

Women and the Criminal Code Chapter 9

REPRODUCTION AND SEXUALITY

PART 1: INTRODUCTION

The issues of abortion, surrogacy and female genital mutilation are issues of great concern to the women of Queensland and are dealt with together on the basis that they each affect a woman's control over her sexuality and reproduction.

The Taskforce chose not to examine the laws of prostitution in Queensland as the Government has recently undertaken a full review and has already announced a new legislative framework for the regulation of the sex industry in Queensland.

PART 2: ABORTION

Inclusion of abortion

Although abortion was not expressly included in our Terms of Reference the Taskforce decided early in our deliberations that it was an issue on which we had to consult and report. It is an offence contained in the Criminal Code that touches specifically on women and is of concern to women. We could not honestly report on the impact of the Criminal Code on women without reporting on the consequences of abortion being an offence.

Issues Paper 6 on Abortion and Surrogacy, published by the Taskforce in June 1999, attracted the largest number of submissions of any Issues Paper. There were submissions both from groups that have advocated for the decriminalisation of abortion for many years, as well as from groups and individuals opposed to abortion.

The Taskforce received a number of well-researched and knowledgeable submissions about abortion from health service providers, academics and other groups with expertise in abortion. We have used those submissions as the basis of much of the discussion in this Chapter rather than undertaking an extensive literature review.

Polarised community views

Abortion is a subject that attracts strong opinion and emotional debate. One view is that abortion is a woman's health and human rights issue:

Women can never have control over their lives and make meaningful decisions about their future if they cannot control when and where they have children. Their potential, education, careers and future happiness is in jeopardy if the decision is taken out of their hands by discriminatory laws. Being forced to carry an unwanted pregnancy to term imposes irreversible circumstances that can alter a woman's financial status, physical, mental and sexual health, self-esteem, social relationships and life goals.

On the other hand, many argue that abortion is taking a life:

Our members are ever vigilant of the need to express our firm belief that life is precious, it exists within the womb and that both mother and child need every support society provides to enable birth to eventuate, including supportive counselling which could well make the difference to a woman's attitude to her pregnancy.

Clearly it is impossible to reconcile these views and we have not attempted to do so. We have endeavoured to take a realistic and pragmatic approach to the presentation of information.

Community attitudes

A number of polls have been conducted over recent years and all tend to indicate strong community support for decriminalisation. In an Anderson McNair poll conducted in 1991, 81% supported a woman's right to have abortion. In 1995 a survey conducted by the Courier Mail indicated that two-thirds of Queenslanders want abortion decriminalised, while a survey of Western Australian gynaecologists in 1990 showed that 100% support legally available abortion.

Although the Taskforce received many submissions from those opposed to abortion, the submissions in favour of improving the availability of abortions spoke cogently of: women's human right to control their fertility; women's health needs; and the realities of poverty and limited life choices for women who are denied the opportunity to terminate an unwanted pregnancy.

MCCOC did not feel "able to make a firm and detailed recommendation to Ministers ... [because the] ... process of consultation has produced two irreconcilable positions, at opposite extremes, with no middle ground." Further, the "issues involved in taking a position on the general issue are not those which are within the particular expertise of this Committee." However, the Committee makes a strong and unassailable point when it concludes:

The Committee would like to emphasise, however, that it is not possible to do nothing. Even doing nothing means taking a position by default [emphasis added].

Global context

Many countries have moved away from focusing on criminality in relation to abortion, towards a concern for women's health and family well being.

The Beijing Declaration that emanated from the Fourth United Nations Women's Conference in 1995 contains a clause to the effect that:

A woman's health and the health of her children, is affected by family planning issues. These include the age at which she begins and stops child-bearing, the interval between each birth, the total number of pregnancies and the socio-cultural and economic circumstances in which she lives and raises her children.

The Declaration calls for countries to review any laws containing punitive measures against women and abortion practices.

The United Nations CEDAW, of which Australia is a signatory, prohibits all forms of discrimination against women in the delivery of health care, and in marriage and family relations respectively. Articles 12.1 and 16.1 (e) of CEDAW provide:

12.1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning...

16.1. States parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women ...

(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

Although this Convention has led to the enactment of federal and state legislation relating to discrimination against women, governments have avoided restructuring the legal regime regarding termination of pregnancy. Arguably, it is Australia's adherence to the Convention that provides the political and legal imperative for this to occur.

Facts about performance of abortions in Australia

The state of abortion law is of critical importance to women. Approximately 14,000 abortions are performed in Queensland each year. It is the second most common gynaecological procedure performed in Australia and is Medicare funded. There is, in fact, "a gross contradiction between the practice and the law of abortion." Interestingly, the proportion of pregnancies aborted in Australia is estimated to have declined from about one-third in 1937 to about one-quarter in 1990, presumably as a result of improved contraception.

Approximately one in three Australian women will have a termination of pregnancy during her lifetime and one in four pregnancies are terminated in Australia every year. Most abortions (over 90%) are performed before the 12th week of pregnancy. All women are represented in the statistics - varying education levels, social classes, religious and cultural backgrounds, single and partnered women, with and without children, with and without paid employment. Approximately 29% of the women are under 20 years, 63% are between 20 to 35 years and 8% are over 35 years.

The reasons for abortions include: the desire for more financial security before having a family; problems within the relationship (ranging from insecurity to domestic violence); spacing between children; feeling that they are too young to mother; pregnancy resulting from rape or incest; identified health problems in the foetus; and study and career issues.

No contraception is 100% effective. As well, some women do not fully understand the issues associated with the use of contraceptives (for example, certain antibiotics interfere with the effectiveness of the pill). Children by Choice report over half of their clients use a regular method of contraception and 39% report using contraception when they became pregnant.

Consequences of criminalisation

Cost and access

The fact that the Criminal Code provides for the prosecution and imprisonment of medical practitioners who perform abortions shapes the provision of abortion services in Queensland, in terms of availability within the private health sector, and in terms of State health policy. There is a lack of choice for women in selecting a health professional to conduct an abortion. Often rural women travel to neighbouring towns and cities to consult with more sympathetic general practitioners or women specific services.

In Brisbane an abortion performed in the first 12 weeks of pregnancy costs about \$170 and rises by \$50 per week thereafter. In Rockhampton, Townsville and Cairns it is \$350 for up to 12 weeks and \$50 per week thereafter. For rural women the costs are significantly higher (for example, a woman from Cape York has additional travel and accommodation costs and is therefore looking at \$600 up front - \$200 Medicare rebate can be claimed back later). By the time she has saved that money she is likely to be more advanced in the pregnancy which increases her costs and the attendant health risks. The most common reasons for delay are: costs; lack of information on where to access services; inconvenience of travel; and child care arrangements.

Those who are most disadvantaged by these circumstances are young women, women living in rural and remote regions of Queensland (where Aboriginal and Torres Strait Islander women are over-represented) and women from lower socio-economic backgrounds. The provision of termination of pregnancy services through private health facilities in Queensland do not meet the stated goals for equity of access to health services because women who are already disadvantaged have the least access to these limited services. There is a continuing need for termination of pregnancy services in public hospitals.

Limits professional quality control

The criminality of abortion means that it is difficult to ensure practitioners are appropriately qualified or experienced. There is an absence of under-graduate and post-graduate training leading to low numbers of qualified professionals to provide services. The criminal aspect creates problems of access to education for doctors, nurses, psychiatrists, psychologists, counsellors and social workers to assist them to understand and integrate the technical, social and emotional aspects of abortion.

As long as doctors are vulnerable to being charged with a criminal offence, many will be reluctant to develop and practice abortion skills. Further, there will be no widespread or systematic establishment of reliable services throughout the community to meet the needs of all women. This also restricts progressive health care concepts such as the implementation of clinical guidelines for free standing day surgery facilities.

Emotional and psychological consequences for the woman

While abortion remains an offence in the Criminal Code, there will be enormous pressure on women not to actively seek abortions and to feel criminal or at least guilty when they do. Women in rural areas who have to consult the local doctor often find the experience "humiliating" or "at the very least an anxious experience" because of the "emotive and moral stigma attached to terminations".

Single, teenage and older women all have differing needs which go far beyond the medical issue of pregnancy termination. What is common to them all is that

legal uncertainty and moralistic bearings on the issue of abortion do nothing to help women's decision-making. Counselling should be directed to facilitation of the woman's own problem solving capacity, with the final decision resting with the woman.

The emotional and social costs of carrying an unwanted pregnancy to term appear to extend to the offspring who show greater psychiatric morbidity and delinquency and less education than matched controls on 21 year follow up.

On the other hand, some submissions suggested long term psychological consequences from having an abortion:

We women regret what we have done. ... We don't really know what we are doing when we have an abortion.

Queensland law

Sections 224, 255 and 226 of the Criminal Code govern abortion law in Queensland. These sections are aimed at: any doctor or other health worker who performs an abortion; the woman herself; and any one who supplies drugs or instruments for the purpose of performing abortions. It is the section that targets doctors that has been used for prosecutions:

Attempts to procure abortion

224. Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.

Accordingly, abortion is a crime but section 282 is accepted as a defence when the abortion is performed "for the preservation of the mother's life".

Surgical operations

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

The Queensland law has been influenced by court decisions in Victoria and New South Wales that have established the legal frameworks for those states. In 1969 Justice Menhennitt laid down the first major contemporary statement relating to the interpretation of the abortion law in Victoria. He said that an abortion could be lawfully performed if it was:

"necessary to preserve the woman from a serious danger to her life or physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail".

Two years later this view was extended by Judge Levine in NSW to include:

"any economic, social or medical ground or reason which ...could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her physical or mental health."

After raids on the Greenslopes clinic in Brisbane in 1985 Doctors Bayliss and Cullen were prosecuted for procuring an illegal abortion. In the case that followed Judge Maguire undertook a detailed examination of the law and concluded that section 282 should be read as the defence to the abortion sections, although he believed that it was originally intended for a different purpose.

The question, therefore, which is critical to understanding the legal position in Queensland is how widely the expression "or upon an unborn child for the preservation of the mother's life" can be interpreted. If it only relates to life and death situations then lawful abortions would be exceedingly rare, given the developments in medical science. However, if some reference can be made to the quality of life of the mother, the defence has much broader application, although its applicability to any particular abortion will often be difficult to gauge in advance.

Judge Maguire took the view that Justice Menhennitt's ruling applied in Queensland but he was not convinced that the wider interpretation expressed by Judge Levine would be adopted here. He concluded by saying:

This ruling serves to illustrate the uncertainty of the present abortion laws of Queensland. It will require more imperative authority (either a Court of Appeal or Parliament) to effect changes if changes are thought to be desirable or necessary with a view to amending and clarifying the law.

The practical results of the Menhennitt and Levine rulings are that abortions are available in Victoria and New South Wales in free-standing clinics and private and public hospitals. In practice, availability is more restricted in Queensland. This is perhaps the result of the law seeming less clear, the highly politicised action around abortion in Queensland (from all sides of the debate) and the geographic remoteness of some communities.

Law in other Australian jurisdictions

Table 1, at the conclusion of this Part, sets out a summary of the laws and practices relating to abortion in the different Australian states and territories. At about the same time as the Menhennitt and Levine rulings were made, South Australia (1969) and the Northern Territory (1971) legislated to legalise abortion in certain situations. Abortion is still an offence in those places but a regulatory framework provides for lawful abortions.

Since then there had been no significant abortion legislation until 1998 when both Western Australia and the Australian Capital Territory moved on the issue in slightly different ways.

The irony appears to be that some attempts to liberalise the laws have created hurdles that in fact impede access to abortions. It is possible that New South Wales and Victoria, with their common law judgments unchallenged for about 30 years, provide women with the most equitable and practical access.

It is useful to examine the major features of the South Australian and Northern Territory models and compare those with the approaches of the late 1990s.

South Australia - 1969

Circumstances in which an abortion can be performed:

- If the pregnancy is under 28 weeks:
 - the continuation of pregnancy involves greater risk to women's life or there is a risk of injury to physical or mental health, taking into account her actual or reasonably foreseeable environment; or
- serious physical or mental abnormalities in the foetus and in either case:
 - it is necessary in the opinions of two qualified medical practitioners
 - it is carried out in "prescribed" hospital or clinic
 - there is a two months residency requirement in SA
- If the pregnancy is over 28 weeks pregnant:
 - then only to preserve the woman's life.
- "parental" or other consent is not required at any age.

Northern Territory - 1973

Circumstances in which an abortion can be performed:

- if the pregnancy is under 14 weeks:
 - continuation of pregnancy involves greater risk to women's life or risk of injury to physical or mental health than termination (no guidance on what to take into account); or
- there is serious physical or mental abnormalities in foetus and:
 - it is necessary in the opinions of two qualified medical practitioners
 - it is carried out by a gynaecologist or obstetrician
 - it is performed in a hospital
- if the pregnancy is between 14 and 23 weeks:
 - where necessary to prevent grave injury to physical or mental health of woman
- if the pregnancy is over 23 weeks:
 - only to preserve woman's life
- if the woman is under 16 years - "parental" or other appropriate consent required.

Western Australia - 1998

Recent legislative reform occurred in Western Australia after a decision was made to charge two doctors. Due to the uncertainty that this decision generated about the legal position of other doctors, all doctors who performed abortions in Western Australia refused to continue until the law was reformed. Two women also tried to self-abort. There followed an extraordinary political campaign involving politicians, doctors, service providers, women's groups, anti-abortion groups and others. The campaign is well documented in a number of articles.

The final outcome was that the existing sections of the Criminal Code (equivalent to sections 224, 225 and 226) were repealed and replaced with one section. The women themselves can no longer be charged, but a maximum penalty of \$50,000 applies to doctors who breach the law.

Circumstances in which an abortion can be performed:

- if the pregnancy is under 20 weeks:
 - it must be performed by a medical practitioner;
 - is "justified under section 334 of the Health Act" and the woman must give "informed consent";
- a medical practitioner must provide certain detailed information and referrals. It must be a different practitioner from the one who will perform the abortion so there must always be two doctors involved;
- it must be determined that the woman "will suffer serious personal, family or social consequences" if the abortion is not performed or that there is serious danger to the physical or mental health of the woman.
- if the pregnancy is over 20 weeks:
 - two medical practitioners from a panel of at least six appointed by the Minister must agree that "the mother, or the unborn child, has a severe medical condition that ... justifies the procedure"; and
- it must be in an approved facility.
- where the woman is under 16 and is a dependent minor the custodial parent must be informed and "given the opportunity to participate in a counselling process" or the woman may apply to the Children's Court for an order.

The Act is to be reviewed within three years and a report is to be presented to Parliament within four years.

It is reported that the new laws have restricted access to abortion services for young women. According to USA research parental involvement laws may cause young women to delay seeking medical services, thereby increasing the risk of the procedure. It may also lead to unwanted births, illegal abortion and suicide.

Australian Capital Territory - 1998

In the ACT no changes were made to the Crimes Act which contains similar provisions to the Queensland Criminal Code. Instead a new Act was introduced which now provides a regulatory framework around the provisions of the Crimes Act.

The Health Regulation (Maternal Health Information) Act 1998 introduced an objects section that sets the tone for the legislation. The objects include:

- ensuring "adequate and balanced medical advice and information" are given to women;
- ensuring abortions are only performed by "appropriately qualified persons in suitable premises";
- providing statistical reports to government;

- providing the right of persons and bodies to refuse to participate in abortions;

The rest of the Act sets out other rules including:

- the practitioner must be a medical practitioner in an "approved facility";
- the practitioner must provide certain information, for example, a detailed list of information and referrals;
- the woman and her doctor must sign a declaration regarding the provision of information;
- the consent of woman in writing must be obtained after a 72 hour "cooling off" period following the declaration about information;
- a seven member Advisory Panel must approve materials for the information; and
- the Minister must receive statistical quarterly reports from approved facilities (non-identifying of patients).

Abortion laws around the world

Table 2, at the conclusion of this Part, gives an overview of abortion laws around the world. It can be seen that "currently about 61% of the world's population live in countries where induced abortion is permitted for a wide range of reasons or without restriction as to reason (most industrialised nations, not including Australia). In contrast, 25% live in nations where abortion is generally prohibited (mainly South America and Africa except South Africa).

United States of America

The famous American decision of *Roe v Wade* occurred at about the same time as our *Menhennitt* and *Levine* rulings, but took a very different approach determined by constitutional rights. The major findings of Justice Blackburn can be summarised as follows:

- government may not interfere with a woman's decision to terminate a pregnancy in any way during the first trimester of pregnancy, except to insist that it be performed by a physician;
- in the second trimester, government has the power to regulate abortion only in ways designed to preserve and protect the woman's health;
- from the third trimester, protection of foetal life becomes a sufficiently compelling reason to justify interference to protect foetal life unless the abortion is necessary to preserve the woman's life.

Issues raised by law reform

Repeal sections 224, 225 and 226 of the Criminal Code

Children by Choice advocates repeal of sections 224, 225 and 226 of the Criminal Code as "a necessary precondition for the guarantee of women's reproductive rights."

Arguably the amendment of these sections, or the introduction of a regulatory framework, could actually jeopardise access to those who were intended to

benefit. As we noted in Western Australia, small details in the regime can create insurmountable hurdles for some women - usually the poorest, least educated and with the fewest resources.

Compromises in regulatory frameworks are generally intended to satisfy or placate some of the concerns raised by those opposed to abortion. Ironically, it is doubtful that they serve any purpose. Those opposed remain horrified by any attempt to improve access to abortions. Those who believe that abortions should be available are often frustrated by the new hurdles and feel dissatisfied. Those who suffer are the women who believe that the new law has improved access to abortion, and then find themselves in a bureaucratic medical maze as they work against time to fulfil the requirements of eligibility.

The Public Health Association of Australia recommends that all reference to lawful, medically provided abortion be removed from the criminal laws and codes of the States and Territories of Australia and that abortion be regulated within the Medical Practitioners Acts.

In France the first steps in law reform were taken by the conservative approach of simply legislating that the offence provisions did not apply to abortions performed within the first 10 weeks. This is in line with policy in the USA where first trimester abortions are considered to be entirely private matters between a woman and her doctor.

Who can perform and where

Many of the regulatory schemes contain conditions about who can perform abortions and where they can be conducted. While quality control is vital in health care, most medical procedures do not have specific laws for such matters and general medical practice standards apply. For example, rules requiring abortions be performed by medical practitioners, limits the possibility of specialist nurses and midwives training and qualifying in this area of work. Requiring the facilities in which abortions are performed to be specially approved often limits access in rural and regional areas. If changes are to be made, ensuring access to services of all kinds for women in these isolated areas of Queensland should be considered.

Limitations based on period of gestation

Many groups suggest that there should be no specified limit on the period of gestation. It is argued that women and doctors do not willingly submit themselves to late abortions.

Age of consent

It was submitted to the Taskforce that the Western Australian provisions requiring young women to obtain Court orders have "caused confusion, complaints and concerns"

Potential framework for restriction

A number of the submissions suggested that any regulatory framework would provide a basis on to which restrictions could be grafted. There could be an inherent danger in attempting to develop a set of rules that try to set out in advance the circumstances in which an abortion is legal or illegal.

Ways forward

Consultative panel

Children by Choice, in recognising the difficulties of rushing change in the law, have recommended that:

- a Consultative Panel be set up to establish a plan for, and oversee the process of, abortion and related services becoming accessible to all Queensland women as an urgent health and social justice goal;
- the Panel be given a time frame of no more than four years, with the planning process to be complete within one year, and it should report to the Minister for Women's Policy, the Attorney-General, the Minister for Health, and the Premier;
- the members of the Panel should be committed to the overall goal of ensuring that Queensland women have reasonable and equitable access to abortion services, and should be women;
- it include a representative from each of the following:
 - Office of Women's Policy
 - Queensland Health
 - Department of Justice and Attorney-General
 - the medical profession
 - the legal profession
 - Children by Choice
 - Family Planning Queensland
 - Women's Health Queensland Wide (a network of women's health services)
 - women in rural and remote areas
 - Aboriginal women
 - young women
 - women of the Torres Strait Islands
 - women from non-English speaking backgrounds;
- the Panel make and implement plans with respect to the following aspects of abortion services, and other fertility control services (but not necessarily limited to them):
 - Set standards for private health facilities in which abortion services are available, in consultation with the Royal Australian College of Obstetricians and Gynaecologists, the Royal Australian College of General Practitioners and the Abortion Providers Federation of Australia.
 - Make recommendations in relation to abortion services within the Queensland public health system, after appropriate consultation, and oversee implementation with regional hospital boards and any other bodies.
 - Make recommendations and oversee the implementation in relation to the Patient Transit Scheme, after consultation with Queensland Health, to ensure that it becomes appropriately accessible to women.
 - Make recommendations about the education of health professionals and the training of health professionals about this issue, after consultation with appropriate medical and educational bodies.

- Make recommendations, and consult about their implementation, to ensure wider knowledge and availability of emergency contraception.
- Make recommendations for, and consult about their implementation, contraceptive and safe sex education in primary and secondary schools.
- Make recommendations about the provision of information, counselling, and post-abortion counselling for Queensland women.

Appropriate facilities

Another submission suggests publicly funded and free-standing clinics should be provided in regional centres, and that these should have overnight facilities and be linked to the public hospital system. These should adopt the Abortion Providers Federation of Australia Standards of Practice and Guidelines for Member Facilities.

Training and education for providers

In South Africa the Choice on Termination of Pregnancy Act 1996 became operative on 1 February 1997. It permits abortions to be performed upon the woman's request through the first trimester of pregnancy - a dramatic change from the previous law. This has required the urgent training and education of service providers about the technical procedures and also the issues relevant to working with women who have chosen to terminate a pregnancy.

The Planned Parenthood Association of South Africa has been conducting workshops with service providers. The goals of the workshops are to:

- facilitate the implementation and management of abortions in an efficacious manner;
- gain an understanding of providers' concerns regarding abortion;
- assist providers in relating their values to their clients' needs; and
- develop recommendations for incorporating such training sessions into regular programs for providers.

Prevention

A number of submissions suggested that Australia should change its attitude towards RU486 (widely touted as the "morning after" pill). One argued that it should be part of total health care for Queensland women. The Taskforce does not have enough information about this pharmaceutical product to comment.

Education on sexuality and reproduction

Submissions generally indicated strong support for sex education in schools, although anti-abortion submissions tended to suggest that such education could be negative and dangerous.

The risks associated with indiscriminate sexual behaviour (eg sexually transmitted diseases) should be clearly communicated, along with the fact that the only 100% safe means of avoiding STDs is to have a monogamous long term heterosexual relationship with uninfected partners. The only 100% safe way to avoid pregnancy is to avoid heterosexual relations.

Submissions in favour proposed there be broad education about contraception,

sexually transmitted diseases, hygiene and sexual preference . It was also suggested that basic education should begin at preschool.

Counselling

Post abortion counselling, education and family planning services should be offered by qualified health practitioners to help avoid further unwanted pregnancies.

Deliberations

Options

The Taskforce considered the following options:

1. Leave the law as it stands.
2. Make no legislative change but establish a panel to review abortion laws, practices and procedures with a view to possible change in the future.
3. Repeal the relevant sections of the Criminal Code.
4. Repeal the relevant sections and then establish a panel to investigate issues such as access in public hospitals, training and education for service providers and community education on wider related issues.
5. Amend the relevant sections so that they only apply to abortions performed after a specific number of weeks of gestation.

Discussion

A small minority of the Taskforce prefer there be no change to the existing law. These views are based either on the belief that the termination of a pregnancy is inconsistent with the sanctity of life, or because they believe the current law already allows access to terminations and no legislative change is necessary.

For many Taskforce members, the issue of equity of access rather than personal or moral views is the most important factor. The Taskforce endeavoured to take a pragmatic and realistic approach and not be drawn into the emotional arguments that attend this issue.

A significant majority is of the view that the sections of the Criminal Code that criminalise abortion should be repealed. Some believe that this should occur in conjunction with the establishment of a panel as set out in option 4. Others do not support any further action because they do not want to encourage abortions, but believe that the current uncertain status, and criminal taint, creates an adverse environment for many women - including women who are poor, socially disadvantaged or geographically isolated.

One member does not support repeal of the current laws but supports the establishment of a panel that could examine repeal of the laws as an option.

Early in discussions we considered recommending a regulatory framework which would lead to laws similar to South Australia, the Northern Territory, Western Australia or the ACT. We also considered the option of retaining the current law but clarifying the existing defence. However, ultimately, these ideas were unanimously rejected. The Taskforce is mindful that regulatory frameworks can

operate against those women most in need of assistance. The more we considered the rules which would apply, the less we were inclined to enter that arena to make judgments in advance of circumstances.

Table 1:

Summary of Law and Practice of Abortion in Australia

State Legislation Common Law Decisions Legal Interpretation Availability of Legal Abortion

Queensland Criminal Code 1899

ss 224, 225 and 226 R v Bayliss and Cullen (1986),

Maguire J, District Court serious danger to woman's life or physical or mental health free-standing clinics

Victoria Crimes Act 1958

ss 65 and 66 R v Davidson (1969)

Menhennitt J, Supreme Court serious danger to woman's life or physical or mental health free-standing clinics, private and public hospitals

New South Wales Crimes Act 1900

ss 82, 83 and 84 R v Wald (1971)

Levine J, District Court economic, social or medical grounds causing serious danger to woman's physical or mental health free-standing clinics, private and public hospitals

Tasmania Criminal Code

ss 134 and 135 untested nil free-standing clinic

Northern Territory Criminal Code

ss 172, 173 and 174 untested pregnant under 14 weeks

- risk to women's life or risk of injury to physical or mental health
- serious physical or mental abnormalities in foetus
- opinions of 2 medical practitioners
- carried out by gynaecologist or obstetrician
- in a hospital Darwin and Alice Springs hospitals by specialist gynaecologist and obstetrician

Australian Capital Territory Crimes Act 1900

ss 42, 43, 44

Health Regulation (Maternal Health Information) Act 1998 untested *must be performed by a medical practitioner

- in an approved facility
- woman must be provided with specified advice, information and referral
- woman and doctor must sign declaration about information etc
- 72 hour "cooling off" period free-standing clinic

South Australia Criminal Law Consolidation Act 1935 (as amended)

ss 81, 82 and 82A untested pregnant under 28 weeks

- risk to women's life or risk of injury to physical or mental health - taking into account her actual or reasonably foreseeable environment; or
- serious physical or mental abnormalities in foetus
- opinions of 2 medical practitioners

- carried out in prescribed hospital or clinic
- 2 months residency in SA free-standing clinic and prescribed hospitals

Western Australia Criminal Code 1913
 s 199 and 259
 Health Act 1911
 s334 untested pregnant under 20 weeks

- must be performed by medical practitioner
- woman will suffer serious personal, family or social consequences; or
- serious danger to physical or mental health of woman
- woman must give "informed consent"
- woman must be provided with specified advice, information and referral free-standing clinics

Table 2:

INTERNATIONAL FAMILY PLANNING PERSPECTIVES 24(2): 56-64 Page 59
 Table 1. Countries, by restrictiveness of abortion law, according to region,
 1997

Abortion

Restrictiveness The Americas and the Caribbean Central Asia, the Middle East
 and North Africa East and South Asia and the Pacific Europe Sub-
 Saharan Africa

To save the woman's life

No. of countries = 54

Percentage of world's people = 25%

Brazil -R
 Chile -ND
 Colombia
 Dominican Republic
 El Salvador -ND
 Guatemala
 Haiti
 Honduras
 Mexico -R
 Nicaragua - SA/PA
 Panama - PA/R/F
 Paraguay
 Venezuela Afghanistan
 Egypt -SA
 Iran
 Lebanon
 Libya -PA
 Oman
 Syria -SA/PA
 United Arab
 Emirates -SA/PA
 Yemen Bangladesh
 Indonesia
 Laos

Myanmar
Nepal
Papua New
Guinea
Philippines
Sri Lanka Ireland Angola
Benin
Central African Rep
Chad
Congo (Brazzaville)
Cote d'Ivoire
Dem. Rep. of
Congo -F
Gabon
Guinea-Bissau-SA/PA
Kenya
Lesotho Madagascar
Mali
Mauritania
Mauritius
Niger
Nigeria
Senegal
Somalia
Sudan -R
Tanzania
Togo
Uganda
Physical
Health

23 countries
10% of people Argentina -R (limited)
Bolivia -R/I
Costa Rica
Ecuador -R/I (limited)
Peru
Uruguay -R Kuwait -SA/PA/F
Morocco -SA
Saudi Arabia -SA/PA Pakistan
Rep. of Korea -SA/R.I/F
Thailand - R Poland -R/I/F Burkina Faso -R
Burundi
Cameroon -R
Eritrea
Ethiopia
Guinea Malawi -SA
Mozambique
Rwanda
Zimbabwe -F/R/I
Mental
Health
20 countries
4% of people Jamaica -PA
Trinidad & Tobago Algeria
Iraq -SA/F/R/I
Israel -F/R/I

Jordan Australia
Hong Kong -F/R/I
Malaysia
New Zealand -F/I Northern Ireland
Portugal -PA/F/R
Spain -F/R
Switzerland Botswana -F/R/I
Gambia
Ghana -F/R/I Liberia -F/R/I
Namibia -F/R/I
Sierra Leone
Socio-economic
Grounds
6 countries
20% of people India -PA/R/F
Japan -SA
Taiwan -SA/PA/I/F Finland -R/F
Great Britain -F Zambia
Without restriction
As to reason

49 countries
41% of people
Canada - L
Cuba*-PA
United States -PV
Puerto Rico -PV Armenia*
Azerbaijan*
Georgia*
Kazakstan*
Kyrgyz Rep*
Tajikistan*
Tunisia*
Turkey* -SA/PA
Turkmenistan*
Uzbekistan* Cambodia%u2020 -PA
China -PA/L
Mongolia*
N. Korea -L
Singapore%u2021
Vietnam -L Albania*
Austria%u2020
Belarus*
Belgium%u2020
Bosnia-
Herzegovina* -PA
Bulgaria*
Croatia* -PA
Czech Rep.* -PA
Denmark* -PA
Estonia*
France* -PA
Germany%u2020
Greece* -PA
Hungary%u2020
Italy%A7 -PA
Latvia*

Lithuania*
Macedonia* -PA
Moldova*
Netherlands -PV
Norway* -PA
Romania%u2020
Russian Red.*
Slovak Rep.* -PA
Slovenia* -PA
Sweden**
Ukraine*

Yugoslavia* -PA South Africa*

* Gestational limit of 12 weeks. %u2020Gestational limit of 14 weeks.
%u2021Gestational limit of 24 weeks. %A7 Gestational limit of 90 days. **
Gestational limit of 18 weeks. Notes: For gestational limits, duration of
pregnancy is calculated from the last menstrual period, which is generally
considered to occur two weeks prior to conception. Thus, statutory gestational
limits calculated from the date of conception have been extended by two weeks.
ND - Existence of defence of necessity is highly doubtful. SA = Spousal
authorisation required. PA = Parental authorisation required. R - Abortion
allowed in cases of rape. I = Abortion allowed in cases of incest. F = Abortion
allowed in case of foetal impairment. L = Law does not indicate gestational limit.
PV = Law does not limit viability abortions.

The information in this Table was provided in the submission from the Women's
Electoral Lobby

PART 3: SURROGACY

What is surrogacy?

Surrogacy is an arrangement whereby one woman agrees to gestate a baby for
another woman or agrees to hand over an unborn child to another woman or
family to raise as her/their own.

The concept is quite ancient. The Bible describes situations in which the
husbands of barren%uF020women father children by other women and then
adopt those children into the home and family of the original couple. The Book of
Genesis records that Sarah invited Abraham to "go in unto my maid; it may be
that I may obtain children by her" . This form of surrogacy was dependent on the
social structure of the time.

These slave women gave birth to children for their mistresses involuntarily,
receiving no payment for their efforts.

Types of surrogacy

There are various ways in which surrogacy can occur and new forms of
reproductive technology have recently expanded these. Examples include:

- a couple may be unable to have children because the woman has no
uterus - perhaps as a result of a medically required hysterectomy. Both
the man and woman may otherwise be fertile. In this situation they could
use reproductive technology processes to produce an embryo from one of
her ovum and his sperm. The embryo can then be implanted in the uterus
of a 'surrogate' mother who then undertakes the pregnancy. The original

couple become the social and genetic parents but the surrogate mother has carried the child to birth.

- if the first woman is infertile then her partner can provide his sperm to the surrogate mother, either through artificial insemination or sexual intercourse, and she undertakes the pregnancy. This way the child is genetically related to the father's side of his or her social parents.
- a woman who is already pregnant may not wish to rear the child she is carrying, to terminate her pregnancy, or to place her child in the formal adoption process. If she privately enters into an arrangement to place the child, after its birth with another family such that the child will be 'treated' as the child of any person or persons other than the woman - this is considered surrogacy in Queensland.

Traditional practices

An extended concept of kinship and flexible notions of child rearing among Native Americans, West African and Pacific Island societies involve children living in different households throughout their young lives. This practice may enable infertile couples to rear children although it is not limited such situations .

In Queensland the Torres Strait Islander community exercises a form of traditional giving and receiving of children (formerly known as Torres Strait Islander traditional adoption) as part of their child rearing practices. A child born to a single woman or to a couple is commonly given either to close friends or to a member of the woman's broad extended family to rear. Not only does this give an infertile couple the opportunity to raise a child but also encourages the reciprocity and obligation that strengthens alliances between families.

This customary practice has not been recognised under Queensland's formal law, and it sometimes conflicts with a number of official laws and procedures regulated by the Adoption Act 1975, the Registration of Births Deaths and Marriages Act 1962, the Status of Children Act 1978 and the Children's Services Act 1965. Further, some forms of the practice are specifically prohibited under the Surrogate Parenthood Act 1988.

Two matters arise for consideration by the Taskforce because of this:

- women and families in the Torres Strait are being placed in the invidious position of breaching certain laws when they are engaged in a practice that they see as an essential part of their society. This in itself requires redress; and
- customary practice provides a traditional Indigenous lens for the Taskforce to look through when considering whether legislative reform should be recommended.

Australian legislation

Surrogacy contracts

In Queensland all forms of surrogacy are prohibited under the Surrogate Parenthood Act 1988 and carry a maximum penalty of 3 years imprisonment or 100 penalty units (\$7,500). The offence is entering into a 'prescribed contract' either to bear a child to be reared by others or to agree to hand over to others a child that has already been conceived.

The Act makes it clear that surrogacy is an offence whether or not it is undertaken for payment and it prohibits the advertising of surrogacy services. Some states have no laws about surrogacy, thereby leaving its legality in doubt. Those states with legislation do not criminalise 'altruistic' surrogacy. In Victoria, South Australia and Tasmania the offences relate only to commercial surrogacy and advertising or procuring surrogacy arrangements.

In Queensland the Children's Services Act 1965 also applies. It makes it an offence for a person to have a child under 10 years in his or her charge in any premises for more than 48 hours unless that person is registered as some form of official child care centre or is a "father, mother, relative or guardian of the child concerned". This section is rarely invoked but it was used by DFYCC to remove a child from the home of intended parents in 1991 thereby thwarting the efforts of a group of friends to conduct an informal surrogacy arrangement. It would seem that there is no equivalent provision under the Child Protection Act 1999 or the Child Care Act 1999.

As far as the Taskforce is aware there has been no case in Queensland where parties to a surrogacy arrangement have been penalised seriously. In the case referred to in the preceding paragraph the "surrogate" mother and intended mother were both charged under the Surrogate Parenthood Act (interestingly the intended father was not) but the Magistrate discharged the women without recording a conviction.

The ACT appears to have taken the most liberal view of surrogacy. Although its legislation is very similar to the three states mentioned above, it allows for more intervention. For example, the provision of "professional or technical services" (for example, reproductive technology) is only prohibited in respect of commercial surrogacy whereas in Tasmania it is prohibited in all situations.

The legislation in all states makes surrogacy contracts illegal and unenforceable, even where they are not automatically offences. This means that, where a dispute arises, they cannot be enforced against either the "surrogate" mother or the intended parents by using contract law principles. The ACT legislation provides that where there are any legal proceedings arising out of a surrogacy contract "the welfare and interests of the child" shall be regarded as the paramount consideration.

A medical clinic has been established in Canberra to assist people wanting to enter surrogacy arrangements. It cannot introduce potential parties but can work with parties who have identified each other. There are quite stringent eligibility requirements, detailed medical and legal information is provided and counselling is mandatory. Only "gestational" surrogacy is undertaken - that is where the surrogate mother provides no genetic material and both gametes came from the intended social parents. A number of submissions to the Taskforce recommended this limitation.

Parenthood of children born through surrogacy

As the use of reproductive technology has become more common in Australia, legislation has been necessary to clarify the legal position of children born through these processes - to ensure their legitimacy. Legislation has also ensured that no legal responsibility was vested in a donor of a gamete (ovum or sperm). Therefore the Family Law Act 1975 provides that a child born to a woman "as a result of the carrying out of an artificial conception procedure while the woman was married to a man" is considered to be their child. It also covers de facto relationships. The various equivalents of Queensland's Status of

Children Act have similar provisions.

All of this legislation turns on the child being born to the woman who will then raise the child. It has nothing to do with the genetic parentage of the child. A child genetically unrelated to both parties will be legally considered their child if IVF procedures were used which involved donor ovum and sperm. However, these same provisions mean that in a surrogacy arrangement the child is legally the child of the "surrogate" mother and not of the intended parents even if they have provided both gametes.

It is difficult to tell whether this result was intentional or whether, in an attempt to keep up with changes in reproductive technology, legislation was introduced to cover the most usual circumstance with no thought being given to the consequential problems for surrogate arrangements. If a woman's infertility is a result of an inability to produce ova or due to her husband's infertility, the couple can use IVF, the woman will gestate the child in her uterus and the child will be legally theirs. However, where a problem with the woman's uterus, or with carrying the pregnancy to term, causes the infertility, gestation of the child by another woman is an offence in some places and in almost all places in Australia the child is legally the child of the "surrogate" mother.

World view

United States of America

In the United State of America surrogacy arrangements occur in a number of ways in different states. Some cases, where disputes have arisen, have received world press. In fact, the practices throughout the states vary widely. Some states embrace the contractual model and allow the intended parents to become the legal parents. The most commonly applied laws prohibit enforcement of paid surrogacy contracts although some have a "cooling off period" similar to that allowed in adoption consents (for example, Florida allows revocation by the surrogate mother within seven days of birth).

There is usually an extensive regulatory structure for unpaid surrogacy which involves medical and psychological screening, submission of the contract to a judge for approval before the pregnancy, and home studies of both the intended parents and the surrogate (including her partner and other family).

United Kingdom

The Surrogacy Arrangements Act 1985 (UK) was rushed into law in the United Kingdom when a particular case, that came to be known as the Baby Cotton case, came to the attention of the British public. It is unashamedly a stop-gap measure - the government was panicked into legislative action by a vociferous media and populist demand. The Act prohibits commercial surrogacy activities such as advertising, recruitment of women as surrogates and negotiation of surrogacy arrangements by agencies.

In 1990 the Human Fertilisation and Embryology Act clarified a number of issues regarding surrogacy. In particular, section 30 allows a court to make an order providing for a child to be treated in law as the child of a husband and wife who are the intended parents in a surrogacy arrangement where-

- the child was carried by a woman other than the wife as a result of the placing in her of an embryo, or sperm and eggs, or her artificial insemination;

- gametes of the husband or wife or both were used to create the embryo;
- the husband and wife apply to the court for an order within six months of the birth of the child;
- the child's home is with the husband and wife;
- the court is satisfied that the father and woman who carried the child "have freely, and with full understanding of what is involved, agreed unconditionally to the making of the order";
- no money or other benefit (other than for expenses reasonably incurred) has passed between the parties.

Issues and concerns in relation to surrogacy

Public policy issues

Surrogacy contracts are traditionally considered to be contrary to public policy on the basis that they are sexually immoral (until recently for pregnancy to happen it was often necessary for the intended father to have sexual intercourse with the surrogate mother) and they interfere with the contract of marriage.

It is also argued that surrogacy amounts to a private adoption process, and that there are public policy benefits to adoptions being controlled by the state. For example, to ensure proper screening and selection of prospective parents and legal certainty of parentage.

Polarised views

The issue of surrogacy creates polarised views within the community. One view holds that all surrogacy is bad and should be prohibited. The reasons tend to range from religious and moral positions, a fear of turning children into commodities, to feminist considerations of the inevitable exploitation of the surrogate mother. A number of submissions to the Taskforce expressed a negative view of surrogacy. For example one submission described it as "the buying and selling of other humans".

The contrary view is that all surrogacy should be allowed. Clinics and agencies should be established to bring potential surrogate mothers and commissioning parents together. This would facilitate screening of prospective parties in a variety of ways, ensure counselling and provide a framework for the agreement. Some suggest that surrogate contracts should be legal and enforceable in the same manner as any commercial contract.

Neither position appears to gain favour in Australia although, with some exceptions, the trend is towards prohibition. The exceptions generally derive from sympathy for the position of infertile couples, who in other circumstances may have a medical remedy available. One submission to the Taskforce explained that although the writer was not in favour of surrogacy she could "feel for those couples who desperately want children and can't have them", and therefore advocated for surrogacy to be legal in some circumstances.

One submission in favour of legalisation strongly disagreed with arguments that surrogacy relegates women and children to "commodity status" in the context of non-commercial surrogacy. On the contrary, a surrogate woman in a non-commercial arrangement is motivated by the desire to provide an opportunity for an infertile friend or relative to access and enjoy the experience of parenthood.

Another submission noted that, as an alternative to legalising surrogacy, the causes of increasing rates of infertility need to be researched, while another referred to the effects on siblings being unknown, the possibility of distortion in relationships with grandparents and potential problems with laws of inheritance.

Inquiries and reports

By 1996 there had been 10 committees of inquiry in Australia into surrogacy and related reproductive technology. All but one "expressed grave reservations about the practice or recommended that it be prohibited" . The one report which decided in favour was the National Bioethics Consultative Committee's second Discussion Paper on Surrogacy. This Paper proposed legislation which sought "to sanction surrogacy arrangements as a constructive way to address the problems of human infertility" . These views were not well supported by the community and have not been followed by any state or territory that has legislated.

Is surrogacy inherently exploitative?

Some argue that surrogacy is inherently exploitative of the surrogate mother. Lori Andrews studied the lives of over 80 surrogate mothers in the USA. She suggests that the attitude that surrogacy must necessarily be exploitative may well be paternalistic, and that perhaps it is time to accept that women are able to give informed consent about issues concerning their bodies. After all, it is expected that women and men can give informed consent about sterilisations, sex change operations, heart surgery and other elective surgery.

In support of altruistic surrogacy one submission to the Taskforce stated that "the view that a woman should be prevented from providing assistance to an infertile friend of relative on the basis that she may be subject to exploitation in so doing is paternalistic. Such a legislative stance fails to accord recognition to a woman's right to privacy and self-determination". The Women's Legal Service reports that most requests for information on surrogacy laws come from potential surrogate mothers considering surrogacy for their sister or a friend. They are generally shocked to be told that even altruistic surrogacy is illegal in this state.

While there are some appalling examples of exploitation and unhappiness that have reached the world headlines, these cases do not reflect the norm and may well not be prevented by current Queensland legislation.

One critical issue is domestic violence. It is well known that pregnant women are not immune from violence from their partner:

Violence involving children often occurs pre-natally - simultaneous spouse and child abuse. For many women, pregnancy does not provide a respite from abuse as might be expected. Many women continue to be abused or threatened during their pregnancies. In fact, abuse in the relationship often begins with the first pregnancy or escalates during pregnancy.

This risk to potential surrogates needs to be remembered and any regulatory processes regarding surrogacy must screen for domestic violence in the intimate relationship of the proposed surrogate mother.

Adoption and surrogacy

It is the handing over of a child born to a woman that appears to discomfort most. We have learned only recently the sad and haunted stories of women who

gave up children for adoption when single motherhood was socially intolerable. We have also watched generations of our Indigenous peoples torn apart by government practices that separated children from their kin. As Margaret Brinig comments in respect of women who wish to be surrogates:

They may simply enjoy being pregnant and the powerful feeling of creation that comes with giving birth. But the dark side of these good feelings is that women are not programmed to have children and then part with them. A contract made beforehand, even though it may make the rational part of the placement easier, cannot affect these biological drives.

We simply do not yet know enough to compare surrogacy and adoption, but they are very different processes for the parents and the children. There is much to suggest that it is the genetic link that adopted people search out to understand themselves. It is possible that these same issues simply do not apply to "gestational" surrogacy in particular. It may be that for some surrogate mothers the handing over of the child equates with the relinquishing of babies by young adopting mothers in the 1960s and 1970s - but for many the fact that the pregnancy was intentionally entered into for a specific purpose creates an entirely different dynamic.

The fact that surrogates themselves view their position as different from that of biological mothers in the adoption situation should caution policymakers against unthinkingly applying an adoption/family law paradigm to the situation.

One submission to the Taskforce suggested "loosening up the adoption laws so that a mother can relinquish her child to named adoptees", but the reality is that there are not enough children available for adoption to begin to meet the numbers of infertile couples wishing to create a family.

It may also be that the issues that arise in adoption may be overcome in surrogacy by more open processes. In Australia, parties to surrogacy are generally related or very close friends.

It has been suggested that information on the birth certificate should include the names of any gamete donors, the name of the birth mother and the names of the social parents.

Commercial versus non-commercial surrogacy

In light of consultations and the general community views expressed elsewhere, the Taskforce has not considered seriously the option of legalising commercial surrogacy. We do not believe that it would meet with community acceptance. For example, one submission stated that "commercial surrogacy should always be prohibited since it amounts to buying a child". However it is interesting to consider that couples pay out huge amounts of money to secure overseas adoptions and the cost of one IVF cycle is about \$7,000 to \$9,000. The community appears to accept payments being made to adoption agencies and fertility clinics but not to women who are prepared to change their lives for nine months and carry a child.

As Shultz notes ironically, this pattern:

smacks all too familiarly of the notion that while men get paid for their efforts, skills and services [sperm are among the things for which men get paid] women, being women, should do their women-things out of purity of heart and sentiment.

Nonetheless, coercion may be more likely in unpaid surrogacy between relatives and friends, and an altruistic surrogate may find herself economically dependent upon her family or the commissioning parents during the course of pregnancy .

The deep concerns about commercial surrogacy possibly emanate from situations where gestational surrogacy is considered on a mass scale - for example, using poor women in Third World or war ravaged countries to gestate the genetic children of rich Western couples at exploitative rates. These concepts are clearly intolerable and would meet with no acceptance in the Australian community.

There is also a lack of clarity about when surrogacy becomes commercial. For example it is argued by some that medical, hospital and travelling expenses should not be labelled as commercial. But what about loss of wages, maternity wear, nutritional food?

Disputes

One submission raised the issue of potential conflicts during pregnancy - can the commissioning parents ban alcohol or cigarettes, dictate antenatal tests or the consequences of foetal abnormality. While these matters should be dealt with at the outset, in the form of a contract, not all areas of potential dispute can be eliminated.

One way to resolve disputes in surrogacy arrangements regarding placement of the child would be to strictly enforce the terms of any agreement as if it were a commercial contract. Another would be to rely on the Family Court to deal with the matter, as outlined below. One submission to the Taskforce that recognised the potential difficulties with surrogacy still suggested that it should not be illegal provided the surrogate mother had the "final say" about keeping the baby.

Attitude of the Family Court

Disputes about the "custody" or "residence" of the child in a surrogacy arrangement will most probably be settled by the Family Court applying the usual test of "best interests of the child". In *Re Evelyn*, Justice Jordan took this view and held that the provisions of the Family Law Act dealing with the paramountcy of that principle enabled him "to consider the case on its merits without being unduly fettered by legal fictions based on broad considerations of public policy" . On appeal the Full Court of the Family Court upheld this approach and the decision was ultimately confirmed in the High Court.

The case involved a surrogacy arrangement whereby Mrs S was artificially seminanted by semen from Mr Q, the husband of Mrs Q, who was unable to carry a pregnancy. The two women were close friends, the suggestion had come from Mrs S, and Mr S had consented. Mr and Mrs S already had three children and Mr and Mrs Q had an adopted son. The child was living with the Qs and was about 6 months old when Mrs S took action to retrieve the child into her family.

Justice Jordan held that "the agreement itself is void and unenforceable". However "it would not be appropriate to totally disregard the motives, intentions, hopes and expectations for the four adults who entered into this arrangement to create a human life and to charter the course that that human life was intended to take".

The expert opinions given during the trial differed significantly, with each acknowledging the complexity of the arrangement. Each recommended that the

child, known as E, should live with the parties who had engaged them - emphasising alternately the importance of retaining the bond with the primary carer (Mrs Q), the father and the adopted brother; or of developing bonds with the biological and gestational mother Mrs S, Mr S and the three biological siblings.

Some of the judge's findings from expert evidence include:

- the number of children born from surrogacy arrangements is very, very small. E will need special help from her parents to enable her to integrate this very special, unique and unusual method of creation into her self-concept. E will not have any societal model to help her integrate her identity.
- E's "best interests will be served by providing her with full and frank disclosure about the circumstances of her birth in a planned and age-appropriate way".
- "The need to understand and deal with her surrogacy will be a major developmental issue for E... an order placing E in the residence of her biological mother provides her with the optimum situation in which to best work through the issues. Ideally, the child should have ready access to the adult best able to answer the complicated issues which might arise, preferably as and when they arise ... the biological mother provides the optimum environment with which to deal with [identity] issues, given the importance of the relationship between the child and the biological parent of the same sex in terms of identity issues." This observation somewhat begs the question of what would have been the result if the child had been a boy.
- "It is likely that E will experience a sense of rejection by her biological mother if she remains [with the Qs]... There is no evidence before me ... [that] ... the child would experience a sense of rejection by her biological father to the same degree and effect." This raises the question of what would have been the result if E had not been the genetic daughter of Mrs S.

Although the judgment leaves open many issues, and another case may be decided in a different way, it is clear the Family Court provides a forum for dealing with disputes in surrogacy situations.

What regimes can be devised?

There are four main legal options for surrogacy:

- legal recognition and the ability for the commissioning parents to enforce the surrogacy contract, even against an unwilling relinquishing surrogate;
- acceptance that it is contrary to public policy but not illegal. Contracts would not be enforceable and disputes would be settled in the Family Court after applying the usual test of the best interests of the child;
- regulation through some official avenue. This approach generally proposes that potential commissioning parents and surrogates apply for permission to enter surrogacy arrangements. It provides some protection for all parties - screening, counselling and an agreed process to follow;
- total prohibition.

Risks in maintaining criminal regime

Despite the inherent complexities in, and social discomfort with, surrogacy arrangements, criminal prohibition, as we have now, is not the solution. First, it means that traditional practices of the Torres Strait Islander community are made into criminal offences when no harm has been shown. Secondly it throws families and friends into the criminal justice system when they are engaged in an intensely private and personal matter.

When Tasmania introduced its legislation prohibiting commercial surrogacy only, the government made it clear that nothing controversial was occurring but:

in line with the recommendations of a joint meeting of Commonwealth and State ministers responsible for Health and Social Welfare, [the government] does not believe that the legislation should penalise parties to [altruistic] surrogacy

One confidential submission received detailed the plight of a couple who went through 13 unsuccessful attempts at IVF before applying for an overseas adoption. They then discovered that the husband was six months outside the permissible age to adopt. Eventually the couple, knowing they were in breach of Queensland law, travelled to Canberra with a couple who were close friends to attempt a surrogacy arrangement which was unsuccessful. As the submission says:

It is not possible for me to put in words the grief, horror and utter despair we felt at hearing our last chance for parenthood was ruled out because of Queensland legislation. ... I am now a criminal. This is so ridiculous and this law needs to be changed. ... I didn't seek to hurt or take anything from another, I just wanted to have what most women want, to have a child to love and nurture.

What are the real public policy considerations?

If the law of surrogacy is to be reformed - even to decriminalise altruistic surrogacy, then the following matters should be considered:

- the need to ensure there is fully informed consent from the surrogate mother and her family (partner and children);
- perhaps, a requirement that the surrogate mother should already have one healthy child;
- the medical history of the commissioning mother should demonstrate the high need for a surrogacy arrangement;
- the possibility of limiting surrogacy arrangements such that the "gestational" mother is never also the genetic mother. A number of submissions to the Taskforce made this suggestion;
- the certainty of legal parenthood afterwards - a way in which the social parents can become the legal parents and the surrogate mother and her partner can be divested of legal responsibility;
- the need for a cooling off period for the surrogate mother - if so for how long?
- a method to settle disputes that gives priority to the child's best interests - the Family Court appears to provide this when the dispute is about placement;

- a method to resolve disputes that may arise during the pregnancy (for example, severe disability, illness of the surrogate mother, inability to work during pregnancy, health, smoking, eating habits etc);
- the need to ensure proper care for the surrogate mother during pregnancy;
- the need to prepare for the psycho-social well being of child - this may involve counselling;
- counselling for all parties before entering the process;
- clear rules regarding children's right of access to information;
- the details to be recorded on the birth certificate (Article 8 of the United Nations Convention on the Rights of the Child provides that a child has a right "to preserve his/her identity and family relations");
- appropriate financial assistance and what this will include;
- screening of the potential surrogate mother for drug and alcohol addictions;
- screening for any diseases the surrogate mother could contract through artificial insemination or IVF;
- examining the ability of the commissioning parents to be open and honest with the child; and
- the question of who will have access where reproductive technology is involved.
- the Taskforce received a submission advocating for access for lesbians and gay men that suggested that the lesbian, bisexual, gay and transgender communities are already engaging in surrogacy arrangements in breach of the law.

Deliberations

Options

The Taskforce considered the following options:

1. To leave the law as it stands.
2. Exempt traditional or customary practices.
3. Criminalise commercial surrogacy arrangements only.
4. Establish a committee to examine surrogacy more thoroughly.
5. Make all forms of surrogacy legal.
6. Develop a regulatory framework.

Discussion

The Taskforce overwhelmingly supports prohibiting commercial surrogacy only. Opinions were quite divided and people reached this decision for different reasons, but it was generally felt that it was inappropriate and unhelpful to

involve the criminal justice system in this intensely private matter between relatives and friends. Some of the members are only in favour of exempting traditional practices from the present law. However, other members are concerned about how such practices would be defined. There was also a feeling that, if the practice is to be permitted in one part of the Queensland community, it should be permitted everywhere.

Recommendation 82

That the Surrogate Parenthood Act 1988 be amended such that only commercial surrogacy and associated activities be rendered offences.

PART 4: FEMALE GENITAL MUTILATION (FEMALE CIRCUMCISION)

What is female genital mutilation?

The QLRC issued a Report on female genital mutilation in September 1994.

"Female genital mutilation" is a phrase that has gained international acceptance and has been used to describe a variety of ritual practices in certain communities throughout the world. These practices range from a cut to a female's genitals, to the removal of a genital organ.

In Australia most women affected by female genital mutilation are from Horn of Africa Countries such as Eritrea, Somalia, Ethiopia and Sudan. There are cultural considerations in any attempt to prevent the continuation of this practice in Australia. Issues of colonialism, cultural practices and racism affect any legislative proposals.

Why is female genital mutilation performed?

Various reasons have been given for this practice: control of sexuality increasing fertility; ensuring virginity prior to marriage; and reasons of hygiene and aesthetics. It is not a religious requirement.

Health issues

The health issues arising out of female genital mutilation are many. There are no known medical advantages to the procedure.

Health issues include risks of pain, bleeding, blood poisoning, infection, damage to other organs; vaginal, uterine and urinary tract infections; severe scar formations, sterility, painful periods, painful sexual intercourse, childbirth complications and death. The risks vary with the type of female genital mutilation undertaken. The more intrusive the procedure, the higher the risks.

Submission to the Taskforce

On 6 July 1999 Family Planning Queensland ("FPQ") made a submission to the Taskforce in relation to female genital mutilation.

It noted that there is no legislation in Queensland to prevent children being removed from this State for the practice of female genital mutilation to occur. FPQ have heard anecdotal evidence of children being taken overseas and interstate for the procedure.

FPQ recommend express legislative prohibition of female genital mutilation in Queensland and the banning of the removal of a child from Queensland for the practice to occur. They advise that women who are being pressured to subject their daughters to the practice feel better protected if they can point to an express legislative provision banning the practice.

Queensland Law Reform Commission Report

The QLRC considered the current legal position in relation to female genital mutilation. It stated that under the current Criminal Code, female genital mutilation would fall within the offences of unlawful wounding and grievous bodily harm. Arguably, the consent of the woman would provide no defence to these offences.

The QLRC considered the defence under section 282 of the Code:

Surgical Operations

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

The QLRC noted that while there may be no medical benefit to the procedure, it could be argued that there are cultural benefits to the practice, but surmises that it would be difficult for a jury in Queensland to accept that view. There would also be difficulties in proving that the operation was performed "in good faith and with reasonable care and skill".

Express prohibition of female genital mutilation

The QLRC believed there is sufficient ambiguity in the defence under section 282 to warrant the inclusion of an express prohibition against female genital mutilation.

The QLRC also noted that the then Cabinet had endorsed the inclusion of an express provision at a meeting on 22 August 1994.

The QLRC recommended the following legislative changes:

- A prohibition of female genital mutilation, except for certain medical reasons, to be included in a separate division of the Queensland Criminal Code, the commencement of which should be deferred until after the satisfactory implementation of the education programs (Recommendation (v)).
- Penalty for breach of the prohibition should be by way of fine and/or imprisonment. Maximum penalty should be five years and the type of mutilation, cultural beliefs of the individual and their knowledge of Australian law should be taken into account in determining the appropriate penalty (Recommendation (vi)).
- Prohibition of one or more acts constituting the offence of female genital mutilation being performed in other Australian jurisdictions on a young person normally resident in Queensland (Recommendation (vii)).

Other jurisdictions

Female genital mutilation is prohibited in Victoria, New South Wales, ACT and South Australia.

South Australia, Victoria and the ACT also prohibit the removal of a child from the jurisdiction for the purpose of having female genital mutilation performed. New South Wales makes it an offence to perform the procedure outside of New South Wales provided the victim was ordinarily resident in New South Wales.

Deliberations

Option

The Taskforce released the following option for discussion -

That consideration be given to the legislative changes recommended by Family Planning Queensland and the Queensland Law Reform Commission in relation to female genital mutilation.

Results of consultation

Comments received by the Taskforce on the option of specific legislative prohibition of female genital mutilation were strongly supportive of the option. One submission argued however that "cultural beliefs and knowledge of the Australian law should be taken into account in determining the appropriate penalty".

The Children's Commission noted that if it appears a child is in real danger of undergoing female genital mutilation, a care and protection order could be sought from the Director-General of DFYCC. The Children's Commission also noted that educational programs are essential in reducing the incidence of this practice. DFYCC also argued that the provisions of the Child Protection Act 1999 would be sufficient to protect children at risk of female genital mutilation and that a specific legislative prohibition is unnecessary.

One submission also supported the penalty being by way of fine or imprisonment for up to five years and that there should also be an offence of female genital mutilation being performed outside of Queensland provided the victim is ordinarily resident in Queensland.

Detective Inspector D J Alcorn of the QPS Child & Sexual Assault Investigation Unit supported consideration being given to the legislative changes recommended by the QLRC. The submission also recommended consideration of specific offences.

While supporting a separate offence, QHGGT also recommended consideration of issues of abuse of children.

Discussion

The Taskforce acknowledges that under the current law, the only theoretical basis for a defence to the performance of female genital mutilation is if a jury was satisfied that the "benefit" referred to in section 282 of the Criminal Code ("Surgical Procedures") included a cultural benefit.

Notwithstanding the fact that there are no recorded prosecutions for female genital mutilation in Queensland, the Taskforce acknowledges the international movement for the eradication of this practice, which is considered a breach of international human rights. Part of the eradication process involves ensuring that the practice has been expressly outlawed by relevant legislation.

The Taskforce also acknowledges that education plays an even more important role in the eradication of this practice and that such education has to be sensitive to cultural practices and concerns. However it notes that it is women from those countries where the practice exists who are calling for its universal condemnation. The fact that this practice is carried out on minors who could not be generally considered capable of giving informed consent to the procedure is another factor supporting its express prohibition.

The Taskforce overwhelmingly endorses the following recommendation.

Recommendation 83

That the Criminal Code be amended to include specific provisions outlawing the practice of female genital mutilation. The definition of female genital mutilation should exclude gender reassignment operations. The prohibition should include an offence of removal of a person from the State for the purpose of performing female genital mutilation.