumcision" is used specifically to mean removing the prepuce or foreskin of the penis or the clitoris. In young girls

this procedure is extremely difficult to perform. However, in general use the term is not so precise and merely describes ritualistic cutting of the genitals for cultural or religious reasons. In the latter sense, "female circumcision" is no different from male circumcision, as both are cutting rituals performed on a child with no demonstrated positive impact on health. One difference between the two practices is that male circumcision is a clear requirement of some religions while "female circumcision" is not. The most important difference, however, is that even the most minimal form of "female circumcision" can affect a girl's normal sexual function. Evidence in the medical literature on the effect of circumcision on male sexual function is not as yet well established.[1]

The most common types of female genital cutting rituals involve amputation of part or all of the clitoris and the labia minora resulting in irreparable physical damage and increased risk of health complications (the anatomy of the external female genitalia and the effects of female genital mutilation on health are described in section 3). It is because of the severity and irreversibility of the damage inflicted on the girl's body that the procedure has been termed "female genital mutilation", often abbreviated to FGM. This is currently the term used in all official documents of the United Nations and in the documents of world conferences such as the Programme of Action of the International Conference on Population and Development, 1994 (*9*), and the Declaration and Platform for Action of the Fourth World Conference on Women, 1995 (*10*). Its use has also been endorsed by WHO (*11*). In this book "female genital mutilation" is used except when quoting a source in which the term "female circumcision" is used.

## Early classifications

A review of the literature reveals a wide range of terminology and descriptions of types and classifications of female genital mutilation. The first recorded attempt at classification was put forward by Daniell in 1847 (*12*). He described four types of clitoridectomy and excisions of labia in West Africa but did not mention any stitching of the vulva. Roles (*13*) in his review of anthropological literature of the nineteenth century described the ritual in East Africa as comprising three types: clitoridectomy, clitoridectomy and removal of the labia minora, and clitoridectomy with removal of the labia minora and majora.

[1] For further discussion of this subject, please see, for example, Taylor, Lockwood & Taylor, 1996 (*8*).

Worsley (*14*), who worked in a maternity hospital in Sudan in the 1930s, also wrote of three types:

> "a) introcision, or cutting into the vagina at an early age; b) the circumcision of women, paring the edges of the labia, together with excision of the clitoris; and c) infibulation proper, which is the aforementioned circumcision, but followed by almost complete closure of the vulval orifice".

Introcision was described by the British, when they entered Australia, as being a part of the complex initiation rituals of both sexes among some Aboriginal tribes. These rituals varied by region and introcision was not uniformly present among all subgroups. Worsley reported (*14*) that it was practised among the Petta-Petta tribe in the following manner:

> "When the girl reaches puberty, the whole tribe, of both sexes, is assembled. The operator, an elderly man trained for the purpose, enlarges the vaginal orifice by tearing it downwards with three fingers bound round with opossum string. In other districts the perineum is split up with a stone knife. This is usually followed by compulsory intercourse with a number of young men, and... [other practices] for the rejuvenation of the tribal aged and infirm."

In contemporary literature, Shandall (*15*) put forward a much-quoted classification in 1967, based on one of the earliest clinical studies of a large sample of "circumcised" women, which describes four types:

> "Type 1: Circumcision proper. This is the circumferential excision of the clitoral prepuce and is clearly analogous to male circumcision. In Muslim countries it is known as Sunna circumcision.
>
> Type 2: Excision. Besides the prepuce, this involves the removal of the glans clitoridis or even the clitoris itself and may include part, or the whole, of the labia minora.
>
> Type 3: Infibulation. This is also called Pharaonic circumcision. It involves partial closure of the vaginal orifice after excision of a varying amount of vulval tissue. In its drastic form, all or part of the mons veneris, labia majora and minora, and the clitoris are removed and the raw areas left to heal across the lower end of the vagina. After the operation, the thighs are strapped together and kept so for 40 days, complete occlusion of the introitus being prevented by the insertion of a small sliver of wood commonly a match-stick.
>
> Type 4: Introcision. This is the cutting into the vagina or splitting of the perineum, either digitally or by means of a sharp instrument, and is the severest form of circumcision."

These types correspond to those put forward by Verzin (*16*) in 1975. This classification was more accurate than the previous ones but still had several drawbacks, namely:

- The existence of a ritual operation which can be classified as type 1 or "true circumcision" has never been adequately documented. What is locally referred to as Sunna circumcision in many countries often includes removal of part or all of the clitoris, as is the case in Egypt and Sudan.
- The term "Pharaonic" is a Sudanese colloquial reference to infibulation and also implies a historical origin which is still open to question. The same type of female genital mutilation is referred to as "Sudanese circumcision" in Egypt. The use of colloquial terminology in the literature without reference to a standardized scientifically-based classification has resulted in confusion when comparing reports from different countries.
- Including introcision in a formal classification is not useful. There is no evidence of this practice outside Australia, either in Sudan or other African countries that practice female genital mutilation. A recent inquiry to the Australian government revealed that there are no known reports of the practice currently among the indigenous population (unpublished communication).

Many modifications of the Shandall classifications followed, adding further to the confusion (*16–22*).

## Current WHO classification

Recognizing the need for a standardized classification, WHO convened a Technical Working Group on Female Genital Mutilation in Geneva, Switzerland, in July 1995. That Technical Working Group described the practice, and WHO's attitude to it, as follows (*11*):

> "Female genital mutilation is a deeply rooted, traditional practice. However, it is a form of violence against girls and women that has serious physical and psychosocial consequences which adversely affect health. Furthermore, it is a reflection of discrimination against women and girls.
>
> WHO is committed to the abolition of all forms of female genital mutilation. It affirms the need for the effective protection and promotion of the human rights of girls and women, including their rights to bodily integrity and to the highest attainable standard of physical, mental and social well-being.

WHO strongly condemns the medicalization of female genital mutilation, that is, the involvement of health professionals in any form of female genital mutilation in any setting, including hospitals or other health establishments."

The joint statement on female genital mutilation issued in April 1997 by WHO, UNICEF and UNFPA gave the following definition to the practice (*23*):

"Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whethe<<r for cultural or other non-therapeutic reasons."

The three agencies classified the different types of female genital mutilation as follows:

Type I Excision of the prepuce, with or without excision of part or all of the clitoris.

Type II Excision of the clitoris with partial or total excision of the labia minora.

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

## Description of the different types of female genital mutilation

Female genital mutilation is usually performed by traditional practitioners, generally elderly women in the community specially designated for this task, or traditional birth attendants. In some countries, health professionals—trained midwives and physicians—are increasingly performing female genital mutilation. In Egypt, for example, preliminary results from the 1995 Demographic and Health Survey indicate that the proportion of women who reported having been "circumcised" by a doctor was 13%. In contrast, among their most recently "circumcised" daughters,

46% had been "circumcised" by a doctor. Further aspects of this development are considered in section 5.

The procedures employed in each type of female genital mutilation are described below.

### *Type I*

In the commonest form of this procedure the clitoris is held between the thumb and index finger, pulled out and amputated with one stroke of a sharp object. Bleeding is usually stopped by packing the wound with gauzes or other substances and applying a pressure bandage. Modern trained practitioners may insert one or two stitches around the clitoral artery to stop the bleeding.

### *Type II*

The degree of severity of cutting varies considerably in this type. Commonly the clitoris is amputated as described above and the labia minora are partially or totally removed, often with the same stroke. Bleeding is stopped with packing and bandages or by a few circular stitches which may or may not cover the urethra and part of the vaginal opening. There are reported cases of extensive excisions which heal with fusion of the raw surfaces, resulting in pseudo-infibulation even though there has been no stitching (*24–26*).

Types I and II generally account for 80–85% of all female genital mutilation (*27*), although the proportion may vary greatly from country to country.

### *Type III*

The amount of tissue removed is extensive. The most extreme form involves the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora. The raw edges of the labia majora are brought together to fuse, using thorns, poultices or stitching to hold them in place, and the legs are tied together for 2–6 weeks (*28, 29*). The healed scar creates a "hood of skin" (*17*) which covers the urethra and part or most of the vagina, and which acts as a physical barrier to intercourse. A small opening is left at the back to allow for the flow of urine and menstrual blood. The opening is surrounded by skin and scar tissue and is usually 2–3 cm in diameter but may be as small as the head of a matchstick (*14, 18*).

If after infibulation the posterior opening is large enough, sexual intercourse can take place after gradual dilatation, which may take weeks, months or, in some recorded cases, as long as two years (*21*). If the opening is too small to start the dilatation, recutting (defibulation) before intercourse is traditionally undertaken by the husband or one of his female relatives using a sharp knife or a piece of glass. Modern couples may seek the assistance of a trained health professional, although this is done in secrecy, possibly because it might "undermine the social image of the man's virility" (*30*).

In almost all cases of infibulation (*15, 17, 18*) and in many cases of severe excision (*26*), defibulation must also be performed during childbirth to allow exit of the fetal head without tearing the surrounding scar tissue. If no experienced birth attendant is available to perform defibulation, fetal and/or maternal complications may occur because of obstructed labour or perineal tears.

Traditionally, "re-infibulation" is performed after the woman gives birth. The raw edges are stitched together again to create a small posterior opening, often the same size as that which existed before marriage. This is done to create the illusion of virginity, since a tight vaginal opening is culturally perceived as more pleasurable to the man (*30*). Because of the extent of both the initial and repeated cutting and suturing, the physical, sexual and psychological effects of infibulation are greater and longer-lasting than for other types of female genital mutilation.

Although only an estimated 15–20% of all women who experience genital mutilation undergo type III, in certain countries such as Djibouti, Somalia and Sudan the proportion is 80–90%. Infibulation is practised on a smaller scale in parts of Egypt, Eritrea, Ethiopia, Gambia, Kenya and Mali, and may occur in other communities where information is lacking or still incomplete.

### *Type IV*

Type IV female genital mutilation encompasses a variety of procedures, most of which are self-explanatory. Two procedures are described here (*13*).

The term "angurya cuts" describes the scraping of the tissue around the vaginal opening.

"Gishiri cuts" are posterior (or backward) cuts from the vagina into the perineum as an attempt to increase the vaginal outlet to relieve obstructed labour. They often result in vesicovaginal fistulae and damage to the anal sphincter.

# 2.

# Prevalence and epidemiology

## Background

Documentation of the prevalence of different types of female genital mutilation began in the early twentieth century with reports by European travellers and missionaries. Since the 1950s, small studies have been undertaken by physicians and gynaecologists in some countries, using clinical records or direct interviews with patients (*15, 16, 31*).

The first national survey ever to be undertaken was conducted by the Faculty of Medicine of the University of Khartoum in Sudan in 1979 (*19*). The Sudan Fertility Survey, also conducted in 1979 (*32*), and the Demographic and Health Survey of Sudan in 1990 (*33*), also included questions on female genital mutilation. Sudan is the only country with comprehensive and reliable national prevalence data over time.

In 1993, the inclusion of a basic module questionnaire on female genital mutilation in the Demographic and Health Surveys[1] was approved (J. Sullivan, Demographic and Health Surveys, personal communication), and has since been used in several countries in Africa. Demographic and Health Survey data on female genital mutilation have recently become available for Central African Republic, Côte d'Ivoire, Egypt, Eritrea, Mali and Yemen. The United Republic of Tanzania has also included questions on female genital mutilation in its current Demographic and Health Survey. It is hoped that if the module is adopted by other countries as well, more accurate data on national prevalence of female genital mutilation will become available.

The first comprehensive article on the epidemiology of female genital mutilation worldwide was published by Hosken in 1978 (*7*). In 1979, the first edition of *The Hosken report* was published, in which the author presented a global review and country-by-country estimates of the prevalence of the practice (*34*). Although the report did not specify the exact

[1] The national Demographic and Health Surveys are prepared and organized by Macro International Inc., 11785 Beltville Drive, Calverton, MD 20705, USA.

methodology by which the data were collected, these figures remain a major source for global estimates of female genital mutilation. A literature review of available studies by Toubia published in 1993 (*35*) made modifications to Hosken's figures on the basis of more recent country studies and reports. These figures were updated again in 1995 (*27*) and 1996 (*36*).

Current estimates of prevalence are presented in Table 1 and are based on an extensive review of the most recent published literature and unpublished reports and on the most recent results from completed Demographic and Health Surveys. For countries for which results of studies with adequate sample size or regional representation were available, the estimates are based on such studies. However, the majority of published studies and surveys had sample sizes that were too small, not representative or clinically based. In addition, some reports did not state clearly how the samples were selected. The authors are also aware of a number of other studies, including several Demographic and Health Surveys and a comparative study of the results obtained using the Demographic and Health Survey module in African countries, which are currently under way or whose results became available too late for inclusion. For countries where no specific or reliable studies were found, Hosken's latest estimates are used. On the basis of these figures it is estimated that over 132 million women and girls have experienced female genital mutilation. It is also estimated that some two million girls are at risk of undergoing some form of the procedure every year.

## Africa

### *Benin (estimated prevalence 50%)*

A study undertaken by the National Committee on Harmful Traditional Practices in 1993 indicated a prevalence of 50% (*39*). Female genital mutilation is practised mainly in the northern region, in the provinces of Atacora, Borgou and Zou. It is virtually non-existent in the provinces of Atlantic and Mono. The main ethnic groups practising female genital mutilation include the Bariba, Boko, Nago, Peul and Wama. The procedure is most commonly carried out between the ages of 5 and 10, although among the Nago it is often undertaken in adult women after they have already given birth several times. Type II is the most common form reported.

**Table 1. Current estimates of female genital mutilation**

| Country | Female population[a] | Prevalence[b] | Number |
|---|---|---|---|
| Benin | 2 730 000 | 50 | 1 365 000 |
| Burkina Faso | 5 224 000 | 70 | 3 656 800 |
| Cameroon | 6 684 000 | 20 | 1 336 800 |
| Central African Rep. | 1 767 000 | 43 | 759 810 |
| Chad | 3 220 000 | 60 | 1 932 000 |
| Côte d'Ivoire | 7 089 000 | 43 | 3 048 270 |
| Democratic Republic of the Congo | 22 158 000 | 5 | 1 107 900 |
| Djibouti | 254 000 | 98 | 248 920 |
| Egypt | 28 769 000 | 97 | 27 905 930 |
| Eritrea | 1 777 000[c] | 90 | 1 599 300 |
| Ethiopia | 2 087 000 | 85 | 24 723 950 |
| Gambia | 496 000 | 80 | 396 800 |
| Ghana | 8 784 000 | 30 | 2 635 200 |
| Guinea | 3 333 000 | 60 | 1 999 800 |
| Guinea-Bissau | 545 000 | 50 | 272 500 |
| Kenya | 13 935 000 | 50 | 6 967 500 |
| Liberia | 1 504 000 | 60 | 902 400 |
| Mali | 5 485 000 | 94 | 5 155 900 |
| Mauritania | 1 181 000 | 25 | 295 250 |
| Niger | 4 606 000 | 20 | 921 200 |
| Nigeria | 64 003 000 | 40 | 25 601 200 |
| Senegal | 4 190 000 | 20 | 838 000 |
| Sierra Leone | 2 408 000 | 90 | 2 167 200 |
| Somalia | 5 137 000 | 98 | 5 034 260 |
| Sudan | 14 400 000 | 89 | 12 816 000 |
| Togo | 2 089 000 | 50 | 1 044 500 |
| Uganda | 10 261 000 | 5 | 513 050 |
| United Republic of Tanzania | 15 520 000 | 10 | 1 552 000 |
| Total | | | 136 797 440 |

[a] *The world's women.* New York, NY, United Nations, 1995 (*37*).
[b] Prevalence expressed as a percentage. Prevalences for Central African Republic, Côte d'Ivoire, Egypt, Mali and Sudan from Demographic and Health Survey results.
[c] *World population prospects: the 1994 revision.* New York, NY, United Nations, 1994 (*38*).

## *Burkina Faso (estimated prevalence 70%)*

A limited study in 1993 of 805 female genital mutilations indicated prevalence of 73% among girls aged 12–14 years and 88% among women aged 20–24 (*40*). There was little difference between rural and urban areas. However, among girls whose mothers had received secondary education, prevalence was significantly lower (48%) than among those whose mothers had not (78%). Subsequently, the national committee working to control the practice (Comité National de Lutte contre la Pratique de l'Excision)

reported that it was widespread among Christians, Muslims and animists in the provinces of Comeo, Ganzourgou, Houet, Kenedougou, Kossi, Kadiogo, Mouhoun, Nahouri, Yatenga and Zounweogo. All groups practise types I and II. The Gourounsi, Leo and Tiebele do not practise female genital mutilation. A limited survey in 1995 showed that prevalence of type I in girls aged 2–3 years was 70.6%. Prevalence of type II in the age group 12–14 was 70.5% and in the age group 20–24 was 80.1% (*41*). This report provides the basis for the current prevalence estimate.

### *Cameroon (estimated prevalence 20%)*

Female genital mutilation is prevalent in certain areas of Cameroon. There are no published studies of national prevalence, but a study by the National Committee on Harmful Traditional Practices in 1994 covered the south-west and far north provinces where the practice is known to occur (*42*). The sample was not stratified and was selected randomly from primary schools, maternity units, traditional birth attendants and communities. In this highly selected population, female genital mutilation was practised by 100% of Muslims and by 63.6% of Christians. Only types I and II were reported. The total prevalence rate for the country, estimated by observers to be 20%, is based on anecdotal evidence.

### *Central African Republic (estimated prevalence 43%)*

The 1994–1995 national Demographic and Health Survey provided the first comprehensive data on female genital mutilation in the country (*43*), indicating an overall prevalence of 43%. However, the rate varies by region and ethnic group. Région Sanitaire IV was found to have the highest prevalence at 91% and, among ethnic groups, prevalence was greatest among the Banda and Mandjia at 84% and 71% respectively. While there was no significant difference between rural and urban dwellers, there was a strong difference between women with no education or with primary schooling (47%) and those with secondary education (23%). There is some indication that prevalence is declining, as it was found to be 53% among women aged 45–49 years and only 35% among women aged 15–19. However, the lower figure in the latter group may be partly due to the fact that nearly 10% of genital mutilations are undertaken after the age of 15, so this age group may include women who have not yet undergone the procedure. In general, however, the majority of girls undergo genital mutilation between the ages of 7 and 15. The survey provided no information on the types practised.

### *Chad (estimated prevalence 60%)*

A UNICEF-supported study was undertaken in the south, east and central regions and in N'Djamena, covering nine communities (unpublished data, 1991). Types I and II were found to predominate; type III was not reported. This partial study is the basis of the current prevalence estimate.

### *Côte d'Ivoire (estimated prevalence 43%)*

The 1994 national Demographic and Health Survey provided the first reliable data (*44*) and indicated an overall prevalence of 43%. This varied from 31% in Abidjan to 57% in the rural savannah region; however, overall prevalence in the rural areas was 45%. Female genital mutilation was found to be much more prevalent among the Muslim population (80%) than among Catholics and Protestants (16%). The most striking difference was between women with no education (55%) and those with primary or secondary education (24%). There does appear to be a slight trend toward reduced prevalence, as the rates for age groups 25–29 and 30–34 were 47% while the rate for those aged 15–19 was 35%. While some women in the latter group may not yet have undergone the procedure, the majority of girls have done so before the age of 10. The survey provided no information on the types of genital mutilation performed.

### *Democratic Republic of the Congo (estimated prevalence 5%)*

No report by a national group or published study was found. The current prevalence estimate is based on previous estimates by Hosken.

### *Djibouti (estimated prevalence 98%)*

There have been no official studies on prevalence in Djibouti, but the Ministry of Health and the national women's union (Union National des Femmes de Djibouti) have reported that female genital mutilation is almost universal, with type III the most common procedure (*45*).

### *Egypt (estimated prevalence 97%)*

The preliminary results of the 1995 national Demographic and Health Survey show a surprisingly higher rate than previously estimated. A validation study is currently being conducted by the Egyptian Fertility Care Society on a subsample, comparing self-reporting and clinical examination. The final results of the survey and the validation study should yield valuable information, as the survey included extensive questions on the

procedure, complications, "circumcision" of women's daughters, and attitudes and beliefs.

Female genital mutilation is practised throughout the country by Muslims and Christians. Type I is the common procedure, although type III is reported in areas of south Egypt closer to Sudan (*46, 47*).

### *Eritrea (estimated prevalence 90%)*

In 1993, Eritrea gained independence from Ethiopia. Female genital mutilation is known to be practised by Eritrean Christians and Muslims. The Eritrean People's Liberation Front, which is the governing party, and the National Union of Eritrean Women, have taken a position against the practice since the 1970s. There are no published statistics on prevalence in Eritrea following independence from Ethiopia. While two surveys conducted in Ethiopia in 1985 and 1990 (see section on Ethiopia, below) did not produce statistics specific to Eritrea, which was a war zone at the time, they give the general impression that female genital mutilation is as widespread in Eritrea as it is in Ethiopia. Results from the recent Demographic and Health Survey in Eritrea will provide the first reliable data on prevalence.

### *Ethiopia (estimated prevalence 85%)*

Female genital mutilation is common among Christians and Muslims, and was practised by Ethiopian Jews, who now live in Israel. Types I and II are common except in the areas bordering Somalia, particularly Hararghe, where type III is practised. In 1984, the Ethiopian Ministry of Health together with UNICEF conducted a prevalence survey in five regions — Addis Ababa, Arssi, Eritrea, Gojjam and Hararghe (*48*). The findings suggest that the practice is almost universal in the areas studied, although no overall prevalence rates are cited. A further survey in 1990, sponsored by IAC, included 20 of the 31 administrative regions, covering 73% of the population of the country (*49*). This showed that 85% of the women surveyed had undergone genital mutilation. There is some regional overlap between the two surveys. However, high prevalence regions such as Diredawa, Eastern Hararghe and Ogaden were not included in the 1990 survey. Two ethnic groups, the Begas and the Wellega, do not practise female genital mutilation.

### *Gambia (estimated prevalence 80%)*

A study by Singhateh published in 1985, covering several regions in Gam-

bia, indicated a prevalence rate of 79% (*50*). However, the sample was not representative of the total population. The study reported different prevalence rates for different ethnic groups (100% for the Mandinga and Serehule, 93% for the Fula, 65.7% for the Jola and only 1.9% for the Wollof). All groups practise types I and II.

### *Ghana (estimated prevalence 30%)*

According to Kadri (*51*), female genital mutilation is practised in two secluded regions of Ghana — in the Upper East region by the Bussansi, Frafra, Kantonsi, Kassena, Kussasi, Mamprushie, Moshie and Nankanne ethnic groups and in the Upper West region by the Dargarti, Grunshie, Kantonsi, Lobi, Sissala and Walas ethnic groups. Adherence to the practice in these regions ranges from 75% to 100%. A study by Twumasi (*52*) in Accra and Nsawam in the south found female genital mutilation only among migrant communities from the northern part of Ghana and from neighbouring countries.

### *Guinea (estimated prevalence 60%)*

No studies have been conducted on prevalence and estimates are based on reporting by the National Committee on Harmful Traditional Practices (Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Femme et l'Enfant, CPTAFE; unpublished data, 1991).

### *Guinea-Bissau (estimated prevalence 50%)*

A limited non-representative survey by the national women's union (Union Démocratique des Femmes de la Guinée-Bissau) reported type II female genital mutilation in almost 100% of Muslim women (unpublished data, 1990). Muslims constitute about 50% of the population.

### *Kenya (estimated prevalence 50%)*

Types I, II and III have all been reported in Kenya, where they are practised by several ethnic groups. The Maendeleo ya Wanawake Organization, the largest women's organization in Kenya, conducted a survey in 1991 in four districts in which female genital mutilation is known to be widely practised — Kisii, Meru, Narok and Samburu (*53*). The overall prevalence in these districts was 89.6%. There are no surveys of other districts in Kenya. Given that female genital mutilation is not practised in some major districts and that it is being abandoned by the increasing

urban population, prevalence is currently estimated at 50% for the country as a whole.

### *Liberia (estimated prevalence 60%)*

According to a 1984 report (*54*), female genital mutilation is practised in most parts of Liberia and only three ethnic groups do not perform it. The estimated prevalence, based on a limited survey, is between 50% and 70%. The practice, type II only, is part of the initiation into the secret Sande or bush school.

### *Mali (estimated prevalence 94%)*

The results from the 1995–1996 national Demographic and Health Survey indicate an overall prevalence of 94% (*55*). Female genital mutilation is practised throughout Mali, except for the regions of Gao and Tombouktou. Types I and II are predominant (52% and 47% respectively), with type III representing less than 1%. There are no significant differences in prevalence between women from rural areas and those from urban areas, or between women with no education or primary education (94%) and those with secondary education (90%). Female genital mutilation is practised by all religious groups, ranging from 85% among Christians to 94% among Muslims, and across all ethnic groups. The two groups with lower prevalence rates are the Tamacheck (16%) and the Sonrai (48%), both of which reside mainly in the regions of Gao and Tombouktou.

### *Mauritania (estimated prevalence 25%)*

According to the Director of Social Affairs in the Ministry of Health of Mauritania, 20–25% of the population undergo female genital mutilation (unpublished data, 1987).

### *Niger (estimated prevalence 20%)*

While there are no published studies on national prevalence, two published reports indicate that female genital mutilation is practised in three provinces: Diffa, Niamey and Tillabery (*56, 57*). The ethnic groups concerned who perform mainly types I and II are the Arabes (Shuwa), Gourmanche, Kourtey, Peulh, Songhai and Wogo. These reports from 1992 and 1993 are the basis of the current prevalence estimate.

### *Nigeria (estimated prevalence 40%)*

Female genital mutilation is acknowledged to be widely practised in Nigeria and particularly among the three major tribes — the Hausa, Ibo and Yoruba. The practice is said to be declining in large urban centres. In 1985, the Nigerian Association of Nurses and Nurse-midwives conducted a national but non-representative survey and found that 13 out of 21 states had populations who practise female genital mutilation (*58*). Types I, II and III were all reported, as were gishiri cuts (type IV). Based on this limited sample, the average prevalence for the areas surveyed was 39.2%. This is considered low by many observers given that major ethnic groups practise female genital mutilation.

### *Senegal (estimated prevalence 20%)*

A national study by Mottin-Sylla (*59*) reported prevalence in 1990 at around 18%, revising the 1976 estimate of 35%.

### *Sierra Leone (estimated prevalence 90%)*

According to a 1984 study by Koso-Thomas (*20*), all Christian and Muslim ethnic groups in the country practise female genital mutilation, except for the Krios who live in the western region and in the capital of Freetown. Only types I and II are performed as part of the initiation rituals of the Bundo and Sande secret societies. The current prevalence estimate is based on the reporting by Koso-Thomas.

### *Somalia (estimated prevalence 98%)*

Two documents published in 1982 and 1989 indicate that female genital mutilation is almost universal in Somalia with over 80% of procedures being of type III and the remainder type I (*60, 61*).

### *Sudan (estimated prevalence 89%)*

The 1990 Sudan Demographic and Health Survey reported that 89% of ever-married women in the northern, eastern and western provinces had been "circumcised" (*33*). This is a 7% drop from the 96% found in the Sudan Fertility Survey of 1979 (*32*). The majority of women (85%) had undergone type III and only 15% had undergone type I. There was little variation in the distribution of types of female genital mutilation between rural and urban areas but there were differences in type by region. Twice as many women under 25 years (20%) as those over 40 years (10%) had

Of the 65 local social work departments canvassed, 10 reported casework intervention because of suspected female genital mutilation (*64*). The Department of Health is sponsoring FORWARD to map out the profiles of communities for whom female genital mutilation is a deep-rooted traditional practice and to review all the programmes implemented to date on female genital mutilation in the United Kingdom. The outcome of this project will be published.

## *North America*

The African Resource Centre in Ottawa, Canada, has reported 12 000 African immigrants in the city but did not indicate whether they came from countries where female genital mutilation is practised (unpublished data, 1993). Canada receives immigrants and refugees from all over Africa but the numbers of Eritreans, Ethiopians and Somalis have increased significantly in the past 10 years.

The United States of America receives immigrants and refugees from all African countries. The 1990 census, which does not carry detailed information on the country of origin of citizens and residents, indicated that the total African-born population was 363 819 and that 10 357 African-born immigrants were admitted to the country between 1991 and 1994. According to preliminary statistics collected by the Research, Action and Information Network for Bodily Integrity of Women (RAINB♀), women constitute 40.7% of the African-born population in the country. The 11 largest groups come from the following countries: Egypt, Ethiopia, Ghana, Kenya, Liberia, Nigeria, Sierra Leone, Somalia, Sudan, Uganda and the United Republic of Tanzania. The prevalence of female genital mutilation varies widely among populations from these countries. RAINB♀ is currently undertaking a study of African immigrants in the New York metropolitan area, *inter alia* collecting population statistics and conducting a needs assessment for health and social services. The aim of this study is to assist women who have suffered from genital mutilation and to prevent its occurrence among immigrant children.

## *Israel*

Between 1984 and 1990, the Government of Israel undertook a major resettlement programme for the entire Jewish population of Ethiopia. This group is known to practise female genital mutilation (*65*). A preliminary report (*66*) did not find evidence of a continuation of the practice following immigration but a more thorough investigation is needed to substantiate this. A recent study by Asali et al. (*67*), which included interviews with 21 Bedouin women, indicated that female genital mutilation has

been practised in this ethnic group. Girls are most commonly "circumcised" between the ages of 12 and 17. However, physical examination of 37 young women from these tribes revealed only small scars on the prepuce of the clitoris or on the upper labia minora, indicating that the procedure may have been modified to a non-cutting ritual in more recent years.

## Evidence of prevalence in other regions

### *Arabian peninsula*

A limited inquiry on female genital mutilation conducted in the city of Sana'a, Yemen (S. Thadeus, unpublished data, 1992), found that the practice was localized to a few ethnic groups, and was predominantly of type I. The primary groups involved had historically been traders across the Red Sea and some had settled in East Africa. The recent national Demographic and Health Survey included two questions on female genital mutilation. These questions did not refer to prevalence in Yemen, but asked whether women approved or disapproved of the practice and what their reasons were for approval or disapproval.

Bahrain, Oman, Saudi Arabia and United Arab Emirates are listed in some publications as having female genital mutilation. No national reports or documented evidence were found regarding the practice in these countries.

### *South and South-East Asia*

According to reports by Ghadially (*68*) and Srinivasan (*69*), female genital mutilation is practised in India by the small ethno-religious minority, the Daudi Bohra of the Ismaili Shia sect of Islam. The total population concerned is around half a million in the Bombay area and in small immigrant communities in Africa and North America.

According to Pratiknya of Gadjah Mada University in Indonesia, genital cutting operations took place in that country in the past but are no longer performed in the country (*70*). However, various non-cutting rituals involving the clitoris still persist in Indonesia. These include cleaning with herbal juice, symbolic cutting and light puncture of the clitoris. According to the 1997 WHO/UNICEF/UNFPA classification, symbolic cutting and light puncture of the clitoris are considered to be type IV female genital mutilation.

Several writers have reported genital mutilation practices among some Muslims in Malaysia but no reports by national groups or documented evidence of the practice have been found.

minora (equivalent to the shaft of the penis), the labia majora (equivalent to the scrotum), and the opening to the vagina.

The clitoris has four distinct parts: a small glans or head, a short body of two incompletely separated corpora cavernosa, continuous posteriorly with a pair of crura (*72*). All the parts are made of spongy, vascular, erectile tissue. The mature clitoris (glans and body) is about 2–2.5 cm in length with the crura twice as long. The size varies widely between individuals, depending on genetic and endocrine influence. Its prominence outside the lips varies with the development of the adjacent vulva.

The prepuce (foreskin) is a fold of epithelium above the clitoris which may or may not cover the entire glans. In young girls it is not well developed (2–3 mm in length) and difficult to separate from the glans. This is important to remember when comparing type I female genital mutilation to male circumcision.

The labia majora are two prominent longitudinal cutaneous (skin) folds extending from the mons veneris to the anterior boundary of the perineum. Their outer surface is pigmented and covered with hair and the inner surface is smooth and contains large sebaceous (lubricating) follicles.

The labia minora are made of cavernous erectile tissue with a high concentration of sensory nerve endings.

Lowry (*73*) summarizes the histological evidence regarding the sensitivity of the female external genitalia as follows:

> "In summary, the clitoris contains, in most women, a large number of receptor nerve endings; in some women, other areas may contain more. In almost all women, the labia minora are also highly sensitive."

The vagina is the least sensitive area, with sensory nerve endings limited to a ring around the inlet.

The above descriptions indicate the importance of the clitoris and labia minora as the primary sensory organs in the female sexual response. Cutting part or all of them will undoubtedly interfere with, though not necessarily abolish, the physical receptivity of sexual stimulation in women. Human sexual arousal is also brought about by other sensory and non-sensory stimulants. The secondary organs include the lips, breasts and other areas of heightened sexual sensitivity. Non-tactile physical senses, such as smell, vision and hearing, can transmit sexually stimulating messages. Individuals vary in terms of their psychological predisposition towards sexual arousal as well as in their ability to achieve sexual satisfaction. Emotions, as part of the psychological milieux within which sexual arousal occurs, are known to be a strong factor, particularly in women. Finally, social conditioning with regard to appropriate sexual behaviour plays a crucial role in both sexual arousal and the ability to seek and

attain sexual pleasure. The impact of female genital mutilation on sexual response is discussed in more detail below.

## Physical consequences and complications

All types of female genital mutilation involve removal or damage to the normal functioning of the external female genitalia and can give rise to a range of well documented physical complications. Psychological effects are less well documented in the scientific literature but descriptions are abundant in anecdotal evidence and in women's stories of their experiences (*74*).

The occurrence of physical complications depends on several factors, including the extent of cutting, the skill of the operator, the cleanliness of the tools used on the surrounding area, and the physical condition of the child. Although serious complications are possible following all types of female genital mutilation, those resulting from type III occur more frequently, tend to be more serious and last longer. Complications may be fewer when the procedure is undertaken by a skilled operator, although cases of death from uncontrolled bleeding from the clitoral artery have occurred even when it was performed by a trained physician (*75*).

The physical complications listed below are summarized from the published literature and focus on the short-term and long-term problems that occur with types I, II and III.

### *Immediate complications — all types*

#### Death

While anecdotal evidence is frequently mentioned (*18, 21*), no study has ever been undertaken to determine the proportion of female child mortality that is attributable to female genital mutilation. Death can result from severe bleeding (haemorrhagic shock), from the pain and trauma (neurogenic shock) or from severe and overwhelming infection (septicaemia). Asuen reported a case of a 23-year-old multiparous Nigerian woman who was "circumcised" one day prior to admission for delivery. A live baby girl was delivered but the woman's circumcision wound became infected and four days later she became comatose and died (*76*).

#### Haemorrhage

Severe bleeding (haemorrhage) is the most common immediate complication and evidence of its high incidence is abundant in the literature (*18, 21, 77*). In El Dareer's study, bleeding accounted for almost one-quarter (22%) of all reported complications (*19, 78*). Amputation of the clitoris

cuts across the clitoral artery in which blood flows at high pressure. To stop the bleeding, the artery must be packed tightly or tied with a running stitch, either of which may slip and lead to haemorrhage (*79*). Secondary haemorrhage can occur after the first week as a result of sloughing of the clot over the artery owing to infection. An acute episode of haemorrhage or protracted bleeding can lead to anaemia (*80*) or, if very severe, to death.

### Shock

Immediately after the procedure the child may enter a state of shock from the pain, psychological trauma and exhaustion from screaming. The short-term and long-term effects of this state of physical and psychological shock have not been reported.

### Injury to neighbouring organs

As the procedure is commonly performed with no anaesthesia or with local anaesthesia only, the girl screams and wriggles from fear and pain. The cutting instrument may be crude and the practitioner may be inexperienced or have failing eyesight. Any of these can result in injury to the urethra (*18*), the vagina, the perineum or the rectum and can lead to the formation of fistulae through which urine or faeces will leak continuously (*81*).

### Urine retention

Pain, swelling and inflammation around the wound and subsequent infection can lead to urine retention, which may last for hours or days, but is usually reversible. Intervention with a catheter or removal of stitches may be necessary before urine can be passed normally.

### Infection

Infection is very common and can be caused by unsterile instruments. It can also occur within a few days of the operation as the area becomes soaked in urine and contaminated by faeces (*21*). The degree of infection varies widely from a superficial wound infection to a generalized blood infection or septicaemia. Unsterilized tools and faecal matter can cause infection with tetanus spores or bacteria that will cause gangrene.

### Severe pain

The majority of procedures are performed without anaesthetic. When local anaesthesia is used, pain in the highly sensitive area of the clitoris

returns within 2–3 hours of the operation. Applying the local anaesthesia is itself extremely painful because the area of the clitoris and labia minora has a dense concentration of nerves and is highly sensitive. The use of general anaesthesia adds to the risk of death since it is usually not applied by a specialist with paediatric experience.

## *Long-term complications of types I and II*

### Failure to heal

Infection, separation by the urine flow and movement during walking may prevent the wound edges from healing. A weeping wound oozing pus or a chronic infected ulcer may result, which will require proper dressing and expert handling. Even if healing is complete, the rigid vulnerable scar over the clitoris may split open during childbirth. This may lead to renewed profuse bleeding from the clitoral artery.

### Abscess formation

In cases where the infection is buried under the wound edges or an embedded stitch fails to be absorbed, an abscess can form which will usually require surgical incision and repeated dressing over a period of time.

### Dermoid cyst

This is the most common long-term complication of all types of female genital mutilation. It results from the embedding of skin tissue in the scar. The gland which normally lubricates the skin will continue to secrete under the scar and form a cyst or sac full of cheesy material. The reported size of dermoid cysts ranges from that of a small pea to that of a grapefruit or football. Although not a serious threat to physical health these cysts are extremely distressing (*82*). Small dermoid cysts should be left alone to avoid further damage to the area, and the woman should be reassured. If cysts become very large or infected, surgical removal may be unavoidable.

### Keloids

There is a genetic susceptibility to keloids (excessive growth of scar tissue) in many of the ethnic groups that practice female genital mutilation. Vulval keloids are disfiguring and psychologically distressing. Treatment is often unsuccessful since surgical removal frequently provokes further growth.

### Stenosis of the artificial opening to the vagina

With infibulation, the artificial opening to the vagina can be so small that it closes almost completely over time. This may cause incomplete voiding of urine or haematocolpos (retained menstrual blood) and make sexual intercourse impossible (*21*). Products of miscarriage could also be retained in the vaginal canal leading to severe infection. A case of a primary stone in the vagina due to obstruction in a 33-year-old woman from the Ibo ethnic group in Nigeria has been reported (*87*). The stone caused severe pain, infertility and dribbling of urine. Although the Ibo are known to practise type II genital mutilation, in this case the vaginal opening was narrowed by fused labia which created an infibulation-like occlusion.

### Complications of labour and delivery

During childbirth, the infibulated woman must be defibulated to allow the fetal head to emerge from the vagina. This increases the risk of bleeding and wound infection. If an experienced attendant is not available to perform defibulation (anterior episiotomy), labour may become obstructed (*88*). Prolonged obstructed labour can cause moderate-to-severe complications for the mother and the child. No studies have been undertaken on the precise impact of infibulation on perinatal outcome. However, cases of ruptured vulval scar, perineal tears, fetal distress and vesicovaginal and vesicorectal fistulae have been reported (*81*). There have also been reports of severe lacerations, including third-degree tears involving the anal musculature and injuries to the urinary tract including avulsion (tearing away) of the urethra from the bladder (*89*). Although female genital mutilation may contribute to maternal mortality there is no evidence of the extent of that contribution. It has been claimed that female genital mutilation doubles the rate of maternal mortality (*90*). This allegation has not been substantiated by any published study. One well documented study was undertaken by DeSilva on 173 mostly infibulated Sudanese women living in Saudi Arabia and delivering in a well-equipped hospital (*88*). There was significant delay in the second stage of labour, increased haemorrhage and increased occurrence of severe fetal asphyxia. There was no increase in maternal or neonatal mortality, which may be the result of the availability of resuscitation facilities in the hospital. Similar effects on labour occurring in rural areas may yield different outcomes. Evidence from Somalia (*77*) regarding the effect of infibulation on fetal and maternal outcome is weak because of small sample size, absence of information on other characteristics of the mothers and no control group. Moreover, the high rates of vesicovaginal and vesicorectal fistulae in Africa occur primarily as a result of pregnancy in very young girls whose

pelvises are not well developed. The true contribution of female genital mutilation to this condition has still not been verified.

### Injury to neighbouring organs

This can occur during defibulation performed crudely to enable sexual intercourse to take place or during labour. Spontaneous injury or tearing of the perineum can also occur as a result of strong uterine contractions during labour (*81*).

## Psychological and sexual effects

The few studies and reports available on the psychological and sexual effects of female genital mutilation are qualitative, in the form of case studies, rather than quantitative in nature, and therefore do not indicate the prevalence of such complications.

### *Effect on the psychological health of girls*

There is only one published case of psychopathology in a child resulting from "fear of circumcision" in the medical literature (*91*).[1] This scarcity probably reflects the lack of attention by the research community to documenting these problems rather than the rarity of the condition. Other evidence suggests that the perception of the incident by the girl is not simply negative, despite the pain and trauma. The desirability of the ceremony for the child, with its social advantages of peer acceptance, personal pride and material gifts is strongly juxtaposed to the physical suffering in the stories of many women (*77, 92*). One description of the opposing forces acting on the child is provided from Burkina Faso (*25*):

> "In areas where excision is practised, unexcised girls are constantly mocked by friends who have undergone the operation. Those yet to be excised may be terrified by older girls' description of what is in store for them."

The balance between the positive and the negative in the girl's experience is what will shape her reaction and will determine how she remembers the incident. A study in Somalia asked 159 girls aged 8–16 to draw their experience of the moment of their "circumcision" and the period of convalescence afterwards (*93*). All the girls remembered the exact day and time they were "circumcised", their age, who the "circumciser" was and where the procedure took place. Psychological analysis of the girls'

[1] This study also documented two cases of psychopathology directly related to female genital mutilation in adult women.

young Ibo women in Nigeria (*97*). He found no difference in what he termed "levels of promiscuity" between "circumcised" (type II) and "uncircumcised" women. He also reported that only 58.8% of the former experienced orgasm in contrast to 68.7% of the latter. This study also showed that when the clitoris is removed the labia minora and the breasts take over as the most erotic organs in the body.

Shandall studied 4024 women from his outpatient clinic in northern Sudan and reported that over 80% of those with type III (infibulation) did not know of or experience orgasm, compared to around 10% of those with type I or who were "uncircumcised" (*15*). El Dareer conducted a national survey, also in north Sudan, and reported similar results (*19*). In her study, 50% of women reported no sexual pleasure, 23% were indifferent to sexual intercourse and the remainder experienced pleasure all or some of the time. It is important to remember that in northern Sudan over 90% of women undergo type III genital mutilation. Another study, by Lightfoot-Klein, contradicted this evidence; out of 300 Sudanese women with infibulation, 90% reported pleasurable sex with frequent orgasm (*95*). The author does not adequately describe her methodology but admits to using two senior nurses, both with a thriving "circumcision" practice on the side, as her translators. In fact this study contradicts the findings of a previous study by the same author which reported severe pain and suffering with sexual intercourse and lack of pleasure with sex by infibulated women in Sudan (*98*).

Karim and Ammar studied 331 "circumcised" women who attended their outpatient clinic in Cairo (*99*). Of these, 29% did not experience any sexual satisfaction during intercourse, 30% experienced some satisfaction but did not reach orgasm and 41% experienced satisfaction and orgasm frequently. Although the sample contained women with types I, II and III genital mutilation, no clear conclusion was reached as to the difference in sexual experience of women with the different types. Also given possible confounding variables, such as social conditioning and the quality of the marital relationship, these numbers could be meaningful only if compared to the experiences of women with no genital mutilation in the same society. Another study of Egyptian women (133 who had undergone types I and II female genital mutilation and 26 who were "uncircumcised") was conducted by Badawi who reported that a greater proportion of the latter had sexual excitement in response to stimulation of the genitals compared to those with genital mutilation (*100*). The study also found that 50% of the "uncircumcised" women and 25% of those with genital mutilation experienced orgasm with manual stimulation of the clitoris/clitoral area. However, the size of the sample of uncircumcised women was very small.

Koso-Thomas reported on the experience of arousal, sexual feelings from genital stimulation and possibility of reaching climax among "circumcised" women in Sierra Leone (*20*). Her sample included 47 women with clitoridectomy (type I) and 93 women with clitoridectomy and excision of labia (type II). An interesting finding was the difference between 14 women with sexual experience before the procedure and 33 who experienced sex only afterwards. All respondents were fully conscious of themselves as sexual beings, a perception that the experience of genital mutilation did not seem to alter. With regard to their response to male sexual advances, those who had experienced sex before had positive reactions and those who experienced it only afterwards had a neutral response. When asked about the level of arousal experienced, no woman in either group reported intense arousal but those with previous experience were better able to detect a mild stimulation. None of the women experienced orgasm, but the women with no previous sexual experience remained neutral while those with previous experience became aroused but unfulfilled.

From Burkina Faso, Kere and Tapsoba reported on the sexual experience of several women and men whom they interviewed and who live with the consequences of female genital mutilation (*26*). Many of the women reported pain and discomfort with intercourse; some experienced a degree of sexual arousal but most did not experience orgasm.

From the evidence cited, it is clear that all types of female genital mutilation interfere to some degree with women's sexual response but do not necessarily abolish the possibility of sexual pleasure and climax. As explained on page 24, some of the sensitive tissues of the body and the crura of the clitoris are embedded deeply near the pubic symphysis and are not removed when excision of the protruding parts take place. Even women with infibulation often have parts of the sensitive tissue of the clitoris and labia left intact. Some studies suggest that, apart from the external genitals, other erogenous zones in the body may become more sensitized in women with genital mutilation, particularly when the overall sexual experience is pleasurable with a caring partner. Also, the psychological and cortical components of the sexual experience in women with genital mutilation are influenced by various factors that are not always predictable. Better designed studies are needed before more light can be shed on the effects of female genital mutilation on women's sexuality.

## *Effect on men's sexuality*

For men who have to live with the genital mutilation of their wives and sexual partners, the experience can also be unpleasant. A woman from Burkina Faso has described how she feels about sex (*27*):

to stop the practice. Methodologies for monitoring and evaluating different interventions are also lacking. A study from Sudan moves in this direction by assessing the effects of past campaigns and identifying which media and messages were most successful *(109)*. The researchers were partially successful in achieving their stated goals.

Given the social and behavioural factors involved in female genital mutilation it is reasonable to suggest that future research should be focused on behavioural and programmatic aspects of combating the practice. Epidemiological studies are needed to establish baseline prevalence rates. The inclusion of questions on the practice in more Demographic and Health Survey questionnaires will ensure that such baseline data are available for most countries in the near future. Clinical research to quantify the contribution of female genital mutilation to the mortality and reproductive morbidity of girls and women could be useful in influencing policy decisions, and would provide the information base needed for developing clinical support for girls and women who suffer from the health complications of female genital mutilation.

## Suggested research agenda

There is clearly a lack of data on the extent, types and effects of female genital mutilation throughout the world, and little research has been undertaken on ways of combating the practice and managing its consequences. This section highlights gaps in current knowledge and provides suggestions for appropriate future research in the following main areas: epidemiology, health effects, behavioural determinants, and programme design and evaluation.[1]

### *Epidemiology*

Epidemiological research should address two sets of questions:

- Is there sufficient evidence that female genital mutilation is practised in the particular country or community to justify taking action?
- What is the scale of the problem: what groups in the country practise female genital mutilation; at what age is it performed; who performs the procedure; and what different methods are used?

[1] An in-depth discussion of research issues can be found in *Inroads to behavioral change: a research agenda for female genital mutilation and other reproductive and sexual health issues (110)*.

### *Prevalence rate*

Prevalence rates can be reported by type of procedure, ethnic group, religious following, income, education, age at which female genital mutilation is undertaken etc. Researchers who study female genital mutilation should familiarize themselves with the WHO four-type classification on page 6. Local terminologies and practices should be investigated and matched to this classification. Local variations as to who, how, when and why communities practise female genital mutilation are considerable. Research designed to inform people/organizations carrying out interventions, will therefore need to take into consideration the local factors that influence continuation and those that are the most likely to bring about change in each community. For example, in some countries, ethnic and religious affiliations are currently the most significant causes of continuation, while emerging variables such as parents' level of education, income level, mother's employment, nuclear family structure and female-headed households may influence future decision-making in the family.

### *Measuring trends over time*

Studying the prevalence of female genital mutilation among different age groups through multiple cross-sectional surveys or longitudinal multigenerational studies is the most definitive means of measuring change. However, both of these types of studies, especially the latter, are expensive and require major investments in human and material resources. Since behavioural change in relation to such a deeply rooted practice is expected to be slow, measurable change will be detected only over long periods.

### *Establishing population at risk at local level*

Given the wide variations in the practice of female genital mutilation, exact knowledge of the age at which it is carried out at any particular time and place and of how social trends may shift the practice to a younger or older age is important in order to identify who has escaped the practice and who is still at risk. Such detailed information is useful for the design of interventions to promote behavioural change.

### *Age-specific prevalence rates*

This indicator could measure the incidence of female genital mutilation among an identified population at risk and could be used as a faster measure of trend than multigenerational studies. For example, if the age at

which female genital mutilation is performed in a particular community is known to be 4–8 years, the prevalence of genital mutilation among girls in that age group who attend school can be documented. A community-based intervention can be implemented, prevalence in the same age group measured every 2–3 years in the same schools and changes in prevalence rates noted.

The advantage of using age-specific indicators is that the population to be studied may be found in a defined location such as a primary school. Its major drawback is that, unless the age at which genital mutilation is performed and the proportion of girls who attend school remain constant, the measure is not reliable. Another consideration is that the behaviour of families who send their girls to school may be different from that of families who do not, so that the prevalence rate in school may not match that of the general population. In addition, varying school enrolment rates must be taken into consideration.

Despite the limitations, age-specific prevalence rates from the same setting may still prove useful as measures of change over a relatively short period of time.

### *Health effects*

In this category five questions should be addressed. The first relates to the short-term health effects of female genital mutilation, the remaining four to the long-term consequences, namely:

(1) What is the contribution of genital mutilation to the mortality and morbidity of girls?

(2) Do complications of genital mutilation increase the risk of maternal mortality?

(3) What is the contribution of the practice to reproductive morbidity?

(4) What are the effects of genital mutilation on women's psychological and sexual health?

(5) How does genital mutilation affect women's fertility and use of family planning?

To date, the majority of studies on the health consequences of female genital mutilation have been carried out among clients of gynaecology clinics. What is missing is measurement of the contribution of the practice and its complications to the overall morbidity and mortality of girls and women. Although such studies are no longer necessary to justify action against female genital mutilation, they may influence the decisions

of policy-makers towards starting programmes and passing professional regulations or legislation to combat the practice.

Measuring the burden of disease due to female genital mutilation is important and can be used in calculating the cost of this unnecessary practice to the beleaguered economies of Africa and in convincing governments to support abolition programmes.

### *Mortality in girls*

Although some studies and reports document the occurrence of death among girls who have recently undergone genital mutilation (*111*), and there is considerable anecdotal evidence to suggest that it is by no means rare, there has been no systematic investigation of the scale of the problem. Death may be caused by neurogenic shock, immediate severe bleeding or overwhelming infection, and can therefore be easily linked to the procedure. However, later deaths due to slower bleeding, heart failure from severe anaemia or secondary infection may not be attributed to the operation. Several methodologies can be used to measure mortality from genital mutilation in girls, including an adaptation of the "sisterhood method" used for maternal mortality and secondary analysis of survey data collected using questions on the age at which the procedure is undertaken and child mortality. Reliable data on mortality would be most useful to all concerned in designing policies and programmes to combat female genital mutilation.

### *Morbidity in girls and effect on education*

Various degrees of bleeding amounting to haemorrhage are known to be common to all types of female genital mutilation. By the time a girl undergoes the procedure at age 4–16, she may already be anaemic from inadequate nutrition and/or from menstrual blood loss. The acute bleeding following the operation may initiate or exacerbate an already existing anaemia (*102*). Anaemia is known to be a major debilitating condition for girls. Its effects are particularly relevant in the pre-pubertal and early reproductive years, as anaemic children have reduced learning abilities. As a result, genital mutilation may contribute to reduced educational achievement of girls.

Genital mutilation may also affect a girl's education more directly. The ritual may be performed during school days, healing may take a long time or the girl may develop infection or other complications which cause her to miss school. In parts of Kenya, girls are removed from school to undergo the procedure and are then married immediately and not allowed

to return to school (*53*). In such communities, stopping female genital mutilation may reduce the numbers of early marriages. School absenteeism or drop-out due to female genital mutilation needs to be documented through research. Studying the effect of the practice on girls' health and educational achievements is important to programmes for children.

## *Maternal mortality*

Although some correlation between female genital mutilation and maternal mortality probably exists, no studies have provided conclusive evidence to substantiate this. In fact, few studies adequately document the effect of genital mutilation on pregnancy outcomes. In Somalia, it has been observed that some women deliberately starve themselves to reduce the size of the fetus in an attempt to avoid the complications of infibulation (*22*). However, research on women with malnutrition has shown that the condition has little effect on the incidence of prolonged or obstructed labour. One study reports the possibility of higher incidence of fetal distress among infibulated women. However, the mechanism by which this may occur if the woman has been adequately defibulated is not scientifically obvious nor was any explanation suggested by the study (*88*). There have been anecdotal reports of stillbirths.

Retention of the products of miscarriage in the vaginal canal has been reported with types II and III female genital mutilation. Obstructed second stage of labour due to tough scars around the vaginal exit is often mentioned but no documented evidence has been found. In fact, since the elasticity of the birth canal itself is not affected by any type of female genital mutilation there should be no reason for obstructed labour. In infibulated women, the most likely outcome would be severe perineal tearing around the narrowed outlet beyond the vaginal introitus if defibulation is not performed. The scar is unlikely to be too tough to be torn by uterine contraction.

Female genital mutilation may contribute to maternal mortality and morbidity through increased risk of bleeding or infection. However, incidents of intrapartum or postpartum haemorrhage or septicaemia solely attributable to it have not been reported. Female genital mutilation and its complications are more likely to add incrementally to other causes of maternal mortality and morbidity than to be the sole causative factor. More detailed information is needed before definitive statements on this subject can be made. Whatever the possible mechanisms, the contribution of genital mutilation to the alarmingly high rates of maternal mortality in Africa needs to be scientifically documented.

### *Reproductive morbidity*

The list of immediate and long-term complications of female genital mutilation, both common and rare, is a directory of reproductive morbidity. Case reports are abundant in the literature and further studies can only add to this information by quantifying its contribution to common conditions, such as reproductive tract infections and infertility.

### *Psychological effects*

The psychological effects are the least explored area of clinical research on female genital mutilation. It is therefore important to investigate the relationship between female genital mutilation, gender inequality and women's subordination. It is also important to look at the role the experience plays in shaping the personal identity and self-image of young women in terms of their right to control their bodies, as their sexuality may influence their reproductive decisions later in life. Understanding the psychosocial dynamics of female genital mutilation may therefore enhance understanding of other reproductive health decisions women make, including health-seeking behaviour and decisions related to childbearing. Other important psychological questions are:

- What are the mechanisms of internalization of social roles which make women accept and defend female genital mutilation?
- Why is it difficult and painful for women to realize the damage done to them through female genital mutilation?
- What counselling and/or support systems do women need to reject the practice and protect their daughters from it?

Finding ways to heal women psychologically will not only benefit them individually, but may be essential to stop them from perpetuating the practice. Unless women recognize and accept the damage done to them and find the means to cope with their own pain they will not attempt to stop female genital mutilation.

It would also be useful to determine whether there is a difference in the social, educational and personal achievement of girls who have undergone genital mutilation compared with those who have not. This question could be answered through case-control studies, with careful attention to possible confounding factors, such as wealth, family status, and rural or urban dwelling.

### *Sexual effects*

More attempts have been made to study sexual effects of female genital

chastity is more valuable than her life, health risks become irrelevant. For this reason, it is important to separate chastity as a moral attribute from physical cutting of the genitals. This is a prime strategy of the Egyptian task force on female genital mutilation. Public testimonies by non-circumcised women who are highly respected as role models may be more effective in these communities than health or religious messages (*112*).

### *Identifying causes of behavioural change*

No studies have been undertaken to investigate the reasons why certain individuals, families or communities have stopped practising female genital mutilation. There is a need to study the profile of these social pioneers so they are identified, targeted and recruited as agents of change in their communities. Researchers are currently looking into the experience of a village in the socially conservative region of upper Egypt, where the population stopped practising female genital mutilation because of an intervention implemented by an NGO affiliated to the church. Case studies of families can provide useful information for the design of appropriate interventions and the development of new, more effective messages.

Where a measurable decline in the practice has occurred, it is important to study the role of direct and indirect causes of that decline. Examples of direct causes are specific education and training efforts, media campaigns or personal counselling by health care providers. Indirect causes may include increased levels of female education, improvement in women's economic autonomy, and the effects of urbanization or modernization in shifting the decision-making process to the nuclear family. An attempt should be made to assess the role each factor plays in the ultimate decision to stop the practice.

### *Programme design and evaluation*

Some of the questions to be answered in this regard are:

- Who are the key groups in the family or the community who are likely to change their attitude more readily and how powerful are they in the decision-making hierarchy?
- Who are the best messengers to persuade individuals and communities against the practice? What training do they need and where should they be located?
- How should messages and interventions against female genital mutilation be designed and how can their effectiveness best be evaluated?

- How can changes in the prevalence of the practice best be monitored over time?

### *Designing effective messages to motivate change*

In the past, messages developed for interventions against female genital mutilation were based on the knowledge and untested instincts of members of the community. While these are prerequisites for any such intervention, it is also important to analyse systematically the content and effect of different messages.

Change can be motivated by challenging the perceived benefits of female genital mutilation to those who hold power, such as fathers, uncles, elderly women and other family members. The perceived benefit for girls' morality and health also has to be challenged. Developing messages on the benefits of not practising female genital mutilation to all parties concerned may be a good counter-tactic. These and many other strategies need to be tried and tested.

### *Operational research*

No research has been undertaken on the operational aspects of implementing interventions against female genital mutilation. The desirability, feasibility and means of integrating messages against the practice into school curricula, professional training and individual counselling within the health services is uncharted territory. Educational materials should be developed according to identified needs and their impact should be assessed. Examples of materials developed for these purposes are available, but there has to be more systematic testing of their design and impact.

### *Economic research*

For policy decisions as well as programme priorities, some research on the economic aspects of female genital mutilation is needed. Firstly, it is important to determine whether attempts to persuade practitioners, who benefit both socially and economically, to seek alternative employment have been successful. Some evidence suggests that this approach in relation to a service that is highly in demand may benefit the supplier but may not improve the overall situation since the same suppliers may continue despite alternative training or, even if they stop, other suppliers will step in to fill the demand. In some countries, such as Egypt, the profile of practitioners has changed — current mothers mainly experienced genital

mutilation at the hands of traditional practitioners while in the case of their daughters the procedure was undertaken primarily by doctors. Patterns of modernization of the practice have also been reported among affluent families in Nigeria, Somalia and Sudan. While legislation may not affect traditional practitioners who operate outside the formal system, physicians and trained health personnel may be more responsive to legislative measures through fear of losing their license or reputation.

A second area of research is to calculate the economic costs of treating complications and of the burden of disease and disability attributable to female genital mutilation. This could be important in persuading governments to support programmes and legislation to combat the practice.

### *Evaluation and monitoring*

If the abolition of female genital mutilation is to become a reality, each investment in research and each intervention should have a built-in means of measuring its contribution to the ultimate goal of stopping the practice. Evaluation of the efficacy of a particular project and monitoring of the effectiveness of the overall programme against the practice are different exercises which need different approaches and techniques.

Project evaluation is a shorter-term exercise that looks at how a particular project is moving towards its stated goals. For example, a mass education campaign with messages directed at men could be evaluated quantitatively by finding out the number of men who were reached and how many times they heard the message. It can be evaluated qualitatively by finding out how much of the information in the message they retained and whether it had any effect on their attitudes and intended behaviour. Such an assessment may be made at the end of the intervention or at intervals during it.

A project designed to convince the public and policy-makers of the need to pass legislation against female genital mutilation should be evaluated on the basis of its ability to show an effect on public opinion, the views of government officials and the direction of the debate. These are intermediate indicators, while the ultimate measure for this effort is the passing of legislation.

Programme monitoring refers to the effectiveness of all the efforts concerned in reducing the incidence of the practice. As discussed above, the monitoring of change could be partially achieved by measuring the decline in age-specific prevalence rates. Other short-term community monitoring techniques, such as a register of girls who have not undergone genital mutilation, could be developed with the assistance of health workers and community leaders. This type of monitoring was used successfully in

one project in Nigeria (*58*). Monitoring of programmes would also include the documentation of progress of policies, changes in legislation and professional regulations designed to combat the practice, and the amount of financial and human resources invested in abolition efforts. The ultimate monitoring indicator is the decline of female genital mutilation prevalence rates over time. Such monitoring is possible with the integration of questions on female genital mutilation into repeated national surveys, such as the Demographic and Health Survey, which is undertaken approximately every 10 years.

# 5.

# International, regional and national agreements and actions

Female genital mutilation has recognized implications for the human rights of women and children. It is also considered to be a form of violence against the girl, which affects her life as an adult woman. A summary of the international and regional legal instruments which relate to female genital mutilation is available from WHO.[1] These instruments are elaborated further in this section.

## International

A series of human rights instruments dating from 1948, which are legally binding on States Parties, contain language concerning the rights to health, non-discrimination on the basis of sex or gender, and physical and mental integrity. Female genital mutilation violates each of these precepts. More recently, language in international conference declarations has directly addressed harmful traditional practices in general and, in some cases, female genital mutilation specifically.

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948, established a number of basic human rights principles, among them, the inherent freedom and equality of all human beings (*114*, Article 1). Starting from these principles, it sets out a number of basic human rights to which each person is entitled. Article 3 guarantees the right to life, liberty and security of person. This principle has come to be articulated as providing the basis for the right to physical and mental integrity. The Declaration prohibits torture and "cruel, inhuman or degrading treatment or punishment" (Article 5).

The International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights, comple-

[1] *Female genital mutilation.* Geneva, World Health Organization, 1996 (unpublished document WHO/FRH/WHD/96.26; available on request from Family and Reproductive Health, World Health Organization, 1211 Geneva 27, Switzerland).

mentary human rights treaties adopted by the United Nations General Assembly in 1966 and legally binding on States Parties, have provisions applicable to the practice of female genital mutilation (*115, 116*). The first is the right to self-determination, set out in Article 1.1 of the International Covenant on Economic, Social and Cultural Rights. This guarantees to all persons, *inter alia*, the right to "freely determine their ... social and cultural development". Article 12 of the International Covenant on Economic, Social and Cultural Rights expands the right to health set out in Article 25.1 of the Universal Declaration of Human Rights, declaring that all persons have a right "to the enjoyment of the highest attainable standard of physical and mental health", specifying that States Parties should create conditions amenable to ensuring the provision of prevention as well as treatment of adverse health conditions. The International Covenant on Civil and Political Rights supplements the above, adding that, "Every human being has the inherent right to life", which "should be protected by law" (Article 6). With regard to health and the individual person, it proscribes "torture or ... cruel, inhuman or degrading treatment or punishment" (Article 7). It also expressly prohibits the non-consensual subjection of persons to medical or scientific experimentation (Article 7).

The 1979 Convention on the Elimination of All Forms of Discrimination against Women, legally binding on States Parties, strongly promotes the rights of women and specifically addresses discriminatory traditional customs and practices (*117*). It calls on States Parties to take immediate steps towards eliminating such discrimination by refraining from future discriminatory acts or practices, as well as "to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women" (Article 2f). Article 5 obligates States Parties to "modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women". States Parties are obligated in Article 10 to ensure that women have "access to specific educational information to help to ensure the health and well-being of families". Finally, in Article 12, States Parties are obligated to "take all appropriate measures to eliminate discrimination against women in the field of health care...". The provisions of the Convention, although they do not expressly refer to female genital mutilation, establish a strong international legal basis for the institution of measures to eliminate the practice.

The 1985 Nairobi Forward-Looking Strategies for the Advancement of Women suggest a number of ways in which the international community could promote the rights of women (*118*). Several provisions are

applicable to female genital mutilation, although there is no specific reference to the practice. Paragraph 148 calls on governments to establish plans for the promotion of women's health and development to "identify and reduce risks to women's health and to promote the positive health of women at all stages of life". There is a more direct statement against harmful practices in paragraph 150 which states that "health education should be geared towards changing those attitudes and values and actions that are discriminatory and detrimental to women's and girls' health". The same paragraph goes on to state that "steps should be taken to change the attitudes and health knowledge and composition of health personnel so that there can be an appropriate understanding of women's health needs".

The 1993 United Nations Declaration on Elimination of Violence Against Women (*119*) expressly states in its Article 2: "Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including ... dowry-related violence ... female genital mutilation and other traditional practices harmful to women..." (*119*).

The 1989 Convention on the Rights of the Child, ratified by all states where female genital mutilation is practised, specifically sets out human rights principles applicable to children (*120*). Among other things, the Convention on the Rights of the Child establishes the child's right to develop physically, mentally and socially to his or her fullest potential, to freely express his or her opinion, and to participate in decisions concerning his or her future. Article 19, which protects children from "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation", is applicable to female genital mutilation. More specifically, however, the Convention on the Rights of the Child refers to harmful traditional practices in Article 24.3 which states that "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children".

A World Medical Association statement on Condemnation of Female Genital Mutilation was adopted by the 45th World Medical Assembly in Budapest, Hungary, in 1993 (*121*). The statement condemns both female genital mutilation and the participation of physicians in the practice.

Building on growing human rights precepts, the 1993 Vienna Declaration and Programme of Action strongly supports the rights of women and girls (*122*). It is applicable to female genital mutilation not only in this way, but also in its specific mention of harmful traditional practices and in its condemnation of them. Reflected in this Declaration is the acceptance by the international community that women's rights are human rights

and that violence against women is a human rights violation, even if the perpetrator is a private individual or family member. Paragraph 9 states that "the human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights". It goes on to state that "the human rights of women should form an integral part of the United Nations human rights activities including the promotion of all human rights instruments relating to women". Further, the same paragraph declares as priority objectives of the international community the "full and equal participation of women in the political, civil, economic, social and cultural life", as well as "the eradication of all forms of discrimination on grounds of sex". Paragraph 9 then calls for the elimination of gender-based violence and sexual exploitation, including acts and practices "resulting from cultural prejudice", since such acts and practices are "incompatible with the dignity and worth of the human person". It suggests that the international community may achieve the above goals through legal means and other national action, and through cooperation among nations in programmes of economic and social development, including education, health and social support. Finally, the paragraph "urges governments, institutions, intergovernmental and nongovernmental organizations to intensify their efforts for the protection and promotion of human rights of women and the girl-child". Paragraph 10, which addresses the issues of sexual violence and gender bias, expressly calls for "the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices, cultural prejudices and religious extremism".

The 1994 Declaration and Programme of Action of the International Conference on Population and Development (ICPD), which strongly advocates gender equity and equality and women's empowerment as well as directly addressing reproductive health and rights issues, make five specific mentions of female genital mutilation and calls for its prohibition (*9*). The document represents a shift at the international level away from thinking about female genital mutilation primarily as a health issue and towards considering it as an issue of women's health and rights. It also specifically calls for the abolition of female genital mutilation in paragraph 4.22: "Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among nongovernmental and community organizations and religious institutions to eliminate such practices". Paragraph 5.5 characterizes female genital mutilation as coercive and discriminatory, calling for the adoption and enforcement of measures to eliminate it. Paragraph 7.35 characterizes it as both a "violation of basic rights" and "a major lifelong risk to women's health". This paragraph includes female genital mutilation in a class of

harmful practices which were "meant to control women's sexuality" and which have "led to great suffering". Reflecting the status of female genital mutilation as a violation of the right to health, paragraph 7.40 specifically delineates ways in which governments and communities can eliminate the practice. This paragraph emphasizes the urgency of such action and suggests that "steps to eliminate the practice should include strong community outreach programmes involving village and religious leaders, education and counselling about its impact on girls' and women's health, and appropriate treatment and rehabilitation for girls who have suffered mutilation". It adds that such services "should include counselling for women and men to discourage the practice". Finally, paragraph 7.6 states that "active discouragement of harmful practices such as female genital mutilation should also be an integral component of primary health care including reproductive health care programmes".

The 1995 Report of the World Summit for Social Development held in Copenhagen makes specific provisions for the rights of women (Commitment 5) and of the girl child (Commitment 6) (*123*). It also specifically refers to female genital mutilation, reinforcing the ICPD language condemning the practice. In keeping with this, Commitment 6(y) calls for increased international support and cooperation "for education and health programmes based on respect for human dignity and focused on the protection of women and children, especially against exploitation, trafficking and harmful practices, such as child prostitution, female genital mutilation and child marriages".

The Declaration and Platform for Action of the Fourth World Conference on Women, held in Beijing in September 1995, builds on all of this prior action. In addition to strong statements supporting women's and girls' rights, it reinforces the ICPD language calling for an end to the practice of female genital mutilation (*10*). In paragraph 39, which refers to the rights of girls, the document lists female genital mutilation as one of the various forms of sexual and economic exploitation to which girls are often subjected. Paragraph 93 refers to female genital mutilation in the context of social discrimination. It recognizes that conditions "that subject [girls] to harmful practices, such as female genital mutilation" which "pose grave health risks" are common. It goes on to recognize the need for girls to have access to health services, including counselling, as well as access to sexual and reproductive health information. Additionally, this paragraph recognizes that "a young woman's right to privacy, confidentiality, respect and informed consent is often not considered" with respect to health services, and the need for young men to be educated "to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction".

Female genital mutilation also receives specific mention in the Platform's section on the strengthening of preventive programmes that promote women's health. The document calls for the United Nations and other relevant international organizations, governments, NGOs, the mass media and the private sector to respect women's health programmes. In paragraph 107(a), which calls for prioritization of various educational programmes for women, the Platform calls for the placement of "special focus on programmes for both men and women that emphasize the elimination of harmful attitudes and practices, including female genital mutilation...".

In the section on equality and non-discrimination, the Platform issues a particularly strong call to governments to ensure, via national constitutions or appropriate legislation, women's equality as well as the elimination of discrimination on the basis of sex (paragraph 232, (a) et seq.). According to section (d) of this paragraph, governments should remove legal provisions not in accord with these principles. Paragraph 232(g) calls for urgent government action to "combat and eliminate violence against women, which is a human rights violation, resulting from harmful traditional or customary practices, cultural prejudices and extremism". Along these same lines, paragraph 232(h) calls for the prohibition of "female genital mutilation wherever it exists", as well as for the "support of efforts among non-governmental and community organizations and religious institutions to eliminate such practices". More generally, various provisions of paragraph 232 call for the implementation of legal and educational measures to ensure the rights of women. Finally, in the section on the girl child, paragraph 259 lists female genital mutilation as an example of gender discrimination, and paragraph 277 calls for the development of "policies and programmes, giving priority to formal and informal education programmes that support girls" as well as placing emphasis on programmes to educate "women and men, especially parents, on the importance of girls' physical and mental health and well-being, including the elimination of discrimination against girls in food allocation, early marriage, violence against girls, female genital mutilation, child prostitution...".

## Regional

The African Charter on the Rights and Welfare of the Child, adopted by the Organization of African Unity (OAU) in 1990, protects many of the rights ensured by the Convention on the Rights of the Child (*124*). Article III of the Charter ensures the right to "equality between the sexes". Also applicable to female genital mutilation are Article XIV.1, which

on legal minors with no power or faculties to consent. Consent by parents or guardians is not acceptable when the act performed is damaging rather than beneficial to the child. The argument that female genital mutilation performed under hygienic and medically controlled conditions is a lesser evil compared to the greater risk of severe complications is also not acceptable, since the cause of the risk is human behaviour, which can be changed, and not an uncontrollable pathology such as malignancy. Since all medical research and clinical efforts aim at making uncontrollable causes of damage to the human body more controllable, it would be unethical for a health professional to damage a healthy body in order to prevent more destructive human behaviour. It is therefore difficult to find a medico-legal justification for the performance of female genital mutilation on children by health professionals.

# 6.

# WHO policies and activities

WHO started its efforts to promote the elimination of harmful traditional practices in the 1970s. These efforts included gathering information on female genital mutilation, especially regarding its epidemiology and health consequences. These efforts, which are still continuing, include advocacy at international, regional and national levels for the elimination of female genital mutilation. On the basis of research findings, WHO works to promote technically sound policies and approaches to the prevention of female genital mutilation and the management of its health consequences, and to provide support to national networks or organizations and groups involved in developing relevant policies, strategies and programmes. Since the early 1980s, WHO has issued several statements and adopted resolutions on female genital mutilation. These activities and policies are considered below in more detail.

The Seminar on Traditional Practices held in Khartoum, Sudan, in February 1979, which was sponsored by the WHO Regional Office for the Eastern Mediterranean, was the first international forum on female genital mutilation. It took the unprecedented step of formulating recommendations on the elimination of female genital mutilation by governments, including the setting up of national commissions for the coordination of activities aimed at doing this.

In August 1982, WHO made a formal statement of its position to the United Nations Commission on Human Rights, endorsing the recommendations of the Khartoum seminar. WHO's main points were:

— that governments should adopt clear national policies to abolish the practice of female genital mutilation, and to inform and educate the public about its harmfulness;

— that programmes designed to combat the practice should recognize its association with extremely adverse social and economic conditions, and should respond sensitively to women's needs and problems;

— that the involvement of women's organizations at the local level should be encouraged, since awareness and commitment to change must begin with them.

In the same statement, WHO expressed its unequivocal opposition to any medicalization of the operation, advising that under no circumstances should it be performed by health professionals or in health establishments. Together with UNICEF, WHO also stated its readiness to support national efforts against female genital mutilation and continued collaboration in research and dissemination of information.

In the ensuing years, WHO's role included providing technical and financial support for national surveys, for the training of health workers and for grassroots initiatives. For example, WHO supported the NGO Working Group on Female Circumcision which was established in 1977 under the auspices of the Commission on Human Rights to coordinate the actions of NGOs in this area. In 1983, WHO and the NGO Working Group on Female Circumcision convened an informal meeting on the subject with African delegates to the Thirty-sixth World Health Assembly.

In 1984, WHO headquarters and its Regional Offices for Africa and for the Eastern Mediterranean joined UNICEF and UNFPA in providing technical and administrative support and financial assistance to a seminar in Dakar organized by the NGO Working Group on Female Circumcision and sponsored by the Government of Senegal. The Dakar seminar gave further impetus to the establishment of national committees in all countries where female genital mutilation is practised. It set up the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) to act as a bridge between the groups working among the people and those providing support for their activities.

The efforts of IAC and the NGO Working Group on Traditional Practices Affecting the Health of Women and Children (formerly the NGO Working Group on Female Circumcision) have led to the formation of 24 national committees in Africa that carry out activities for the elimination of this practice with the support of the United Nations and other international funding agencies. WHO continued its support to IAC by cosponsoring the IAC regional seminars on traditional practices affecting the health of women and children in Africa, held in Ethiopia in 1987 and in 1990. The outcome of the 1990 IAC seminar was a proposal for a change in terminology from "female circumcision" to "female genital mutilation". WHO also provided funding to IAC to undertake a comparative study of female genital mutilation and contraceptive use among women in Djibouti and Sierra Leone.

The subject of female genital mutilation, along with other harmful practices, was also discussed during a Regional Workshop on Women, Health

and Development, jointly sponsored by WHO, UNICEF and UNFPA in November 1984 in Damascus, Syrian Arab Republic.

In September 1988, the Thirty-fifth session of the WHO Regional Committee for the Eastern Mediterranean passed a resolution on maternal and infant mortality (socioeconomic implications) which stated that women's health must be safeguarded by ensuring the elimination of harmful traditional practices, including female genital mutilation. The WHO Regional Office for the Eastern Mediterranean has also supported the establishment of a regional network of national focal points on women's health through which it supports various activities aimed at the prevention of harmful traditional practices including female genital mutilation.

At its Thirty-ninth session in 1989, the WHO Regional Committee for Africa adopted Resolution AFR/RC39/R9 on traditional practices affecting women and children, recommending that Member States: "(1) prohibit the medicalization of female circumcision and discourage health personnel from performing the operation; (2) include in training programmes for health and traditional birth attendants relevant information on the dangers of female circumcision; and (3) encourage research projects to identify the most effective means of controlling these practices."

WHO participated in a Regional Seminar on Traditional Practices Affecting the Health of Women and Children, organized by the United Nations Centre for Human Rights in Ouagadougou in 1992. The seminar recommended that the terminology "female genital mutilation" be used in the future. In the same year WHO issued a joint statement on female genital mutilation with the International Federation of Gynecology and Obstetrics drawing attention to its harmful effects on health and suggesting approaches for action to abolish the practice (*90*).

In 1993, the Forty-sixth World Health Assembly adopted Resolution WHA46.18 on maternal and child health and family planning for health which stated that harmful traditional practices such as female genital mutilation "further restrict the attainment of the goals of health, development and human rights for all members of society". Notable here are the changes in language. The stronger and arguably more accurate term "female genital mutilation" is substituted for the term "female circumcision" and there is a recognizable shift from addressing the practice only in terms of a health issue towards acknowledging it as both a health and a human rights issue. The resolution urged Member States to continue the monitoring and evaluation of their efforts to eliminate the practice and requested the Director-General to "collaborate with other organizations and bodies of the United Nations system, governmental and nongovernmental organizations in contributing to the preparation of a plan of action for eliminating harmful traditional practices affecting the

health of women, children and adolescents".

The Forty-seventh World Health Assembly in 1994 adopted Resolution WHA47.10 which recognized that traditional practices such as female genital mutilation and early sexual relations and reproduction "cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding". The resolution went on to urge Member States "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" and "to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation". It also requested the Director-General to "mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels".

In 1995, WHO convened a Technical Working Group on Female Genital Mutilation, which met in Geneva, Switzerland from 17 to 19 July, to draw attention to female genital mutilation and its health consequences, to begin the process of developing standards and norms in relation to the practice and to make recommendations for future action. On the basis of its recommendations, the WHO definition and classification of female genital mutilation reproduced on page 6 was drawn up.

The WHO Regional Office for Africa and UNFPA co-funded the IAC training seminar aimed at strengthening the operational capacity of its national committees, which was held in Burkina Faso in July 1995.

The WHO Regional Office for Africa launched a regional plan of action for accelerating the elimination of female genital mutilation in the countries of the Region in March 1997. WHO also published a joint statement on female genital mutilation together with UNICEF and UNFPA in April 1997 (*23*).

# 7.
# Conclusion

The centuries-old practice of female genital mutilation used to be shrouded in silence. However, in the past five years that shroud has been removed and female genital mutilation has become one of the most talked about subjects among women's groups, especially in Africa. It is a topic of national and international media attention and most international assistance agencies have developed policies or programmes to combat it. It was an important issue at the World Conference on Human Rights in 1993, a clearly stated violation of reproductive and health rights at the International Conference on Population and Development in 1994 and one of the major issues exposed at the United Nations Fourth World Conference on Women in 1995. Many have reached the conclusion that, recognizing the imbalance of power between men and women that underlies the practice, the most effective strategies for dealing with female genital mutilation include helping women to empower themselves within their own culture and community. Essentially this means that the struggle to stop the practice as a health risk and a violation of women's rights must be led by women from the communities where it occurs. Since Africa is the region where this practice predominates it is natural that African women have been at the forefront of exposing it locally and internationally.

This does not mean, however, that others have no role to play. The support of men and of people from other cultures who are sympathetic to the views of African women opposed to the practice is vital. A number of groups have the potential to provide assistance in this regard.

## The international development aid community

International organizations working in Africa and other communities where female genital mutilation is practised have a major role to play. Such organizations can respond to requests for resources (both technical and financial) from local NGOs and government programmes that are opposed to the practice. The limitations of this review do not permit a full

report on the policy and funding trends in programmes to combat female genital mutilation over the past 10 years but the overall picture suggests a rapidly rising political interest in the issue with a much slower, and often non-existent, rise in budget for grants or activities. If this trend continues, the current interest in the topic may eventually fade and the practice may once again be shrouded in silence.

## International women's groups

Women's groups can help by monitoring progress towards eliminating female genital mutilation and by helping to make sure that resources continue to be available when needed. Women's groups can support the promotion and protection of the health and development of women and girls by listening to what women affected by this practice have to say and by following their lead.

## National governments

Some national governments have made a clear and public commitment to stop female genital mutilation through laws, professional regulations and programmes and by signing international declarations that condemn the practice. The launching of the WHO African Region's "Plan of action for accelerating female genital mutilation elimination in Africa" in March 1997 has contributed to a growing interest in the subject among governments. Some have begun developing national policies and plans of action for eliminating female genital mutilation, including setting targets for elimination and developing national-level and district-level indicators for monitoring and evaluating programmes. There is more emphasis on integrating efforts to prevent female genital mutilation into existing health and education programmes and on building partnerships with nongovernmental groups and communities in order to bring about change. Although passing laws to criminalize female genital mutilation may not be appropriate in view of the current stage of development of the movement against the practice in certain countries, it is still important to consider doing so in due course.

## National groups

National NGOs, universities and other institutions, and professional associations can help to draw attention to the need to promote and protect reproductive health and to eliminate female genital mutilation. Governments are more likely to take action against the practice when greater numbers of citizens oppose it.

It is essential to document, review and evaluate approaches and programmes. If activities to combat female genital mutilation are to be successful, the needs and concerns of national groups cannot be ignored.

Finally, it is now possible to believe that the beginning of the end of female genital mutilation is here. Women in Africa and elsewhere, perhaps for the first time ever, have a serious chance of abolishing this humiliating practice while at the same time addressing other problems of discrimination and inequality that they face. With the right approaches locally and sensitive international support, female genital mutilation can and will be defeated.

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Female genital mutilation has been practised for more than 2000 years. At least 130 million women and girls alive today have undergone the procedure. Yet despite the fact that female genital mutilation is very common in some areas – and leads to serious health problems – little is known about it outside the communities where it is practised. This overview provides the information needed to understand both the social importance of this practice and the dangers it presents to the health of the women and girls who undergo it. It explains what the different types of female genital mutilation involve, what kinds of mental and physical complications result, and what research still needs to be done in order to put an end to the practice.

This book does not make for easy reading. It describes a brutal and humiliating practice that has been condemned by international agreements and national governments. Yet because that practice still persists this book has had to be written. The authors present ample evidence why, for the sake of all the women at risk, female genital mutilation must become a thing of the past.

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NewScientist

# Female circumcision: Fighting a cruel tradition

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By **SUE ARMSTRONG**

When 'Joanna,' born and brought up in Britain, was eight years old she was sent home to her native Somalia for what she thought was to be a holiday with her grandparents. Instead, within days of her arrival she was taken with her older sister to a place where the village women held her down, stripped her naked, parted her legs and sliced off her genitalia.

'Because I was very young I didn't know what was happening. I had ladies holding every part of my body, even my mouth so that I couldn't scream. I remember the pain to this day,' said Joanna, now 18.

Her own operation was the first she knew of female circumcision, a traditional practice that affects an estimated 80 million women in the world today. The practice is most widespread in Africa where it occurs in 28 countries. The custom is also found among groups in the Middle East, Far East and, according to some reports, the descendants of West African slaves in Brazil. As wars and poverty scatter people around the world, female circumcision is becoming an issue wherever practising groups have settled, including Europe, America and Australia.

The term 'female circumcision' is misleading for it implies an operation similar to male circumcision – simply the removal of a piece of skin. The female operation nearly always involves the removal of healthy (and highly sensitive) organs, and delegates to a recent conference in Addis Ababa on harmful traditional practices called for it to be known henceforth as 'female genital mutilation' (FGM) which they believe reflects more accurately the cruel and radical operation so many young girls are forced to undergo.

Female circumcision entails different things in different cultures. The mildest form – known to Muslims as 'sunna' and the least common – involves the removal of the prepuce or hood of the clitoris. It is the only operation analogous to male circumcision. Excision involves the removal of the clitoris and labia minora; while infibulation, the most drastic form known also as 'pharaonic circumcision,' involves the removal of all the external genitalia and the stiching up of the two sides of the vulva to leave only a tiny opening for the passage of urine and menstrual blood.

The opening is preserved by the insertion of a sliver of wood or a reed, and often the stitching is done with Acacia thorns held in place with silk, catgut or horsehair. The wound is then dabbed with anything from alcohol or lemon juice to ash, herb mixtures or cow dung, and the child's legs bound together until it has healed. Anaesthetics are rarely used and the child is held down by a number of women, frequently including her own relatives. This form of circumcision is practised widely in only three countries – Sudan, Somalia and Mali.

In reality the distinction between the types of circumcision is often irrelevant since it depends on the sharpness of the instrument used, the struggling of the child, and the skill and eyesight of the operator. In most cultures this is an elderly woman from the village who may use a variety of instruments from a razor blade or pair of scissors to a broken bottle, depending on the setting.

The circumciser's social status varies from place to place. In Mali, the operators are usually women of the blacksmiths' caste who are thought to be in touch with the occult. In the Upper East Region of Ghana – the only part of the country where female circumcision is practised – the traditional operator enjoys high status: he or she is not allowed to farm, but is supported entirely by the community. Elsewhere an operator may be a lowly person who earns little more than pocket money for performing circumcisions as a sideline. Many are also traditional birth attendants.

In some countries medical staff have carried out circumcisions in an attempt to avoid some of the dangers of unskilled operations performed in insanitary conditions. No one is quite sure how many clinics perform circumcisions, as the sensitivity of the subject makes research extremely

difficult. But a study by Marie Assaad of the American University of Cairo, prepared for a seminar on traditional practices organised by the WHO in 1979, found that 12 per cent of the female circumcisions were performed by physicians, 53 per cent by traditional midwives (dayas), 12 per cent by barbers and less than 5 per cent by nurses. Another study carried out in Cairo found that professional midwives were performing 19 per cent of the operations and doctors 10 per cent.

Until recently, the City Hospital in Bamako, capital of Mali, employed a person exclusively to perform female circumcisions because the operation was so frequently requested by the parents of newborn girls. But this services has reportedly been discontinued because of growing opposition to the medicalisation of female circumcision – a stand taken unequivocally by the WHO.

The operation is generally performed on girls before they reach puberty. In many places it was once an initiation rite into adulthood, and accompanied by drumming, dancing, feasting and gifts. But most experts agree the operation being performed on an ever younger age and that is has less and less to do with initiation into adulthood.

The immediate and long-term risks to health are enormous. Many little girls bleed to death because clumsy operators have cut into the pudendal artery or the dorsal artery of the clitoris. Others die of post-operative shock because no one knows how to resuscitate them and the hospital is too far, or those involved are reluctant to seek help because they are ashamed of the botched operations. The use of unsterilised instruments and traditional compounds to staunch bleeding carries a high risk of tetanus, infection and septicaemia. And some children suffer acute urinary retention because they are afraid to pass urine on the raw wound.

Sometimes the hole left after infibulatin is too small to allow the passage of menstrual blood which collects, instead, in the abdomen. There have been instances where girls have been beaten and even killed to preserve the honour of their families who believed that their swelling bellies and absence of periods indicated pregnancy. Dysmenorrhoea is so common among infibulated women that in northern Sudan, where the incidence of female circumcision is 90 per cent, every female is entitled to one day off school or work per month.

If the Bartholin gland, responsible for lubricating the vulva, is damaged during circumcision, secretions may accumulate in the vulva and form cysts which become painful abscesses when infected. Some girls develop a neuroma at the site of the excised clitoris – a miserable condition that renders the whole area unbearably sensitive.

Not surprisingly, such conditions, as well as the presence of thick and hard scar tissue, cause sexual difficulties. Intercourse is often difficult and the woman may tear. Sometimes penetration is impossible, and in some place notably Mali, Somalia and parts of Sierra Leone, it is the custom for the husband to take a knife to his new bride on their wedding night.

Clitoridectomy means the removal of the organ responsible for female orgasm and some women, unable to respond or receive sexual pleasure, become frigid or depressed. Some, who are aware that circumcision is not universal, realise they are mutilated. 'I felt as if I was less of a woman, as if I was abnormal' said a young woman from the Masai tribe of Kenya whose marriage to an Englishman foundered on sexual problems and who has not chosen celibacy. 'I never had any sexual feelings all the time I was with him. I just felt used. To this day I've never felt anything. (Circumcision) is something that leaves a scar in your life for a long time.'

Little has been written about the effect of circumcision on a woman's sexuality. However, interviews conducted by Olayinka Koso-Thomas, a doctor in Freetown, Sierra Leone (described in her book The Circumcision of Women: a Strategy for Eradication, available from Zed Press in London) offer some insights. Of the 140 women involved, 47 had undergone clitoridectomy only, while 93 had been excised. Some had experienced sexual intercourse before circumcision, and this seemed to affect their responses: they were the only women who experienced any arousal in response to male advances prior to love making. These women were also more likely than other circumcised women to experience mild sexual stimulation during intercourse. Generally, the more extreme the operation, the greater was the loss of sexual feeling. None of the women felt any intense stimulation during intercourse.

Interestingly, all Koso-Thomas's interviewees were 'proud of their feminine being and personality.' However, those who had experienced intercourse before circumcision 'expressed disappointment with the condition of their womanhood and the diminished level at which they were expected to peform as human beings.' Most others, especially those from the more conservative rural areas, 'seemed to have resigned themselves to the fate which their societies had decreed for them'.

Koso-Thomas canvassed opinon among men, too. Of the 15 she interviewed, 10 said they preferred uncircumcised women as sexual partners because they got more intense pleasure and liked to share the experience with their partners. Of the five who preferred circumcised partners, one said he believed women were not intended to enjoy sexual intercourse. All the illiterate men from rural areas believed women who were uncircumcised were unclean and oversexed.

Many circumcised women suffer infertility as a result of frequent pelvic infections or scar tissue blocking the fallopian tubes. But those who conceive are likely to experience problems in childbirth such as prolonged labour and internal laceration because of the lack of elasticity in the scarred birth canal. Paul Correa, gynaecologist and former head of maternity services at Danec Hospital in Dakar, Senegal, found that haemorrhage from internal tearing was the most common labour complication among circumcised women, and the most frequent cause of maternal death.

The origins of female circumcision are impossible to establish though it is known to be a practice that is centuries old, evident among the mummies of ancient Egypt, Efua Forkeno, co-editor of the 1983 Minority Rights Group report on female circumcision and now director of the

London-based Foundation for Women's Health Research and Development (FORWARD), warns against dismissing this as 'just another barbaric custom out of Africa.'

'Circumcision has been practised in some form by the natives of every continent at one time or another,' she said. In 1886 an eminent London obstetrician, Isaac Baker Brown, published his book, On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy and Hysteria in the Female, in which he recommend clitoridectomy as treatment for all such 'feminine weaknesses.' He performed such operations for years before his drastic treatment was challenged by the British Medical Association and he was struck off the medical register. But clitoridectomy as a cure for various mental disorders could also be found in medical textbooks in America at the time.

There is no doubt that practice is a means of suppressing and controlling the sexual behaviour of women. Female circumcision is a physiological chastity belt: a cruel extension of the iron contraptions within which the crusaders of the 12th century locked their women's pelvises or the rings that the early Romans put through the labia majora of their female slaves to ensure their faithfulness.

It is still deeply rooted in underdevelopment and the low social status of women – which explains the paradox that those who are victims of the practice are also its stongest proponents. Circumcision is a passport to social acceptance, and people dare not challenge it while community support is the only means of individual survival.

Many explanations are put forward for supporting the custom today. Some practitioners associate it with religion, though there is no basis for it in either the Koran or the Bible – and, significantly, female circumcision is not practised in Saudi Arabi, the cradle of Islam. Some believe female genitalia are unclean and cutting them away purifies a woman; that the sex drive of an uncircumcised woman is uncontrollable; or that, unless they are cut, the clitoris and the labia will grow until they hang down between a woman's knees.

Other myths and misconceptions abound. According to the Bambaras of Mali, each baby is born with rudimentary characteristics of the opposite sex which must be cut away to make the child wholly male or female. Thus the prepuce or foreskin, of the penis (considered to be vestigial hymen) and the clitoris (considered to be a vestigial penis) are both removed. Some groups in Nigeria believe that if the head of the baby touches the clitoris during childhood, the child will die.

A researcher working in Egypt was told by qualified nurses that they would have their daughters circumcised to protect them from delinquency. And women have also admitted in interviews that they subjected their daughters to the same painful fate as themselves out of spite.

Exploding the myths does little to loosen the grip of the custom on traditional societies: they cling to it as a vital part of their cultural identity and simply find new rationales when the old ones are refuted. In Kenya and Sudan, where the misionaries and then the colonial administrations campaigned against it, female curcumcision became a symbol of resistance to foreign influence. Jomo Kenyatta, then a freedom fighter and subsequently the first president of independent Kenya, championed the pratice. In recent years Kenyatta's successor, President Daniel Arap Moi, has issued a decree against it. But Arap Moi is a member of the Luo tribe which does not circumcise its women and, like the colonial powers before him, he has been accused of trying to suppress the culture of tribes to which he does not belong.

For many years, African governments used a similar argument to deflect the WHO from the issue. And the same shocked and furious response greeted Western feminists when they tried to take the lid off the subject again during the United Nations Decade of Women, 1975 to 1985. They were accused of racism and cultural imperialism, and told to mind their own business. But this time African and Arab women picked up the gauntlet and they have, with great discretion, set about understanding female circumcisoin's role in society, and have since dictated the style of the campaign against it.

At a conference in Dakar in 1984 on 'traditional practices affecting the health of women and children,' financed largley by the WHO and UNICEF, delegates agreed that national committees should be established within each country where female circumcision was practised. They subsequently set up the Inter Africa Committee (IAC) – a shoestring operation based in Geneva – to act as a bridge between the local groups and outside supporters who fund the work. (Circumcision is an extremely low priority for national governments strapped for cash and wary of such a controversial issue).

National committees have ben set up in 22 African countries. 'Our main weapon in fighting these traditions is education,' said Berhane Ras-Work, Ethiopian-born director of the IAC. 'We target women first for they have to realise the importance of their own health. In many African countries, women don't consider their health as important because they work and die taking care of others. Most women think that pain is part of their life. We have to convince them that life without pain is possible, life without disease is possible.'

This takes skill and wisdom, for infomation about the health hazards of female circumcision tends simply to be dismissed by people who value the practice as a mark of morality and marriageability. The personal discomfort and danger, no matter how severe, is often preferable to bieng an uncircumcised outcast. Abolitionists who fail to recognise and respect this fact lose credibility.

Furthermore, convincing a teenage girl or young mother of the danger and pointlessness of curcumcision leads only to doubt and anxiety and changes nothing if they cannot decide their fate or that of their small daughters. Campaigners must, therefore, make efforts to reach the decision-makers, who are frequently the older women and the menfolk in a family.

They msut also take into account the fact that circumcision is a source of income to traditional operators. So health education addressed to this group has to be combined with training for an alternative livelihood – and, importantly, one that carries the same social status. One campaign in Ghana, for example, offers circumcisers the chance to become traditional birth attendants, equally respected by the community. In Ethiopia, on

the other hand, a group of women who earned little for their services as circumcisers are training as bakers and sandal makers for which their is a demand.

The IAC conference, held in the Ethiopian capital of Addis Ababa in November to assess the progress of the abolition campaign so far, identified insufficient and unpredictable funding as the maior handicap. The big UN donors such as UNICEF and the WHO (which were among the first to governments. Officially they can only support country projects at the request of the government, and most governments decline to get involved. However, the WHO does offer more covert support through the IAC and as part of other health programmes.

Otherwise campaigns rely on a handful of European and American nongovernmental aid organisations for support. Lack of cash means they are run largely by volunteers whose time is limited, and who frequently lack the training and organisational skills necessary to make the most of their deep personal commitment. A Swedish evaluation team who visited projects in Kenya, Egypt and Mali prior to the Addis conference commented: 'What they all have in common is that they have gone through a period of trial and error as they have had no knowledge of how to approach this very sensitive issue. Consequently they have had little planning, and seldom defined targets or target groups.'

Evaluation teams visited six African countries and they brought back anecdotal evidence of slow change at the grassroots. In Mali, for example, a team member who attended a meeting for rural women was amused to see the campaigner come striding through the village with the IAC teaching aid – a female torso with removable genital parts – carried on her head like a pitcher of water. 'That represented a huge step forward in a country where you couldn't even mention the subject a decade ago,' she said.

In Ethiopia another evaluator found a Muslim and a Christian priest, two men of considerable influence, who had been so shocked by a film they saw on female circumcision that they had joined forces to fight it among their followers. However, the fact that no programme has been able to demonstrate sweeping change clearly exasperates some campaigners who believe the time has come for a more militant approach.

'They have had education campaigns in the Sudan since the 1940s, and where has it got them?' asked Dorkeno from the FORWARD group. 'In the north female genital mutilation is still nearly 100 per cent prevalent.' She believes it is time to start talking about sexual politics and human rights. 'This has a lot to do with how women have been conditioned to see their roles in society. We should be looking at how women are able to cope with the pressures to conform, and start developing support structures for those who want to opt out.'

Dorkeno, who works among immigrant groups in Britain, speaks for a minority of campaigners. Most of those working in male-dominated rural AFrica are not ready to make such a strong challenge to the status quo. Any hint of 'feminims' or 'women's liberation,' they say, would kill their campaigns.

Whatever their chosen approach, nobody close to the action has any doubt taht putting an end to female circumcision is an uphill struggle, or that the target of 'abolition by the year 2000' is more of a rallying cry than a real possibility. To give their efforts a boost, they ended their conference in Addis by calling on governments in all the countries where female circumcision still prevails to pass laws against it.

There is a danger that outlawing such a deep-rooted and valued tradition will drive it underground and make people reluctant to seek medical help when accidents happen. But many grassroots campaigners feel there is a limit to what they can achieve on their own. They need the support of people in high places to give them credibility, and a law is a practical statement of that support as well as a useful weapon.

Not only their governments but the whole international community should heed their call. For in the final analysis, the fact that millions of downtrodden women consent to their own torture and that of their daughters is one of the greatest conundrums and tragedies of our time.

Sue Armstrong is a freelance journalist based in South Africa

AN END TO 'FEMALE GENITAL MULTILATION'?

There are many international conventions that ostensibly offer women and children protection from genital multilation, including the Universal Declaration of Human Rights adopted by the United Nations in 1948. Article 5 states that 'no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.'

Female circumcision, as a specific issue, was first put on the agenda of the UN Centre for Human Rights in 1981, when Efua Dorkeno of the Foundation for Women's Health Research and Development was allowed to address the Working Group on Slavery. It was subsequently taken on by the Centre's Sub-Commission on Prevention of Discrimination and Protection of Minorities which formed a special working group of experts, drawn widely from health and child welfare, to study harmful traditional practices and to recommend ways of eliminating them.

Throughout its history as a human rights issue, however, female circumcision has had to fight for its voice. Only constant badgering from a small core of dedicated African women has kept the subject from being swept under the carpet on numerous occasions. But despite the fact that so many governments pay only lip service to declarations, failing to give them the weight of national law, the women have won some small victories. In 1991 for example the first seminars on harmful traditional practices to be held under the auspices of the Centre for Human Rights will take place in Africa and Asia. And the campaigners say that at least the conventions give them scope to raise the issue with governments who would rather turn a blind eye to the practice.

One of the most important advances on the human rights front, however, came last Setember when world leaders met in New Yrok to discuss the protection of children. Carried along by the cause and the warmth of media attention, many governments signed the resulting Convention on the

Rights of the Child without hesitation. It effectively condemns female circumcision as torture and sexual abuse, and Dorkeno is determined that this time the impetus for abolishing the practice must not be allowed to die as the spotlight moves on.

'This is one of the major socia evils of our time,' she declared. 'The film screened at the Addis conference showed a six-month-old child being cut in public somewhere in Africa. At the end of the operation the child was in such a state of distress her tongue was literally hanging out. There are thousands of children undergoing this operation daily.

'We need to look at all possible ways of combating it. That will involve not just information, but legislation, law enforcement, and active protection of children,' she said. 'It's a must. Otherwise we'll have another 3000 years waiting for traditinal societe to evolve, and I don't thing it's fair on women or children.

SURGICAL CHILD ABUSE, THE BATTLE TO STOP FEMALE CIRCUMCISION IN BRITAIN

Several of Britain's immigrant communities come from countries in which female circumcision is practised. For many immigrants, keeping their cultural traditions alive is vital to their sense of identity in an alien land, and over recent years it has become apparent that thousands of young girls in Britain are at risk of genital mutilation.

'Considering the groups form Somalia, Sudan, Ethiopia, West and East Africa, we're talking about up to 10,000 children at risk in the United Kingdom as a whole,' said Efua Forkeno, Ghanaian-born director of FORWARD (Foundation for Women's Health Research and Development) which is at the forefront of the eradication campaign in Britain.

The most common practice is for families to send their young daughters is back to Africa for the operation, said Dorkeno. But she has had reports that traditional operators have also been brought to Britain to perform circumcisions. 'We're investigating to see if we can find some of them,' she said. 'But the community is very very secretive and very protective, so it's difficult to find out who is actually doing it.'

The psychological consequences of the operation may be more severe for a young woman living in Britain than they would be in her native country, because sooner or later she becomes aware of the fact that she is different from many of her peers. 'The black child in Britain already faces a lot of pressure, and many suffer badly from his added stigma. They're ashamed to talk to their friends, and the can't talk to their parents because their parents' believe it's a good thing for them,' said Dorkeno. 'Quite a number come to our project with their difficulties.'

Female circumcision has probably been practised in Britain ever since immigrant groups first settled with their families. But for a long time the extreme sensitivity of the issue caused it to be swept firmly under the carpet by those professionals who become aware of it in the course of their work. Few are prepared to step into the racial minefield, even if they were prepared to breach the taboos surounding sexual matters.

British law has always offered protection against such a practice, but in 1985 specific legislation was passed in the form of Prohibition of Female Circumcision Act, which was introduced by MP Marion Roe, The act makes it an offence for any person to excise, infibulate or otherwise mutilate the whole or any part of the labia majora, labia minora or clitoris of another person to aid, abet, counsel or procure another person to preform such acts.

With the wall of silence breached and female circumcision declared unequivocally illegal, it soon became clear that professionals – such as health personnel, social workers, teachers – who have to confront the issue in the course of their work needed special training and support, and, most importantly a framework for action. So, in February 1989, FORWARD organised the first national conference on female genital mutilation in Britain, to explore some of the extremely complex ethical, social and legal issues involved in combating it.

Among them was the question of whether female circumcision constitutes child abuse and should thus be listed among the categories of children 'at risk' on the child abuse register. The issue is extremely controversial: some people – notably members of the London Black Women's Health Action Project which plays a strong part in the eradication campaign – argue that labelling families as child abusers, and therefore criminals, is counterproductive because it alienates immigrant groups rather than encouraging them to change.

Most such families, they say, see the circumcision of their daughters as an act of love, not cruelty. Attitudes will never change if people are put on the defensive. These objections are taken seriously by fellow campaigners, although the consensus is that female circumcision should be recognised as child abuse, thus clearly empowering professionals to take action to protect little girls at risk.

As with cases of child sexual abuse, many social workers find themselves crippled with uncertainty about the best kind of action to take. Having explored the various options, campaigners believe that making children at risk 'wards of court' is often the most appropriate course of action, because it prevents parents from making unilateral decisions about the child's welfare without subjecting the child to the misery of removal from the family.

As everywhere, education and consciousness raising are essential parts of the campaign. Following the 1989 conference, FORWARD drew up an action plan that aims to make all those who come into professional contact with immigrant families aware of the practice of female circumcision and to enlist thier cooperation in combating it.

The plan suggests setting up grassroots information and counselling services, and support groups for families wanting to challenge tradition – for even in far-off Britain, many immigrants find it hard to question the values and to resist the pressure to conform to their native societies. The action plan aims, too, to create some sort of consultative body that will include members of the community and the social services and act as a vital channel of communication between the two as they feel their way through the minefield.

Despite its painstaking efforts to put the issue on the agendas of health and social services, however, the campaign to eradicate female circumcision in Britain remains hamstrung by its cultural sensitivity. On several occasions Dorken has had phone calls from distressed general practioners who alrerted to her to the fact that genital mutilation was occurring in their area but who refused to identify themselves or the children in imminent danger.

'We presume they're wary of getting involved in a culturally bound and sensitive issue,' she said. 'We understand their fears, but unless we all confront the issue, we rob these little girls of the only defence they have – the campaign against female circumcision.'

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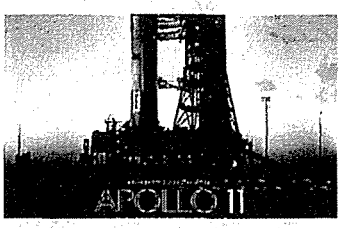


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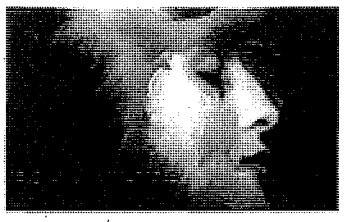

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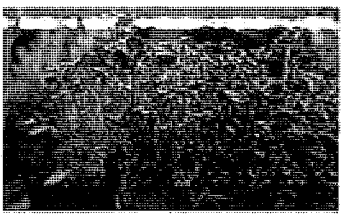

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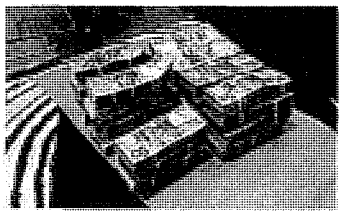

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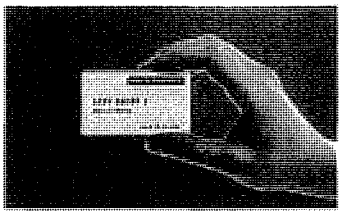

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IN THE HIGH COURT OF AUSTRALIA

SYDNEY REGISTRY

No. S43 of 2019

No. S44 of 2019

No. S45 of 2019

BETWEEN:

The Queen

Appellant

and



A2

Kubra Magennis

Shabbir Mohammedbhai Vaziri

Respondents

**Respondents' Joint Submission on the *Criminal Appeal Act 1912* (NSW)**

**Part I:**

1. These submissions are in a form suitable for publication on the internet.

**Part II:**

2. These submissions address the question of whether s.s6(2) and 8(1) of the *Criminal Appeal Act 1912* (NSW) permit the Court to decline to enter a verdict of acquittal and also decline to order a re-trial where an appeal has been upheld. Those provisions are directed to the Court of Criminal Appeal. They are applied by this Court, pursuant to s37 of the *Judiciary Act 1903* (Cth), which provides that this Court, "in the exercise of its appellate jurisdiction may affirm reverse or modify the judgment appealed from, and may give such judgment as ought to have been given in the first instance ...".

3. Section 6(1) of the *Criminal Appeal Act* sets out the circumstances in which the court is to "allow" or "dismiss" an appeal against conviction. Section 6(2) provides:

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> Subject to the special provisions of this Act, the court shall, if it allows an appeal under section 5(1) against conviction, quash the conviction and direct a judgment and verdict of acquittal to be entered.

4. Section 8(1) provides:

> On an appeal against a conviction on indictment, the court may, either of its own motion, or on the application of the appellant, order a new trial in such manner as it thinks fit, if the court considers that a miscarriage of justice has occurred, and, that having regard to all the circumstances, such miscarriage of justice can be more adequately remedied by an order for a new trial than by any other order which the court is empowered to make.

5. Section s6(2) applies irrespective of which of the three limbs in s6(1) led to the appeal being allowed. That is, s6(2) applies where the appeal is allowed, but no finding has been made that the verdict was unreasonable or cannot be supported having regard to the evidence. This raises the question of the appropriateness of the entry of a verdict of acquittal in circumstances where there is evidence on which the jury could have convicted but additional considerations militate against the discretion to order a new trial pursuant to s8(1). The respondents submit that in these circumstances the court does have a power to quash a conviction and make no further order. It is, however, further submitted that the court can, in such circumstances, enter a verdict of acquittal and that this will often be the preferable course.

*It is open to the Court to quash the conviction and decline to make a further order*

6. This Court has on numerous occasions quashed a conviction but made no order for a new trial, without entering a verdict of acquittal.

7. *Maher v The Queen* [1987] HCA 31; (1987) 163 CLR 221 involved a successful appeal against conviction with respect to a count which had been added to the indictment after the jury had been sworn, with the result that the jury were never sworn to try the particular count. The Court observed the failure to comply with the *Jury Act 1929* (Q) "may render a trial a nullity, at least in the sense that the conviction cannot stand" and (with apparent regard to the statutory language) was "such a miscarriage of justice require as to require the conviction to be set aside" (at 233). The Court concluded, that "[a]s there was no power to order or permit [the count] to be added to the indictment, there should be no order for a new trial on that

indictment". The Court did not, however, order an acquittal (which would have suffered from the same difficulty). No order being made, it was left to the prosecuting authorities to present a new indictment charging the same offence.

8. The decision in *Maher v The Queen* highlights a difficulty where the trial is affected by invalidity of the indictment. It is necessary that the conviction be quashed but there can be no order made for a new trial on the indictment the subject of the appeal. See also, in this regard, *R v Halmi* (2005) 62 NSWLR 263 where the indictment failed to properly invoke the jurisdiction of the District Court. The Court of Criminal Appeal (Bell J, with whom Simpson and Buddin JJ agreed) set aside the conviction and sentence but made no order for either acquittal or retrial. The same approach was taken in similar circumstances in *R v Brown and Tran* (2004) 148 A Crim R 268. It is noted that in *R v Janceski* (2005) 64 NSWLR 10 (which involved the same issue as in *R v Halmi*) Howie J, in expressing his conclusion said there "should be a retrial" on one of counts in the indictment (at [286], 57), however it may be doubted that this was an order made pursuant to s8(1) of the *Criminal Appeal Act*, particularly in the light of his what his Honour said at [216], 41. The dilemma was expressly adverted to by Simpson J (as her Honour then was) in *R v Swansson; R v Henry* (2007) NSWLR 406, where her Honour said at ([179]-[180], 435):

> By s 6 of the *Criminal Appeal Act*, this Court is required, where satisfied that any of the grounds has been made out, to "allow the appeal". The inevitable consequence is the quashing of the conviction. By s 8 the Court is empowered, where satisfied that the miscarriage of justice found can more readily be remedied by an order for a new trial than any other order available to it, to make such an order. But how can this Court, in the same breath, declare the trials to have been nullities — never to have taken place — and order that new trials be held?
>
> In my opinion, the Court should merely quash each conviction. It will be a matter for the Director of Public Prosecutions to determine the future course of the allegations against the appellants.

9. This Court has on numerous occasions quashed a conviction but made no order as to retrial. A number of these are demonstrative of the desirability, in some cases, of quashing a conviction but making no order as to acquittal or retrial.

10. In *Gerakiteys v The Queen* (1984) 153 CLR 317 the appellant successfully challenged his conviction in the Court of Criminal Appeal but appealed to this

Court against the Court of Criminal Appeal's order that a new trial be held. This Court allowed the appeal, varying the orders of the Court of Criminal Appeal by deleting the order for a new trial. Notably, the Court did not substitute verdicts of acquittal. The appeal against conviction was allowed on the basis that there was no evidence of the broad conspiracy charged against the appellant. An insufficiency of evidence would ordinarily give rise to a right to an acquittal. In *Gerakiteys* however, the deficiency related to the particulars of the conspiracy charged. There was evidence of narrower conspiracy and no bar to a new trial being held in relation to such a conspiracy. While the entry of an acquittal is unlikely to have given rise to successful plea in bar of autrefois convict, any such issue was avoided by quashing the conviction and making no order for a new trial. See particularly per Gibbs CJ at 321, Murphy J at 322, Deane J at 336.

11. In *Calabria v The Queen* (1983) 151 CLR 670 the situation was similar to that in *Gerakiteys* in that the appellant was not properly convicted of the offence in the indictment but there was evidence of another offence. Again, the conviction was quashed with no orders made as to either retrial or acquittal. See also, in a similar vein, *Andrews v The Queen* (1968) 126 CLR 198, particularly at 211.

12. In *Croton v The Queen* (1967) 117 CLR 326, Barwick CJ, (with whom McTiernan J agreed, forming the majority), held that while there was no evidence to support the charge, there was evidence capable of sustaining an alternative verdict which had not been left to the jury. His Honour relied on a number of factors, including but not limited to the conduct of the case at first instance, to conclude that a retrial should not be ordered. The conviction and sentence were quashed, but no other order made.

13. In *Callaghan v The Queen* [1952] HCA 55; (1952) 87 CLR 115 the appellant was tried on a charge of manslaughter. The jury acquitted him on that charge but found him guilty of the (uncharged but statutorily available) alternative of dangerous driving occasioning death. His appeal to this Court was allowed on the basis that the trial judge was in error to direct the jury that the alternative charge required a lesser degree of negligence (see at 120-121). The Court accepted (at 125) it had the power to order a retrial on the

uncharged statutory alternative but noted "the complicating circumstance that the jury's verdict ought rationally to mean that the appellant was not guilty of the requisite want of care and precaution". That fact together with the portion of the sentence that had already been served led the Court to conclude that "[i]n all the circumstances we think that we ought not to order a new trial, but we ought simply to quash the conviction". While arguably, the verdict was unreasonable on the basis of inconsistency with the acquittal for manslaughter which would warrant an acquittal, this was not the basis on which the Court reasoned.

14. Similar orders were made in *Whitehorn v The Queen* (1983) 152 CLR 657, in the context of a finding the verdict was unreasonable (see Gibbs CJ and Brennan at 660-1 and Dawson J at 690-1). Similarly, *Timbu Kolian v The Queen* (1968) 119 CLR 47, at 55, 56, 70, 71.

15. Consistent with the approach in the above cases, it has not been uncommon in the NSW Court of Criminal Appeal to quash the conviction(s) and sentence(s) of an appellant and either make no further order or decline to order a re-trial and decline to order an acquittal. For example, in *R v O'Donohue* [2011] NSWCCA 458 Bell J (with whom Heydon JA and Dowd J agreed) set aside the verdict and conviction and made no order for a re-trial or acquittal. See also *R v Newhouse* [2001] NSWCCA 294 at [10], *Skondin v R* [2005] NSWCCA 417, *Hamilton* (1993) 68 A Crim R 268). In *R v Love* (1989) 17 NSWLR 608, the Court (comprised of Gleeson CJ, Newman and Loveday JJ) considered there should be no new trial and simply quashed the convictions and sentences.

16. In *R v Giovannone* (2002) 140 A Crim R 1 at [126]-[127] Mason P (with whom Hidden J and Carruthers AJ agreed) considered that, in circumstances where a significant proportion of the custodial part of the sentence imposed in respect of the count affected by the trial judge's error had been served, it was appropriate not to order a new trial (at [126]). The conviction was quashed but no verdict of acquittal was entered in respect of it (at [127]). In *McConnell* (1993) 69 A Crim R 39 the conviction was quashed and no new trial was ordered. Cripps JA did not consider it appropriate to enter an acquittal given that there was evidence upon which the jury

could properly convict and proposed that the conviction be set aside (at 40-41). Wood J said: "While I would not be prepared to direct an acquittal, I am of the view that there should be no order for a new trial" (at 42).

17. It is noted that in *Spies v The Queen* (2000) 201 CLR 603 at [103]-[104], the plurality said:

> If this Court were now to refuse to order a new trial of that charge, the appellant would be acquitted of all charges. Unless the interests of justice require the entry of an acquittal, an appellate court should ordinarily order a new trial of a charge where a conviction in respect of that charge has been set aside but there is evidence to support the charge. In the present case, given the competing considerations, it cannot be said that the interests of justice require that the appellant be acquitted of the s229(4) charge. That being so, it is a matter for the prosecuting authority to determine whether in all the circumstances there should be a further trial of the s229(4) charge.

18. In *Gilham v R* [2012] NSWCCA 131 McClellan CJ at CL expressed a similar view (at [648]):

> ...the discretion [in s8(1)] is only to be exercised if the court determines that the evidence presented at trial was sufficiently cogent to justify a conviction, for if it was not, an acquittal must follow as a matter of course: *Director of Public Prosecutions (Nauru) v Fowler* (1984) 154 CLR 627 at 630; *Gerakiteys v The Queen* (1984) 153 CLR 317 at 322 (Gibbs CJ), 331 (Deane J). For the reasons discussed under the unreasonable verdict ground of appeal, the evidence before the jury was sufficiently cogent to justify the applicant's conviction. It is therefore necessary, in view of the other successful grounds of appeal, to consider whether the applicant ought to be acquitted or retried.

19. McClellan CJ at CL was in the minority in respect of the orders made but Fullerton and Garling JJ do not appear to have doubted his summary of the principles. Each member of the Court was of the view the appeal should be allowed. McClellan CJ at CL would have ordered a new trial. Fullerton and Garling JJ were of the view, having regard to the combination of factors relevant to the discretion, a new trial should not be ordered, and verdicts of acquittal entered.

20. The respondents also note the similar approach in *Pedrana* (2001) 123 A Crim R 1 at [71] where Ipp AJA (with whom Wood CJ at CL agreed) said that ss6(2) and 8(1) of the *Criminal Appeal Act* "do not empower the court to order that no new trial should be held. Nor do they empower the court to quash the conviction and make no other order."

21. The respondents note the inconsistency between these cases and those referred to earlier. The decisions in *Spies*, *Gilham* and *Pedrana* do not deal with the difficulty in entering an acquittal or ordering a retrial in circumstances such as where an indictment (or a charge in an indictment) has been found to have been of no effect. While s6(2) is in mandatory terms it must be read with s8. Section 8(1) provides a discretion to order a new trial. Where an appeal is "allowed" pursuant to s6(1), with the necessary result that the conviction is quashed, the choice given by s8(1) is between an order for a new trial and the making of no order. It is not necessary in these circumstances to revert to s6(2) and order an acquittal where no new trial is ordered.

*It is open to the Court to quash the conviction and enter a verdict of acquittal irrespective of the limb of s6(1) of the Criminal Appeal Act which leads to the appeal being allowed*

22. While it is submitted, above, that the Court has a power to quash a conviction and make no order as to either acquittal or retrial, the respondents make the further submission that the power to enter an acquittal is not dependent on the particular limb of s6(1) which leads to conviction. In this regard the respondents note the discretionary nature of s8(1). Indeed, the English legislation on which s6 is based had no provision corresponding to s8(1) with the result that the English provision necessarily contemplated the entry of an acquittal upon a successful appeal notwithstanding the verdict was not unreasonable or unable to be supported by the evidence. See the discussion in *Weiss v The Queen* (2005) 224 CLR 300 at [20]-[22], 309-310.

23. For a recent consideration by the Court of Criminal Appeal of factors leading to the entry of an acquittal see *Castagna v R; Agius v R* [2019] NSWCCA 114 at [190] – [205] and the cases there referred to, including relevant decisions of this Court. Note also *Gilham v R*, *McConnell*, referred to above. The Court is referred to the submissions of the respondents (Magennis's submissions at [52]-[65]; A2 and Vaziri's submissions at [26]-[30]) in relation to the factors relevant in the present cases.

Dated: 24 July 2019

**Tim Game** **Hament Dhanji**

10 **Georgia Huxley** **David Randle**

Counsel for Magennis Counsel for A2 and Vaziri

IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY

No. S43 of 2019
No. S44 of 2019
No. S45 of 2019

BETWEEN:


**The Queen**
Appellant

and

**A2**
**Kubra Magennis**
**Shabbir Mohammedbhai Vaziri**
Respondents

## APPELLANT'S SUBMISSIONS ON QUESTION NOTIFIED BY COURT ON 12 JULY 2019

**Part I:**

1. The appellant certifies that this note is in a form suitable for publication on the internet.

**Part II:**

2. On 12 July 2019, the Senior Registrar notified the parties that the Court would be assisted by submissions on the question whether ss 6(2) and 8(1) of the *Criminal Appeal Act 1912* (NSW) permit the New South Wales Court of Criminal Appeal (**CCA**), if of the view that there has been a miscarriage of justice in any respect but that a new trial is not appropriate, *not* to order that a verdict of acquittal be entered, i.e. to make no further order than to quash the conviction.

3. In the appellant's submission, properly construed ss 6 and 8 of the *Criminal Appeal Act* do not permit the CCA to allow an appeal against conviction; quash the conviction; and make no further order. It follows that it would not be open to this Court to take that course in the present appeals.

4. Where the CCA allows an appeal pursuant to s 6(1) of the *Criminal Appeal Act*, s 6(2) provides:

> "Subject to the special provisions of this Act, the court shall, if it allows an appeal under section 5(1) against conviction, quash the conviction and direct a judgment and verdict of acquittal to be entered."

5. Section 6(2) is in mandatory terms: "the court *shall* ...". It establishes what has been described as a "default position" as to the orders of the court where an appeal against conviction is allowed.[1] That default position does not apply where orders are made pursuant to the "special provisions" of the *Criminal Appeal Act*. Those special provisions include s 7, which allows for the entry of a substituted verdict, and s 8, which empowers the court to order a new trial.

6. Section 8(1) provides:

> "On an appeal against conviction on indictment, the court may, either of its own motion, or on the application of the appellant, order a new trial in such manner as it thinks fit, if the court considers that a miscarriage of justice has occurred, and, that having regard to all the circumstances, such miscarriage of justice can be more adequately remedied by an order for a new trial than by any other order which the court is empowered to make."

7. The respondents' argument as to the construction of these provisions is that (Respondents' Joint Submissions (**RS**) [21]):

> "[w]here an appeal is 'allowed' pursuant to s 6(1), with the necessary result that the conviction is quashed, the choice given by s 8(1) is between an order for a new trial and the making of no order. It is not necessary in these circumstances to revert to s 6(2) and order an acquittal where no new trial is ordered."

8. The appellant submits that this understanding of the provisions should be rejected, for two main reasons.

9. *First*, it is the command in s 6(2) that the court make orders including the entry of a verdict of acquittal that is subjected to the special provisions of the Act – i.e. relevantly for present purposes, s 8. If an order for a new trial is made under s 8(1), the command in s 6(2) ceases to operate. If, however, no order for a new trial is made, s 6(2) provides that the court "shall" enter a verdict of acquittal.

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[1] *R v Giam* (1999) 104 A Crim R 416; [1999] NSWCCA 53 at [42] per Spigelman CJ (Abadee and Adams JJ agreeing).

10. *Secondly,* s 8(1) does not provide a self-contained discretion, such that there is no reference back to s 6(2). The clearest indication in the statutory language that s 8(1) does not operate in that way is the reference in s 8(1) to the identified "miscarriage of justice" being "more adequately remedied by an order for a new trial than by any other order which the court is empowered to make". The comparative assessment that s 8(1) requires directs attention to the other orders the court may make, namely, an order for the entry of a verdict of acquittal under s 6(2) or, in an appropriate case, an order for the entry of a substituted verdict under s 7. This point was made by Spigelman CJ (Sully and Ireland JJ agreeing) in *R v Johnston* (1998) 45 NSLWR 362 at 380 (emphasis added):

> "Considering what order should be made the Court must have in mind the interconnection between s 6 and s 8 of the *Criminal Appeal Act 1912*. Section 6(2) states that the court "shall" direct a judgment and verdict of acquittal, but this is "subject to the special provisions of the Act". Section 8 is such a "special provision" and provides that a new trial may be ordered if the miscarriage of justice "can be more adequately remedied by an order for a new trial than by any other order", *relevantly, a verdict of acquittal.*"

11. The respondents submit that, once a court undertakes to consider whether a new trial ought be granted in the terms of s 8(1), the relevant choice is between making that order or making no order at all. The difficulty with this submission is that it omits the entry of a verdict of acquittal from the court's consideration at that time. The court may determine, for example, that no order for a new trial should be made and that, instead, a verdict of acquittal should be entered. The comparison called for by s 8(1) envisages that the court may determine that an order, other than an order for a new trial, more adequately remedies the identified miscarriage of justice. If such a view were reached, the court would be directed back to s 6(2), for the purpose of making orders including the entry of a verdict of acquittal. The respondents' submission requires that, in those circumstances, s 6(2) be read otherwise than in accordance with its mandatory terms in order to preserve the possibility that the court makes neither order.

12. The construction of ss 6 and 8 of the *Criminal Appeal Act* that the appellant advances accords with analysis in this Court that has proceeded on the basis of the grant of a new trial and the entry of a verdict of acquittal being alternatives. For example, in *R v Taufahema* (2007) 228 CLR 232, Gummow, Hayne, Heydon and Crennan JJ said

(at [51]): "The question is whether an order for a new trial is a more adequate remedy for the flaws in that trial than an order for an acquittal". As the respondents have noted (RS [17]), Gaudron, McHugh, Gummow and Hayne JJ said in *Spies v The Queen* (2000) 201 CLR 603 (at [103]) that "[i]f this Court were now to refuse to order a new trial of that charge, the appellant would be acquitted of all charges."

13. The appellant acknowledges that there are cases in which, on an appeal against conviction under the *Criminal Appeal Act*, a conviction has been quashed and no order for either the entry of a verdict of acquittal or for a retrial has been made. The cases cited by the respondents at RS [15]-[16] do not, however, involve any stated analysis of the proper construction of ss 6 and 8.

14. Other decisions of the CCA have regarded cases involving the omission of an order for the entry of a verdict of acquittal (where no order is made for a new trial), as an "oversight" on the part of the court in question.[2] In *R v Pedrana* (2001) 123 A Crim R 1; [2001] NSWCCA 66, Ipp AJA (Wood CJ at CL agreeing) said (at [71]):

> "Section 6(2) empowers this Court to quash the conviction, direct a judgment and verdict of acquittal to be entered. Section 8(1) empowers this Court, in the alternative, if it considers that a miscarriage of justice has occurred, to quash the conviction and to order a new trial. In my opinion, the sections do not empower the Court to order that no new trial should be held. Nor do they empower the Court to quash the conviction and make no other order."

15. Against what is, in the appellant's submission, the more natural construction of ss 6 and 8 of the *Criminal Appeal Act*, the respondents draw attention to the difficulty of disposing of appeals where the indictment has been found to be defective (RS [8], [21]). Such cases do not, however, require the acceptance of the construction that the respondents advance. Section 8(1) empowers the CCA to "order a new trial *in such manner as it thinks fit*" (emphasis added). In the appellant's submission, the CCA could, in accordance with the emphasised words, order that a new trial proceed in relation to an alternative charge;[3] on the basis of an amended indictment;[4] or, generally, on an indictment presented according to law.[5]

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[2] See *R v Pedrana* (2001) 123 A Crim R 1; [2001] NSWCCA 66 at [71]-[77] per Ipp AJA (Wood CJ at CL agreeing); *ST v Regina* [2010] NSWCCA 5 at [7]-[8] per Basten JA.
[3] See, for example, *Sio v The Queen* (2016) 259 CLR 47.
[4] See *Gerakiteys v The Queen* (1984) 153 CLR 317 at 330-331 per Brennan J.
[5] See *R v Swansson; R v Henry* (2007) 69 NSWLR 406 at [95] per McClellan CJ at CL. See also at [60]-[73] per Spigelman CJ.

16. To the extent the respondents make a separate submission that, in circumstances where there is evidence to support a conviction but factors militating against a new trial, an order for the entry of a verdict of acquittal is "often … preferable" (RS [5], [22]), that submission is contrary to the position stated in *Spies* (2000) 201 CLR 603 at [104], and restated in *Sio* (2016) 259 CLR 47 at [75]. But the appellant does not understand this to be within the scope of the Court's request for submissions. If this understanding is mistaken, further submissions, on this aspect, can be provided if sought.

Dated: 7 August 2019

**David Kell SC**
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# HIGH COURT OF AUSTRALIA

16 October 2019

THE QUEEN v A2; THE QUEEN v MAGENNIS; THE QUEEN v VAZIRI
[2019] HCA 35

Today the High Court allowed three appeals from the New South Wales Court of Criminal Appeal ("the CCA"). A majority of the Court construed the term "otherwise mutilates" in s 45(1)(a) of the *Crimes Act 1900* (NSW), headed "[p]rohibition of female genital mutilation", as bearing an extended meaning that takes account of the context of female genital mutilation. A majority of the Court also held that the term "clitoris" in s 45(1)(a) encompasses the clitoral hood or prepuce.

Section 45(1)(a) of the *Crimes Act* relevantly provides that a person who "excises, infibulates or otherwise mutilates the whole or any part of the labia majora or labia minora or clitoris of any person" is liable to imprisonment. A2 and Magennis were charged upon indictment with having "mutilated the clitoris" of each of the complainants, C1 and C2. Vaziri was charged with assisting A2 and Magennis following the commission of those offences. The Crown case was that A2 and Magennis were parties to a joint criminal enterprise to perform a ceremony called "khatna", which involves causing injury to a young girl's clitoris by cutting or nicking it. The defence case was that Magennis had performed a procedure on C1 and C2, but that it was merely ritualistic. The trial judge in the Supreme Court of New South Wales directed the jury that "[t]he word 'mutilate' in the context of female genital mutilation means to injure to any extent", and that the term "clitoris ... includes the clitoral hood or prepuce". A2 and Magennis were each found guilty by the jury of two counts of female genital mutilation contrary to s 45(1)(a). Vaziri was found guilty of two accounts of being an accessory to those offences.

The CCA allowed the appeals against conviction on the ground that the trial judge had erred in his directions to the jury as to the meaning of the terms "otherwise mutilates" and "clitoris" in s 45(1)(a). The CCA concluded that the word "mutilates" should be given its ordinary meaning for the purposes of s 45(1)(a); it requires some imperfection or irreparable damage to have been caused. The CCA further held that the term "clitoris" does not include the clitoral hood or prepuce. The CCA allowed the appeals on various other grounds, including that the jury's verdict was unreasonable or unsupported by the evidence.

By grant of special leave, the Crown appealed to the High Court. A majority of the Court held that the term "otherwise mutilates" in s 45(1)(a) does not bear its ordinary meaning, but has an extended meaning that takes account of the context of female genital mutilation, and which encompasses the cutting or nicking of the clitoris of a female child. The purpose of s 45, evident from the heading to the provision and the extrinsic materials, is to criminalise the practice of female genital mutilation in its various forms. A majority of the Court also held that the term "clitoris" in s 45(1)(a) is to be construed broadly, having regard to the context and purpose of s 45. It followed that the trial judge did not misdirect the jury as to the meaning of either of these terms. A majority of the Court allowed the appeals, and held that each matter should be remitted to the CCA for determination of the ground alleging that the

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jury's verdict was unreasonable or unsupported by the evidence, in light of the proper construction of s 45(1)(a).

- *This statement is not intended to be a substitute for the reasons of the High Court or to be used in any later consideration of the Court's reasons.*