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

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Abstract This paper proposes in its first part three distinct types of male circumcision out of a medical analysis of the practice. In the second part, these three types are examined with regard to the Convention on the Rights of the Child. It will be shown that in *Type 1*, the therapeutic circumcisions of male children necessary out of a medical indication are obviously not a violation of the rights of the child. Whereas a human rights violation is clearly 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 conclusion for *Type* 2, the circumcisions where all these conditions are present, is less straightforward, although it is clear that personal integrity, the right to be heard, and the best interests of the child are at the centre of this discussion.

Introduction

In May 2012 the *Landgericht* in Cologne delivered a judgment on the circumcision of a male child and stirred up the ongoing debate on this practice. In this case, a Muslim circumciser performed a circumcision on a four-year-old boy, using a scalpel whilst the boy was under local anaesthesia. The procedure was conducted without a medical indication, but after the request out of religious motives by the Muslim parents. Despite the circumcision being performed *lege artis*, complications occurred and the child started bleeding heavily.[1]

The *Landgericht* came to the conclusion that male circumcision, if not medically necessary, is punishable as a criminal offence according to Section 223 of the German Penal Code, which lists the causing of bodily harm as a criminal offence. The Court held that the parents' consent cannot justify the bodily harm and that 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. The Court did not consider the health benefits of male circumcision, instead choosing to focus their decision-making on the religious rationale for continuing the practice on children, while interpreting the best interests of the child as the best *psychical* interests of the child.

The focus of this paper is broader as it attempts to examine circumcision of male children in general and not just solely on the Cologne judgment. This paper will not discuss in detail the history, the motives, or all of the medical effects of male circumcision, as these considerations will be more fully addressed by other contributions. Nevertheless, some key aspects of the medical analysis will be highlighted and will serve as a basis for the legal examination of circumcision of male children in the light of the UN Convention on the Rights of the Child (hereinafter: CRC). This two-step approach, starting from the medical analysis, does not propose a premature legal conclusion; however, it should be noted that a medical consensus would be beneficial for the legal examination.

[1] Landgericht Köln, 151 Ns 169/11, 7 May 2012, par. 4.

Medical Analysis

There is a lack of scientific and medical consensus on the subject of male circumcision,[2] however, some aspects, which appear to be established, are highlighted below.

Without neglecting other studies, which indicate possible positive effects on male circumcision, studies suggesting that there is a 51-61% reduced risk for circumcised men becoming infected with HIV during heterosexual intercourse[3] underpin one of the most prominent arguments in favour of male circumcision. It should be noted that the context of these trials is important in that they were conducted in countries where the HIV virus is highly prevalent, where the rate at which male circumcisions occur is low and where penile-vaginal intercourse is the predominant mode of HIV transmission.[4]

Given that the prevalence of HIV, the percentage of HIV infections through heterosexual contact, the rate of male circumcision, and that the ages of sexual debut are different for each country, it is difficult to transplant these results to other countries.[5] These rates also indicate that male circumcision does not provide complete protection against HIV infection and that sexual activity should 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 risk of infection can be exacerbated in cases where the circumcision wound of the man has not properly healed.[6] It has also been found that circumcision has no protective effects for men who have sex with men.[7] Notwithstanding these contextual remarks as well as the opposition[8] against these studies on male circumcision and HIV prevention, the World Health Organisation (hereinafter: WHO) and UNAIDS are promoting voluntary medical male circumcision

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2 See, inter alia, on the one hand, American Academy of Pediatrics (AAP), Technical Report: Male Circumcision, *Pediatrics*, 130 (2012) 2, 755 – 786; on the other hand, Morten Frisch et al., Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision, *Pediatrics* 131 (2013) 4, 796 - 800 and Steven Svoboda/Robert Van Howe, Out of step: fatal flaws in the latest AAP policy report on neonatal circumcision, Journal of Medical Ethics, 39 (2013) 7, 434 – 441.

3 Bertran Auvert, et al., Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial, PLoSMedice, 11 (2005), 298-299; Ronald Gray, et al., Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomised trial, *Lancet*, 369 (2007), 657-666; Robert Bailey, et al., Male circumcision for HIV prevention in young men in Kyushu, Kenya: a randomised controlled trial, *Lancet*, 369 (2007), 643-656.

4 Marie Fox/Michael Thomson, HIV/AIDS and circumcision: Lost in translation, *Journal of Medical Ethics*, 36 (2010), 799.

5 Morten Frisch et al., Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision, *Pediatrics* 131 (2013) 4, 798.

6 Maria Wawer, et al., Circumcision in HIV-infected men and its effect on HIV transmission to female partners in Rakai, Uganda: A randomised controlled trial, *Lancet*, 374 (2009), 229-237.

7 Gregorio Millett, et al., Circumcision Status and Risk of HIV and Sexually Transmitted Infections Among Men Who Have Sex With Men, *Journal of American Medical Association*, 300 (2008) 14, 674-1684; Jorge Sánchez, et al., Male circumcision and risk of HIV acquisition among MSM, *AIDS*, 25 (2011) 4, 519-523.

8 Gregory Boyle/George Hill, Sub-Saharan African randomised clinical trials into male circumcision and HIV transmission: methodological, ethical and legal concerns, *Journal of Law and Medicine*, 19 (2011), 316–334; Morten Frisch et al., Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision, *Pediatrics* 131 (2013) 4, 798.

on the basis of these studies.[9] Subsequently, a study of nine priority countries found that an average of 26.9% of circumcisions between 2010 and 2012 were performed on children below 15 years old.[10] WHO/UNAIDS also advised a new list of priority countries to roll out the routine offering of medical circumcision for newborn males.[11] Studies on the effects of the policies in these countries are yet to be published. Besides the positive effects of male circumcision, especially its relationship with HIV prevention, another important element coming out of the medical analysis are the complication rates occurring with male circumcision. It is possible to identify several determining factors which have a major impact on the proportion of complications, namely age,[12] the training of the circumciser,[13] and the setting[14]. Another established negative effect of all forms of male circumcision is that it causes pain[15] and that as a consequence the use of anaesthesia is recommended, particularly by the WHO.[16] These factors can be used to identify several types of male circumcision and the author thus introduces three types to differentiate between all forms of male circumcisions, based on its established medical aspects.

Firstly, therapeutic circumcision, or circumcision required as a result of disease or physical pathological conditions that necessitate the penis to be circumcised as a cure, constitutes *Type 1*. Secondly, circumcision under anaesthesia in clinical or comparable settings conducted by medically trained or well-experienced circumcisers is defined as *Type 2*. Circumcisions performed in hospitals as a result of perceived health benefits or as a common practice, as well as some religious circumcisions fall under *Type 2*. Thirdly, circumcisions which lack either a medically trained or well-experienced circumciser to the level of a medical practitioner, clinical conditions, or the use of anaesthesia constitute *Type 3*. This is the residual category comprising all circumcisions missing one of the constituting elements of *Type 2*. The negative effects with *Type 3* are more pronounced and are illustrated for example by the death of 20 boys in May 2013 from the consequences of traditional male circumcision in South Africa.[17]

This typology should preferably be criticized on a medical basis, meaning that it is meant to act as a trigger for a medical differentiation between all practises which are now globally understood as “male circumcision”. No difference is made between

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9 WHO/UNAIDS, Technical Consultation on Male Circumcision and HIV Prevention: Research Implications for Policy and Programming, 2007, 7- 9.

10 Centers for Disease Control and Prevention, Voluntary Medical Male Circumcision – Southern and Eastern Africa, 62 (2013) 47, 956.

11 UNAIDS, Global report: UNAIDS report on the global AIDS epidemic, 2013, p. 18.

12 WHO/UNAIDS (2010), 46; R. Subramaniam/A. Jacobsen, Sutureless circumcision: A prospective randomised controlled study, *Pediatric Surgery International*, 20 *(*2004), 783-785.

13 WHO/UNAIDS (2010), 46; Kemal Atikeler, M., et al., Complications of circumcision performed within and outside the hospital, *International Urology and Nephrology*, 37 *(*2005), 9 – 99; Robert Bailey, et al., Male circumcision for HIV prevention: A prospective study of complications in clinical and traditional settings in Bungoma, Kenya, *Bull World Health Organ*, 86 (2008), 669-677.

14 WHO/UNAIDS (2010), 35; Kemal Atikeler, et al., Complications of circumcision performed within and outside the hospital, *International Urology and Nephrology*, 37 *(*2005), 97-99; J. Naude, Reconstructive urology in the tropical and developing world: a personal perspective, *BJU International*, 89 (2002) Suppl. 1, 34.

15 Janice Lander, et al., Comparison of Ring Block, Dorsal Penile Nerve Block, and Topical Anesthesia for Neonatal Circumcision, *Journal of American Medical Association*, 278 (1997) 24, 2157-2162.

16 WHO/UNAIDS (2010), 64.

17 *See*, Reuters, 16 May 2013.

circumcisions performed for religious reasons or to prevent HIV in this medical analysis, because if they are performed under the same conditions their medical impact does not differ. A “religious” type would also be too broad as it would include all forms of religious practises which can differ markedly. Consequently, some religious motivated circumcisions can fall into *Type 2*, while others can fall into *Type 3*.

Legal Analysis

Although it has not been a prominent issue in the debate on male circumcision thus far, the Convention on the Rights of the Child is used in this paper to examine circumcision of male children as this legal instrument seems to be most suited given its almost universal ratification and its subject, i.e. the child.[18] This Convention allows to discuss all different forms of male circumcision; ranging from circumcisions performed by medically trained personnel in a clinical setting (*Type 2*),[19] to more invasive forms that include “peeling the skin of the entire penis”[20] or using rudimentary instruments and techniques (*Type 3*).[21]

In the context of this conference, it has to be pointed out that the United States (hereinafter: the US) has not ratified this Convention. Nevertheless, the US contributed largely in the drafting of the Convention and even signed the Convention in 1995. Without detailing the rationale as to why the US has not (yet?) ratified this Convention, it is argued that this ratification would make no practical difference in the US.[22] With this in mind, it could be argued that male circumcision in the US is already largely subject to principles and a normative framework comparable to those of the Convention. The scope attributed to parental rights could become a point of discussion if the US ratifies this Convention. However, diverging views on parental rights and subsequent varying policies on male circumcision are already present among the ratifying States of the Convention.

Article 24 (1) CRC: Right to health

Article 24 (1) CRC states that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health” and consequently connects most closely to the medical analysis. Nevertheless, the different interpretations of this Article, illustrated by the underlying and competing conceptions of health as well as by the diverging views expressed within medical articles on the subject of male circumcision lead to a certain stalemate with regard to the interpretation of this right. 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. Moreover, 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. This medicalisation can be seen in legislation on male circumcision passed

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18 The limited scope of this presentation does not allow a discussion of all relevant Articles of the CRC or an extensive analysis of the selected ones.

19 WHO/UNAIDS, Neonatal and child male circumcision: A global review, UNAIDS/10.07E (2010), 5.

20 Debra L. DeLaet, Framing Male Circumcision as a Human Rights Issue? Contributions to the Debate Over the Universality of Human Rights, *Journal of Human Rights*, 8 (2009), 411-412.

21 WHO/UNAIDS (2007a), 19.

22 Mason, M., The U.S. and the International Children's Rights Crusade: Leader or Laggard? *Journal of Social History*, 38 (2005) 4, 955.

in Germany,[23] Sweden,[24] and (to a lesser extent) Norway[25] as well as in the resolution of the Parliamentary Assembly of the Council of Europe.[26]

For *Type 1* and *Type 2*, it is important to bear in mind that medical science and the indications necessitating male circumcision can evolve and that the CRC requires a constant balancing of the risks and effects of operations.

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.[27] A combination of these references indicates clearly that parents have the right to raise their children according to their own traditions and culture(s), bearing in mind the evolving capacities of the child.

Nevertheless, parents, who are opposed to *Type 1* seem to go beyond the allowed margin for parental choice, as they 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 under these circumstances is highly problematic given the health risks involved. The situation for *Type 2* does not lend itself in one direction or another and hereby, the connection with Article 5 (evolving capacities of the child) and Article 12 CRC (the right to be heard) is even more prominent.

Article 12 CRC: Right to be heard

A right that is closely related to this balance between parental guidance and the evolving capacities of the child is Article 12 CRC. This Article indicates that children, who are capable of expressing their views, should be given the possibility to do so in accordance with the age and maturity of the child. Since no limited list of these matters was adopted,[28] male circumcision could fall under its scope. A conflict arises as parents might prefer to circumcise their child before he is capable of expressing his views or religious preferences. However, very young children also have the same rights, even if they cannot express their views in the same way as older children.[29] Reading Article 12 CRC in connection with Article 5 CRC on the evolving capacities of the child, provides an indication that the parental right to direct the child decreases with the child's increased maturity, which is relevant for some Muslim societies who circumcise their children at an older age. It should be noted that it does not automatically mean that parents have the obligation to postpone male circumcision until the child is old enough to give his own view.

The Cologne judgement states that autonomy (*Selbstbestimmung*) would be best achieved by postponing important religious decisions until the child can give his

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23 German Civil Code, Article 1631d.

24 Swedish Law on male circumcision (2001).

25 Norwegian Act on Ritual Circumcision of Boys, § 5–6.

26 Resolution 1952 of the Parliamentary Assembly of the Council of Europe, Children's right to physical integrity (2013), at 7.2 and 7.5.2.

27 See, Preamble, Article 3 (2), Article 5, Article 18 (1), Article 29 (1) (c) CRC.

28 Commission on Human Rights, Report of the Working Group on a Draft Convention on the Rights of the Child, E/CN.4/L.1575 of 17 February 1981, 13-14.

29 CRC Committee, General Comment No. 14, Right of the child to have his or her best interests taken as a primary consideration, CRC/C/GC/14 of 29 May 2013a, at 43 and 21.

consent.[30] Another German court ruled in 2013 that parents and doctors have to be mindful of wishes of the child on an individual case-by-case basis.[31] A similar line of reasoning can be found under the Swedish law on male circumcision, where the procedure cannot be performed against the will of the child.[32] Also Article 12 (9) of the South African Children's Act of 2005 states that male children over 16 years of age may only be circumcised after proper counselling and consent of the child.[33] This somewhat artificial and high age requirement is countered in the following paragraph of the same Article, which states that "every male child has the right to refuse circumcision".[34] The Norwegian act on ritual circumcision states that ritual circumcision cannot be performed against the will of the child.[35]

Only allowing male circumcision where the child consents is a step beyond the above pieces of legislation.[36] In the event that such an interpretation from the perspective of individual autonomy is taken, the question arises how groups advocating for extensive parental rights would react, as this interpretation is an obvious limitation of parental rights.

Personal integrity

Under the concept of personal integrity it is possible to combine all of the rights under the CRC that relate to this concept, such as the protection from physical or mental violence (Article 19 CRC), the prohibition of torture or other cruel, inhuman or degrading treatment (Art. 37 (a) CRC), and the abolishment of traditional practices prejudicial to the health of children (Art. 24 (3) CRC).[37] Personal integrity embodies a protection against external interference of the body and the autonomy to decide on alterations of one's own body. Although *personal* integrity is not mentioned in the CRC, it is present in the Charter of Fundamental Rights of the European Union and the American Convention on Human Rights, which are both legally binding texts. Moreover, both texts also refer to *physical* integrity under this concept. Consequently, *personal* integrity seems to have a stronger foundation in international law than the other concepts that are used, such as bodily integrity and genital autonomy. Besides the presence of pain, other (alleged) negative effects, such as the alteration of the body, also affect the personal integrity of the child. Already several courts have reached the conclusion that male circumcision, even when conducted in medical settings, causes harm.[38] Consequently, it seems rather difficult to dispute the presence of harm with male circumcision. However, the presence of harm does not automatically lead to a human rights violation as a necessary and consented medical procedure can also cause a certain degree of harm.

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30 Landgericht Köln, 151 Ns 169/11 (2012), at 14.

31 Oberlandesgericht Hamm, 3 UF 133/13 (2013), at 39.

32 Swedish male circumcision law (2001), at 3.

33 South African Children Act (2005), Article 12, (9).

34 South African Children Act (2005), Article 12, (10).

35 Norwegian Act on Ritual Circumcision of Boys, §8.

36 Joint Statement from the Nordic ombudsmen for Children and pediatric experts, Let the boys decide on circumcision, http://crin.org/docs/English-statement.pdf (30 September 2013).

37 The application of Article 6 of the CRC could also be examined but due to the limited length of this article, it is not possible to come to the required extensive examination.

38 United Kingdom House of Lords, *R. v. Brown*, 2 All ER 75, 11 March 1993, at 2; ECtHR, *Case of Jehovah's Witnesses of Moscow and Others v. Russia*, No. 302/02, Judgment of 10 June 2012, at 144.

Some clear violations occurring under *Type 3*, in particular under Articles 19, 24 (3) and 37 (a) CRC, are nonetheless apparent. With regard to Article 19 CRC, the unclear differences between *Type 3*, and FGM, uvulectomy as well as teeth extraction, which are defined as violence by the CRC Committee, suggest a violation of this Article. With regard to Article 24 (3), *Type 3* can only be considered as a traditional practice which in any way has a negative impact on the health of a child given the constituting elements of this type. The Concluding Observations on South Africa and Lesotho made by the CRC Committee tend to lean towards this direction, without explicitly outlawing a form of male circumcision.[39]

The situation with regard to *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 for more studies on the short- and long-term effects of *Type 2*. A similar position has been taken by the CRC Committee by requiring a study on the short and long-term complications of male circumcision in its 2013 Concluding Observations on Israel.[40]

Article 14 CRC: Freedom of religion

Freedom of religion is often presented as a central aspect in the examination of male circumcision, as demonstrated by the religious outcry after the Cologne judgment, whereby even the Human Rights Committee expressed a number of concerns.[41] Article 14 (1) CRC formulates this freedom as follows: "1. States Parties shall respect the right of the child to freedom of thought, conscience and religion. 2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child".

Regardless of an individual or collective approach to this right, the wording of Article 14 (2) CRC indicates that the parental right to guide the child in the exercise of his/her right is accessory to the right of the child.[42] This position is opposed to other legal texts[43] which have attributed to parents a right to ensure that the religious education of their children is a more autonomous right whereby children remain a passive object.[44] Accordingly, freedom of religion embedded in 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 in conformity with the Convention as a whole.[45]

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39 CRC Committee, Concluding observations: South Africa, CRC/C/15/Add.122, 23 February 2000, at 33; CRC Committee, Concluding observations: Lesotho, CRC/C/15/Add.147, 21 February 2001, at 44;

40 CRC Committee, Concluding observations: Israel, CRC/C/ISR/CO/2-4 of 14 June 2013b, at 41.

41 Human Rights Committee, List of issues to be taken up in connection with the consideration of the sixth periodic report of Germany, CCPR/C/DEU/Q/6/Add.1 of 12 October 2012, at 86.

42 Eva Brems, Article 14: The Rights to Freedom of Thought, Conscience and Religion, in: Andre Alen et al., A Commentary on the United Nations Convention on the Rights of the Child, Leiden, 2006, 5.

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

44 Brems (2006), 5.

45 Rachel Hodgkin/Peter Newell, Implementation Handbook for the Convention on the Rights of the Child: Fully Revised Third Edition, UNICEF, 2007, 188.

Consequently, the question arises how, for example, a neonate exercises his freedom of religion while being circumcised. Arguing in favour of a special right or legal exception for religious circumcision based on Article 14 CRC, such as in the recently adopted law in Norway,[46] seems consequently doubtful. This Norwegian law opens several questions concerning the non-discrimination of children circumcised for non-religious reasons, especially with regard to the safeguards these children receive.

The CRC seems to be rather in favour of requiring that religious circumcisions follow the same medical requirements as circumcisions conducted out of non-religious motives. The German and Swedish laws on male circumcision follow, to a certain extent, this line of reasoning. Article 1631d of the German Civil Code allows for circumcisions within the first six months after birth by a religious circumciser under the same (health) conditions as other circumcisions of male children.[47] This religious circumciser is required to be specially trained and comparably qualified to a doctor as well as to perform the circumcision conform to the medical *lege artis*.[48]

The Swedish law on circumcision stipulates that circumcision on male children may only be performed by a licensed doctor or on boys under the age of two months by a certified person, in the presence of a licensed doctor or anaesthesiologist responsible for the administration of anaesthetics.[49] This certified person must have the knowledge and experience to perform circumcisions at a standard equivalent to a circumciser in the health service.[50]

Clearly, the creation of conditions for male circumcision might entail the danger of a majority imposing conditions on religious minorities exercising their freedom of religion. The CRC only allows a narrow scope for limitations on freedom of religion embedded in the CRC and the CRC Committee states that State parties should avoid measures that single out a particular religious group.[51] The Advisory Committee on the Framework Convention on the Protection of National Minorities has already found that the legislative framework on male circumcision in Sweden was adopted in cooperation with religious minorities and in a satisfactory manner.[52]

Article 3 (1) CRC: Best interests principle

Article 3 (1) CRC states that "[i]n all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration." This principle is also present in some pieces of legislation on male circumcision. 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 and the current

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46 Norwegian Act on Ritual Circumcision of Boys.

47 German Civil Code, Article 1631d, (1).

48 Ibidem.

49 Lag (2001:499) *om omskärelse* (Swedish Law (2001:499) on male circumcision), http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2001499-om-omskarelse-a_sfs-2001-499/ (20 January 2013), at 4.

50 Ibidem, at 5.

51 CRC Committee, Concluding observations: Germany, CRC/C/15/Add.226 on 26 February 2004, at 30-31.

52 Advisory Committee on the Framework Convention for the Protection of National Minorities, Second opinion on Sweden, ACFC/INF/OP/II(2007)006 on 8 November 2007, at 83.

German legislation on male circumcision takes “the best interests of the child” into account in relation to religious circumcisions.[53]

Notwithstanding the vague wording of this principle leading to several diverging interpretations, two main remarks can be indicated. Firstly, the CRC Committee states that the best interests principle should not be restricted to the best *physical* interest of the child, but should be interpreted in the social and cultural context in which the child or group of children live.[54] Nevertheless, 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 CRC,[55] which invalidates several cultural relativist justifications for *Type 3*.

Secondly, given that the best interests principle is only *a* primary consideration, other interests should be taken into account as well. This is mainly relevant with regard to *Type 2*, were the competing interests are obvious, *in casu* between children and adults; but also between individual and public health concerns. Moreover, the CRC Committee stressed that the best interests of the child should also be analysed with regard to the long-term effects,[56] which seems to favour the inclusion of the interests of children in adolescence, who might be sexually active. Consequently, the relationship between male circumcision and HIV prevention is a considerable factor in the debate on male circumcision.

Conclusion

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 circumciser, in a clinical setting or the use of anaesthesia. This may appear as an obvious conclusion, nevertheless, children still die and face serious complications after their circumcision because of the conditions in which it took place. For most of the circumcisions performed in the US, this conclusion does not seem to be applicable, but it applies to a significant number of circumcisions conducted outside of the US.

Although the applicability of some Articles under personal integrity could be argued under *Type 2*, the lack of a medical consensus on *Type 2* seems to require further studies on the short- and long-term effects of this type. As the boundaries of *Type 2* are essential in the exclusion of the applicability of several Articles, proponents of the circumcision of male children should apply a medically founded perspective on male circumcision if they wish to use the health benefits to support their position. Moreover, within *Type 2*, the views of the child according to its evolving capacities should be central to the decision making process on the circumcision.

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

54 CRC/C/GC/14, 17 April 2013, at 32 and 48.

55 CRC/C/GC/14, 17 April 2013, at 57.

56 Ibidem, at 16 (e) and 84.

Nevertheless, the best interests principle seems to make it necessary to differentiate further within *Type 2*, namely between countries with and without a high risk of heterosexual HIV transmission and low circumcision rate. This extra distinction is justified by the high prevalence of HIV in some regions that requires the consideration of new measures, whereby the research on the relationship between male circumcision and HIV is the cornerstone. Clearly, if new studies were to disprove previous studies on this relationship, this distinction, as well as WHO/UNAIDS policies would become problematic.

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, "high" should be interpreted and determined from the medical point of view, for example with the use of terminology such as (hyper)-epidemic. 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.

In countries with a high risk of heterosexual HIV transmission, the best interests principle does not seem to clearly oppose the circumcision of male children. However considering circumcision, the views of the child, in accordance with their age and maturity, should be taken into account. In countries with a low risk of heterosexual HIV transmission, the mere preventive status of some positive effects becomes more apparent, as in these regions the benefits are less significant. 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, as a result, the views of the child become even more central.

The novelties of the approach taken in this paper are the three types of male circumcision, which allows for a necessary diversification between all different forms of male circumcision. The resulting diversified approach, with a 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. However, it seems to fit better into a human rights framework than other current approaches, which are too often a blunt attack or a blind defence of "male circumcision".

In light of the previous analysis, the Cologne judgement cannot be regarded as a curiosum, given the existing case law on male circumcision before its delivery, *inter alia*, in the United States, the United Kingdom, and Germany. These judgments considered 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 the legal choice of the parents. Notwithstanding the presence of other case law, the Cologne judgment's singularity is that it goes to the heart of the debate, namely to the question of whether or not male circumcision is a violation of the rights of the child.

In addition to case law, legislative attempts have been made to regulate or, in some cases, to ban the practise of circumcision of male children.[57] New legislative attempts, after the delivery of the Cologne judgment, such as those in Germany and Norway, might indicate a certain trend in Europe. The non-binding recommendation of the Parliamentary Assembly of the Council of Europe might even enforce this claim for the international level, but this text should be correctly valued with regard to the institutional position of this body, its representative value as well as the internal support and consequent weight of this text.

The current pieces of national legislation on male circumcision do not univocally condemn male circumcision without the consent of the child as a human rights violation. They rather create conditions for circumcision of male children, while they have arguably different underlying political and societal reasons of existence, varying from moving towards banning male circumcision to enabling it under certain conditions. Nevertheless, the creation of a more regulating framework and towards the exclusion of *Type 3*, as for example in German and Swedish legislation, should at least be adopted by international organizations, including WHO, UNICEF, and the CRC Committee, as an aspect in their battle against HIV.

In the foregoing analysis the author has indicated several diverging interpretations of the discussed Articles with regard to male circumcision. It has yet to be seen to what extent these interpretations are consistently applied in other situations in which parental choices seem wrong or even harmful to their children, for example with regard to nutrition, alcohol and smoking, as well as with regard to all interferences with the personal integrity of children.

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[57] See, South African Children's Act No. 38 of 2005; Lag (2001:499) *omomskärelse* (Swedish Law on male circumcision).