

European Master's Degree
In Human Rights and Democratisation

Awarded Theses
of the Academic Year
2012/2013

"The Cologne judgment: a curiosity or the start sign
for condemning circumcision of male children
without their consent as a human rights violation?"

Thesis *by* Jonathan Alfons J Bernaerts



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FOREWORD

The *European Master's Programme in Human Rights and Democratisation* (E.MA) is the first Master's course in human rights and democratisation launched and financed by the European Commission that later served as model for establishing other Regional Master's around the world. Since January 2013 these are all connected and managed by the *European Inter-University Centre for Human Rights and Democratisation* (EIUC) under the *Global Campus of Regional Master's Programme* (GC).

E.MA is a one-year master's course aimed at preparing professionals to respond to the requirements of daily work in international organisations, field operations, governmental and non-governmental bodies, and academia. The programme offers an action and policy-oriented approach to learning about human rights, democratisation and international relations from legal, political, historical, anthropological, and philosophical perspectives. This interdisciplinary nature and wide-ranging scope of E.MA reflect the benefits of true European inter-university cooperation in human rights education. It is an inter-disciplinary programme that reflects the indivisible links between human rights, democracy, peace and development.

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Each year the E.MA Council of Directors selects five theses which stand out not only for their formal academic qualities but also for the originality of topic, innovative character of methodology and approach, and potential usefulness in raising awareness about neglected situations or issues and capacity for contributing to the promotion of the values underlying human rights and democracy.

The E.MA Awarded Theses of the academic year 2012/2013 are:

- AHMED, Fatma, *Unravelling the Puzzle of Piracy. A Somali Perspective*, Supervisor: Prof. Hans-Georg Ehrhart, University of Hamburg (Germany).
- BERNARTS, Jonathan, *The Cologne Judgment: A Curiosity or the Start Sign for Condemning Circumcision of Male Children Without Their Consent as a Human Rights Violation?*, Supervisors: Prof. Hannes Tretter, Prof. Manfred Nowak, University of Vienna (Austria).
- DE MAN, Annelie, *Are We Protecting Future Generations' Right to Food? A Study of Intergenerational Obligations*, Supervisor: Prof. Jean Allain, Queen's University of Belfast (United Kingdom).
- HESSLING, Leonard, *Water and the Arab Uprisings – The Human Right to Water and Sanitation in Post-Transition Egypt*, Supervisor: Vincent Durac, University College Dublin (Ireland).
- ODOYO, Roselyn Awuor, *From Russia with Love: An Impact Assessment of Resolution A/HRC/21/L2 on Sexual Minorities in Africa*, Supervisor: Prof. Maria Teresa Beleza, New University Lisbon (Portugal).

This volume includes the thesis *The Cologne Judgment: A Curiosity or the Start Sign for Condemning Circumcision of Male Children Without Their Consent as a Human Rights Violation?* by Bernarts, Jonathan, and supervised by Prof. Hannes Tretter and Prof. Manfred Nowak, University of Vienna (Austria).

BIOGRAPHY

Jonathan Bernarts has a background in philosophy and law and holds MA degrees in law from the University of Antwerp and Toulouse as well as the European Master Degree in Human Rights and Democratisation by

EIUC. He previously held internships at UNICEF Belgium, the Thailand Institute of Justice and the EU delegation at the Council of Europe. He is currently a visiting fellow at the Department “Law & Anthropology” of the Max Planck Institute for Social Anthropology in Halle (Germany).

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ABSTRACT

Following the Cologne judgment the debate on circumcision of male children has received a new impetus. Nonetheless, this debate is still too often contaminated with biased opinions, as such this thesis attempts to give an objective analysis of the human rights aspects of the circumcision of male children. In this thesis the circumcision of male children is examined singly without an attempt to argue a non-discrimination violation against men given the alleged similarities with some forms of female genital mutilation. From a medical point of view on the practice, three distinct types of male circumcision can be defined. In the legal analysis these three types are examined with regard to the Convention on the Rights of the Child. Consequently, this thesis concludes that a human rights violation is apparent with regard to *Type 3*, the circumcision of male children lacking either a medically trained or well-experienced circumciser to the level of a medical practitioner, clinical conditions or the use of anaesthesia. The importance of this thesis lies in its new typology of circumcision of male children and the extensive examination of the applicable rights of the Convention on the Rights of the Child, including the recent General Comment No. 14 of the Committee on the Right of the Child on the best interests of the child.

Like past editions, the selected theses amply demonstrate the richness and diversity of the E.MA programme and the outstanding quality of the work performed by its students.

On behalf of the Governing Bodies of EIUC and E.MA and of all participating universities, we congratulate the author.

PROF. FLORENCE BENOÎT-ROHMER
EIUC Secretary General

PROF. RIA WOLLESWINKEL
E.MA Chairperson

JONATHAN BERNAERTS

THE COLOGNE JUDGMENT: A CURIOSITY
OR THE START SIGN FOR CONDEMNING CIRCUMCISION
OF MALE CHILDREN WITHOUT THEIR CONSENT
AS A HUMAN RIGHTS VIOLATION?

After months of work, thanking becomes a joyful activity,

*To my parents, Gerrit and Lieve, for their love and all the opportunities they give me,
To my sister, Lieselotte, the eternal sunshine in my life,
To my supervising professors, Hannes Tretter and Manfred Nowak, for their
advice and expertise despite their busy schedules,*

*To my dear friends, Lieven De Winter, Richard Hynes and Pieter Van der Vloet,
for their suggestions,
To my compagnons de route in Vienna, Melanie and Rebecca,*

And to the countless others for their views and information on the issue.

THE COLOGNE JUDGMENT

AAP	American Academy of Pediatrics
BMA	British Medical Association
CAT	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CRC	Convention on the Rights of the Child
CRC Committee	Committee on the Rights of the Child
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
RDMA	Royal Dutch Medical Association
UNICEF	United Nations Children's Fund
UTI	Urinary Tract Infection
WHO	World Health Organisation

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For a large class of cases – though not for all – in which we employ the word “meaning” it can be defined thus: the meaning of a word is its use in the language.

Ludwig Wittgenstein, *Philosophical Investigations*, G.E.M. Anscombe and R. Rhees (eds.), G.E.M. Anscombe (trans.), Oxford: Blackwell, 1953, para. 43.

INTRODUCTION

Surprisingly enough, a painting of Jackson Pollock has much in common with the current debate on circumcision of male children. Besides the title *Circumcision*¹, the painting has the same interpretative difficulties as exhibited in the current debate. The painting is chaotic, has areas of intense movement, wherein some perceive totemic figures and scenes of violence or chaos. The same can be said for the debate on circumcision of male children: it is chaotic and although most debaters see the same issues including children's rights, freedom of religion and the medical aspect, everyone interprets them from their own point of view which leads to a diversity of outcomes.

The reason for the recent (re-)opening of this debate in Europe is the contested judgment of a Cologne court (hereinafter: the Cologne judgment)² concerning the circumcision on a Muslim boy. Following this Cologne judgment, there has been an explosion of opinions on the practice of male circumcision. Although, this judgment of a domestic court may seem a curiosum, it may, given the controversy that followed, have opened Pandora's Box. With the literature on the subject scattered over a wide range of journals, there is now a need for a more comprehensive approach. This thesis aims to meet this need by providing an accessible overview of the different aspects of the debate. The aim is to sail past the populist debate and to unmask emotional and anti-religious arguments, since too often the debate has been spoiled by both sides, labelling each other as cultish foreskin worshippers or, conversely, as supporters of genital mutilation.

¹ Jackson Pollock, *Circumcision*, January 1946, oil on canvas, 142.3 × 168 cm. Venice Peggy Guggenheim Collection.

² See, Landgericht Köln, 151 Ns 169/11, 7 May 2012.

The perspective the author attempted to use here is common to the style Pollock adopted while painting *Circumcision*. He painted without fear of making changes, destroying the image whilst allowing his vision to come through; consequently, the name for the painting was only later suggested to him³. Thus, the author's method in this thesis was to be as open minded as possible in order to come to a logical and unbiased conclusion. In this way the point of departure remains a question throughout this thesis: is circumcision of male children without their consent a human rights violation under present international law? Questions on how possible violations should be dealt with fall outside the scope of this thesis. Some could argue that the question itself is already proof of a certain bias towards male circumcision. However, since questioning existing truths is the fundamental basis of academic research and progress, it should be possible to discuss issues without being placed immediately in one corner.

In the first chapter, the Cologne judgment will briefly be discussed and used as a springboard from which to examine the other topics of this thesis, followed by a section on the relationship between male circumcision and female genital mutilation (hereinafter: FGM). After this, the motives for the circumcision of male children will be outlined, divided into therapeutic and non-therapeutic circumcisions of male children. This chapter will conclude with a discussion on the prevalence of circumcised children and the geographical area of the debate on the practice. The author utilises a broad perspective from America over Europe and Africa to Asia, which will also be used throughout the thesis. However, this is not done with the aim of promoting worldwide uniformity of the practice, but rather to cover the variety of reasons for the circumcision of male children.

Male circumcision will further be discussed from a medical and legal viewpoint. The inclusion of both perspectives is important, as a medical consensus would arguably make a legal conclusion easier. The medical analysis, in the second chapter, starts with a description of the practice by making a distinction between circumcisions in clinical and non-clinical settings. Secondly, the highly contested positive and negative effects of male circumcision will be presented. Thirdly, the different policies of medical associations worldwide will be outlined to determine whether there is a consensus of opinion.

³ Franck, 1983, p. 68.

The legal analysis, in chapter three, will build on the considerations of the medical analysis and will discuss the relevant rights provided for in the Convention on the Rights of the Child (hereinafter: the CRC). The rights of the parents, the concept of *personal integrity* and the right to freedom of religion are central, with the best interests of the child as the concluding piece to these rights. This will be illustrated with reference to case law and national pieces of legislation, which are not necessarily representative of the legal situation in each region of that country, as regional differences and other administrative acts or medical codes can affect legislation and the way male circumcision is performed.

In the last part the author will attempt to conclude and answer the question as to whether the circumcision of male children without their consent is a violation of the Convention on the Rights of the Child. Consequently, the purpose is comparable to the friend who suggested *Circumcision* as a name for Pollock's painting: generating an overview and clarity.

1.

CIRCUMCISION OF MALE CHILDREN:
DELIMITATION OF THE TOPIC

This chapter will be used to sketch a broader picture of male circumcision, which will be useful with regard to the medical as well as the legal angle of the debate. This chapter opens with a discussion of the Cologne judgment. Following this, a brief history of the practice will be given, which will be followed by a contrasting of male circumcision and female genital mutilation. Finally, the motives for this practice will be discussed, ending with an overview of the prevalence of male circumcision.

1.1. THE COLOGNE JUDGMENT:

A *CURIOSUM* CREATING A NON-EXISTING PROBLEM?

One of the first questions that arises when one contemplates condemning male circumcision is why there are not more complaints by circumcised boys or men. Or more generally, why does the Cologne judgment appear as a *curiosum*? These questions should be nuanced. On the one hand, this judgment is not a *curiosum*, since there is case law on male circumcision, *inter alia*, in the United States, the United Kingdom and Germany. However, most of these judgments consider the validity of parental consent and not the legality of the practice as such. The majority of these rulings state that a ritual circumcision of a male child, performed *lege artis* with the consent of both parents is a legal choice of the parents⁴. Besides this existing case law, there are also legislative attempts to regulate or in some cases to ban the practice of

⁴ See, *infra*, Part 3.6.2.

circumcision of male children⁵. Nevertheless, the general trend in states appears to be towards little or no legislation specific to the circumcision of male children. Consequently, this judgment cannot be seen entirely as a *curiosum* in either the case law or compared with legislative attempts.

On the other hand, scholars put psychological, cultural and social reasons forward to argue why children and men do not regularly challenge their circumcision⁶. Moreover, it could be argued that there is currently no existing legal framework in place for those men who would wish to file a complaint with regard to their circumcision.

Notwithstanding these remarks, the Cologne judgment is currently the most famous decision on male circumcision. Its singularity as a judgment is that it goes to the heart of the debate, namely to the question of whether male circumcision is a violation of the rights of the child. Given the focus and the outcome of the judgment, it is possible to consider the judgment as a *curiosum*. It is different from previous case law, in that it does not circle around issues of parental consent or the *lege artis* of the procedure, but focuses on the rights of the child.

To fully understand the novelty and the implications of the judgment, it is important to make some preliminary remarks before looking at the judgment in detail. First, it should be clear that the *Landgericht Köln*'s jurisdiction does not extend over the whole of Germany and therefore its judgments are only binding on the lower courts in this region. Consequently, contrary to what is believed by some, the judgment did not ban circumcision in Germany. Secondly, the Court evaluated the practice of male circumcision against both German criminal and civil law, contrary to what will be discussed in this thesis, where the focus will be on the Convention on the Rights of the Child, a document ratified by Germany.

The facts of this case are important for a correct understanding of the judgment. A Muslim circumciser, the defendant in the proceedings, performed a circumcision on a four-year-old boy, with a scalpel under local anaesthesia without a medical indication for this procedure, but after the request out of religious motives by the Muslim parents. Although, the circumcision was performed *lege artis*, complications

⁵ See, Article 1631d, (1) Bürgerliches Gesetzbuch (German Civil Code); South African Children's Act No. 38 of 2005; Lag (2001:499) om omskärrelse (Law (2001:499) on male circumcision).

⁶ See, *inter alia*, Goldman, 1999, p. 97; Darby & Svoboda, 2007, p. 312.

occurred when the child started bleeding heavily⁷. The *Amtsgericht* (Trial Court), which was the first court dealing with the case, acquitted the Muslim circumciser arguing that the violation of the bodily integrity of the boy was justified by the valid consent of both parents, which had been given in accordance with the well-being of the child⁸. The *Landgericht Köln* however came to the conclusion that male circumcision, if not medically necessary, is punishable as criminal violence according to Section 223 of the German Penal Code, which lists the causing of bodily harm as a criminal offence. Nevertheless, the Court realised that the general acceptance and historical approval in existence meant that the circumciser could not be found guilty as he acted due to an unavoidable mistake of law.

The references in the judgment to the elements necessary for the establishment of criminal liability, *inter alia*, *actus reus* and *social adequacy* are outside the scope of this thesis. Nevertheless, the judgment of the Court contains arguments that are relevant within a human rights analysis. First, it is important to note that the Court considered that there was no consent by the child, who was not old enough to understand the situation. The Court rules that the parents were not capable of consenting for the bodily harm, since under the German Civil Code custody only covers measures of upbringing which serve the best interests of the child⁹. Second, the Court stated that parents' fundamental rights are limited by the fundamental right of the child to physical integrity and personal autonomy (*Selbstbestimmung*)¹⁰. When the Court weighed the rights of the parents and the child, it concluded that the child's body is permanently and irreparably changed by the circumcision, which conflicts with the child's interest of later being able to make his own decision on his religious affiliation. The Court stated that, conversely, the parents' right of upbringing is not unreasonably adversely affected if they are required to wait until the boy is of age to decide for himself whether to be circumcised as a visible sign of his affiliation to Islam¹¹.

As a conclusion on the judgment, the consent of the parents cannot

⁷ Landgericht Köln, 151 Ns 169/11, 7 May 2012, para. 4.

⁸ Ibidem, para. 5.

⁹ Landgericht Köln, 151 Ns 169/11, 7 May 2012, para. 14.

¹⁰ Ibidem.

¹¹ Ibidem.

justify the infliction of bodily harm. For the human rights debate, it is interesting to note that the Court's reasoning is that a circumcision, for purposes of avoiding exclusion by their religious community and of respecting the parental right of upbringing, is not in line with the best interests of the child.

Without considering the outcome of male circumcision as a violation of the rights of the child, there are several problems with this judgment. To list only three, first, the Court does not consider the health benefits male circumcision might have, nor does it reflect more generally on the medical debate on male circumcision. Second, the *Landgericht Köln* seems to attach in this case a great value to male circumcision with regard to religious affiliation. Nevertheless, it is commonly known that besides Muslims and Jews, other persons not affiliated with any religion circumcise their children for non-religious reasons. Consequently, male circumcision does not necessary lead to a religious affiliation. Third, the Court concludes rather quickly that the circumcision is not in the best interest of the child, by which it seems to equate the best interests with the best *physical* interest of the child. Namely, it stresses the irreversible nature of male circumcision; nevertheless it is possible to imagine other parental decisions that are harmful and irreversible which are genuinely not considered as a criminal offence. These reasons, together with the need for a broader foundation and delimitation, as this Court does not provide enough material to assess the practice of male circumcision by the Convention on the Rights of the Child, ask for further background to this practice.

1.2. HISTORY OF MALE CIRCUMCISION

Male circumcision is one of the oldest surgical procedures¹². The origin of this procedure dates back millennia, although it is not entirely clear where its origins lie. The first recorded evidence of male circumcision is from ancient Egypt, where wall paintings in Egyptian tombs and temples illustrate the operation¹³. Also, studies of mummies from nearly 4,000 years ago show that they were circumcised¹⁴. Others

¹² WHO/UNAIDS, 2010, p. 7.

¹³ Romberg, 1985, p. 1.

¹⁴ Gollaher, 2000, p. 3.

date male circumcision 5,000 years back to indigenous peoples of the African West Coast or even to the Stone Age¹⁵. It is not entirely clear whether the practice was used at this time for medical reasons. Some scholars argue that circumcision is likely to have arisen in the Middle East as a health measure, for preventing recurrent *balanitis*, caused by sand accumulating under the foreskin¹⁶.

Notwithstanding this unclear origin, the practice continued on the wings of religions and cultural traditions. Through the global spread of Islam from the 7th century A.D. on, male circumcision was widely adopted among previously non-circumcising peoples¹⁷. It was only in the late 19th and early 20th century that the religious and traditional background expanded fully to the promotion of male circumcision for medical reasons¹⁸. Given the increased medical knowledge and evolved techniques, the practice achieved even greater prevalence. Notably, in the 1960s the proportion of circumcised men increased, possibly caused by men returning from World War II, who were circumcised to prevent penile infections¹⁹.

1.3. CIRCUMCISION OF MALE CHILDREN WITHOUT THEIR CONSENT VERSUS FEMALE GENITAL MUTILATION

The focus of this thesis is on circumcision of male children. Hereby, a *child* will be defined as it is in Article 1 of the CRC, as “every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.” However, according to the studies on male circumcision by the World Health Organisation (hereinafter: the WHO), it is possible and even necessary for a good understanding of the medical aspects of male circumcision to also introduce the categories of *neonates* (who are aged less than one month) and *infants* (1 to 11 months)²⁰.

Although the focus is on the circumcision of *male* children, it is necessary to clarify the relation with *female* circumcision or *female*

¹⁵ Romberg, 1985, p. 1.

¹⁶ Hutson, 2004, p. 238.

¹⁷ WHO/UNAIDS, 2007a, p. 3.

¹⁸ See, *infra*, Part 1.4.1.

¹⁹ Hutson, 2004, p. 238.

²⁰ WHO/UNAIDS, 2010, p. 7.

genital mutilation. A clear difference is the different attitude towards both practices: female genital mutilation is condemned by almost all human rights bodies, governments and NGOs. However with regard to male circumcision most of these actors are silent (and consequently indirectly accept) or encourage the practice.

Several explanations and biases based on gender, Western culture and religion are indicated in an attempt to explain these different attitudes²¹. Another reason is a possible confusion that might arise from using male and female circumcision (or FGM) under the same heading. The danger is that people start to consider them as equivalent, which might lead to a situation where the supporters of male circumcision start to rethink their opposition to FGM, which would clearly make the fight against FGM more difficult. The avoidance of confusion can also be seen as a reason for the change of female *circumcision* to female *genital mutilation*. However, more references are being made to male *cutting*, male *genital mutilation* or *genital alteration*²². It is argued that the choice for male *circumcision* or *genital mutilation* already indicates a certain approach or bias²³.

Moreover, male circumcision and FGM are both collective terms for a wide range of practices and techniques, which make them hard or even impossible to compare. However, this difficulty in comparing should not lead to the conclusion that all forms of male circumcision are incomparable or less harmful than all forms of FGM. On the contrary, more and more articles are attempting to compare some forms of both practices²⁴.

Nonetheless, it is clear that a mere similarity in the name is not a sufficient base to conclude that male circumcision is also a human rights violation. Such a conclusion should only be reached after thoroughly examining male circumcision. One strategy could be to look at the similarities between some forms of both practices, to advocate for male circumcision as a violation of, *inter alia*, Article 2 CRC on the basis of an alleged discrimination of male children with regard to female children. The danger with this approach is that the focus will attempt

²¹ Van den Brink & Tigchelaar, 2012, pp. 438-442.

²² See, *inter alia*, Davis, 2001, p. 489.

²³ In this thesis male *circumcision* will be used as it still appears to be the general and more neutral term.

²⁴ See, *inter alia*, Delaet, 2009, pp. 405-426.

to establish similarities or distinctions between the practices, thereby blurring the central question of whether male circumcision is a human rights violation.

It should be clear that in this thesis the question is not whether some forms of male circumcision are comparable with some forms of female genital mutilation, but rather whether male circumcision is a human rights violation. In this way, male circumcision is approached separately from FGM.

Nevertheless it can be useful to recall the line of reasoning behind and the history of outlawing female genital circumcision, as it can provide lessons for the approach on the circumcision of male children. Female circumcision was in the initial stage framed as a cultural and health issue; it was only from the 1970s onwards considered a human rights violation²⁵. Hereby, the focus lay initially with insisting on the health consequences and the requirement that health-care professionals performed the practice to reduce complications. However, because of the *medicalisation* of the procedure the violation of women's rights was overlooked²⁶. Consequently, only in the mid-1990s women's rights rather than medical concerns started to dominate the FGM debate, while trying to stop health-care providers from performing female circumcision²⁷.

With regard to the current approach to FGM, it is important to note that although WHO has classified different forms of FGM²⁸, it generally uses a broad definition of female genital mutilation²⁹ to ensure that all forms fall within the definition. Consequently, the current general attitude towards FGM is a condemnation of all forms under this broad definition.

1.4. MOTIVES FOR THE CIRCUMCISION OF MALE CHILDREN

Male circumcision is performed for therapeutic and non-therapeutic

²⁵ Van den Brink & Tigchelaar, 2012, p. 435.

²⁶ Boyle & Carbone-Lopez, 2006, p. 443.

²⁷ Ibidem.

²⁸ UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM & WHO, 2008, p. 4.

²⁹ The WHO defines female genital mutilation (FGM) as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

reasons, a distinction that will be important throughout this whole thesis. Therapeutic circumcisions are those that are performed out of a clear and established medical determinant or indication. Any reason other than these medical indications is catalogued as non-therapeutic, which includes religious, traditional, ritualistic, social and perceived health benefits as motives. The importance of these therapeutic and non-therapeutic motives for this thesis lies in the evolution that might be revealed in them and in the creation of awareness of the context in which they are performed, which is essential for the human rights analysis.

1.4.1. *Therapeutic Circumcision*

The determinants requiring a therapeutic circumcision include diseases or physical pathological conditions that necessitate the penis to be circumcised as a cure. Out of these medical determinants, *phimosis*, whereby a stricture of the foreskin narrows the opening and prevents it from being retracted to uncover the glans of the penis, is the most frequent³⁰. Nevertheless, *phimosis* was diagnosed too often in the past and the development of alternative treatments by corticosteroids may reduce the number of this type of therapeutic circumcision³¹. Other, but more rare indications for therapeutic circumcision are *paraphimosis*, *balanoposthitis*, *balantitis xerotica obliterans*, *preputial neoplasms*, excessive skin and tears in the *frenulum*³². Consequently, therapeutic indications for infant circumcision are rather rare³³.

There are a further two categories that lean towards therapeutic circumcision, but since they lack an established medical indication, they are not considered as *therapeutic* circumcisions. Firstly, some parents prefer a *preventive* circumcision based on studies that show a lower risk of urinary tract infections, HIV, syphilis, penile cancer and canceroids for circumcised men. These preventive health benefits will be discussed later on under the medical section on male circumcision³⁴. However, they are preventive and not curative circumcisions and consequently

³⁰ WHO/UNAIDS, 2007a, p. 14.

³¹ Ibidem.

³² See, Rickwood, 1999, pp. 45-51.

³³ British Medical Association, 2004, p. 259.

³⁴ See, *infra*, Part 1.4.2.3.

non-therapeutic as there is no medical indication necessitating the circumcision.

Secondly, there are circumcisions performed based on *perceived* health and sexual benefits for in some cases *perceived* health conditions. A lot of these benefits were later ruled out by medical science. Still new alleged health benefits emerge constantly. Nevertheless, for previous and current occurrences, *perceived* health benefits cannot be considered as therapeutic as they do not cure any actual condition.

1.4.2. *Non-therapeutic Circumcision*

In addition to circumcisions based on medical indications, there are circumcisions performed out of religious, ritualistic, traditional and social motives, as well as out of the already mentioned perceived health benefits. These motives will now be described, without analysing their medical or legal implications.

1.4.2.1. *Religious Motives*

In this part, several aspects of religious circumcisions, including their evolutions, their place in the religion and the proceedings shall be discussed. The focus will be on Islam and Judaism, which are the biggest groups performing religious male circumcisions. Other religions tend not to be a major determinant for carrying male circumcision. In most forms of Christianity, circumcision is not required as illustrated by Galatians 5:6 and a papal bull of 1442³⁵. Traditional Christian culture viewed circumcision as neutral, as it was considered as neither polluting nor purifying, neither good nor bad and neither true nor false³⁶. However, it should be clear that Islam and Judaism are not the only religions that endorse male circumcision³⁷.

1. *Islam*

In Islam, the practice of male circumcision is also known as *tabera*, which means purification³⁸. Muslims perform male circumcision as a confirmation of their relationship with Allah. However, there is no specific

³⁵ WHO/UNAIDS, 2007a, p. 4.

³⁶ Miller, 2002, p. 501.

³⁷ WHO/UNAIDS, 2007a, p. 4.

³⁸ Ibidem, p. 3.

mentioning of circumcision in the Qur'an. Only the Shai'te school considers it as obligatory (*wajib*)³⁹. The other five schools regard the practice as traditional and strongly encourage it⁴⁰. Circumcision is also a requirement for a man who wants to make the pilgrimage (*hajj*) to Mecca, one of the five tasks in Islam⁴¹. However, others doubt whether male circumcision is a religious requirement or merely a recommended practice⁴².

There is no clearly set date or age for male circumcision in Islam, nevertheless it should happen between birth and puberty⁴³. The flexible date for the practice results in diverse practices among the Muslim community⁴⁴. The prophet Muhammed recommended it to be carried out at an early age and reportedly circumcised his sons on the seventh day after birth⁴⁵. Others wait until the boy is able to read the Qur'an⁴⁶. There are reports stating that in some Muslim countries, including Turkey, circumcision is traditionally undertaken by non-medically trained individuals and not only at the neonatal stage⁴⁷.

II. Judaism

There are several hypotheses about the origin of the male circumcision in the Jewish faith. In any case, the written foundation for male circumcision in Judaism is to be found in the Torah. Circumcision is the outward sign for all male Jews of the covenant (*brit milah*) between God and Abraham, to circumcise himself and his offspring⁴⁸. The circumcision of eight-day-old boys takes precedence over other religious obligations, including the obligation to refrain from labour on the *Sabbath* and over the holiest day of the year, *Yom Kippur*⁴⁹.

Since Genesis 17:14 states that uncircumcised men break the covenant, a circumcised penis is seen as a symbol of identity among Jews⁵⁰. Male circumcision is considered as a form of expressive conduct

³⁹ Rizvi et al., 1999, p. 13.

⁴⁰ Ibidem.

⁴¹ Ibidem.

⁴² Abu-Sahlieh, 2001, pp. 99, 106-108, 126.

⁴³ Gollaher, 2000, p. 46.

⁴⁴ WHO/UNAIDS, 2007a, p. 4.

⁴⁵ Rizvi et al., 1999, pp. 13-16.

⁴⁶ Chessler, 1997, p. 585.

⁴⁷ Özdemir, 1997, p. 138.

⁴⁸ Genesis 17:9-12 and Leviticus 12:2-3.

⁴⁹ Gollaher, 2000, p. 24.

⁵⁰ Chessler, 1997, p. 584.

in the Jewish faith signifying identity⁵¹. Other sources state that to be circumcised is no requirement for a man to be Jewish⁵², as any child born of a Jewish mother is a Jew, whether circumcised or not⁵³.

Nowadays circumcision is almost universal among Jewish people⁵⁴. Nevertheless, as early as 1843 the Reform Jewish scholar Abraham Geiger said, “[i]t remains a barbarous bloody act” and “[i]ts only supports are habit and fear⁵⁵.” The debate that followed, which was considered decisive, reaffirmed male circumcision as an integral part of Jewish culture⁵⁶. However, there are still some Jewish voices that question male circumcision, for instance based on arguments from the Jewish law. Lisa Braver Moss, for instance, states that in Jewish law the rule is that danger to life, even the most rare possibility of complications with male circumcision, takes precedence over all other considerations and therefore, hazardous medical procedures are strictly forbidden⁵⁷.

Reform Jews, who started to question the necessity of male circumcision, have sought alternatives. An alternative, sometimes called *Bris Shalom* (covenant of Peace), is to cut something other than the child’s body, to symbolise the traditional circumcision⁵⁸. Another alternative is *Brit rekhitza* or “covenant of washing,” which harks back to Abraham’s washing the feet of strangers⁵⁹. Moreover, an Alternative Bris Support Group has been formed for parents who wish to consider a *bris* without circumcision⁶⁰.

Nevertheless, in Jewish religion male infants are traditionally circumcised on their eighth day of life, usually performed by a *mohel*, or traditional circumciser, during the *Bris Millah*, a festive occasion with guests.

If possible, ten men constitute a *minyan*, or quorum required under religious law for some religious obligations⁶¹. The parents select a godmother and a godfather (*sandak*) for the ceremony. After this, the

⁵¹ Miller, 2002, pp. 521 and 584.

⁵² See, Goodman, 1999, pp. 22-27.

⁵³ Eisenberg, 2005, p. 152.

⁵⁴ WHO/UNAIDS, 2007a, p. 3.

⁵⁵ Gollaher, 2000, p. 28.

⁵⁶ Ibidem.

⁵⁷ Moss, 1992, p. 20.

⁵⁸ Goldman, 1997, p. 95.

⁵⁹ Davis, 2001, p. 560.

⁶⁰ Chessler, 1997, p. 611.

⁶¹ See, Romberg, 1985, pp. 41-47.

mother hands the child to the godmother, who in turn passes him to the godfather. The godfather holds the child during the *milah* (the actual act of circumcising). Hereafter, the *priah* or the tearing back of the genital membrane underneath the foreskin to the corona takes place⁶². This was (and still is in particular by the ultra Orthodox and Hassidic Jews) followed by the *mezuzah* or *metzitzah B'peh* (the oral suction), whereby the *mohel* sips wine and sucks the just circumcised penis, spitting a mixture of blood and wine into a glass⁶³. However, it seems that this last part is now abandoned or replaced by a sterile glass tube to pull blood from the wound by most Jewish groups⁶⁴. Orthodox Rabbi Moshe Tendler says that a *mohel* who practises *metzitzah* now is foolhardy⁶⁵. On the contrary, Rabbi David Bleich states that the procedure is safe if the *mohel* first rinses his mouth with rum and demands that mothers give the evidence of a negative HIV test before he agrees to perform the procedure⁶⁶. However, this practice is more and more contested, also from within the Jewish community. Afterwards, the assembled crowd joins in a festive meal, the *seudat mitzvah*.

1.4.2.2. *Traditional and Ritualistic Motives*

A second group of motives for non-therapeutic circumcision can be grouped together as traditional and ritualistic reasons for male circumcision. For instance, male circumcision has been performed for many thousands of years in Sub-Saharan Africa and other ethnic groups around the world, including the Aborigines in Australia and the inhabitants of the Philippines, eastern Indonesia and of various Pacific islands⁶⁷.

In the majority of these societies, circumcision is an integral part of a rite of passage to manhood, although its foundations often lie in a test of bravery and endurance⁶⁸. It is argued that the endurance of pain is an essential part of these rituals as it shows the readiness of individuals to transit from childhood to adulthood, from boy to man⁶⁹. In some

⁶² Gollaher, 2000, p. 17.

⁶³ Romberg, 1985, p. 53.

⁶⁴ Davis, 2001, p. 550.

⁶⁵ Ibidem, p. 551.

⁶⁶ Gollaher, 2000, pp. 29-30.

⁶⁷ WHO/UNAIDS, 2007a, p. 4.

⁶⁸ Doyle, 2005, p. 284.

⁶⁹ Hellsten, 2004, p. 249.

of these cultures, circumcision is the norm and there is discrimination against non-circumcised men⁷⁰.

1.4.2.3. *Normality, Social Determinants and Perceived Health Benefits*

Besides the religious, traditional and ritualistic motives, there are also determinants based on social beliefs, the perceived health benefits or the “normality” of male circumcision. Firstly, under this umbrella, the desire to conform to the majority is an important motivation for circumcision. Western studies have revealed that fathers, who are circumcised themselves, choose to circumcise their sons, because they want them to look like their father and conform to the perceived norm⁷¹. This tendency to conform to the majority is often driven by the need for social approval⁷². Some scholars even put the circumcisions performed for religious reasons under this umbrella, as they argue that “religious” circumcisions are not necessarily chosen out of religious belief, but rather out of the fear of rejection by the religious community if it is not performed⁷³.

Secondly, socio-economic status can play a role as well. For instance, a recent Australian survey found that the proportion of circumcised men was significantly associated with higher levels of education and income⁷⁴. An American study found a significant correlation between private insurance and higher socio-economic status, and circumcision⁷⁵. This relation is however not consistent in Sub-Saharan African countries⁷⁶, and neither does it seem to be applicable in, for instance, each European country.

Thirdly, the above mentioned *perceived* health and sexual benefits are reasons for male circumcision. This started with the welcoming of circumcision in the medical field in 1870 by the influential American surgeon Dr John Lewis Sayre⁷⁷. This was later followed by other physicians for the *perceived* preventive and hygienic benefits of male circumcision⁷⁸.

⁷⁰ WHO/UNAIDS, 2007a, p. 5.

⁷¹ Romberg, 1985, p. 12; Hutson, 2004, p. 238; British Medical Association, 2004, p. 259.

⁷² Goldman, 1999, p. 98.

⁷³ Ibidem.

⁷⁴ See, Richters et al., 2006, pp. 547-554.

⁷⁵ See, Nelson et al., 2005, pp. 978-981.

⁷⁶ WHO/UNAIDS, 2007a, p. 6.

⁷⁷ Gollaher, 1994, p. 5.

⁷⁸ Ibidem, p. 10.

Especially, in the English-speaking industrialised world the perception that circumcision results in improved penile hygiene and lower risk of infections was an important factor for the rise of the practice⁷⁹. This was particularly so during the 19th century, influenced by the arrival of anaesthesia in surgery and the studies that discovered a lower syphilis rate amongst Jewish men⁸⁰. By the end of the 19th century male circumcision was advocated in English-speaking industrialised countries as a preventive measure against “conditions” including, cancer, syphilis and masturbation⁸¹. Male circumcision became associated with cleanness and was advocated as a sanitary measure and prophylactic against venereal diseases⁸². This was enforced, especially in a time where cleanliness was a sign of good morals, when the stigma was created that an uncircumcised penis was linked with disease, pollution and contagion⁸³. Circumcision meant that the parent had given the boy every chance by providing him with the right medical care from the beginning, and not doing so was even considered as criminal negligence⁸⁴. Nevertheless, there were already critical voices on male circumcision⁸⁵. Although the growth of male circumcision took place on both sides of the Atlantic, the anxiety ran higher in the United States⁸⁶. In the early years of the 20th century, male circumcision became standard practice in the United States for well-trained physicians and the objections raised were on *poorly* performed circumcisions rather than on the practice itself⁸⁷.

Nowadays, the perceived health benefits as a motive for male circumcision extends beyond English-speaking countries. Clearly, the importance of these social reasons should not be underestimated. A small American cross-sectional study of parents pointed out that 80 per cent of parents made their decision about the circumcision before having discussed the operation with a doctor⁸⁸.

⁷⁹ WHO/UNAIDS, 2007a, p. 7.

⁸⁰ Gollaher, 1994, p. 18.

⁸¹ Ibidem, p. 15.

⁸² Ibidem, p. 11.

⁸³ Fox & Thomson, 2005b, p. 464.

⁸⁴ Gollaher, 1994, p. 23.

⁸⁵ Ibidem, p. 17.

⁸⁶ Fox & Thomson, 2005a, p. 178.

⁸⁷ Gollaher, 1994, p. 22.

⁸⁸ American Academy of Pediatrics, 2012, p. 762.

1.5. PREVALENCE OF MALE CIRCUMCISION
AND GEOGRAPHICAL AREA OF THE DEBATE

All the different motives for male circumcision lead to the estimation that approximately 30 per cent of males worldwide aged 15 years or older are circumcised⁸⁹. The geographical area of the practice expands the Jewish (0.8 per cent) and Muslims (69 per cent) communities and includes a large portion of the non-Muslim or non-Jewish American male youth (13 per cent)⁹⁰.

In Central and South America on the other hand, the practice is rather uncommon⁹¹. In many African countries, especially in North Africa and West Africa, male circumcision is common⁹². In the Middle East and Central Asia the practice is almost universal; although there is generally little non-religious circumcision in Asia⁹³. However, these estimations have to be handled with care since they do not reflect the substantial within-country variations in prevalence due to the social, cultural and religious determinants.

In accordance with the broad geographical spread of the practice, the debate on the circumcision of male children is currently ongoing in the German speaking area, the United States, the United Kingdom and Scandinavia.

⁸⁹ WHO/UNAIDS, 2007a, p. 7.

⁹⁰ Ibidem, p. 11.

⁹¹ Ibidem, p. 12.

⁹² Ibidem, p. 9.

⁹³ Ibidem, p. 10.

2.

MEDICAL ANALYSIS

In the medical analysis, there are several questions that arise, which receive different answers according to the background of the respondent. Consequently, most studies are contested on this issue. Moreover, this thesis is susceptible to changes in the medical world, as studies can be falsified and medical science can evolve, for instance by establishing more evidence on the relation between circumcision and certain diseases. With these remarks in mind, the practice of male circumcision will be described in general, with attention given to the differences between clinical and non-clinical settings. Secondly, the possible effects of circumcision will be presented; it is here that the majority of disagreement exists. Thirdly, out of the necessary humility of a legal scholar in the medical world, the policies of different medical associations will be discussed. Fourthly, the author tries to draw lessons from this medical perspective which can then be applied to the legal analysis.

2.1. DESCRIPTION OF CIRCUMCISION

The most common forms of male circumcision entail the removal of a part or the entire foreskin, which is a continuation of skin from the shaft of the penis that covers the glans of the penis and the urethral meatus⁹⁴. The role of the foreskin is still debated, including contested functions as to keeping the glans moist⁹⁵ or enhancing sexual pleasure due to the presence of nerve receptors⁹⁶.

⁹⁴ WHO/UNAIDS, 2007a, p. 13.

⁹⁵ See, Alanis & Lucidi, 2004, pp. 379-395.

⁹⁶ See, Cold & Taylor, 1999, pp. 34-44.

There are major differences in this procedure. For instance, in the United States, as well as in some other countries male circumcision is performed almost exclusively by medical trained personnel in a clinical setting⁹⁷ and only entails the removal of the foreskin. However, there are more invasive forms that include “peeling the skin of the entire penis” in some tribes in Saudi Arabia or “a subincision of the urinary tube from the scrotum to the glans” by the Aborigines in Australia⁹⁸. Moreover, according to WHO/UNAIDS’ Report in 2010, in some settings such as North Africa, Pakistan, Indonesia, Israel and rural Turkey, the majority of providers are not medically trained⁹⁹. The dissimilarity of these practices leads to a necessary differentiation, also made by WHO/UNAIDS¹⁰⁰, between male circumcision in clinical and non-clinical settings.

2.1.1. *Clinical Setting*

There are four methods for neonatal circumcision used in clinical settings: the dorsal slit, the Plastibell, the Mogen clamp and the Gomco clamp method. These methods use a shield or another device to protect the glans of the penis and to achieve *haemostasis* by crushing or clamping the foreskin (or by ligature for the Plastibell method)¹⁰¹. The Plastibell method is used around the world, including less economically developed countries¹⁰². In North America, the Mogen clamp is widely used because complications are less frequent than they are with the other methods¹⁰³. Moreover, this method is quicker and causes less pain than the Gomco clamp¹⁰⁴. The advantage of the clamp method is that bleeding is rare since the clamp crushes the foreskin edge¹⁰⁵.

One of the key areas of controversy relating to circumcision in a clinical setting was the use of anaesthesia. This was caused by the belief that newborns do not feel pain and that it was inconsequential to them; especially because children have no language to communicate their

⁹⁷ WHO/UNAIDS, 2010, p. 5.

⁹⁸ Delaet, 2009, pp. 411-412.

⁹⁹ WHO/UNAIDS, 2010, p. 5.

¹⁰⁰ WHO/UNAIDS, 2007a, pp. 16-20.

¹⁰¹ WHO/UNAIDS, 2010, p. 12.

¹⁰² WHO/UNAIDS, 2007a, p. 16.

¹⁰³ Ibidem.

¹⁰⁴ Ibidem, p. 17.

¹⁰⁵ Ibidem, p. 16.

experience¹⁰⁶. However, this belief has now been disproven¹⁰⁷. At the very least *local* anaesthesia for the procedure with analgesics is strongly recommended¹⁰⁸.

Even in clinical settings, circumcision is a simpler operation with infants and young children as healing is usually complete within a week¹⁰⁹. Circumcisions of adolescents and adults require different methods and result in more complex procedures¹¹⁰. Also, with adults and adolescents, these methods require additional suturing and dressing of the wound¹¹¹.

In any case, if the circumcision is performed by a doctor, the principles of medical good practices apply¹¹². Consequently, doctors have the duty to favour less invasive techniques if they are equally efficient and available¹¹³.

Moreover, these invasive techniques require the informed consent of the patient, which requires the disclosure by the doctor of the effects, risks, prospects of success and the existence of alternative treatments. Opponents of circumcision contest that this is currently happening and accuse circumcised doctors of giving biased information on the procedure, whilst pointing out that most doctors favouring male circumcision are circumcised themselves¹¹⁴.

2.1.2. *Non-clinical Setting*

Although there are indications that in some societies clinical practices have gained popularity, male circumcision for religious, traditional or ritualistic reasons still frequently takes place in non-clinical settings. These applied procedures differ from the methods in clinical settings. The technique used is mostly a variant on pulling the foreskin forward and cutting through the prepuce above the level of the glans¹¹⁵. One of the problems with this technique is that the extent of foreskin removed varies¹¹⁶.

¹⁰⁶ Fox & Thomson, 2005a, p. 175.

¹⁰⁷ See, Lander et al., 1997, pp. 2157-2162.

¹⁰⁸ American Academy of Pediatrics, 1999, pp. 686-693; WHO/UNAIDS, 2010, p. 11.

¹⁰⁹ WHO/UNAIDS, 2007a, p. 16.

¹¹⁰ Ibidem, p. 17.

¹¹¹ Ibidem.

¹¹² See, *inter alia*, British Medical Association, 2004, pp. 259-263.

¹¹³ Ibidem, p. 259.

¹¹⁴ Hill, 2007, p. 319.

¹¹⁵ WHO/UNAIDS, 2007a, p. 19.

¹¹⁶ Ibidem, p. 20.

In some Jewish circles, the method used is similar to the Mogen clamp, by passing the foreskin through a slit in a metal shield that protects the glans, while a scalpel runs across the shield to remove the foreskin¹¹⁷. The remaining inner foreskin is then pulled back off the glans and the wound is bandaged without the use of stitches¹¹⁸.

Muslims often perform circumcision in non-clinical settings at older ages which increases the risk of complications¹¹⁹. Mostly, the procedure is a variant on the traditional procedure in non-clinical settings. However, there are even more dangerous variants. In some Muslim countries, circumcisions are undertaken by non-medically trained individuals, including barbers and traditional drummers¹²⁰.

In Northern Sudan, the traditional circumciser inserts a straw made from savannah grass into the foreskin pushing the glans of the penis down and pulling the foreskin as far forward as possible¹²¹. A cord is then tied around the foreskin above the glans, and the foreskin is excised with a knife immediately in front of the cord¹²². Studies have examined circumcisions in more traditional groups that utilise even more invasive techniques. For instance, with the Xhosa in South Africa, male circumcisions are carried out with a razor blade or penknife¹²³.

However in 2013, the WHO approved the PrePex device¹²⁴. The device does not require a sterile environment. Moreover, it can be performed by trained low cadre health care providers, such as nurses without surgery and only needs a topical cream as anaesthesia. These characteristics, especially the non-requirement of a sterile environment enables providing and increasing male circumcision in areas with limited resources for surgically training and clinical settings. Nevertheless, this device is not (yet?) available for males under the ages of 18.

¹¹⁷ WHO/UNAIDS, 2007a, p. 19.

¹¹⁸ Ibidem.

¹¹⁹ WHO/UNAIDS, 2010, p. 27.

¹²⁰ Özdemir, 1997, p. 138.

¹²¹ WHO/UNAIDS, 2007a, p. 19.

¹²² Ibidem.

¹²³ Doyle, 2005, p. 282.

¹²⁴ WHO, 2013, p. 1.

2.2. EFFECTS

2.2.1. *Positive Effects*

The first group of positive effects includes the curative effect on the symptoms which make a therapeutic circumcision necessary. A second group of positive effects still includes hygienic benefits, which have their foundation in the opinions of the 19th century when male circumcision was strongly associated with good hygiene and morals. However, opponents of neonatal male circumcision argue that there is no need to wash the foreskin until later in childhood¹²⁵. A third group consists of the, alleged in some cases, preventive effects. These will be discussed in more detail as they are pivotal to many arguments that favour male circumcision.

Firstly, some studies have shown that circumcised men have a lower risk of several urinary tract infections (hereinafter: UTI) than uncircumcised men¹²⁶. These are infections involving “any part of the urinary system, including urethra, bladder, ureters, and kidney¹²⁷.” In males, the majority of these infections occur during the first year of life¹²⁸. However, the risk of urinary tract infections is rather low, namely approximately 1 per cent among boys under two years old¹²⁹.

Secondly, other studies indicate a lower risk of invasive penile cancer¹³⁰. Nevertheless, penile cancer is considered a rather rare form of cancer (in the United States 0.58 cases per 100,000 individuals between 1993 and 2002)¹³¹ and a decrease in the incidence of penile cancer has been noted in countries with both high (United States) and low (Denmark) circumcision rates¹³². Moreover, not all studies point in the same direction and it is difficult to establish the number of male circumcision it would take to prevent a case of penile cancer¹³³. Penile cancer is linked to infection with human papilloma viruses, which can

¹²⁵ Hutson, 2004, p. 238.

¹²⁶ WHO/UNAIDS, 2010, p. 54.

¹²⁷ American Academy of Pediatrics, 2012, p. 767.

¹²⁸ Ibidem.

¹²⁹ Ibidem.

¹³⁰ See, *inter alia*, Daling et al., 2005, pp. 606-616; Larke et al., 2011, pp. 1097-1110.

¹³¹ See, Barnholtz-Sloan et al., 2007, pp. 361-367.

¹³² American Academy of Pediatrics, 2012, p. 768.

¹³³ Ibidem.

also be prevented through condom use and prophylactic vaccination¹³⁴.

Other studies point out that circumcised men are two thirds less likely to have a human papilloma virus infection of the penis, and consequently their female partners are half as likely to develop cervical cancer compared with uncircumcised men and their partners¹³⁵. One recent study suggests that the female partners of circumcised men have reduced risks of some vaginal infections¹³⁶.

Thirdly, and most importantly in this group of preventive effects, are the studies that point to a reduced risk of HIV infections. Three trials in South Africa¹³⁷, Uganda¹³⁸ and Kenya¹³⁹ conducted between 2005 and 2007, show that circumcised men have a 51-61 per cent reduced risk of becoming infected with HIV during heterosexual intercourse¹⁴⁰. All of these trials had a two year follow-up and were halted when interim results prompted the conclusion that it would be unethical to withhold circumcision from the control groups any longer. Moreover, the context of these trials is important as they were conducted in countries where the virus is highly prevalent and where penile-vaginal intercourse is the predominant mode of HIV transmission.

In April 2009, a Cochrane review, a systematic assessment of health-care interventions which aims to provide the most comprehensive and reliable source of evidence, assessed the effectiveness of male circumcision in preventing the acquisition of HIV. The review concluded that “there is strong evidence that medical male circumcision reduces the acquisition of HIV by heterosexual men by between 38 per cent and 66 per cent over 24 months¹⁴¹.” However, the review also noted that further research was required to assess the feasibility, desirability and cost-effectiveness of implementation within local contexts¹⁴².

There are several reasons put forward for this connection between male circumcision and a decreased risk on HIV acquisition. Firstly, uncircumcised men have an increased risk of genital ulcer diseases¹⁴³

¹³⁴ Frisch et al., 2013, p. 798.

¹³⁵ See, Castellsagué et al., 2002, pp. 1105-1112.

¹³⁶ Tobian & Gray, 2011, p. 1479.

¹³⁷ See, Auvert et al., 2005, pp. 298-299.

¹³⁸ See, Gray et al., 2007, pp. 657-666.

¹³⁹ See, Bailey et al., 2007, pp. 643-656.

¹⁴⁰ WHO/UNAIDS, 2007a, p. 22.

¹⁴¹ Siegfried et al., 2009, p. 2.

¹⁴² Ibidem.

¹⁴³ See, Weiss et al., 2006, pp. 101-109.

which leads to an increased risk of HIV acquisition¹⁴⁴. Secondly, the tissue from the inner surface of the foreskin contains a high concentration of Langerhans cells, which are accessible HIV-1 target cells¹⁴⁵. Although, the concentration of these cells is comparable to those in the glans of the penis and the outer foreskin, those in the inner foreskin are closer to the epithelial surface due to the lack of keratin¹⁴⁶. Consequently, these cells are more likely to be the first to be infected by HIV-1¹⁴⁷. As a result, the cells in the inner foreskin and frenulum of uncircumcised men are directly exposed to vaginal secretions during intercourse, while the penile shaft of circumcised men is covered with a thickly keratinised epithelium, providing some protection from infection¹⁴⁸.

Nevertheless, these rates also indicate that circumcision does not provide complete protection against HIV infection and that it should at least be accompanied with safer sex practices. Moreover, other studies pointed out that women do not enjoy the same protection after the circumcision of their male partners; indeed, with women the effect can even be to the contrary as in cases where the wound has not properly healed¹⁴⁹. It was also found that circumcision had no protective effects for men who have sex with men¹⁵⁰.

Another study went further by transferring these results to the United States. It concluded that male circumcision before the age of sexual debut would reduce HIV acquisition among heterosexual males in the United States¹⁵¹. Using the average efficacy of 60 per cent out of the African trials and assuming that the protective effect of circumcision applies only to heterosexuals, they concluded a 15,7 per cent reduction in lifetime HIV risk for males¹⁵².

Although the results are contested, as will be shown, circumcision is now used for HIV prevention with adolescent and adult men, with the possibility that it will be used for neonatal and child circumcision as well¹⁵³. The critique on these positive effects of male circumcision is

¹⁴⁴ WHO/UNAIDS, 2010, p. 54.

¹⁴⁵ *Ibidem*.

¹⁴⁶ See, McCoombe & Short, 2006, pp. 1491-1495.

¹⁴⁷ See, Donoval et al., 2006, pp. 386-391.

¹⁴⁸ See, McCoombe & Short, 2006, pp. 1491-1495.

¹⁴⁹ See, Wawer et al., 2009, pp. 229-237.

¹⁵⁰ See, Millett et al., 2008, pp. 1674-1684; Sánchez et al., 2011, pp. 519-523.

¹⁵¹ See, Samson et al., 2010, pp. 1-8.

¹⁵² See, *ibidem*.

¹⁵³ WHO/UNAIDS, 2010, p. 7.

threefold: an attack on the studies at the basis of the positive effects, their context relativity and a balancing of the risks. Firstly, the results themselves have been challenged. Opponents believe that the three trials, which established the decreased HIV risk rate with circumcised men, only show that “male circumcision can reduce the risk of men contracting HIV in the specific conditions in which the trials were conducted that is, given high HIV prevalence, low circumcision prevalence and where sexual transmission of the virus is predominantly heterosexual¹⁵⁴.” Consequently, the way in which these results are presented sometimes has been challenged in that it tends to indicate that male circumcision would always lead to an increased protection of 60 per cent against HIV, without regard to the context of the trials¹⁵⁵.

Furthermore, opponents attack the method used in these trials. These three randomised controlled trials are criticised because they were not subject to blinding and consequently there is potential for the influence of observer bias¹⁵⁶. Also, these trials were terminated early which can overstate any putative effect¹⁵⁷. However, *inter alia*, the American Academy of Pediatrics (hereinafter: the AAP) does not share this critique. They state that there is fair evidence that circumcision is protective against heterosexually acquired HIV infection in men¹⁵⁸.

Secondly, despite the study’s attempt to transplant the results to other countries, opponents believe that the results of studies in African states may not necessarily be extrapolated to men in other parts of the world at risk of HIV infection¹⁵⁹, since these studies only considered areas with high HIV prevalence and where heterosexual female to male transmission of HIV through penile-vaginal transmission is the predominant way of sexual infection. In other parts of the world, where the HIV prevalence is lower and the risk of HIV is predominantly through homosexual contact and the use of infected needles amongst drug users. Another factor to take into account, is the different age of sexual debut, which also varies geographically.

Consequently, even if these studies are correct and applicable to other parts of the world, opponents question the necessity and effectiveness

¹⁵⁴ Fox & Thomson, 2010, p. 799.

¹⁵⁵ *Ibidem*.

¹⁵⁶ Dalton, 2007, p. 312.

¹⁵⁷ Hill, 2007, p. 320.

¹⁵⁸ American Academy of Pediatrics, 2012, p. 764.

¹⁵⁹ American Urological Association, 2012, p. 1.

of male circumcision, given the possibility of the development of a vaccination for newborn children before reaching sexual maturity¹⁶⁰. Clearly, more studies on the feasibility, desirability and cost-effectiveness of the implementation of circumcision in local contexts are needed¹⁶¹.

Thirdly, opponents question whether the risks connected to the operation outbalance the preventive effect on diseases with a small risk, like urinary tract infections. Since for instance, only one per cent of boys suffer a urinary tract infection in the first year of life, some find it difficult to justify circumcising all male newborns when only one per cent will benefit by reduction in urinary tract infection risk¹⁶².

2.2.2. *Negative Effects*

2.2.2.1. *Possible Complications*

Although the negative effects of male circumcision lie mainly in the possible complications of the procedure, such effects can also be understood more broadly including other negative changes, such as an alleged reduced sexual satisfaction and an alteration of the body. Nevertheless, it is clear that, just as with any other surgical procedure, circumcision can result in further complications.

The *early* complications (during or in the immediate aftermath of the operation) tend to be minor and treatable: pain, bleeding, swelling or inadequate skin removal¹⁶³. However, serious complications can occur during the procedure, including death from excess bleeding and amputation of the glans of the penis if the glans is not shielded during the procedure¹⁶⁴.

Late (or post-operative) complications include the formation of a skin bridge between the penile shaft and the glans, infections, urinary retention, meatal ulcer, *impetigo*, fistulas loss of penile sensitivity, sexual dysfunction and oedema of the glans penis¹⁶⁵. Some authors even point out that circumcised newborns are more likely to acquire a range of infections than uncircumcised newborns¹⁶⁶.

¹⁶⁰ Hill, 2007, p. 320.

¹⁶¹ Fox & Thomson, 2010, p. 800.

¹⁶² Hutson, 2004, p. 239.

¹⁶³ WHO/UNAIDS, 2010, p. 35.

¹⁶⁴ *Ibidem*.

¹⁶⁵ *Ibidem*.

¹⁶⁶ Hill, 2007, p. 320.

What circumcisions in a clinical setting and a non-clinical setting have in common is that they cause pain. Infants circumcised with no anaesthesia, experience severe pain but also an increased risk of choking and difficulty in breathing¹⁶⁷. Even when anaesthetics are used, it relieves only some parts of the pain and its effects stop before the post-operative pain subsides¹⁶⁸.

Consequently, *local* anaesthesia is recommended, *inter alia*, by the World Health Organisation and the AAP. It is the easiest solution for neonates and infants, who can still be held and for boys aged around four to five years upwards, who are able to remain still enough to cooperate with the procedure¹⁶⁹. However for older boys, the use of *local* anaesthetic is more problematic, as they are unlikely to be able to remain still during the procedure¹⁷⁰. In this case, *general* anaesthesia can be used, which has greater associated risks¹⁷¹. Therefore WHO/UNAIDS states that it “may be preferable to postpone the circumcision until the boy is older and able to cooperate with the procedure whilst under local anaesthesia¹⁷².” Despite this pain, most circumcisions performed by traditional circumcisers are carried out with no anaesthesia¹⁷³.

There are also other effects, which do not strictly fall under the definition of a medical consequence. For instance, the loss of skin results in an irreversible loss of nerve endings; however there are now techniques for foreskin restoration that regenerate skin over the glans of the penis¹⁷⁴. There are also studies that report a reduction in sexual satisfaction after the circumcision¹⁷⁵. For example, the hyper-stimulation of the *glandis corona* during intercourse can trigger early ejaculation and dissatisfaction for both partners¹⁷⁶.

Nevertheless, there are also studies that point to the contrary, for instance that circumcised men report significantly less pain during intercourse than uncircumcised men and a greater sexual sensitivity

¹⁶⁷ See, Lander et al., 1997, pp. 2157-2162.

¹⁶⁸ See, Stang et al., 1988, pp. 1507-1511.

¹⁶⁹ WHO/UNAIDS, 2010, p. 64.

¹⁷⁰ WHO/UNAIDS, 2009, Chapter 6, p. 4.

¹⁷¹ WHO/UNAIDS, 2010, p. 11.

¹⁷² *Ibidem*.

¹⁷³ *Ibidem*.

¹⁷⁴ See, Griffiths, Bigelow & Loewen, 2010, pp. 189-198.

¹⁷⁵ Dalton, 2007, p. 313.

¹⁷⁶ Hill, 2007, p. 319.

two years after the circumcision¹⁷⁷. The problem with both categories of studies on sexual pleasure is that it is highly subjective and consequently hard to translate in quantitative data¹⁷⁸. With regard to sexual activity, the AAP concluded that there is good evidence suggesting sexual function is not adversely affected with circumcised men compared with uncircumcised men¹⁷⁹.

Besides the divergent studies on sexual satisfaction, the question regarding the established consequences remains the same: how often they occur and what the determinants are. However, there are several problems with listing the complication rates and determinants. Firstly, at the moment there is a lack of studies reporting the proportion of circumcised males with a resulting complication¹⁸⁰. The existing literature consists of case reports and case series, which illustrate what can happen but not how often it happens. Secondly, the duration of the follow-up in studies is often too short or not active to get a good impression of the late complications¹⁸¹. Thirdly, there is a problem with the definition of these complications, since often precise definitions are lacking within the studies¹⁸². The lack of definitions generates a wide variety of results, for instance *bleeding* can be interpreted in several different ways¹⁸³. Clearly, it would be useful to produce a standard classification of complications following male circumcision so as to be able to compare the results more easily in future studies¹⁸⁴.

The lack of a standard classification with regard to complications led WHO/UNAIDS to exclude, in their 2010 Report on male circumcision, all cases of minor bleeding, some other minor complications and cases of excess residual foreskin or inadequate circumcision as they may involve further surgery, which are not all medical complications *per se*¹⁸⁵. Nevertheless, this exclusion is already problematic, as the risks would not have occurred without the circumcision.

With these remarks in mind, it is possible to look at the rate of complications according to some determinants.

¹⁷⁷ American Academy of Pediatrics, 2010, p. 769.

¹⁷⁸ Darby & Svoboda, 2007, p. 310.

¹⁷⁹ American Academy of Pediatrics, 2010, p. 769.

¹⁸⁰ WHO/UNAIDS, 2010, p. 35.

¹⁸¹ *Ibidem*.

¹⁸² *Ibidem*.

¹⁸³ *Ibidem*.

¹⁸⁴ *Ibidem*, p. 48.

¹⁸⁵ *Ibidem*, p. 35.

2.2.2.2. *Determinants for the Complication Rates*

A first determinant is the setting. In clinical settings, WHO/UNAIDS found that the median frequency of any adverse event occurring was 6 per cent (range 2-14 per cent), and the median frequency of any *serious* adverse event was 0 per cent (range 0-3 per cent)¹⁸⁶. Adverse events most commonly occurred among boys circumcised mainly for medical, rather than religious or cultural reasons, possibly because the underlying medical condition results in a more complicated procedure¹⁸⁷.

On the one hand, in clinical settings, adverse effects can include excessive bleeding, haematoma formation, sepsis, an unsatisfactory cosmetic effect, lacerations of the penile or scrotal skin and injury to the glans¹⁸⁸. This list may seem extensive, however with neonatal circumcision in clinical settings, the complication rates are considered low. These rates are significantly higher for adult circumcision¹⁸⁹. Other complication rates exist for circumcision; however the question remains over the definitions given to *complication*¹⁹⁰.

WHO/UNAIDS has reported higher frequencies of adverse events in non-clinical settings. Moreover, the complications are more serious and even include penile amputation¹⁹¹. For instance, a high frequency of complications was reported in a retrospective study from Turkey, where 407 boys were circumcised at two traditional mass circumcision events¹⁹². The age of the boys at the time of circumcision varied between 1 and 15 and the procedure took place in non-sterile conditions by unlicensed providers. Overall, complications were noted in 73 per cent of the boys. The study also showed that there was inadequate screening of the boys before the procedure¹⁹³. Mass circumcisions, practised by some traditional groups, can clearly have serious health implications due to the unsterilised and unwashed blade¹⁹⁴.

Jewish ritual circumcision that includes *metzitzah B'peh* with

¹⁸⁶ WHO/UNAIDS bases its findings on ten prospective studies of complications in children aged one year old or older following circumcision by medically trained providers.

¹⁸⁷ WHO/UNAIDS, 2010, p. 41.

¹⁸⁸ WHO/UNAIDS, 2007a, p. 17.

¹⁸⁹ WHO/UNAIDS, 2010, p. 46.

¹⁹⁰ WHO/UNAIDS, 2007a, p. 17.

¹⁹¹ WHO/UNAIDS bases its findings on five studies of complications following circumcision by non-medically trained providers.

¹⁹² See, Atikeler et al., 2005, pp. 97-99.

¹⁹³ *Ibidem*.

¹⁹⁴ Naude, 2002, p. 34.

direct oral-genital contact carries a serious risk of transmission of the Herpes Simplex Virus or HSV from *mohels* to neonates, which can be complicated by protracted or severe infection¹⁹⁵. Other research from April 2006 until December 2011 of 11 infant males who underwent circumcision with confirmed or probable mouth to genital suction were estimated to be 3.4 times more likely to be subject to the HSV-1 infection than male infants who were unlikely to have had direct oral suction¹⁹⁶. However, both studies on this Jewish practice are contested¹⁹⁷.

Contrary to the findings of the study in Turkey are the findings of a study in South-West Nigeria, which showed complications in 2.8 per cent of the cases after the circumcision, mainly conducted by traditional providers of circumcision¹⁹⁸. Notwithstanding the Nigerian study, circumcisions undertaken in non-clinical settings have significant risks of serious adverse events, mainly due to a lack of training of the provider and non-sterile tools¹⁹⁹. Consequently, the boys undergoing circumcisions in clinical settings performed by trained practitioners in industrialised nations have fewer complications than boys in non-industrialised nations where circumcisions are mostly performed by poorly trained practitioners in non-medical settings²⁰⁰. For instance, another study examined a historical group in Turkey finding a significantly higher rate of complications, when circumcisions were performed by the traditional circumcisers compared with those by physicians²⁰¹.

Besides the setting of the circumcision, there are also circumstantial factors with the entry into manhood rites that contribute to a rise in the complication risks. As a certain level of hardship is required in this process, boys are not given water or food after the circumcision, which can lead to dehydration²⁰². Moreover, hospitalisation due to the occurrence of complications is sometimes discouraged as it disrupts the honourable completion of the rite²⁰³. It should be clear that these practices and their serious consequences have not been relegated to the past. In a province in South Africa, the Department of Health registered

¹⁹⁵ See, *inter alia*, Gesundheit et al., 2004, pp. 259-263.

¹⁹⁶ Centers for Disease Control and Prevention, 2012, pp. 405-409.

¹⁹⁷ See, Berman, 2012, pp. 12-31.

¹⁹⁸ See, Myers et al., 1985, pp. 581-588.

¹⁹⁹ WHO/UNAIDS, 2010, pp. 44-45.

²⁰⁰ American Academy of Pediatrics, 2012, p. 772.

²⁰¹ See, Atikeler et al., 2005, pp. 97-99.

²⁰² Naude, 2002, p. 34.

²⁰³ Ibidem.

243 deaths and 214 amputations from circumcisions between 1995 and 2004²⁰⁴. Despite the efforts of the administrative and political bodies in South Africa, this still occurs. For instance in May 2013, when 20 boys died from the consequences of traditional male circumcision²⁰⁵.

A second major determinant for the complication rate is the experience and training of the surgeons²⁰⁶. Several studies stress the importance of careful training and experience of the provider²⁰⁷. This was most clearly evidenced in a Nigerian study²⁰⁸ in which 24 per cent of the boys reported complications, but only 1.6 per cent of them circumcised at a public university teaching hospital by medical doctors reported complications²⁰⁹. The high frequency of adverse events following circumcision by untrained providers in non-sterile settings is also striking in two studies of traditional circumcision in Turkey and Kenya, which found a prevalence of around 80 per cent²¹⁰.

Moreover, a study in Israel found there was no difference in the rate of complications in newborn circumcision between hospitals-based physicians and well-trained, home-based ritual circumcisers²¹¹. This study points out that untrained providers generate more complications than well-trained providers, but also that not all complications should be attributed to the settings outside hospitals²¹².

A third determinant is the age at which the circumcision takes place. In general, complications occur less frequently among neonates and infants than among older boys²¹³. Moreover, WHO/UNAIDS concluded that following neonatal and infant circumcision the median frequency of any adverse event was 1.5 per cent (range 0-16 per cent) and the median frequency of any *serious* adverse event was 0 per cent (range 0-2 per cent)²¹⁴. Older boys have higher frequency of complications (up to 14 per cent)²¹⁵, even when conducted by trained

²⁰⁴ Sidley, 2006, p. 62; Eastern Cape Department of Health, *s.d.*, p. 1.

²⁰⁵ See, Reuters, 16 May 2013.

²⁰⁶ WHO/UNAIDS, 2007a, p. 17.

²⁰⁷ WHO/UNAIDS, 2010, p. 46.

²⁰⁸ See, Osuigwe, Ikechebelu & Okafor, 2004, pp. 246-251.

²⁰⁹ See, *ibidem*.

²¹⁰ See, Atikeler et al., 2005, pp. 97-99; Bailey, Egesah & Rosenberg, 2008, pp. 669-677.

²¹¹ See, Chaim et al., 2005, pp. 368-370.

²¹² American Academy of Pediatrics, 2012, p. 774.

²¹³ WHO/UNAIDS, 2010, p. 46.

²¹⁴ WHO/UNAIDS bases in findings on 16 prospective studies from 12 countries.

²¹⁵ WHO/UNAIDS bases in findings on 5 studies.

providers in sterile settings²¹⁶. By the time they reach adolescence and adulthood there is an even higher frequency of complications than with children under 12 years of age²¹⁷. Factors attributing to this lower frequency of complications among neonates and infants relate to the simpler nature of the procedure in this age group and to the healing capability of newborns²¹⁸. Furthermore, with neonatal circumcision suturing is usually not necessary, whereas it is commonly needed with circumcisions in the post-neonatal period²¹⁹.

2.2.2.3. *Conclusion*

In the studies selected by the WHO/UNAIDS for their 2010 Report, there was a wide variation in the reported frequency of adverse events after circumcision. Proponents of male circumcision most often recognise these risks; however, from their perspective the risks are not that frequent. Moreover, they place emphasis on the medical and non-medical risks which are associated with *not* circumcising, rather than the risks connected to the procedure²²⁰. WHO/UNAIDS concludes that further studies with monitoring of the risks following circumcision are needed to document complications using standardised definitions, to compare the risks associated with different methods of circumcision and to evaluate the impact of the training of the circumcisers²²¹. However, it is already clear that several factors influence the complication rates, such as age at circumcision, the training and expertise of the provider as well as the sterility of the conditions²²².

2.2.3. *Psychological Effects*

The difference between physiological effects, on the one hand and the positive or negative effects on the other hand, is that the former is less researched and documented, which is also the reason for putting them aside. Sigmund Freud was one of the first to develop an alleged correlation between physiological issues and male circumcision. According to Freud,

²¹⁶ See, Subramaniam & Jacobsen, 2004, pp. 783-785.

²¹⁷ WHO/UNAIDS, 2010, p. 46.

²¹⁸ *Ibidem*.

²¹⁹ *Ibidem*.

²²⁰ Fox & Thomson, 2005a, p. 162.

²²¹ WHO/UNAIDS, 2010, p. 49.

²²² *Ibidem*, p. 46.

male circumcision symbolises physiological castration and he suggested a possible connection with castration fears, neuroses and circumcision²²³.

This idea was picked up by Immerman and Mackey who described circumcision as “low-grade neurological castration²²⁴.” Their studies are part of recent research on the long-term psychosexual effects of circumcision. These studies state that severing of erogenous sensory nerve endings in the foreskin during infancy leads to atrophy of non-stimulated neurons in the brain’s pleasure centre during the critical developmental period²²⁵.

Other authors catalogue male circumcision as a traumatic experience²²⁶. Goldmann argues that circumcision is a traumatic event, for children as well, given the forcible restraint, the cutting-off of a part of the penile skin and the experience of pain²²⁷. This argument is only strengthened, if the circumcision is performed without anaesthesia²²⁸.

Men have associated anger, a sense of loss, fear, distrust and grief, jealousy of intact men, shame and a sense of having been violated with their circumcision²²⁹. Numerous reasons have also been put forward as to why reports on these feeling are rather scarce, for instance the acceptance of beliefs and cultural assumptions, the painful emotions and the fear of rejection of their feelings by the community²³⁰. Nevertheless, these alleged long-term psychological effects are based mostly on reports from self-selected men, who themselves have contacted institutions such as the American Circumcision Resource Center²³¹.

Even more than with the positive and negative effects, there is much more research to be done in the field of psychological effects of circumcision, especially with regard to population-based prospective studies of long-term psychological effects of male circumcision²³². At the moment, it is hard to determine whether the problems related to male circumcision are smaller or greater than estimations based on previous studies on the psychological effects.

²²³ Boyle et al., 2002, p. 333.

²²⁴ Immerman & Mackey, 1998, p. 372.

²²⁵ Boyle et al., 2002, p. 334.

²²⁶ See, Lander et al., 1997, pp. 2157-2162.

²²⁷ Goldman, 1999, p. 94.

²²⁸ Boyle et al., 2002, p. 332.

²²⁹ See, Hammond, 1999, pp. 85-92.

²³⁰ Boyle et al., 2002, p. 333.

²³¹ Goldman, 1999, p. 95.

²³² Frisch et al., 2013, p. 798.

2.3. POLICIES

At the current stage of medical science, it is not possible to draw a conclusive medical examination of male circumcision out of the established positive and negative effects. Consequently, the medical angle does not put forward one clear answer to male circumcision of children. Following the saying “Cobbler, stick to thy last,” it is wise to look at the conclusions of specialised organisations and medical associations in relation to these studies in their policy statements.

However, this strategy is not uncontested as opponents of male circumcision accuse medical societies of being political organisations whose purpose is to advance the interests of their physician-members who benefit from male circumcision²³³. Two arguments are put forward for this theory, namely, the loss of income and the exposure to risks of lawsuits for the caused injuries if male circumcision would be outlawed²³⁴. Moreover, it should be clear that these organisations are not part of the legislature and therefore cannot decide which practices are illegal. However, some of them have authoritative voices in debates on human rights violations.

Keeping those remarks in mind, it can be useful to look at the policies of the WHO and some medical associations. Although not a strict medical organisation, the most notable absentee on this list is UNICEF, which to date has not come forward with a global policy on the circumcision of male children.

At a global level, WHO/UNAIDS states that there is “a clear need to improve the safety of circumcision at all ages through improved training or retraining for both traditional and medically trained providers²³⁵.” Moreover, WHO/UNAIDS puts the best interests of the child forward as a guiding principle²³⁶. It states that informed consent must be obtained from parents²³⁷. However, in the case of children who have some capacity to appreciate the risks and benefits associated with the procedure, the child’s assent should also be sought, and they should be counselled about the risks and benefits in a language that they can understand²³⁸.

²³³ Hill, 2007, p. 318.

²³⁴ *Ibidem*.

²³⁵ WHO/UNAIDS, 2010, p. 49.

²³⁶ *Ibidem*, p. 10.

²³⁷ *Ibidem*, p. 51.

²³⁸ *Ibidem*, p. 10.

Yet for areas with a HIV epidemic WHO/UNAIDS has gone a step further. In 2007 they encouraged countries with hyperendemic and generalised HIV epidemics and low prevalence rates of male circumcision to expand access to safe circumcision services, as well as to examine how to promote neonatal circumcision in a safe, culturally acceptable and sustainable manner²³⁹. Subsequently, a study of nine priority countries found that an average of 26.9 per cent of circumcisions between 2010 and 2012 in resulting programs were performed on children below 15 years old²⁴⁰. WHO/UNAIDS also advised a new list of priority countries to roll out the routine offer of medical circumcision for newborn males²⁴¹.

The American Urological Association has shown a slight preference for the procedure in their policy papers of 2007 and 2010, if conducted by an experienced medicinal practitioner. For instance, they have stated that “[t]he risks and disadvantages of circumcision are encountered early whereas the advantages and benefits are prospective²⁴².” Nevertheless, the AUA still leaves the final decision with the parents and leaves room for ethnic, cultural, religious and individual preferences next to the medical benefits and risks²⁴³.

The American Medical Association concluded in 2009 that the “[e]xisting scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision²⁴⁴.” Moreover, they stated that the procedure is not essential to the child’s current well-being and parents should determine what is in the best interests of the child²⁴⁵.

The American Academy of Pediatrics has a more recent and lengthy technical Report on male circumcision, in which they attempt to evaluate all (?) the relevant scientific articles. They concluded in 2012 that the current evidence indicates that “the health benefits of newborn male circumcision outweigh the risks and the benefits justify access to this

²³⁹ WHO/UNAIDS, 2007b, p. 9.

²⁴⁰ Centers for Disease Control and Prevention, 2013, p. 956.

²⁴¹ UNAIDS, 2013, p. 18.

²⁴² American Urological Association, 2012, p. 1.

²⁴³ Ibidem.

²⁴⁴ American Urological Association, 2009, p. 1.

²⁴⁵ American Medical Association, 2009, p. 1.

procedure for families who choose it²⁴⁶.” Hereby, the AAP added that those who perform the circumcision should be adequately trained and use both effective sterile techniques and pain management²⁴⁷. However, the decision remains with the parents, who should receive objective information on the potential benefits and risks from the physicians²⁴⁸. The Report also suggests that parents “may wish to consider whether the benefits of the procedure can be attained in equal measure if the procedure is delayed until the child is of sufficient age to provide his own informed consent²⁴⁹.”

This Report presents a change compared to their 2009 policy paper which stated that “existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision²⁵⁰.” Clearly, the AAP still does not recommend it as a routine operation, but shifts the decision making more and more towards the parents, thus it seems to focus on the responsibility of the parents. Nevertheless, also in the 2012 Report the AAP states that “[t]he true incidence of complications after newborn circumcision is unknown [...],” and “[t]here are no adequate analytic studies of late complications in boys undergoing circumcision in the post-newborn period²⁵¹.”

Outside the United States the positions are more reticent. The British Medical Association (hereinafter: the BMA) believes that “the medical harms or benefits have not been unequivocally proved except to the extent that there are clear risks of harm if the procedure is done inexpertly²⁵².” Consequently, the BMA does not have a policy on these issues, since “it would be difficult to formulate a policy in the absence of unambiguously clear and consistent medical data on the implications of the intervention²⁵³.” However, they believe that the choice is with the parents and it is for society to decide what limits should be imposed on this choice²⁵⁴.

Other medical associations place even more weight on the inherent

²⁴⁶ American Academy of Pediatrics, 2012, p. 778.

²⁴⁷ Ibidem.

²⁴⁸ Ibidem.

²⁴⁹ Ibidem, p. 760.

²⁵⁰ American Academy of Pediatrics, 2009, p. 691.

²⁵¹ American Academy of Pediatrics, 2012, p. 774.

²⁵² British Medical Association, 2004, p. 260.

²⁵³ Ibidem.

²⁵⁴ Ibidem.

physical, sexual, and psychological harm of circumcision. The Royal Australian College of Physicians states that “the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand²⁵⁵.” The Royal Dutch Medical Association (hereinafter: the RDMA) goes a step further by contesting that there is convincing evidence that circumcision is useful or necessary in terms of prevention or hygiene²⁵⁶. The RDMA believes that circumcision entails the risk of medical and psychological complications²⁵⁷. Consequently, they state that “in light of the complications which can arise during or after circumcision, circumcision is not justifiable except on medical/therapeutic grounds²⁵⁸.” Moreover, “[i]nsofar as there are medical benefits, such as a possibly reduced risk of HIV infection, it is reasonable to put off circumcision until the age at which such a risk is relevant and the boy himself can decide about the intervention, or can opt for any available alternatives²⁵⁹.”

Nevertheless, these diverging medical policies could be explained by the fact that they are serving a different population within a different cultural setting, where certain factors are less relevant. This line of reasoning will also be an important factor in the legal debate. Moreover, it should not be forgotten that also with the more reticent or on occasion hostile positions towards the circumcision of male children, the decision of the parents is still central in the decision-making process.

2.4. CONCLUSION: 3 TYPES OF MALE CIRCUMCISION

It became clear throughout the medical analysis that there is still no medical consensus on the circumcision of male children resulting in different policies of medical associations. Notwithstanding these divergent medical opinions, two conclusions can be drawn: the complication rates of male circumcision depend on the setting,

²⁵⁵ Royal Australian College of Physicians, 2010, p. 5.

²⁵⁶ Royal Dutch Medical Association, 2010, p. 5.

²⁵⁷ Ibidem.

²⁵⁸ Ibidem.

²⁵⁹ Ibidem.

equipment and the expertise of the provider; and neonatal circumcision is a simpler procedure than adult circumcision.

Moreover, following the medical analysis and the thread running through the reviewed policies, it seems justified and even necessary for a correct judgment in the legal analysis to differentiate between different forms of male circumcision. This idea of a classification of male circumcision is not in itself new, as shown by the existing differentiations between therapeutic and non-therapeutic circumcision and the existence of other typologies²⁶⁰.

Before presenting the proposed typology, some preliminary remarks should be made. Firstly, the proposed types can require further development after the legal analysis, because even if there would be a medical consensus, *quod non*, other non-medical issues have to be considered as well, for instance freedom of religion. Secondly, this proposed typology depends to a certain extent on the medical evidence currently available of which an apparent common denominator is taken. Since previous studies can be falsified and medical science can evolve, for instance, by finding alternatives for therapeutic circumcisions or by establishing more evidence *pro* or *contra* the practice, this typology will obviously be susceptible to change.

Bearing in mind these remarks and using the complication rates as a motivating factor, three types of circumcision emerge out of the medical analysis. Therapeutic circumcision constitutes *Type 1*. Circumcision in clinical or comparable settings by medical schooled personnel or well-trained and experienced persons, under anaesthesia is called *Type 2*. The “perceived health, common practice”-type, commonly performed in the United States as well as some religious circumcisions fall under this *Type 2*. Clearly, this *Type 2* does not contain the more excessive forms of male circumcision, for example peeling of the penis or the slitting of the urinary tube.

Circumcisions lacking either a medically trained or well-experienced circumciser to the level of a medical practitioner, clinical conditions or the use of anaesthesia constitutes *Type 3*. In this way, this is the residual category comprising all circumcisions missing one of the constituting

²⁶⁰ Abu-Sahlieh, 2001, p. 9, identifies 4 types which differ according to the procedure. Darby & Svoboda, 2007, p. 308, come to 5 types based on a scale of what the consequences are for the foreskin, frenulum, sliding functionality and frenular nerves. Van den Brink & Tigchelaar, 2012, pp. 427-428, use the African, American and Abrahamic type.

elements of *Type 2*, given that all of these elements have a major influence on the complication rates. Most of the ritual circumcisions as well as the mass circumcision carried out by untrained circumcisers using unsterile equipment, which are associated with the most serious complications, even life threatening ones, fall in *Type 3*. Nevertheless, it should be clear that initiation schools, where the circumcision is performed by well-trained circumcisers with the use of anaesthetics, can fall within *Type 2*. Moreover, the core of this *Type 3* is immune to the evolutions in medical science, as complication rates can only diminish by *medicalising* the procedures, by which these practices would fall into *Type 2*.

After the presentation of this typology some further remarks are necessary. Firstly, the typology should be criticised on a medical basis, meaning that this typology is to act as a trigger for a medical differentiation between all the practices which are now understood as “male circumcision.” Consequently, given the medical background of the boundaries between these types, these limits should be further interpreted and developed scientifically with regard to concrete medical definitions, which is not within the scope of this thesis²⁶¹. At the moment, although some practices fall clearly in one type or another, others are hard to classify. For these practices, evolution in medical science and new study results are particularly relevant.

Secondly, since the consequences of circumcisions performed for religious reasons or to prevent HIV, if preformed under the same conditions, do not differ, they are not differentiated. As a result, there is no separate “religious type.” This type would be too broad, as it would include all forms of religious practices which differ markedly, for instance in relation to age and the various differences between the providers. Consequently, some religious motivated circumcisions can fall into *Type 2*, while others can fall into *Type 3*. Hopefully, it is clear that these types without a religious type, do not lead to a neglect or downplay of freedom of religion in this thesis, as it will be considered in the next chapter.

Thirdly, although, these types correspond to a limited extent to regional differences (*Type 2* as an American and *Type 3* as an African type), which have been chosen as a way of categorising in the past²⁶²,

²⁶¹ A further development could be stricter boundaries of *Type 2*, by requiring the usage of a certain technique while performing the male circumcision.

²⁶² Van den Brink & Tigchelaar, 2012, p. 427.

this regional categorisation is not chosen as it leads to some difficulties: circumcisions in Europe, for non-religious reasons would fit into the American type and the practices of the Aborigines in Australia into the African type. In addition, within these regions there are also circumcisions of the other regional type taking place. Moreover, the encouragement by the WHO of male circumcision in the fight against HIV can lead to a situation where the African type evolves into the American type.

Notwithstanding this typology and lessons from the medical angle, a human rights analysis of the circumcision of male children is broader than just the medical benefits and risks, as potential non-medical benefits and risks have to be taken into account. The following legal analysis will allow these other interests to be examined.

3.

LEGAL ANALYSIS

In the discussion on the circumcision of male children, several rights from a variety of sources are put forward to argue in favour or against the practice. As stated in the introduction, participants in this debate often agree on the rights that are applicable. Nevertheless, opponents of the practice seem to interpret these rights more from a perspective of individual freedom and autonomy, while proponents tend to stress the importance of collective, cultural and familial structures behind these rights. More often than not, this is done without a thorough legal analysis of these rights.

The purpose of this part is to elaborate on the content of these rights, *in contrario* to the Cologne judgment, and to come to a justifiable balancing of rights. The wording of a *balancing of rights* seems a bit unfortunate in the case of circumcision of male children. This tends to imply a *battle of rights*, as is found in “freedom of speech” versus “right to private life” cases for instance. However, in the circumcision debate, the rights are more intertwined. It should be clear that it is not a debate in which the parental religious convictions stand against the rights of the child, though it is often presented as such. The debate is broader than this juxtaposition, as it should also include issues such as circumcisions for non-religious reasons. Moreover, the religious affiliations of the parents are not necessarily in opposition to the rights of the child.

Furthermore, it should be clear that the focus will not be on German law, since this thesis has a broader perspective. Consequently, the focus will be on the United Nations Convention on the Rights of the Child by applying the relevant articles of this Convention to the circumcision of male children. There will be case law put forward out of different legal systems thus providing other sources of inspiration for the interpretation

of the CRC. The decision to use this Convention should also be further elaborated.

On the one hand, the power of this Convention lies in its almost universal ratification²⁶³, which justifies it as the applicable text to the worldwide practice of male circumcision. Nevertheless, the popularity demonstrated by its ratification was due to vagueness in some provisions. The numerous reservations and declarations made by states allow them a certain margin of interpretation. These reasons for the multiple interpretations of the Convention are enforced by the reference in the Preamble of the CRC to take “due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child²⁶⁴.”

On the other hand, the same examination of male circumcision could be done on the basis of other universal, regional or national legal texts, which could lead to different results. Nevertheless, the question would be how reconcilable such interpretations are with the almost universal ratification of the CRC.

Lastly, it should be stressed once more that the question of this legal analysis will be whether there are human rights violations in the three types of circumcision outlined above. If this would be the case, these possible human rights violations require a debate on possible legal and extra-legal solutions; however this is outside the scope of this thesis.

3.1. PARENTAL GUIDANCE AND DIRECTION

The Convention on the Rights of the Child stresses on several occasions the guidance that parents provide in a child's upbringing and the importance of the family and social unit. Even already within the Preamble, it is declared that “the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities

²⁶³ The USA in particular has not ratified this Convention. Nevertheless, the American jurisprudence seems to follow to a certain extent the provisions of this Convention, as it for example applies the concept of the best interests of the child, which is mentioned in Article 3 CRC.

²⁶⁴ See, the Preamble of the CRC.

within the community.” Moreover, Article 3 (2) CRC states that state parties have to take the rights of the parents into account while ensuring the child’s protection and care necessary for his or her well-being. Article 18 (1) CRC also makes it clear that both parents have “the primary responsibility for the upbringing and development of the child”, whereby “the best interests of the child will be their basic concern.” Therefore, according to Article 29 (1) (c) CRC, the education of the child shall be directed to the development of respect for the child’s parents.

Concerning the parental guidance, Article 5 CRC points to the rights and duties of parents “to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.” References to this article are used to show that “[i]n no sense is the Convention ‘anti-family,’ nor does it put children against their parents²⁶⁵.” Nevertheless, several reservations and declarations have been made by states in regard to this article. The use of “evolving capacities” in Article 5 CRC indicates that the drafters of the Convention did not want to create arbitrary age limits or a definition of maturity, but preferred the link with “due weight in accordance with the age and maturity of the child²⁶⁶.”

However, the Committee on the Rights of the Child (hereinafter: the CRC Committee) has stated that the “exercise by the child of the rights” of the CRC “applies equally to younger as to older children²⁶⁷.” Furthermore, the CRC Committee made clear in General Comment No. 7 that “Article 5 contains the principle that parents (and others) have the responsibility to continually adjust the levels of support and guidance they offer to a child²⁶⁸.” The wording of Article 5 CRC and the clarification by the CRC Committee has made it clear that this parental direction and guidance is limited not only by the evolving capacities of the child, but also by other articles, including Articles 19 and 24 (3) CRC²⁶⁹. Besides this parental guidance and direction, cultural rights are to be mentioned here as well. The Preamble of the CRC urges to take

²⁶⁵ Hodgkin & Newell, 2007, p. 75.

²⁶⁶ Ibidem, p. 77.

²⁶⁷ CRC/C/GC/7/Rev.1, 20 September 2006, para. 16.

²⁶⁸ Ibidem, para. 17.

²⁶⁹ Hodgkin & Newell, 2007, p. 79.

into due account “the importance of the traditions and cultural values of each people for the protection and harmonious development of the child.” Other articles mention this respect for the cultural background of the child as well, in particular Article 30 CRC.

A combination of these references indicates that parents have the right to raise their children according to their own traditions and culture, bearing in mind the evolving capacities of the child. In this process parents can clearly make choices that seem wrong or even harmful to others, given the differing opinions on the development of a child. One can think of the physical and psychological consequences of the parental choices, with regard to nutrition, alcohol and smoking for instance. Some of these decisions can have, similarly to circumcision, an irreversible effect on the child.

Despite these diverging options, even those with questionable characteristics, these parental choices do not automatically lead to violations of the rights of the child. Moreover, it seems clear that parents in general want to give their children the best possible upbringing and that they do not make choices, as with male circumcision, in order to hurt or abuse their child. They rather have the desire that their child would be regarded and embraced as a full member of their family and of their religious, social or ethnic community.

Consequently, it seems fair that the CRC respects parental choices in the guidance and education of their child. However, this freedom of parental choice does not allow parents, *inter alia*, to go against the best interests of the child (protected by Article 3 CRC), or to significantly endanger the child’s life, health or well-being (protected by Article 24 CRC). The Convention also makes reference to the evolving capacities of the child indicating that the parental guidance has to diminish in line with the growing maturity of the child. It is in this light that the Court in Cologne suggested that parents have to wait with the circumcision until the child can decide²⁷⁰.

A *prima facie* evaluation of these parental rights, leads to the conclusion that parents, who are opposed to *Type 1* seem to go beyond the allowed margin for parental choices, as to put the child’s health at risk. For *Type 3*, the situation is reversed, as it seems that the parental decision to circumcise their child in these circumstances is highly problematic

²⁷⁰ Landgericht Köln, 151 Ns 169/11, 7 May 2012, para. 14.

given the health risks involved. The situation for *Type 2* does not lend itself in one direction or another. Some argue that if there is no medical consensus on the health effects of male circumcision, as in *Type 2*, parents are in the best position to decide what is in the best interests of the child²⁷¹. Others argue that given the only preventive positive effects *Type 2* offers, parents should respect the evolving capacities of the child and postpone the circumcision until these preventive measures gain more relevance.

3.2. ARTICLE 12 CRC: RESPECT FOR THE VIEWS OF THE CHILD

This article indicates that children, who are capable of expressing their views, should be given the possibility to do so in accordance with their age and maturity²⁷². Since no limited list of these matters was adopted²⁷³, male circumcision is arguably one of the matters. Clearly, there is an implicit tension between the rights of the child and the parental rights, who might prefer to circumcise their child before he is capable of expressing his own view. Nevertheless, babies and very young children have the same rights as all children to have their best interests assessed, even if they cannot express their views or represent themselves in the same way as older children²⁷⁴.

This article should be read together with two other articles, namely Articles 3 and 5 CRC. The relation between Article 3 and Article 12 CRC is one of complementarity and reciprocal reinforcement: the former aims to realise the child's best interests, whilst the latter provides the methodology for hearing the views of the child(ren) and their inclusion in all matters affecting them²⁷⁵.

Article 5 CRC requires that the evolving capacities of the child must be taken into consideration when the right to be heard is at stake²⁷⁶. Consequently, the more the child has experienced, understands and knows, the more the parents of the child will have to transform their direction and guidance into reminders and advice, and later, to an

²⁷¹ Van den Brink & Tigchelaar, 2012, p. 433.

²⁷² Article 12 CRC.

²⁷³ E/CN.4/L.1575, 17 February 1981, pp. 13-14.

²⁷⁴ CRC/C/GC/14, 29 May 2013, para. 43.

²⁷⁵ Ibidem.

²⁷⁶ Ibidem, para. 44.

exchange on an equal footing²⁷⁷. Nevertheless, this transformation will not take place at a fixed point in a child's development, but will steadily increase as the child is encouraged to contribute his or her views²⁷⁸. Consequently, as the child matures, his or her views should receive increasing weight in the assessment of their best interests. Even if they cannot express their views or represent themselves in the same way as older children, young children should still be given the chance to express themselves. For instance, as General Comment No. 12 of the CRC Committee makes clear verbal expression by the child is not required²⁷⁹. Nevertheless, national viewpoints vary widely, even in Europe, as to what age the views of the child should be given due importance.

Article 5 CRC on its own does not seem to automatically mean that parents have the obligation to postpone male circumcision until the child is old enough to give his own view. It implies that the parental right to direct the child decreases with the child's increased maturity, which is relevant for some Muslims who circumcise their children at an older age.

The CRC Committee also linked Article 12 with Article 24 (1) CRC in General Comment No. 4 on "Adolescent health and development in the context of the Convention on the Rights of the Child," stating the states have to "ensure that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development"²⁸⁰. This is especially relevant for male circumcision, as it underscores the outcome of the previous paragraphs.

This conclusion was endorsed in the Cologne judgment, as it states that autonomy (*Selbstbestimmung*) would be best achieved by postponing the important religious decision until the child can give his consent²⁸¹. Moreover, the line of reasoning can be found in the Swedish law on male circumcision, where the procedure cannot be performed against the will of the child²⁸². Also Article 12 (9) of the South African Children's Act of 2005 states that male children over 16 years old may only be circumcised after the consent of the child and following proper

²⁷⁷ CRC/C/GC/14, 29 May 2013, para. 84.

²⁷⁸ *Ibidem*.

²⁷⁹ CRC/C/GC/14, 29 May 2013, para. 21.

²⁸⁰ CRC/GC/2003/4, 17 March 2003, para. 39(d).

²⁸¹ Landgericht Köln, 151 Ns 169/11, 7 May 2012, para. 14.

²⁸² Lag (2001:499) om omskärelse (Law (2001:499) on male circumcision), para. 3.

counselling of the child²⁸³. This age is somewhat artificial and high age requirement is countered in the following paragraph of the same article, which states that “[t]aking into consideration the child’s age, maturity and stage of development, every male child has the right to refuse circumcision²⁸⁴.”

3.3. ARTICLE 24 (1) CRC: ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH

This article is probably the best illustration as to how opponents and proponents of male circumcision provide differing interpretations of various rights. For instance, the recognition of Article 24 (1) CRC by the CRC Committee in General Comment No. 15 as an inclusive right that extends to “a right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health²⁸⁵,” is just as the article, susceptible to two very different interpretations.

On the one hand, male circumcision is seen as having a negative impact on the health of the child because of its possible complications. On the other hand, the practice is encouraged, in particular by the WHO, in order to allow the child to achieve the highest attainable standard of health given its preventive effects, especially in relation to HIV infection. In addition, the CRC Committee has stressed in its General Comment No. 3 to take the best interests of the child into consideration with regard to HIV policies²⁸⁶. The mere *preventive* status of certain procedures is not a major obstacle, as Article 24 (2) (f) CRC mentions that states parties have to take *preventive* health measures as well. Moreover, the CRC Committee has shown great concern when immunisation rates within a state party have dropped²⁸⁷. Nevertheless, the question remains one of whether these preventive measures outweigh the possible complications that can occur with male circumcision²⁸⁸. Consequently, the different interpretations of this article, illustrated by the underlying and competing conceptions of health, come to the

²⁸³ Article 12 (9) of the Children’s Act of 2005.

²⁸⁴ Article 12 (10) of the Children’s Act of 2005.

²⁸⁵ CRC/C/GC/15, 29 May 2013, para. 2.

²⁸⁶ See, CRC/GC/2003, 17 March 2003.

²⁸⁷ Hodgkin & Newell, 2007, p. 363.

²⁸⁸ See, *infra*, Parts 3.3 and 3.6.3 for a comparison with immunisations.

forefront and impede an easy conclusion on this article. Clearly, they also undermine further clarifications of this article through the drafting history and General Comments. Notwithstanding these underlying competing conceptions of health which lead to a certain stalemate with regard to the interpretation of this right, several remarks can be made.

Firstly, although the condemnation and legal restrictions on male circumcision may lead to underground practices, which can be more detrimental for the health of the child, it should be stressed once more that this does not come into play when considering the practice as a human rights violation. Nevertheless, these arguments are unmistakably important as they help to determine policy options such as education and awareness raising, available after a possible classification as a human rights violation has been made.

Secondly, studies point out that male circumcision used in the prevention of HIV may result in a downplaying of the importance of the use of other preventative measures and may even lead to an increase in high risk behaviour out of a false belief that circumcision will provide full protection²⁸⁹. This enforces the previous remark that justifications or condemnation of the practice should be followed not only by legal measures, but by awareness raising and other measures with regard to HIV.

Thirdly, the question is which type of person, human rights scholars, judges and decision makers have in mind when considering human rights. There seems to be a clear difference in providing and even encouraging forms of sexual protection for sexually active persons, on the one hand, and adopting preventive measures years before sexual activity, on the other hand. The question is whether a human rights analysis has to allow for a child to be circumcised in order to prevent possible dangers he can face in a future in which he will be sexually active.

Fourthly, it should be made clear, that in the debate on male circumcision, besides the individual health concerns, public health interests are also relevant. The high prevalence of HIV in certain areas demands that new options to stop the spread of this disease should be thoroughly considered. Moreover, given the support and even funding for male circumcision as a public health response to HIV by WHO, NGOs and

²⁸⁹ See, Baeten, Celum & Coates, 2009, pp. 182-184.

national governments, it seems reasonable to discuss the other stakes as well and not to just focus on the subject from the viewpoint of an individual choice²⁹⁰.

Fifthly, the relation between a reduction in HIV acquisition and male circumcision seems to be established, at least while also referring to the context of the trials indicating this relationship. In this legal analysis, this context has to be repeated once more, not to point out the difficulties of translating these results to other regions, but to stress the relationship between the clinical setting and the results. It is hard to argue in favour of the health benefits of *Type 3* given the circumstances in which it is performed. In other words, or to put it more bluntly, the preventive effects cannot be considered if the child dies during the ritual.

In sum, Article 24 (1) CRC is the article where the competing health interpretations come to the forefront. However, these diverging interpretations are not an obstacle to condemning *Type 3* as a violation of Article 24 (1) CRC, given its clear negative impact on the health of the child. If proponents of the circumcision of male children wish to use Article 24 (1) CRC in favour of the practice, they should support a *medicalisation* of the practice as well. For *Type 1* and *Type 2*, it is important to bear in mind that medical science and the indications for male circumcision can evolve and that the CRC requires a constant balancing of the risks and effects of operations.

3.4. PERSONAL INTEGRITY

Under the concept of *personal integrity*, all rights under the CRC²⁹¹ that relate to this concept are combined. This concept embodies a protection against external interference of the body and the autonomy to decide on alterations of one's own body²⁹². In scholarly articles comparable classifications are often made under *bodily integrity*²⁹³ or

²⁹⁰ Fox & Thomson, 2012, p. 257.

²⁹¹ Given the occurrence of deadly complications within the three types of circumcision, but also the broad interpretation given to "development," the application of the right to life and development of the child (Article 6 CRC), could also be examined. Due to the limited length of this thesis, it is not possible to come to a needed extensive examination of this article, which is required to judge on the possible violations under this article.

²⁹² Van den Brink & Tigchelaar, 2012, p. 432.

²⁹³ Ibidem.

genital autonomy. The former is not mentioned in the CRC or in other international human rights treaties, although it is frequently implied and read into treaties by numerous authors. Personal integrity is also not mentioned in the CRC, nevertheless it is mentioned in the Charter of Fundamental Rights of the European Union²⁹⁴ and the American Convention on Human Rights²⁹⁵. Moreover, both texts also refer to *physical integrity* under this concept. Consequently, *personal integrity* seems to have a stronger foundation in international law, whilst including the meaning of *bodily integrity*.

The latter, *genital autonomy*, is also used while admitting that *bodily integrity* is a better-developed legal concept which subsumes the right to *genital autonomy*²⁹⁶. Although the concept of *genital autonomy* may be more precise for male circumcision than the concept of *personal integrity*, it depends on another concept and is subsequently subject to the same flaws as the concept of *bodily integrity*.

3.4.1. Does the Circumcision of Male Children Cause Harm or Invoke the Suffering of Pain?

Without wanting to erase the significant differences between the articles constituting the concept of personal integrity that will be discussed here, they all require a certain form of harm or suffering of pain to be deemed applicable. Before trying to approach this concept of harm from a legal perspective, it should be made clear that the presence of harm does not necessarily lead to a human rights violation, as certain justifications are possible, for instance consent to medical practices or other justifications in the best interests of the child.

The physical harm in *Type 3* is obvious. However, proponents of male circumcision often downplay or deny the harm inflicted by this procedure, by including or assuming that the procedure is done under pain control measures by well-trained or experienced providers. Nevertheless, these assumptions are not correct with regard to *all* practices falling under the umbrella of male circumcision. By making these assumptions however, they in fact enforce the conclusion regarding the problematic character of *Type 3*.

²⁹⁴ Article 3 of the Charter of Fundamental Rights of the European Union.

²⁹⁵ Article 5.1 of the American Convention on Human Rights.

²⁹⁶ See, *inter alia*, Delaet, 2012, p. 556.

Contrary to this, the existence of harm caused by *Type 2* is less apparent, given the divergent medical opinions. Although the concept of harm is not “a transcendental notion” over time, place and culture²⁹⁷, the recommendations made by several medical associations on the use of anaesthetics with circumcision of male children make it hard to dispute the presence of a certain form of harm.

Besides the pain, there is also the alteration of the body, which affects the personal integrity. However, Benatar and Benatar do not consider male circumcision as mutilation after drawing analogies between male circumcision and other surgical procedures such as breast reduction, liposuction and rhinoplasty²⁹⁸. These comparisons seem to suggest that these practices also affect the personal integrity of a person and it opens the question whether parents can consent to liposuction without it being medically necessary to their children.

Consequently, some case law indicates that male circumcision, even in a medical setting, causes harm. In *R v. Brown*, Lord Templeman even stated that ritual circumcision involves intentional violence resulting in actual or sometimes serious bodily harm²⁹⁹. Similarly, the European Court of Human Rights (ECtHR) observed that circumcision does harm the believers’ well-being³⁰⁰. Both cases will be discussed in more detail further on³⁰¹. Although these recognitions of male circumcision as harmful are not apparent in United States courts, American tort law provides a remedy for poorly performed circumcisions³⁰², which are “dreadful” enough to reach the threshold establishing liability³⁰³.

Notwithstanding the stronger condemnations of female genital mutilation as harmful³⁰⁴, violence against women³⁰⁵ and torture³⁰⁶, the above arguments indicate that there are grounds to consider each type

²⁹⁷ Smart, 1999, p. 392.

²⁹⁸ Benatar & Benatar, 2003, p. 36.

²⁹⁹ United Kingdom House of Lords, *R v. Brown*, 2 All ER 75, 11 March 1993, para. 2.

³⁰⁰ ECtHR, *Case of Jehovah's Witnesses of Moscow and Others v. Russia*, no. 302/02, 10 June 2012, para. 144.

³⁰¹ See, *infra*, Parts 3.5.3 and 3.6.2.

³⁰² See, *inter alia*, Supreme Court of Pennsylvania, *Doe v. Raezer*, 664 A.2d 102, 27 September 1995; Court of Appeal of Louisiana, *Felice v. Valleylab, Inc.*, 520 So. 2d 920, 8 January 1988.

³⁰³ Miller, 2002, p. 504.

³⁰⁴ A/54/38, 20 August 1999, para. 5; CRC/C/GC/13, 18 April 2011, para. 29.

³⁰⁵ A/47/38, 29 January 1992, para. 20; CCPR/C/21/Rev.1/Add.10, 29 March 2000, para. 11.

³⁰⁶ CAT/C/GC/2, 24 January 2008, para. 18.

of male circumcision as harmful as well. Since this is also the case for medical operations, further questions on the duration, prevention, reduction and complications of the harm appear.

Even with regard to possible treatments for a health condition, as *Type 1*, the CRC Committee requests that the advantages of all possible treatments must be weighed against all possible risks and side effects, and the views of the child must also be given due weight based on his or her age and maturity³⁰⁷. Hereby, it should not be forgotten that medical standards evolve, which can mean that this category can increase or reduce, as happened in the past, for instance with regard to *phimosis*. Consequently, children within *Type 1*, should be provided with adequate and appropriate information so as to understand the situation and all the relevant aspects; and be allowed, when possible, to give their consent in an informed manner³⁰⁸.

With regard to *Type 2*, it is clear that there are other non-therapeutic surgeries, which are deferred until children have sufficient maturity and understanding to participate in the decision-making process³⁰⁹. Hereby, the parental consent becomes more problematic with regard to the autonomy to decide over the own body, when operations are not regarded as life saving or of undeniable benefit for the child. Courts, for instance in the UK, tend to take the position, in cases of non-therapeutic circumcisions, that the decision should not be taken against the wishes of one parent³¹⁰. Nevertheless, the first chapter underlined the importance of neonatal circumcision in some social and religious communities, in which the capability of the child to consent is limited.

As mentioned in the section on the parental guidance and education in the CRC, parental preferences must accord with the best interests principle, which will be examined in more detail under Article 3 CRC³¹¹. Under the following articles, which constitute the notion of *personal integrity*, it will be examined whether there are reasons and justifications for the harm of male circumcision or whether it should be condemned as a human rights violation.

³⁰⁷ CRC/C/GC/14, 17 April 2013, para. 77.

³⁰⁸ CRC/C/GC/14, 17 April 2013, para. 77; BMA, 2004, p. 261.

³⁰⁹ British Medical Association, 2004, p. 261.

³¹⁰ See, Court of Appeal, Civil Division, *Re J (A Minor)* (Prohibited Steps Order: Circumcision), 25 November 1999; High Court of Justice, Family Division, *Re S* (Specific Issue Order: Religion: Circumcision), 30 March 2004.

³¹¹ See, *infra*, Part 3.6.3.

3.4.2. *Relevant Articles*

3.4.2.1. *Article 19 CRC: Protection from Physical or Mental Violence*

The central question to determine whether circumcision of male children can fall within the scope of this article is to discover what constitutes violence. In General Comment No. 13, the CRC Committee emphasised that *violence* is not limited to physical and/or intentional harm³¹². Moreover, the CRC Committee made clear that the frequency, the level of severity and the intent to harm are not prerequisites for the definitions of violence; and that there are no exceptions for acts considered as violence³¹³. The CRC Committee also stated that Article 19 CRC has to be read in connection with Article 3 CRC namely, that “[a]n adult’s judgment of a child’s best interests cannot override the obligation to respect all the child’s rights under the Convention³¹⁴.”

Nevertheless, the CRC Committee does not mention the circumcision of male children under one of the forms of violence in its non-exhaustive list in General Comment No. 13³¹⁵. Female gender mutilation is mentioned, as it is commonly used as illustration for a form of violence under Article 19 CRC, given the acceptance of the harmful health effects of FGM.

For *Type 1* it seems only logical not to consider this as an act of violence. The different approach under this article between *Type 1* and FGM is justified given the therapeutic necessity of the operation within this type. However, for *Type 3*, the difference with female genital mutilation, uvulectomy and teeth extraction, which are mentioned by the CRC Committee³¹⁶ seems less clear, which points in the direction of a violation of this article. Moreover, the clarifications of the CRC Committee, which indicate the absence of a threshold and the absence of justifications³¹⁷ under Article 19 CRC even places *Type 2* in a contested position.

³¹² CRC/C/GC/13, 18 April 2011, para. 4.

³¹³ Ibidem, para. 17.

³¹⁴ Ibidem, para. 61.

³¹⁵ Ibidem, para. 22.

³¹⁶ Ibidem, para. 29.

³¹⁷ Ibidem, paras. 4 and 17.

3.4.2.2. Article 37 (a) CRC: Torture or Other Cruel, Inhuman or Degrading Treatment

Opponents of male circumcision regularly refer to the practice as a form of torture³¹⁸. However, these allegations should be examined with regard to the different requirements for the qualification as torture.

Firstly, General Comment No. 20 of the Human Rights Committee made it clear that “[i]t is the duty of the State party to afford everyone protection through legislative and other measures as may be necessary against the acts prohibited by Article 7 [of the ICCPR], whether inflicted by people acting in their official capacity, outside their official capacity or in a private capacity³¹⁹.” The Committee against Torture has made clear that “the failure of the State to exercise due diligence to intervene to stop and sanction facilitates and enables non-State actors to commit acts impermissible under the Convention [against Torture] with impunity”, which the Committee applied to the failure of states parties to prevent and protect victims of female genital mutilation³²⁰.

Secondly, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak considered in his 2008 Report FGM as a form of torture as it “involves the deliberate infliction of pain and suffering³²¹” and has a gender-specific character³²². He further stressed that “[t]he pain is usually exacerbated by the fact that the procedure is carried out with rudimentary tools and without anaesthetic³²³.”

However, the decisive criterion in the distinction between torture and cruel or inhuman treatment is the requirement of a specific purpose of the conduct³²⁴. This requirement seems to be absent in the three identified types of male circumcision, whereas with regard to FGM this purpose is found in the underlying gender-based discrimination³²⁵. Nevertheless, the constituting elements of *Type 3*, which are comparable with FGM, lead to the conclusion that *Type 3* matches the definition of

³¹⁸ See, *inter alia*, Svoboda, 2013, p. 473.

³¹⁹ HRI/GEN/1/Rev.6, p. 151, 10 March 1992, para. 2.

³²⁰ CAT/C/GC/2, 24 January 2008, para. 18.

³²¹ A/HRC/7/3, 15 January 2008, para. 50.

³²² *Ibidem*, para. 30.

³²³ *Ibidem*, para. 50.

³²⁴ Nowak & McArthur, 2008, p. 558.

³²⁵ See, *inter alia*, CAT/C/GC/2, 24 January 2008, para. 18; A/45/38, 6 June 1990; A/54/38/Rev.1, Chapter I, 20 August 1999, para. 18.

cruel and inhuman treatment³²⁶. The boundaries used for the delimitation of *Type 2*, namely the use of anaesthetics and performed by medically well-trained and experienced circumcisers seem to avoid the classification as cruel and degrading treatment.

3.4.2.3. *Article 24 (3) CRC: Abolishing Traditional Practices Prejudicial to the Health of Children*

Mentioned several times above, Article 24 (3) CRC is one of the central rights to be considered when answering the question whether the circumcision of male children is a human rights violation. However, it must firstly be seen whether male circumcision falls within the scope of this article. To see what is included in “traditional practices prejudicial to the health of children,” it is useful to look at the discussions during the drafting of the CRC with regard to this article. Some delegations wanted to limit the *traditional practices* to those that cause “serious harm³²⁷” or those which “seriously and adversely [a]ffect³²⁸,” while another delegation wanted just “affect” without qualification³²⁹. However, the current wording, without “seriously” or “seriously and adversely” indicates that the Working Group did not want to limit Article 24 (3) CRC in that sense or to install a threshold³³⁰. Moreover, it seems to suggest that “any aspect of a traditional practice which in any way has a negative impact on the health of a child, whether mental or physical, temporary or permanent, must be abolished³³¹.”

Besides the absence of a limitation or threshold in this article, the drafting history also provides some more concrete insights about which practices should be labelled as traditional harmful practices. Clearly, the article was drafted with female genital mutilation in mind and although, some delegations were in favour of explicit inclusion of FGM in the article³³², no consensus was reached.

In the end there was an agreement that *traditional practices* would include all practices that are mentioned in the 1986 Report³³³ of the

³²⁶ Nowak & McArthur, 2008, p. 558.

³²⁷ E/CN.4/1987/25, 9 March 1987, paras. 30 and 32.

³²⁸ Ibidem, para. 33.

³²⁹ Ibidem.

³³⁰ Tobin, 2009, p. 378.

³³¹ Ibidem.

³³² E/CN.4/1987/25, 9 March 1987, paras. 30, 34, 35 and 38.

³³³ E/CN.4/1986/42, 4 February 1986, pp. 7-8.

Working Group on Traditional Practices Affecting the Health of Women and Children³³⁴. The practices envisaged here were “female circumcision, other forms of mutilation (facial scarification), force feeding of women, early marriage, the various taboos or nutritional practices which prevent women from controlling their own fertility, nutritional taboos and traditional birth practices³³⁵.” However, this list is not an exhaustive list of all practices within the scope of Article 24 (3) CRC. Consequently, in the 1994 UN Seminar on traditional practices and its subsequent Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children the practices were extended to early marriage, early pregnancy, dowry and status of divorced women³³⁶.

Although, the circumcision of male children is not mentioned in any of these listed practices, the omission of any threshold allows *Type 3* to be included in this article and also opens the debate on *Type 2*. Especially, since the CRC Committee has considered practices under Article 24 (3) CRC that are not in the above mentioned lists³³⁷.

Nevertheless, the Special Rapporteur on Traditional Practices Affecting the Health of Women and Children, Halima Embarek Warzazi, objected twice to this inclusion. Firstly, in 1997 she stated that “circumcision of male children did not concern the United Nations as only female circumcision was deemed a harmful practice to be eradicated” and even added that “it would seem inappropriate to consider under one head both female circumcision which is harmful to health and male circumcision which has no undesirable effect and is even considered to be beneficial³³⁸.” The timing of the statement is remarkable since in 1997 the beneficial effects of male circumcision were more speculative than now and the trials establishing the relationship between male circumcision and HIV acquisition had not even started. Nevertheless, it is hard to argue any longer that male circumcision has no undesirable effect, especially in *Type 3*.

Secondly, in 2000, Halima Embarek Warzazi recalled that her mandate concerns “traditional practices affecting the health of women

³³⁴ E/CN.4/1987/25, 9 March 1987, para. 37.

³³⁵ Ibidem, para. 18.

³³⁶ E/CN.4/1986/42, 4 February 1986, para. 18.

³³⁷ Tobin, 2009, p. 381.

³³⁸ E/CN.4/Sub.2/1997/10, 25 June 1997, para. 18.

and the girl child³³⁹.” Nevertheless, she declared that “the harmful effects of male circumcision cannot in any way be compared or equated with the violence, danger and risk faced by girl children and women³⁴⁰.” Regrettably, she used the term *male circumcision* to cover a variety of different practices. To avoid this type of generalisation, more and more scholarly articles attempt to present certain forms of male circumcision as equally detrimental, with regard to their consequences, as certain forms of female circumcision³⁴¹.

The CRC Committee classified male circumcision under the heading “traditional practices” in its Concluding Observations on South Africa in 2000³⁴². It expressed its concern over the unsafe medical conditions under which male circumcision was – and still is – carried out³⁴³. Without classifying male circumcision as a *harmful* traditional practice, the CRC Committee recommended that “the State party take[s] effective measures, including training for practitioners and awareness-raising, to ensure the health of boys and protect against unsafe medical conditions during the practice of male circumcision³⁴⁴.”

In its Concluding Observations on Lesotho, the CRC Committee also requested “the State party [to] address health risks associated with male circumcision³⁴⁵.” Guinea-Bissau also mentioned in its State Report that “[t]raditional practices and customs are causing serious problems for children and women” and that “[t]he circumcision of boys aged 9-13 years and the partial or total excision of the clitoris in girls aged 7-12 years among the Fula and Mandinga ethnic groups are the most cruel and harmful practices³⁴⁶.” However, this was not repeated in the consequent Concluding Observations of the CRC Committee³⁴⁷. In its latest State Report, Guinea-Bissau again mentioned situations which put “the children’s rights at risk, particularly when they are living in camps where circumcision or incision (*fanado*) is carried out” and stressed that “[e]ven knowing of the inhumane conditions of these places or the type of treatment that the children endure, public authorities remain passive

³³⁹ E/CN.4/Sub.2/2000/17, 27 June 2000, para. 54 (no emphasis added).

³⁴⁰ *Ibidem*.

³⁴¹ See, *inter alia*, Delaet, 2009, pp. 405-426.

³⁴² CRC/C/15/Add.122, 23 February 2000, para. 33.

³⁴³ *Ibidem*.

³⁴⁴ *Ibidem*.

³⁴⁵ CRC/C/15/Add.147, 21 February 2001, para. 44.

³⁴⁶ CRC/C/3/Add.63, 26 July 2001, para. 52.

³⁴⁷ See, CRC/C/15/Add.177, 13 June 2002.

out of their respect for tradition³⁴⁸.” Once more, this was not included in the consequent Concluding Observations of the CRC Committee³⁴⁹. In its latest session in 2013, the CRC Committee expressed in its Concluding Observations on Israel its concern about reported short- and long-term complications arising from some traditional male circumcision practices³⁵⁰. This was a consequence of the Report of Ben Shalem, which was issued to the CRC Committee³⁵¹ and demanded the CRC Committee to require Israel to stop male genital mutilation, to prosecute every person who puts the bleeding penis of an infant or child into their mouth and sucks it, and to ensure that any male circumcision still taking place must be done with proper and adequate pain control during and after the procedure³⁵². Nevertheless, the CRC Committee only recommended that Israel should undertake a study on the short- and long-term complications of male circumcision³⁵³.

The decisions of the CRC Committee, including the request to address the health risks in South Africa and Lesotho, as well as the request to issue a study on the complications in Israel, seems to be in line with the proposed typology following the medical analysis. It can be said that the CRC Committee tends to consider, without explicitly mentioning these three types, the health risks of *Type 3* as established, but that it requires more information of *Type 2*.

However, the CRC Committee has not condemned (yet?) a type of or the practice of male circumcision in its entirety. This reluctance by CRC Committee to declare this practice as harmful could be due to a variety of reasons. First, the Preamble of the Convention stresses the “importance of the traditions and cultural values of each people for the protection and harmonious development of the child³⁵⁴.” Second, several scholars criticise the CRC Committee for having a certain cultural and gender bias in their work, which is illustrated by the tension between the condemnation of the non-Western female genital mutilation and the tolerance of the Western male circumcision³⁵⁵.

³⁴⁸ CRC/C/GNB/2-4, 7 December 2011, para. 52.

³⁴⁹ See, CRC/C/GNB/CO/2-4, 14 June 2013.

³⁵⁰ CRC/C/ISR/CO/2-4, 14 June 2013, para. 41.

³⁵¹ Ben Shalem, 2013, pp. 1-2.

³⁵² Ibidem, p. 2.

³⁵³ CRC/C/ISR/CO/2-4, 14 June 2013, para. 42.

³⁵⁴ See, the Preamble of the CRC.

³⁵⁵ Tobin, 2009, p. 375.

Third, a classification of male circumcision as a harmful practice would be highly controversial and would open the door for challenges of all forms of male circumcision. However, by differentiating between types of male circumcision this generalisation and consequent condemnation of all forms of circumcision could be avoided.

For the author it nevertheless seems clear that, given the established health consequences, *Type 3* should be classified as a traditional harmful practice, which requires the immediate action of states. The decision of the CRC Committee to require more studies on the short- and long-term consequences of circumcision in Israel seems reasonable, especially given that the general practice of male circumcision in Israel seems to fall within *Type 2*. The upcoming General Comment of the CRC Committee on traditional harmful practices will hopefully bring more clarity by outlining the criteria for determining a harmful practice or by explicitly including or excluding the circumcision of male children.

3.4.3. *Conclusion on Personal Integrity*

The in-depth examination of articles under *personal integrity* indicates two clear findings. First, *Type 1* is relatively unproblematic, especially as it follows the requirements of Article 24 (1) CRC, and if it respects Article 12 CRC. Secondly, there are some clear violations in *Type 3*, in particular under Articles 19, 24 (1), 24 (3) and 37 (a) CRC. The situation for *Type 2* is less clear. On the one hand, the *personal integrity* of the child is contested. The lack of a threshold for the applicability of several articles under personal integrity even enforces this claim. On the other hand, there is no medical consensus on the consequences of *Type 2*, which seems to point out at least the necessity of more studies on the short- and long-term effects. Consequently, coming to a definitive position on this practice, solely on the basis of the rights constituting *personal integrity*, would go against the CRC. Especially since the necessity of an analysis of the best interests principle was readily apparent in a number of instances. Moreover, it also has to be examined how the freedom of religion protected by Article 14 CRC, relates to these preliminary findings under the concept of *personal integrity*.

3.5. ARTICLE 14 CRC: FREEDOM OF RELIGION

Besides parental rights and the personal integrity, freedom of religion is another central aspect in the examination of male circumcision, especially given the religious outcry after the Cologne judgment. The Human Rights Committee also had several concerns following this judgment, which were answered by Germany, stating that “Jewish and Muslim religious life must continue to be possible in Germany³⁵⁶.”

Several questions are deemed to be relevant when examining the relationship between freedom of religion and the circumcision of male children. Firstly, does male circumcision fall under the protection of this article? Secondly, *whose* freedom of religion is at stake: that of the parent or that of the child? Thirdly, what are the limits to freedom of religion? Lastly, how are the rights of minorities protected when considering freedom of religion?

Before trying to answer these questions, it should be recalled that male circumcision is a strong obligation or a recommendable practice within certain religions, although some scholars argue that the practice is not consistent within Judaism or Islam and some have started to develop alternatives to the practices³⁵⁷. However, this type of evaluation and these recommendations are not part of the human rights perspective taken into account in this thesis. These more religious reformative paths belong to people from *within* the religious communities; it is not the task for someone *outside* the religion in question to recommend how a religion should be practised according to the existing *religious* standards.

3.5.1. *The Scope of Article 14 CRC*

The first question to be asked is whether male circumcision falls under Article 14 CRC. The General Comment No. 22 of the Human Rights Committee on the Right to Freedom of Thought, Conscience and Religion, can provide guidance as it states that “the freedom to manifest religion or belief in worship, observance, practice and teaching encompasses a broad range of acts³⁵⁸.” Moreover, in his comment on the

³⁵⁶ CCPR/C/DEU/Q/6/Add.1, 12 October 2012, para. 86.

³⁵⁷ See, *infra*, Part 1.4.2.1.II.

³⁵⁸ CCPR/C/21/Rev.1/Add.4, 27 September 1993, para. 4.

ICCPR Nowak explicitly places circumcision under this right³⁵⁹. It is rarely denied that religious motivated male circumcision falls under the scope of freedom of religion.

3.5.2. Article 14 (2) CRC: Whose Freedom of Religion?

Article 14 CRC is considered as one of most obvious cases where the rights of the child and the rights of the parents can conflict, leading to major discussions in the drafting process of the CRC³⁶⁰ and to the large number of reservations and declarations in relation to this article. The competing rights of the parents and the child come again to the fore given that, although different age requirements exist, most religious circumcisions are required to be done during (early) childhood. For instance, the representative of Morocco made clear that “the rule adopted in Moroccan legislation is that the child shall follow the religion of his father. In this case, the child does not have to choose his religion as the religion of the State is Islam³⁶¹.”

The different perspectives on individual freedom and autonomy, on the one hand, and familial, cultural and collective structures on the other, are respectively translated here into either an individual or a collective approach to religion. In the more collective approach, parents have the right to religiously educate their children in accordance with their own convictions. Moreover, when religion is viewed from a societal viewpoint, this right is also used to protect the religious tradition.

With regard to the right to practise religion as an individual freedom, it is argued that it is uncertain whether a child will follow the same religious traditions as his or her parents, or indeed if he or she decides to follow any religion at all. Consequently, the *Landgericht Köln* judgment stated that the autonomy (*Selbstbestimmung*) could be best achieved, if important religious decisions are postponed until the child can give his or her consent³⁶². Hereby, the relativity of circumcision as a physical mark should also be clear. Although being circumcised is considered by some as being Jewish, other reasons for male circumcision

³⁵⁹ Nowak, 2005, p. 420.

³⁶⁰ Quennerstedt, 2009, p. 168.

³⁶¹ E/CN.4/1987/WG.1/W, p. 35, as reprinted in the Office of the United Nations High Commissioner for Human Rights, 2007a, p. 458.

³⁶² Landgericht Köln, 151 Ns 169/11, 7 May 2012, para. 14.

exist, which do not result in being Jewish. Male circumcision does not physically determine one's religious affiliation, nor is it an obstacle to switch between Judaism and Islam or even to discard any or all religious convictions.

Nevertheless, religious upbringing is commonly accepted and it is rather a question of the extent to which this type of upbringing is imposed upon children that is subject to debate. Moreover, it is possible to argue within the individual approach that freedom of religion of the child could be violated by denying the circumcision as it excludes him from full participation in the religious life of his community.

Notwithstanding this different approaches, the wording of Article 14 (2) CRC indicates that the parental right to guide the child in the exercise of his or her right is accessory to the right of the child³⁶³. This is opposed to other legal texts³⁶⁴ that attribute parents a right to ensure the religious education of their children, which is a more distinctive and autonomous right, whereby children remain a passive object³⁶⁵.

Consequently, freedom of religion under the CRC is a right of the child. Parents can provide direction, but only if it is consistent with the evolving capacities of the child and is in conformity with the whole of the Convention³⁶⁶. Moreover, the wording of Article 14 CRC does not support the concept of children automatically following their parent's religion. However, there are of course articles which support the position that children should have the right to acquire their parents' religious beliefs if so desired³⁶⁷.

3.5.3. Article 14 (3) CRC: Limits on the Manifestation of One's Religion or Beliefs

There are two sorts of limits on freedom of religion provided in Article 14 (1) CRC: on the one hand, the limits mentioned in Article 14 (3) CRC and on the other hand, the general constraints that the best interests principle outlined in Article 3 CRC places on parental upbringing, which will be discussed later on. Restrictions based on

³⁶³ Brems, 2006, p. 5.

³⁶⁴ See, *inter alia*, Article 2 of the First Additional Protocol to the ECHR, Article 18 (3) ICCPR and Article 13 (3) ICESCR.

³⁶⁵ Brems, 2006, p. 5.

³⁶⁶ Hodgkin & Newell, 2007, p. 188.

³⁶⁷ *Ibidem*.

Article 14 (3) CRC are justified if they are prescribed by law, serve one of the listed interests and are necessary to protect the invoked interest(s). Out of the enumerated interests in Article 14 (3) CRC, public health or morals and the fundamental rights and freedoms of others are the most likely grounds that states will invoke for justifying potential restrictions on male circumcision.

Firstly, the invocation of the “rights and freedoms of others” could, with regard to the circumcision of male children, be used to protect the rights of the child, especially the rights under personal integrity. For instance, in *Dablab v. Switzerland* the ECtHR did not find the limitations on the wearing of religious symbols in schools for the protection of the rights and freedoms of others unreasonable. The ECtHR stated that the veil could be characterised as a “powerful external symbol,” which could be limited to prevent a proselytising effect, especially given the position of the applicant as a teacher to children who were aged between four and eight³⁶⁸. Also in *Leyla Şahin v. Turkey*, the ECtHR pointed out the impact an Islamic headscarf may have on others³⁶⁹.

Nevertheless, it seems that wearing a veil is difficult to compare with male circumcision. On the one hand, male circumcision is not a powerful external symbol, as it is hidden most of the time. On the other hand, the consequences of male circumcision, positive or negative, are more permanent than those relating to wearing a veil. Moreover, the validity of this reasoning of the ECtHR is questioned in the light of Article 14 CRC, since the CRC Committee seems to hold a different point of view³⁷⁰. For instance, the Committee expressed its concern over regulations prohibiting the wearing headscarves by schoolgirls³⁷¹. The CRC Committee seems to advocate herein for the autonomy of the child in deciding whether to wear a headscarf³⁷². With regard to the circumcision of male children this line of reasoning of the CRC Committee leads a focus on the decision of the child on the procedure.

The ECtHR also held that the refusal to grant a child exemption from Saturday school in conformity with their rules of religion of the

³⁶⁸ ECtHR, *Dablab v. Switzerland*, no. 42393/98, 15 January 2001 (admissibility decision).

³⁶⁹ ECtHR, *Leyla Şahin v. Turkey*, no. 44774/98, 10 November 2005, para. 99.

³⁷⁰ Brems, 2006, p. 37.

³⁷¹ CRC/C/15/Add.181, 13 June 2002, para. 29; CRC/C/15/Add.240, 30 June 2004, para. 25.

³⁷² Brems, 2006, p. 37.

parents was justified by the protection of the child's right to education³⁷³. Moreover, in *Prince v. Massachusetts* the US Supreme Court declared that a state could constitutionally prohibit (even religiously inspired) child labour³⁷⁴. Furthermore, it stated that although "parents may be free to become martyrs themselves, it does not follow [that] they are free, in identical circumstances, to make martyrs of their children [...]"³⁷⁵.

Notwithstanding the possible reasoning in favour of "the rights and freedoms of others" as a legitimate aim for restrictions on circumcisions of male children, it was concluded under the previous paragraph that the freedom of religion under Article 14 CRC belongs to the child. In this way, it seems contradictory under the CRC to justify limiting the freedom of religion of the child by "the rights and freedoms" of the same child. Under other texts however, as shown by the jurisprudence of the ECtHR and the US Supreme Court, the rights and freedoms of others are indeed a pertinent ground for justifying a restriction of the freedom of religion of the parents or even of the religious circumcisers.

Secondly, "public health or morals" is another relevant justification states may invoke to limit male circumcision. Hereby, lifesaving blood transfusions or mandatory vaccinations for children are contrary to the religious belief of the parents the obvious restrictions of religious freedom in the name of public health³⁷⁶. Moreover, Article 5 (5) of the Declaration on the Elimination of Religious Intolerance and of Discrimination based on Religion or Belief states that religious practices must not be injurious to the physical or mental health of the child. Hereby, it could be argued that the circumcision of male children threatens their physical health given the risks involved in the operation³⁷⁷.

In *Dogru v. France* and *Kervanci v. France*, the ECtHR ruled that it is not unreasonable to find the wearing of a veil, such as the Islamic headscarf, incompatible with sports classes for reasons of health or safety³⁷⁸. Moreover, in *Jehovah's Witnesses of Moscow v. Russia* the

³⁷³ ECtHR, *Martins Casimiro and Cerveira Ferreira v. Luxemburg*, no. 44888/98, 27 April 2009 (admissibility decision).

³⁷⁴ US Supreme Court, *Prince v. Massachusetts*, 1944, 321 US 168-169.

³⁷⁵ *Ibidem*, 321 US 170.

³⁷⁶ Brems, 2006, p. 32.

³⁷⁷ *Ibidem*, p. 34.

³⁷⁸ ECtHR, *Dogru v. France*, no. 27058/05, 4 December 2008, para. 73; ECtHR, *Kervanci v. France*, no. 31645/04, 4 December 2008, para. 73.

ECtHR observed that circumcision practised on Jewish or Muslim male babies may harm the believers' well-being³⁷⁹. In this case, the ECtHR stated that domestic judgments did not identify any harm and stressed that the refusal of blood transfusion was an expression of the free will of the adult members of the community exercising their right to personal autonomy³⁸⁰. However, the ECtHR distinguished this refusal from the parental refusal on behalf of the child³⁸¹. Consequently, with regard to circumcisions of male children this reasoning can be turned around, since the harm of male circumcision is already recognised by the Court and it is not an expression of the free will of the child as the parents decide for him.

As mentioned above, possible limitations must also be "necessary" or proportionate to protect these invoked interests³⁸². The ECtHR considered in *Hoffmann v. Austria* that the transfer of parental rights away from a member of Jehovah's Witnesses, can serve a legitimate aim, namely the health and rights of children, given that the mother may refuse to consent to necessary blood transfusions for her children³⁸³. However, the ECtHR stated that a distinction based essentially on a difference in religion, which resulted in the withdrawal of the children from the applicant was disproportionate in regard to the legitimate aim³⁸⁴.

In *Church of Lukumi Babalu Aye v. City of Hialeah*, the US Supreme Court allowed indirect limitations on freedom of religion when they are part of neutral and general applicable laws³⁸⁵. These limitations do not need to be justified by a compelling governmental interest³⁸⁶, even if the law has an incidental effect on a particular religious practice³⁸⁷.

Moreover, granting a special right or legal exception for religious circumcision would lead to several problems. Firstly, as argued before, from a medical point of view this form of favouritism for religious

³⁷⁹ ECtHR, *Case of Jehovah's Witnesses of Moscow and Others v. Russia*, no. 302/02, 10 June 2012, para. 144.

³⁸⁰ Ibidem.

³⁸¹ Ibidem, para. 137.

³⁸² Article 14 (3) CRC.

³⁸³ ECtHR, *Hoffmann v. Austria*, no. 12875/87, 23 June 1993, para. 34.

³⁸⁴ Ibidem, para. 36.

³⁸⁵ US Supreme Court, *Church of the Lukumi Babalu Aye, Inc. and Ernesto Pichardo v. City of Hialeah*, 1993, 508 US 520.

³⁸⁶ US Supreme Court, *Sherbert v. Verner*, 1963, 374 US 398.

³⁸⁷ Ibidem, 508 US 531.

groups is ungrounded. Some scholars counter this argument stating that persons practise circumcision for non-religious reasons do not lose any religious liberty and that a *religious* exemption merely restores the religious freedom that was in place before a ban³⁸⁸. It is true that the non-religious performers of circumcision would not lose any of their *religious* liberty with a total ban on the circumcision of male children; however, they have lost their freedom to perform the circumcision. Secondly, this would require a religious motivation as a necessary element for a lawful circumcision. The question therefore arises as to how this would be controlled. It is useful to recall the opinion of the US Supreme Court that “[i]t is not within the judicial ken to question the centrality of particular beliefs or practices to a faith, or the validity of particular litigants’ interpretations of those creeds³⁸⁹.”

In the line with the requirement of neutral and general applicable law of the US Supreme Court, opponents to male circumcision proposed in 2010 in San Francisco a bill which aimed to criminalise all forms of non-therapeutic circumcision on males under the age of eighteen³⁹⁰. It clearly ruled out a religious exemption³⁹¹, which is in the light of the medical analysis a defensible decision. This proposal was removed from the ballot by a judicial order on the basis that the State of California already had a law regulating medical procedures, which prohibits the city of San Francisco from having an ordinance on a medical practice such as male circumcision³⁹².

In opposition to the reasoning of this proposal in San Francisco, the South African Children’s Act of 2005 attributes lawfulness to circumcisions of males under the age of sixteen for religious purposes, in accordance with the practices of the religion concerned³⁹³. However, this Act seems to confer too much freedom to the religious practices, as it does not mention requirements of training or experience of the circumcisers or the use of anaesthesia. Nevertheless, certain provinces in

³⁸⁸ Weil, 2012, p. 732.

³⁸⁹ US Supreme Court, *Employment Div., Ore. Dept. of Human Res. v. Smith*, 1990, 494 US 887.

³⁹⁰ See, Initiative Measure to Be Submitted Directly to the Voters: Genital Cutting of Male Minors (hereinafter: San Francisco Ballot Proposal).

³⁹¹ Article 5002 (b) of the San Francisco Ballot Proposal.

³⁹² Weil, 2012, p. 706.

³⁹³ Article 12, (8), (a)-(b) of the Children’s Act No. 38 of 2005, as amended by Children’s Amendment Act No. 41 of 2007 and Child Justice Act No. 75 of 2008 (hereinafter: Children’s Act of 2005).

South Africa have adopted further legislation on the performer, the place and the conditions of the circumcision as well as on age requirements and the consent of the person who receives the circumcision³⁹⁴.

The legislative solutions in Germany and Sweden seem to have found a better balance between the religious and health interests. The new Article 1631d of the *Bürgerliches Gesetzbuch* (the German Civil Code), which was adopted in December 2012, allows circumcisions within the first six months after birth by a religious circumciser under the same (health) conditions as other circumcisions of male children³⁹⁵. This religious circumciser is required to be specially trained and comparably qualified with a doctor³⁹⁶. However, the question is whether the reference in this article to the *lege artis* (*Regeln der ärztlichen Kunst*) includes for instance the use of anaesthetics. On the website of the Ministry of Justice, anaesthesia is listed as one of the requirements³⁹⁷.

The idea behind the Swedish law on male circumcision is comparable³⁹⁸. It stipulates that circumcision on male children may be performed only by a licensed doctor or on boys under the age of two months by a person certified by the National Board of Health and Welfare, in the presence of a licensed doctor or anaesthesiologist responsible for the administration of anaesthetics³⁹⁹. A person applying for a licence must establish that they have the knowledge and experience to perform circumcisions at a standard equivalent to a circumciser in the health service⁴⁰⁰. Moreover, this law states the circumcision cannot be performed against the will of the child⁴⁰¹. Consequently, under both legislations religious circumcisions are possible within medical settings. More importantly, both pieces of legislation do not allow religious circumcisions *carte blanche* as their conditions rule out *Type 3* and create boundaries for *Type 2*. Similar legislation seems to be in the pipeline in Norway⁴⁰².

In sum on the limits on freedom of religion, the ECtHR has allowed limitations to freedom of religion in several cases, of which those

³⁹⁴ Application of Health Standards in Traditional Circumcision Act 2001 of South Eastern Cape and Initiation School Health Act 2004 of Free State.

³⁹⁵ *Bürgerliches Gesetzbuch* (German Civil Code), Article 1631d, (1).

³⁹⁶ *Ibidem*.

³⁹⁷ Bundesministerium der Justiz, 2013, p. 1.

³⁹⁸ See, Lag (2001:499) om omskärelse (Law (2001: 499) on male circumcision).

³⁹⁹ *Ibidem*, para. 4.

⁴⁰⁰ *Ibidem*.

⁴⁰¹ *Ibidem*, para. 3.

⁴⁰² See, The Proposal of the Norwegian Ministry of Health, 2011.

necessary for the aim of public health and the rights and freedoms of others have particular relevance for the circumcision of male children. Under the CRC, there seem to be lawful motivations in accordance with the outlined interest in Article 14 (3) CRC to outlaw *Type 3*. With regard to *Type 2*, limits on freedom of religion could play a role as well, for example by imposing the performance of male circumcision under anaesthetics, by a well-trained, experienced provider, or by restricting the *metzitzah B'peh*. The examples of German and Swedish legislation on circumcision of male children seem to find a fair balance between religious and health interests.

3.5.4. Article 30 CRC: Religious Minorities' Rights to Religion

Given the fact that male circumcision is often practised by minorities in certain states, Article 30 CRC becomes relevant. The CRC Committee has clarified that the scope for limitations on the freedom of religion is narrow and that state parties should avoid measures that single out a particular religious group⁴⁰³.

In his 2012 Report, the Special Rapporteur on Freedom of Religion or Belief, Heiner Bielefeldt, named the obstacles against religious rituals or ceremonies a violation of Article 27 ICCPR, namely the rights of the persons belonging to religious minorities⁴⁰⁴. Hereby, he referred explicitly to the Cologne judgment. The Special Rapporteur seems to regard male circumcision as a ritual of religious socialisation of children, which is essential to their religious identities⁴⁰⁵. However, since the Report was published before the adoption of the new German legislation in Article 1631d, (1) *Bürgerliches Gesetzbuch* (German Civil Code)⁴⁰⁶, it is unclear whether the Special Rapporteur also considers this legislation as a violation.

The Opinion of the Advisory Committee on Framework Convention for the Protection of National Minorities regarding the above mentioned Swedish law on male circumcision⁴⁰⁷, which requires certain conditions to be fulfilled for a legal circumcision, can provide guidance⁴⁰⁸. The

⁴⁰³ CRC/C/15/Add.226, 26 February 2004, paras. 30-31.

⁴⁰⁴ A/HRC/22/51, 24 December 2012, para. 49.

⁴⁰⁵ Ibidem.

⁴⁰⁶ See, *supra*, Part 3.5.3.

⁴⁰⁷ See, *supra*, Part 3.5.2.

⁴⁰⁸ See, ACFC/INF/OP/I(2003)006, 25 August 2002.

Advisory Committee stated that this law affects the right of persons belonging to Jewish minorities to practise their religion, but it considered that the health conditions contained therein pursue a legitimate aim, namely the health of children, which appears proportionate in relation to this aim⁴⁰⁹. The importance of this Opinion is that it indicates that legislations imposing conditions on male circumcision can be proportionate. Moreover, the Advisory Committee encouraged in this Opinion the national authorities and persons belonging to a Jewish minority to engage in a dialogue to find pragmatic solutions for the implementation of this legislation⁴¹⁰.

In 2008, the Advisory Committee on the Framework Convention for the Protection of National Minorities was “informed by representatives of the Jewish community that the implementation of the new legislation in this sphere has been carried out in a satisfactory manner⁴¹¹.” This can be used to argue that limitations on the practice of male circumcision do not necessarily have to lead to outrages in religious communities.

3.5.5. Conclusion on the Freedom of Religion

In concluding on the freedom of religion, it is important to stress once more the multiple reservations and declarations that have been made by several state parties on this article of the CRC. These can be used to refute or to disregard the following conclusion, but only to the degree that they are not incompatible with the object and purpose of the CRC, as made clear in Article 51 (2) CRC.

Firstly, it seems, without much discussion, that male circumcision falls within the scope of freedom of religion. Secondly, it became clear that it is the child who should exercise this freedom of religion, whereby parents can provide direction, only if consistent with the evolving capacities of the child and in conformity with the Convention. Thirdly, the limits on freedom of religion in Article 14 (3) CRC seem not to oppose either a ban of *Type 3* or limits on *Type 2*, if the chosen options are proportionate with regard to the legitimate aims. It was shown how public health can serve as a legitimate aim in the light of the jurisprudence of the ECtHR and the CRC Committee. Moreover, the decision of the

⁴⁰⁹ ACFC/INF/OP/I(2003)006, 25 August 2002, para. 40.

⁴¹⁰ *Ibidem*.

⁴¹¹ ACFC/OP/II(2007)006, 8 November 2007, para. 83.

Advisory Committee of the Framework Convention for the Protection of National Minorities showed that laws restricting freedom of religion with regard to male circumcision can be proportionate to a legitimate aim, namely the health of children. The information received by this Advisory Committee also indicated that limitations on freedom of religion can be done in a manner that satisfies religious communities.

Consequently, freedom of religion does not create a trump card against restrictions on the circumcision of male children. Nevertheless, the best interests principle is another test for these allegedly possible limits on freedom of religion.

3.6. ARTICLE 3 (1) CRC: BEST INTERESTS PRINCIPLE

In several earlier articles it was stated that the relevant article should be read together with Article 3 CRC on the best interests of the child. Consequently, it is positive evolution that pieces of legislation on the circumcision of male children refer explicitly or implicitly to the best interests of the child in accordance with Article 3 CRC, which requires that “[i]n all actions concerning children [...] the best interests of the child shall be a primary consideration⁴¹².” For example, Article 9 of the South African Children’s Act of 2005 seems to imply that the child’s best interests should be applied in the decision on male circumcision. The current German legislation on male circumcision takes “the best interests of the child” into account in relation to religious circumcisions⁴¹³.

Notwithstanding a certain vagueness in the concept “best interests of the child,” the absence of the consideration of the best interests of the child violates Article 3 CRC. For instance, the adoption of an amendment of the New York City Health Code in 2012, established after the above mentioned research on the relationship between *metzitzah B’peh* and the transmission of the herpes simplex virus infection⁴¹⁴, is lacking this reference. The amendment only requires written consent of parents who still want to perform this part of the rite on their children⁴¹⁵. Although

⁴¹² Article 3 CRC.

⁴¹³ CCPR/C/DEU/Q/6/Add.1, 12 October 2012, para. 86; Article 1631d, (1) Bürgerliches Gesetzbuch (German Civil Code).

⁴¹⁴ See, *supra*, Part 2.2.2.1 on the negative effects of the circumcision of male children.

⁴¹⁵ Article 181.21, “Consent for direct oral suction as part of a circumcision”, of the New York City Health Code.

the medical foundation of this regulation is similar to the approach in this thesis, the outcome cannot be supported, because the rights of the child, especially the right to be heard or the best interests' principle do not form part of this legislation. Unfortunately, the medical foundation here is merely coupled with stricter consent requirements for the parents and not to an evaluation of interests of the person undergoing the practice. Clearly, the best interests of the child are not the primary concern in this half-hearted rule, as political interests seem to dominate the views. Moreover, the controversy suggests once more that a solely legislative solution is not always a recipe for success.

Notwithstanding its importance and the references in national legislations, it was already mentioned that Article 3 CRC still contains a certain vagueness. Therefore, it is used as an argument for and against circumcision. Opponents of circumcision of male children put an emphasis on the physical interests of the child while arguing that it constitutes a harmful traditional practice. Proponents put the emphasis on inclusion within the religious, cultural or social environment or argue that the known health benefits of neonatal circumcision outweigh any risks associated with the procedure.

Consequently, both sides agree that the circumcision of male children *should* be in the best interests of the child; however the discussion remains whether it always *is*. It is not an easy question to answer since, even on a theoretical level, there is discussion on what is in the best interests of the child, especially when cultural, religious and familial reasons are considered. In order to find the answer to this question, the meaning of best interests has to be examined, as well as its interpretation in different legal systems.

The concept of the child's best interests is not an invention of the drafters of the CRC. It was already mentioned in the 1959 Declaration of the Rights of the Child⁴¹⁶, the Convention on the Elimination of All Forms of Discrimination against Women⁴¹⁷, and was even adopted in several pieces of national legislations before the CRC. However, the Working Group drafting the CRC did not discuss any further definition of "best interests"⁴¹⁸.

⁴¹⁶ Declaration of the Rights of the Child, para. 2.

⁴¹⁷ Articles 5 (b) and 16 (1) (D) of the Convention on the Elimination of All Forms of Discrimination against Women.

⁴¹⁸ Hodgkin & Newell, 2007, p. 37.

General Comment No. 14 of the CRC Committee on “the right of the child to have his or her best interests taken as a primary consideration” of 29 May 2013 provides some additional guidance on how to interpret this somewhat vague principle. The CRC Committee made clear that the child’s best interests refer to “the holistic physical, psychological, moral and spiritual integrity of the child and [...] his or her human dignity⁴¹⁹.” Consequently, the best interests of the child should not be limited to a mere physical interpretation. Although, the reference to the best interests of the child by the *Landgericht Köln* should be welcomed, its interpretation as the best *medical* interest is to be regarded as being too narrow⁴²⁰. Even if the principle would be narrowed down to this interpretation, the question remains whether male circumcision is in fact in the best *medical* interest since the medical debate is still on-going.

Moreover, it should not be forgotten that Article 3 CRC applies to a child as an individual, as well as to children in a particular group which can also lead to different interpretations of the principle⁴²¹. Consequently, for collective decisions, such as a general assessment of male circumcision as a human rights violation, the best interests “must be assessed and determined in light of the specific circumstances of the particular group and/or children in general⁴²².” These specific circumstances include, *inter alia*, “age, sex, level of maturity, experience, belonging to a minority group, having a physical, sensory or intellectual disability, as well as the social and cultural context [...]”⁴²³. Consequently, this obligation and the listed specific circumstances of the CRC Committee supports or even necessitates the division into more specific types of male circumcision on children, as all “children in general” from America, over Europe and Africa to Australia can hardly be considered as “a particular group.” The proposed types following the medical analysis in Chapter 2 also seem to be too broad as a *particular* group of children; that is why they will be further differentiated later on.

The assessment of a particular group of children should also be done by balancing carefully and case-by-case the interests of all parties: *in casu* the child, the parents and the community⁴²⁴. The CRC Committee

⁴¹⁹ CRC/C/GC/14, 17 April 2013, para. 5.

⁴²⁰ Landgericht Köln, 151 Ns 169/11, 7 May 2012, paras. 11 and 14.

⁴²¹ CRC/C/GC/14, 17 April 2013, para. 23.

⁴²² Ibidem, paras. 32 and 48.

⁴²³ Ibidem, para. 48.

⁴²⁴ Ibidem, para. 39.

suggests that if no harmonisation of all these interests is possible, an analysis and weighing of the rights of all those concerned should be done, whereby the best interests of the child should be a primary consideration with high priority and not just one of several considerations⁴²⁵.

General Comment No. 14 also provides guidance as how to assess and determine the best interests of the child, as it draws up a non-exhaustive and non-hierarchical list of elements that could be included in a best-interests assessment⁴²⁶. These elements will now be considered for each of the types, except for the “situation of vulnerability” and “the child’s right to education” as they seem less relevant for male circumcision.

3.6.1. General Comment No. 14: Elements to Be Taken into Account When Assessing the Child’s Best Interests

With regard to the first element, the “child’s views,” the above discussed Article 12 CRC provides for the right of children to express their views in every decision that affects them. On the one hand, this means that in the decision-making process relating to the circumcision the child’s views have to be taken into account, whilst giving their views due weight according to their age and maturity. On the other hand, it could lead to the remarks with regard to this thesis that it has a deficit as it does not include empirical research on the views of the child.

The second element is the “child’s identity.” The CRC Committee stresses the desirability of continuity with regard to a child’s upbringing and to the child’s ethnic, religious, cultural and linguistic background⁴²⁷, which could be interpreted as taking into account the effects that the establishment of male circumcision would have in certain communities. This seems to lead to a form of cultural relativism, whereby male circumcision would be allowed, because a denial of the practice, particularly in *Type 3* could lead to a certain form of exclusion of the child by the community.

However, the CRC Committee adds that “[a]lthough preservation of religious and cultural values and traditions as part of the identity of the child must be taken into consideration, practices that are inconsistent or incompatible with the rights established in the Convention are not

⁴²⁵ CRC/C/GC/14, 17 April 2013, para. 39.

⁴²⁶ Ibidem, para. 50.

⁴²⁷ Ibidem, para. 56.

in the child's best interests" and "[c]ultural identity cannot excuse or justify the perpetuation by decision-makers and authorities of traditions and cultural values that deny the child or children the rights guaranteed by the Convention⁴²⁸." Hereby, the CRC Committee outlaws several cultural relativist arguments against some rights of the Convention, an approach which is supported by several other international human rights documents. Consequently, given the effects that *Type 3* has on Article 24 CRC it cannot be seen as in the best interests of the child.

The CRC Committee develops under "preservation of the family environment and maintaining relations" a third element, again in a rather different context than one suitable for an evaluation of male circumcision, namely the separation of children from the family unit. Nevertheless, the same interpretation as above seems possible. The denial of male circumcision could endanger the family unit in some areas, but it cannot lead to an interpretation of the best interests principle *contra* the other rights in the Convention.

The fourth element is the "care, protection and safety of the child." The CRC Committee makes clear that protection and care are not limited to only protection from harm, but include a more comprehensive idea of ensuring the child's well-being, including material, physical and emotional needs and development⁴²⁹. This underlines once more that the best interests principle cannot be equated with physical interest.

The fifth element is the "child's right to health." The CRC Committee states that the child's right to health and his or her health condition are central in assessing the child's best interests⁴³⁰, which supports the conclusion under the previous elements to not interpret the best interests against Article 24 (1) CRC. Consequently, it illustrates again the difficulties that follow out of the compelling conceptions of health, especially for *Type 2* in an African context for the prevention of HIV.

In weighing these various elements, the purpose of assessing and determining the best interests of the child is to ensure the full and effective enjoyment of the rights⁴³¹. Moreover, the CRC Committee stated once more that the capacities of the child will evolve and that therefore revisable and adjustable measures are preferred over definitive

⁴²⁸ CRC/C/GC/14, 17 April 2013, para. 57.

⁴²⁹ Ibidem, para. 71.

⁴³⁰ Ibidem, para. 77.

⁴³¹ Ibidem, para. 82.

and irreversible decisions⁴³². This could be interpreted as being in favour of postponing the neonatal circumcision of male children, as it is definitive, to a later date.

Concerning the procedural safeguard of the child's best interests, the CRC Committee states that "any decision concerning the child or children must be motivated, justified and explained," which should include all the factual circumstances regarding the child, all relevant elements, the content of these elements in the individual case, and how they have been weighted to determine the child's best interests⁴³³. This requirement is relevant for "public authorities and organizations"⁴³⁴, but also for "all persons who are in a position to assess and determine the child's best interests"⁴³⁵. Consequently, this also applies to parents while deciding on the circumcision of their child.

Besides this general guidance of the CRC Committee on the rights of the child, further direction on the best interests principle could be given by judgments made in comparable situations in several different jurisdictions, although the focus remains on the CRC and these jurisdictions do not give an authentic interpretation of the Convention.

3.6.2. Interpretation of the Best Interests Principle in Different Jurisdictions

In common law countries, the limit to parental consent is formed by the *parens patriae* doctrine, *i.e.* parents are legally required to act in the best interests of their children and if parents do not follow this obligation, state action is triggered⁴³⁶. This principle is even upheld in cases where the potential benefit to a close relative exceeds the risk to the child or in situations where one might reasonably assume many competent patients would consent⁴³⁷. For instance, there are American cases where courts have stopped parents, who gave consent on the behalf of the child to donate a kidney to a sibling⁴³⁸ or to a test to determine bone marrow

⁴³² CRC/C/GC/14, 17 April 2013, para. 84.

⁴³³ Ibidem, para. 97.

⁴³⁴ Ibidem, para. 86.

⁴³⁵ Ibidem, para. 97.

⁴³⁶ Svoboda, Van Hove & Dwyer, 2000, p. 84.

⁴³⁷ Ibidem, p. 89.

⁴³⁸ Court of Civil Appeals of Texas, *Little v. Little*, 576 S.W.2d 493-495, 7 February 1979; Court of Appeal of Louisiana, *In re Richardson*, 284 So. 2d 185-187, 6 November 1973.

compatibility.⁴³⁹ The English Court of Appeal even refused to allow parents of a Siamese twin to separate the two girls in a situation where one severely brain-damaged twin was almost sure to die as a result of the separation, but where in the absence of the procedure both would almost certainly lose their lives within a few years⁴⁴⁰. The Court came to this decision because the separation was not in the best interests of the brain-damaged child⁴⁴¹.

Courts in the United States tend to avoid any confrontation with the legal issues around neonatal male circumcision, probably given the high prevalence of it in the United States⁴⁴². However, there are cases where Courts had to decide on deficient parental consent. In *Schmidt vs. Niznik*⁴⁴³, a custodial mother, who remarried to a Jewish man, wanted to circumcise her nine-year-old son for medical reasons and to accommodate the wishes of her new spouse. The father of the child objected to the circumcision. The Court enjoined the circumcision until the child would reach the age of eighteen and could choose for himself, because it ruled that the evidence for a medical intervention was too small and declined to rule on the religious issue⁴⁴⁴.

In the United Kingdom, there are several cases on male circumcision. Firstly, in *R v. Brown* Lord Templeman stated that male circumcision is a lawful activity, because of the consent made on behalf of the person, thus placing this operation on the same level as tattooing, ear-piercing and boxing⁴⁴⁵. However, given the date of this judgment and the fact that this statement was *obiter dicta* in a case on consensual sado-masochistic sex⁴⁴⁶, this line of reasoning could be disregarded by a subsequent judgment on male circumcision.

Secondly, in 1999 a United Kingdom family court made clear in *Re J* that circumcision “should only be carried out where the parents together approve it or in absence of this agreement, where a court

⁴³⁹ Supreme Court of Illinois, *Curran v. Bosze*, 566 N.E.2d 1325-31, 20 December 1990.

⁴⁴⁰ Court of Appeal, Civil Division, *Re A* (Children) (Conjoined Twins: Medical Treatment), 22 September 2000, paras. 1.7 and 11.8.

⁴⁴¹ *Ibidem*, paras. 111.3 and 111.5.

⁴⁴² Svoboda, Van Hove & Dwyer, 2000, p. 92.

⁴⁴³ Circuit Court of Cook County, Illinois Country Departement, Domestic Relations Division, *Schmidt vs. Niznik*, No. 00 D 18272, 2006.

⁴⁴⁴ *Ibidem*.

⁴⁴⁵ United Kingdom House of Lords, *R v. Brown*, 2 All ER 75, 11 March 1993, para. 2.

⁴⁴⁶ *Ibidem*.

decides that the operation is in the best interests of the child⁴⁴⁷.” It concluded that an order for the circumcision of a five-year-old boy for religious reasons would not be granted, as circumcision was not in the best interests of the child after considering three key factors: the boy was not likely to be brought up in the Muslim religion, he was not likely to have a degree of involvement with Muslims to justify circumcision for social reasons and the risks outweighed the benefits⁴⁴⁸. In another case with similar facts, *Re S*, the Court followed the same approach. It refused to allow a Muslim woman who had separated from her husband to convert and circumcise their son against the will of her ex-husband⁴⁴⁹. In this judgment Baron J held that the child should be allowed to decide for himself which religion, if any, he wished to follow when he was old enough to do so and that it would not be in the boy’s best interests to be circumcised⁴⁵⁰.

Two side notes should be made regarding these last two judgments. Firstly, they deal with cases where one of the parents was opposed to circumcision and they do not consider a circumcision where both parents consent. Consequently, these judgments seem to assume that the socio-religious benefits where a child is brought up in a Muslim or Jewish environment would be sufficient to outweigh the medical risks⁴⁵¹. Secondly, the decisions in these judgments were never legislatively enshrined putting the lawfulness of the circumcision of male children beyond doubt.

3.6.3. *Best Interests of the Child in Other Operations*

Given the remaining vagueness, a comparison with other operations can be useful as means of providing guidance on the best interests principle, especially with other operations where preventive interventions on children are justified.

The best known and most accepted form of preventive intervention is routine immunisation. Immunisations are widely accepted given

⁴⁴⁷ Court of Appeal, Civil Division, *Re J (A Minor)* (Prohibited Steps Order: Circumcision), 25 November 1999, para. 32.

⁴⁴⁸ *Ibidem*, para. 11.

⁴⁴⁹ High Court of Justice, Family Division, *Re S* (Specific Issue Order: Religion: Circumcision), 30 March 2004.

⁴⁵⁰ *Ibidem*.

⁴⁵¹ Fox & Thomson, 2005a, p. 166.

their effectiveness and for being the least invasive means to prevent the contraction and transmission of highly contagious diseases⁴⁵². The individual risk for the patient with immunisations is extremely small, whilst the benefits are more readily apparent when compared with male circumcision. As mentioned before, the diseases that male circumcision prevents usually occur several years later when the person becomes sexually active and as such are dependent on future lifestyle choices.

Furthermore, cosmetic surgery is another comparable operation. There seems to be an acceptance for cosmetic procedure corrections on children only when intended for the correction of clinically verifiable disease, deformity, or injury, such as hare-lip, clubfoot, or any unequivocal congenital or trauma-related defect⁴⁵³. These interventions are found in the best interests of the child, as they avoid, for example, the child being bullied in school. However, this largely reflects the fears of the parents without knowing how the child feels about, for instance, his or her ears or if the child will be bullied⁴⁵⁴.

On the other side of the spectrum, a third operation, although it is contested and controversial as being comparable with circumcision, is mastectomy. There is a growing number of females undergoing mastectomies, when they are categorised as having a high-risk of getting breast cancer. Although only performed on female adults, some argue that this operation could be in the future carried out on young girls, when genetic screening points in the direction of being at high-risk⁴⁵⁵. Nevertheless, it is argued that the chance of getting breast cancer would need to be one to one to justify this operation with parental consent⁴⁵⁶.

3.6.4. *Conclusion on the Best Interests of the Child*

The examination of Article 3 CRC provides more clarity in the human rights analysis of circumcision of male children. It became clear that this best interests principle should not be restricted to the best *physical* interest of the child. Consequently, the principle should be interpreted in the social and cultural context in which the child or

⁴⁵² Hodges. Svoboda & Van Hove, 2002, p. 12.

⁴⁵³ Ibidem.

⁴⁵⁴ Ibidem, p. 13.

⁴⁵⁵ Ibidem, p. 11.

⁴⁵⁶ Ibidem.

group of children live. However, the CRC Committee made very clear that practices inconsistent or incompatible with the rights of the CRC are not in the best interests of the child and that cultural identity cannot excuse or justify the denial of the rights of the CRC⁴⁵⁷, which removes several cultural relativist justifications for *Type 3*.

Some case law on the best interests revealed a rather strict interpretation of the concept in medical cases in general, as well as in the case of male circumcision specifically, where one parent was opposed to the procedure and the other parent wished to undertake it. The comparison with other operations pointed mainly to the general acceptance worldwide of immunisations of children as being a measure justified by public health interests, which again draws the attention to these interests for male circumcision.

Furthermore, it should not be forgotten that the best interests of the child are only “*a primary consideration*,” especially as the Working Group drafting the Convention rejected proposals calling for it to be “*the primary consideration*” or “*the paramount consideration*”⁴⁵⁸. This interpretation was confirmed by the CRC Committee, by acknowledging that the best interests of the child can conflict with other interests and rights, which all have to be carefully balanced to find a suitable compromise⁴⁵⁹.

With regard to *Type 2*, the competing interests are obvious, *in casu* between children and adults; but also between individual and public health concerns. It should be clear that the relationship between male circumcision and HIV prevention is a considerable factor in the debate on male circumcision. Moreover, the CRC Committee stressed that the best interests of the child should also be analysed with regard to the long term effects⁴⁶⁰, which seems to favour the inclusion of the interests of children in adolescence, who might be sexually active. Further conclusions of the application of the best interests principle to the circumcision of male children will be outlined in the next Part, the conclusion of the legal analysis, since the best interests principle functions as an overarching concluding piece.

⁴⁵⁷ CRC/C/GC/14, 17 April 2013, para. 57.

⁴⁵⁸ E/CN.4/L.1575, 17 February 1981, para. 30.

⁴⁵⁹ CRC/C/GC/14, 17 April 2013, para. 39.

⁴⁶⁰ *Ibidem*, paras. 16 (c) and 84.

3.7. CONCLUSION OF THE CONVENTION ON THE RIGHTS OF THE CHILD

Primarily, it should be stressed once more that this conclusion is based on the CRC but of course this analysis could also be made on the basis of other texts. The examination of Article 12 CRC revealed that it seems better to replace the arbitrary imposed age requirements in laws regulating the circumcision of male children⁴⁶¹ by reference to the evolving capacities of the child and by placing an increasing importance on the right of each child to be heard.

In the analysis of the articles under *personal integrity*, the three types became useful to differentiate between the various practices. *Type 1* is relatively unproblematic, and even required under Article 24 (1) CRC, although a constant evolution of the risks and benefits should be made, and the views of the child should be given weight in accordance with their age and maturity. *Type 3* is highly problematic under Articles 19, 24 (1), 24 (3) and 37 (a) CRC, especially given the lack of anaesthetics, the performance by medically untrained circumcisers or a clinical setting.

The analysis of *Type 2* is less clear under these articles. Although the applicability of some articles under *personal integrity* could be defended, the lack of a medical consensus on *Type 2* prevents a clear judgment. In comparison with *Type 3*, the different level of harm, caused by the presence or absence of the indicated complication determinants, is at the basis of this different conclusion⁴⁶². It becomes clear that the medically established boundaries of *Type 2* are essential in the avoidance of violations of several articles. Consequently, proponents of circumcision of male children should respect the medical requirements of *Type 2*, if they use health benefits to support their position. Moreover, the reference to pieces of national legislation, which allow circumcisions to be carried out by experienced and trained circumcisers with the use of anaesthesia, meet the criteria of *Type 2*. Therefore, they more or less create clear boundaries for this type. In addition, it became clear that the presence of consent of the child is a crucial factor in evaluating the body intervention in *Type 2*, especially in the light of the autonomy to decide on alterations of the own body⁴⁶³.

⁴⁶¹ See, *infra*, Part 3.2.

⁴⁶² Van den Brink & Tigchelaar, 2012, p. 443.

⁴⁶³ Ibidem.

The examination of freedom of religion revealed mainly that it is the child who should exercise this freedom. Parents can provide direction but only if it is consistent with the evolving capacities of the child and in conformity with the Convention. Furthermore, the limits on freedom of religion, under Article 14 (3) CRC in combination with Article 3 CRC, prevent that freedom of religion can act as a trump card in the debate. Moreover, it was shown how public health or the rights and freedoms of others can be invoked as legitimate aims with regard to restrictions on circumcisions of *Type 2*. Hereby the Opinion of the Advisory Committee of the Framework Convention for the Protection of National Minorities, with regard to the Swedish law on circumcision of male children indicates that this can be done in a proportionate manner.

The best interests principle seems to make it necessary to differentiate further within *Type 2*, namely between countries with and countries without a high risk of heterosexual HIV transmission. This extra distinction is justified by the high prevalence of HIV in some regions which requires the consideration of new measures. These health measures can even be merely *preventive* given Article 24 (2) (f) CRC. Moreover, interests of public health can receive a large weight in the balancing exercise with the best interests of the child. However, this can be a temporary distinction as these differences in HIV prevalence may disappear.

Three additional remarks should be made with regard to the choice of the wording “countries with a high risk of heterosexual HIV transmission.” Firstly, reference is made to “high risk of heterosexual transmission of HIV” and not to “countries with a high HIV prevalence,” since it is possible to imagine countries with a high HIV prevalence, but where the disease is not spread by heterosexual transmission and thus where male circumcision does not have the same effect. Secondly, the “high” should be interpreted and determined from a medical point of view, as this allows the best analysis of the need of the circumcision of male children. Thirdly, “countries” is used; however it is possible to choose a different scope or group of children, for instance all the children in a certain region.

Consequently, the author comes to a differentiated conclusion with regard to *Type 2*. On the one hand, in countries with a high risk of heterosexual HIV transmission, the best interests principle, interpreted from the perspective of the children in that society, and in combination

with its status as *a* primary consideration which allows public health interests to come into play, seems not to oppose to the circumcision of that specific group of male children. This conclusion is based on evidence that male circumcision reduces the risk of heterosexually acquired HIV infection for men, whilst assuming that these circumcisions fall within *Type 2*. Moreover, also here the consent of the children in accordance with their age and maturity be taken into account.

On the other hand, in countries with a low risk of heterosexual HIV transmission, the conclusion is less straightforward. Here, although medically the effects are the same, the mere *preventive* status of some positive effects becomes more apparent, as in these regions the benefits are less significant. Hereby the doubtful status of *Type 2* with regard to the rights constituting *personal integrity* and the strict interpretation in case law of the best interests principle gains weight. Therefore, at least, the consent of the child becomes central, which requires even more attention to be given to the views of the child in accordance with their age and maturity.

CONCLUSION

Hopefully, this thesis has had a commensurate effect with what one might expect from an explanation of Pollock's painting, namely that the issues at stake become more clearly apparent. Notwithstanding this attempt at clarification, some aspects remain unclear and the current lack of medical consensus calls for more (unbiased) medical studies to be conducted. Besides the shortcomings in the field of medical studies on male circumcision, this thesis sometimes faced its own flaws, as the non-inclusion of the views of children and its susceptibility to changing medical views. Consequently, these shortcomings act as the recommendations for further research, namely on the medical and psychological effects of male circumcision in the short and long term, as well as studies on the views of the child on male circumcision.

Throughout this thesis it became clear that the Cologne judgment cannot be viewed simply as a curiosity as other judgments have dealt with circumcision of male children. Moreover, there have been more and more attempts to show how the practice violates the current human rights framework and to create legislation limiting or outlawing the practice. To see whether these accusations and attempts are justified this thesis followed a two-step analysis.

This two-step analysis revealed a reciprocal relation between the medical and legal analysis. On the one hand, the differentiated legal analysis was based on the results of the medical analysis. On the other hand, the legal analysis confirmed these results, as the boundaries in typology were substantiated by the legal analysis, in that they often coincided with the line between acceptable and non-acceptable.

The medical analysis led to the conclusion of three types of male circumcision, which clearly depends on the currently available medical evidence from which a common denominator was taken. The typology

forms a triptych, whereby therapeutic circumcisions constitute *Type 1*; circumcisions in clinical or comparable settings, by medically well-trained and experienced persons, with the use of anaesthesia *Type 2*; and, circumcisions lacking either a medically trained or well-experienced circumciser, clinical conditions or the use of anaesthesia *Type 3*.

In the legal analysis of circumcision of male children, it became clear that it is difficult under the CRC to uphold the view that any person can circumcise a male child, in any setting, with any available tool, with or without anaesthesia, for any reason. The typology, resulting from the medical analysis, became useful in undertaking the necessarily differentiated approach in several articles. The absence of a separate “religious type,” motivated by the similar consequences of circumcisions chosen for religious or preventive health reasons, if performed under the same conditions, survived the legal analysis. Moreover, it was shown that the limits on freedom of religion can be used to outlaw *Type 3* and to limit *Type 2* under the CRC in a proportionate relationship with the legitimate aims of public health and the rights and freedoms of others.

Type 1 cannot be regarded as a violation of the rights of the child, as it is necessary for the health of the child. With regard to *Type 3*, cultural relativist arguments cannot justify these practices nor prevent its qualification as violence against children, cruel and degrading treatment and a traditional harmful practice, especially given the lack of either a medically trained or well-experienced circumcisers, a clinical setting or the use of anaesthesia.

Although the applicability of some articles under *personal integrity* could be argued for *Type 2*, the lack of a medical consensus on *Type 2* seems to require at least more studies on the short- and long-term effects of this type. At the moment, in the light of the current medical evidence, an apparent different level of harm in comparison with *Type 3* leads to this different conclusion. As the boundaries of *Type 2* seem to be essential in the exclusion of the applicability of several articles, proponents of circumcision of male children should apply a medically founded perspective on male circumcision, if they wish to use the health benefits in favour of their position.

The author came to a differentiated legal analysis of *Type 2*. On the one hand, in countries with a high risk of heterosexual HIV transmission, the circumcision of male children, based on evidence that male circumcision reduces the risk of heterosexually-acquired HIV infection for men, does not violate the best interests principle. Nevertheless, also

with these circumcisions the views of the child should be taken into account, in accordance with their age and maturity.

On the other hand, in countries without a high risk of heterosexual HIV transmission, the conclusion is less straightforward. Although medically the effects are the same, the mere *preventive* status of some positive effects becomes more apparent. Consequently, the strict interpretation in case law of the best interests principle and the consent of the child gain even more weight.

Clearly, the position against *Type 3*, but not opposing of *Type 2* in countries with a high risk of heterosexual HIV transmission, and without a clear answer for *Type 2* elsewhere does not create a unanimous global policy. Nevertheless, it seems to fit better into a human rights frame than current approaches, which are too often a blunt attack or a blind defence of “male circumcision.” The examination of the typology in the legal analysis revealed that the different meanings of “male circumcision” are too diverse to put them under *one* concept; consequently, one has to examine the use of *circumcision*, i.e. its meaning, and on this ground determine whether it is a human rights violation or not.

The small legislative steps in for instance South Africa, Sweden and Germany towards the exclusion of *Type 3* should at least be adopted by international organisations, including WHO and UNICEF as well as the Committee on the Rights of the Child. The CRC Committee should in its upcoming Sessions or relevant General Comments, condemn practices falling under *Type 3* and take a stance on *Type 2*.

At the moment, awaiting further medical research, it is hard to make recommendations on the position with regard to *Type 2* in countries with a low risk of heterosexual HIV transmission. Therefore, the author invites the reader to make, as with the painting by Pollock, his or her own interpretation of *Type 2* in countries without a high risk of heterosexual HIV transmission, bearing in mind a strict interpretation of the best interests of the child and giving weight to the views and consent of the child in accordance to their age and maturity. Nevertheless, it should be clear that in the decision-making process on *Type 2* the best interests of the child should be a paramount consideration, which cannot be neglected as it is still too often the case, for instance out of political motives such as electoral gain. Moreover, ideological, cultural and religious concerns can provide guidance in the interpretation of the best interests of the child; however, they are not goals which can be achieved through the child.

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