

Neonatal circumcision – violation of children’s rights or public health necessity?

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There is a growing body of scientific evidence that medical male circumcision substantially reduces the risk of contracting HIV and other sexually transmitted infections. The procedure has been hailed as offering partial protection against HIV infection for men during sexual intercourse, raising the hope that widespread male circumcision could significantly reduce the incidence of HIV transmission in South Africa. The literature also suggests that this procedure may prevent transmission of the human papillomavirus to women. Neonatal circumcision, which is considered to carry the lowest risk, is viewed as a vital component of the goal of realising generalised circumcision in the population.

This paper investigates the ethical, legal and public health considerations underlying an HIV prevention strategy that includes neonatal circumcision. It reviews the impact of the practice on the rights of children to bodily integrity, and explores whether proxy consent by a parent or guardian on behalf of a child is appropriate and justifiable on grounds of parental preference, religion, culture or public health policy. This is a complex debate and transcends routine classifications when exploring ethical dilemmas. The article concludes that the rights of neonates to bodily integrity should not be tampered with lightly, and that only a severe public health hazard such as the HIV/AIDS pandemic may justify incursion into this constitutionally protected right.

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This paper investigates the ethical, legal and public health considerations underlying an HIV prevention strategy that includes neonatal circumcision. It reviews the impact of the practice on the rights of children to bodily integrity, and explores whether proxy consent by a parent or guardian on behalf of a child is appropriate and justifiable on grounds of parental preference, religion, culture or public health policy. This is a complex debate and transcends routine classifications when exploring ethical dilemmas. The article concludes that the rights of neonates to bodily integrity should not be tampered with lightly, and that only a severe public health hazard such as the HIV/AIDS pandemic may justify incursion into this constitutionally protected right.

An appropriate preventive measure against HIV transmission?

Clinical trials testing the efficacy of circumcision of adult males as a preventive measure against sexually transmitted HIV infection from females to males have been conducted in Kenya, Uganda and South Africa, and demonstrated between 50% and 60% reduction in HIV infection^{3,10-12} (World Health Organization (WHO)/UNAIDS¹² Conclusions and Recommendations 2 reads: ‘The tri-

als ... carried out in Kisumu, Kenya, and Rakai District, Uganda revealed at least a 53% and 51% reduction in risk of acquiring HIV infection, respectively. These results support findings published in 2005 from the South Africa Orange Farm Intervention Trial ... which demonstrated at least a 60% reduction in HIV infection among men who were circumcised’). On the basis of these results, the WHO/UNAIDS concluded that ‘the efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt’.¹²

WHO/UNAIDS therefore recommended that male circumcision should form part of country HIV prevention plans, and parents, who may consent for infant males, should be given adequate information on the benefits and risks of circumcision.¹²

The biological rationale for the reduction of the risk of HIV transmission by circumcision is directly related to the foreskin and its high concentration of Langerhans cells.¹³ Along with macrophages and CD4 dendritic cells, these Langerhans cells are the target cells for HIV, and are found in large numbers in the inner layer of the prepuce.¹⁴ However, the correlation between the presence of Langerhans cells and HIV transmission is not without dispute; Mukherjee¹⁵ refers to the argument that ‘Langerhans cells produce a substance called Langerin that “consumes” HIV, actually preventing infection and accounting for what is a fairly inefficient rate of transmission,’ thus associating the high rate of infections more with sexually risky behaviour. The foreskin is also vulnerable to ‘epithelial disruptions’ (tears during sexual intercourse), and this may further increase sites of entry for the HIV.^{13,14} Healing after circumcision causes an increase in keratinisation of the glans, reducing the likelihood of trauma to the penis during sexual intercourse and therefore penetration of the virus.¹⁶

The current South African National Strategic Plan for addressing HIV/AIDS and sexually transmitted infections (STIs) aims to

reduce the number of newly acquired infections by 50%.¹⁷ An objective of the National Strategic Plan, which is incorporated within goal 2 (reduction of sexual transmission of HIV), is to create a 'comprehensive package that promotes male sexual health'.¹⁷ This includes a directive to review the WHO/UNAIDS recommendations by a 'multidisciplinary working group', which should then make its own prescriptions on the policy to be adopted and implemented in South Africa.¹⁷ Following this the South African National AIDS Council (SANAC) Position Paper on the integration of male circumcision in the HIV prevention strategy endorsed linking male circumcision with campaigns on HIV testing, without making circumcision a condition for the receipt of HIV services.¹⁸ With regard to children, the SANAC position paper recommended improved access to circumcision in the public health sector provided it was 'completely voluntary and in keeping with the provisions on male circumcision in the Children's Act'.¹⁸ The provisions of the Children's Act dealing with male circumcision are dealt with later in this paper, when the legality of neonatal male circumcision in South Africa will be discussed.

The benefits of medical circumcision are not universally accepted. According to the British Medical Association (BMA), circumcision has in the past been erroneously recommended by physicians who misinterpret normal 'anatomical and physiological characteristics of the infant foreskin ... as being abnormal'.¹⁹ With regard to science pointing either to the harmful effects or the benefits, the BMA did not sway definitively in either direction.²⁰

While circumcision of adult males after obtaining consent does not pose an ethical problem, the circumcision of infants and neonates, who are incapable of consenting, raises ethical and legal issues.²¹ Adults are able to exercise free choice, whereas with circumcision of newborns the decision is made by the parent before the child has enough maturity to form an independent opinion. On the other hand, a strong argument is that infant circumcision performed in a clinical setting is a relatively minor procedure with fewer risks than those inherent in adult circumcision, and heals in a shorter period.²² It is asserted that the risk of surgical errors and infection is negligible during this period, making it the optimal time to perform this operation.^{16,23} Furthermore, protagonists maintain that early circumcision avoids undesirable psychological trauma that may affect a person who undergoes the procedure during adulthood.²¹

However, both these assertions are open to challenge on the basis of the extremely high incidence of infant, child and maternal mortality in developing countries. According to the WHO, the under-5 mortality rate for rural populations in South Africa was 71 per 1 000, rising to 182 per 1 000 births in Zambia.²⁴ Complications such as infection can easily occur, and the issue of pain management in infants is not adequately understood. Infections in neonates account for a significant portion of neonatal deaths in resource-poor settings, with a leading cause being unhygienic postnatal care procedures and surroundings.²⁵ Worldwide, approximately two-thirds of deaths in infancy occur in the first 28 days of life.²⁶ A study at King Edward VIII Hospital, Durban, found that a significant number of deaths was due to neonatal sepsis.^{27,28} Fatal consequences of acquired infections can be markedly reduced through the efficient and consistent use of antiseptic agents or antibiotics and strict adherence to hygienic practices.²⁷ However, a major impediment is the lack of resources, both financial and human, to adequately equip health care facilities to manage

the care of neonates. The dichotomy of private and public health care provision in South Africa creates vast disparities in access, such that the range of interventions is significantly limited within the lowest income populations, the group that is most affected by neonatal mortality.²⁹⁻³¹

For the reasons given above, WHO/UNAIDS has advised that to realise generalised circumcision within a population in the long term requires targeting newborns, even though the protective effects will only be evident after some 20 years.¹² The key rationale for this approach is to intervene before sexual debut. There is, however, justifiable concern at the lack of proximity between the circumcision and any immediate, direct benefits for the neonate.

Circumcision and the human rights of children

Because of their recognised vulnerability, children are protected both by rights that apply to all persons and by rights pertaining specifically to them.³² The Universal Declaration of Human Rights (UDHR) provides for the right to security of person and the freedom from cruel and degrading treatment,³³ and for special protections to be afforded mothers and children.³⁴ The Convention on the Rights of the Child (CRC), to which the majority of nations (including South Africa) have acceded, also affords children protection from all violence, injury or abuse,³⁵ and obliges states to do away with 'traditional practices prejudicial to the health of children'.³⁶ The African Charter similarly prohibits the abuse and torture of children, and requires the best interests of the child as the primary consideration prior to action.³⁷

According to van Howe³⁸ and Hill,³⁹ circumcised newborns are more likely than uncircumcised newborns to acquire a range of serious infections. This position contradicts the view that circumcision is harmless in early infancy, espoused by those in favour of the procedure.²¹

Hellsten asserts that non-therapeutic circumcision of male infants should be condemned in the same manner as female circumcision, as both constitute an irreversible and painful breach of bodily integrity.⁴⁰ For some advocates,⁴¹⁻⁴³ the fact that female circumcision is abhorred and outlawed in many jurisdictions, while male circumcision of infants is widely sanctioned, violates the principle of equality (as per Article 7 of the UDHR,⁴⁴ section 27 of the South African Constitution,⁴⁵ and other instruments).

Children are entitled to the same right of choice afforded to adult males on the issue of circumcision. They have a right to freedom of conscience, religion, thought, belief and opinion,⁴⁶ that is separate from any beliefs and opinions held by their parents, and should be equally respected.⁴⁷ It cannot be assumed that people will embrace the opinions of either their parents or a particular branch of the medical fraternity on the issue of circumcision, once they are sufficiently mature to apply their minds to the issues. Children's rights should not be infringed in the name of culture and religion,⁴⁰ or on the grounds of medical opinion based on predictions of lifestyle choices that will be made during adulthood. That said, such rights are not absolute and are subject to limitation under appropriate circumstances, and section 36 of the Constitution holds that rights guaranteed under the Bill of Rights may be limited provided that such limitation is reasonable and justifiable in an open and democratic society.⁴⁸

Parental responsibility of proxy consent and public health policy

Parents and legal guardians are permitted by law to give proxy consent for medical procedures in respect of neonates and infants.⁴⁹ In doing so, they must at all times act in the best interests of the child.⁵⁰ This includes any decision to have a male child circumcised. Infants by their very nature are not engaged in either protected or unprotected sexual activity. The rationale behind any medical recommendation⁵¹ would be that circumcision would perform a prophylactic function in young boys in the future.³⁹

Benatar and Benatar conclude that whether or not to circumcise should remain at the discretion of parents, and that parents must be permitted to make 'value judgements in furtherance of their child's interests'.²¹ In contrast, Rennie *et al.* argue that the principle of non-maleficence should bar neonatal circumcision because no appreciable benefits have been proven to accrue from it.⁵² They assert that the decision does not require proxy consent, as there is no urgency, and nothing is lost by allowing a child to mature and subsequently make an autonomous, informed decision.⁵²

According to Van Howe *et al.*, proxy consent by parents is only permissible where treatment has been established to be medically necessary.⁴¹ Where treatment can be delayed without significant risk of harm, the child must be given the opportunity to make up its own mind.⁴¹ In the US case of *Little v Little* the court held that parental consent to surgical interventions on a child is limited to medical 'treatment', meaning that the removal of a body part, such as an organ, is prohibited unless it is medically indicated⁵³ (cf. Van Howe *et al.*⁴¹).

Nonetheless, prophylactic interventions are routinely performed on healthy individuals for public health reasons, where there is risk of contracting a serious or deadly illness. Hodges *et al.* opine that prior to administering prophylaxis on children it must be established that the intervention is effective in combating the illness and it must be the 'least invasive and most conservative'.⁵⁴ Furthermore, the beneficial result should not depend on uncertain future behaviours and the public health benefits to society must outweigh the rights of the individual not to be interfered with.^{52,55} They argue that neonatal circumcision is speculative of the child's future actions.⁵⁴

Neonatal circumcision and 'risk compensation'

The integration of a possible neonatal circumcision programme into existing health systems is viewed as highly cost-effective, as clinics could offer the service as part of routine postnatal care.^{9,52} It is also suggested that neonatal circumcision will avert the likelihood of risk compensation or 'behavioural disinhibition' caused by the perception of having a decreased risk of acquiring HIV infection.^{14,22,52} The anticipated risk behaviour would take the form of circumcised men engaging in unprotected sex with multiple partners, as was observed in a study in which men having sex with men did not take protective measures in the expectation that they could access post-exposure prophylaxis.⁵⁶ It is argued that children who grow up already circumcised will not experience this confusion relating to the necessity of condom usage.¹⁶

It is clear that the intensive education and counselling of subjects in the three major clinical trials referred to influenced the subsequent sexual practices of the participants in a positive rather than negative manner.⁵⁷ Furthermore, highlighting the vulnerability of all sexually active persons to HIV infection along with appropriate lifestyle choices is vital to the success of any preventive measures, as illustrated by the Ugandan experience,^{55,58} as Sidler *et al.* state: 'Education, female economic independence, safe sex practices and consistent condom use are proven effective measures against HIV transmission. Such a strategy dropped the HIV adult prevalence rate in Uganda from 30% in 1992 to 14% in 1995 to below 8% in 2000. Consistent condom use reduces lifetime risk of contracting HIV by 20%, as opposed to 8% for circumcision'.⁵⁵ Education and counselling must therefore go hand in hand with circumcision in order to produce significant reductions in HIV infection in the long term.

A 'uniquely' sub-Saharan African approach

With respect, many of the commentaries cited reflect contexts where HIV has a relatively low incidence, and do not adequately take cognisance of the realities of high-incidence settings such as sub-Saharan Africa, where public health imperatives dictate a radically different approach – for example, UNAIDS estimated in 2009 that in sub-Saharan Africa 22.4 million adults and children were living with HIV, with 1.9 million new infections in 2008.⁵⁹

South Africa has the highest number of people living with HIV in the world.⁵⁹ One of the major aims of the current South African National Strategic Plan is to reduce the HIV/AIDS transmission rate by 50% by 2011.¹⁷ Having identified the partial protection offered by circumcision against the sexual transmission of HIV, it is considered imperative to implement a policy of male circumcision as a component of HIV prevention in South Africa. Public health necessity notwithstanding, the state is obliged to formulate and implement programmes in a manner that does not infringe on the rights enshrined in the Constitution. A package promoting male sexual health¹⁷ should not ignore the rights of the most vulnerable, namely children.

The legality of neonatal circumcision in South Africa

Section 12(8) of the Children's Act⁶¹ states: 'Circumcision of male children under the age of 16 is prohibited, except when (a) circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or (b) circumcision is performed for medical reasons on the recommendation of a medical practitioner.' Contrast this with section 12(3), which reads: 'Genital mutilation or the circumcision of female children is prohibited.'⁶⁰

Firstly, is circumcision on male infants, for purposes which are not medically indicated, a justifiable infringement of a child's right to security of person in the form of bodily integrity?

An infant has a constitutional right to security of person, the right not to be subjected to violence ('Everyone has the right to freedom and security of the person, which includes the right to be free from all forms of violence from either public or private sources'⁶¹), and the right to bodily integrity ('Everyone has the right to

bodily and psychological integrity, which includes the right to security in and control over their body⁶²), and the state has a duty to protect individuals by restraining others from causing physical injury,⁶³ including the use of legislation to curb such harm.^{64,65} According to Currie and de Waal, section 12(2)(b) 'creates a sphere of individual inviolability', which includes protection from intrusion on bodily integrity and the right to choose in what way any interference may occur.⁶⁶ The Bill of Rights also guarantees the right to religious belief and practice, provided that the exercise of religious belief is not inconsistent with any other provision of the Bill.⁶⁷ Is this apparent incursion into the rights of the child tenable, and can the circumcision of newborn boys be justified on religious, cultural or public health grounds?

South African courts are obliged by Section 28(2) of the Constitution to prioritise the best interests of the child in matters concerning children ('A child's best interests are of paramount importance in every matter concerning the child').⁶⁸ This is also a common law principle the application of which predates the Constitution. It has been enunciated in a number of cases:⁶⁹⁻⁷⁶ in *Botha v Botha*, the court held that the rule of doctor-patient confidentiality had to yield to the best interests of the child, where the proper administration of justice depended on determining the suitability of a parent to retain custody of a child.⁷²

Although children have special protections under various rights instruments, the collective interests of the family and the community also require consideration.⁷⁷ Public health considerations, in the form of HIV prevention, are also pertinent in determining the level of interference permissible.

Secondly, does the protection afforded to female children through a blanket prohibition on circumcision in all its forms, while male infants may be subjected to circumcision in certain instances, amount to unfair discrimination? Section 9(1) of the Constitution of the Republic of South Africa reads: 'Everyone is equal before the law and has the right to equal protection and benefit of the law.'⁷⁸ The Constitutional Court has enunciated the criteria for the determination of unfair discrimination.^{79,80} (in *Hoffman v South African Airways* paragraph 24 sets out a three-step process for evaluating unfair discrimination⁸⁰). The Children's Act, by proscribing female circumcision and permitting male circumcision, appears to deprive male children of equal protection and benefit of the law.⁸¹⁻⁸⁴ Male circumcision is widely practised in South Africa for both religious and cultural reasons. A major concern facing legislators with circumcision performed in terms of certain African cultures is the significant incidence of serious injury and sometimes death: 'the Eastern Cape provincial Department of Health ... recorded 2 262 hospital admissions, 115 deaths and 208 genital amputations for circumcisions between 2001 and 2006'.⁸⁵ A blanket prohibition of male circumcision would hardly be likely to put an end to this traditional practice. It has therefore been recognised and regulated, with the aim of causing minimal infringement of the rights of children while ensuring their protection. Provincial legislation regulating cultural circumcision can be found in Northern Province, the Eastern Cape and the Free State via the Northern Province Circumcision Schools Act 6 of 1996,⁸⁶ the Application of Health Standards in Traditional Circumcision Act 6 of 2001⁸⁷ and the Free State Initiation School Health Act 1 of 2004,⁸⁸ respectively.

While there are important differences between the two, circumcision of male children may be regarded as akin to female circumcision as both are irreversible and involve the unnecessary

and painful removal of a functioning part of the body.⁴¹ According to Fox and Thomson the circumcision performed in the two sexes is differentiated; the harms being emphasised with regard to females, while in males they are brushed aside, in order to ensure its acceptability and facilitate parental consent.²³

It can therefore be argued that within the social and cultural context of South Africa, this differentiation in the Children's Act between male and female children serves a legitimate and vital government purpose. While it is, on the face of it, unfair discrimination on the ground of gender in terms of section 9(3) of the Children's Act,⁸⁹ the impact on male children is mitigated by protections afforded in terms of the Act.^{51,90} The discrimination is also justifiable under the limitation clause, by weighing the injuries and deaths that would ensue if legal mechanisms for regulation were not put in place, against the resultant differentiation in treatment between boys and girls.

Public health considerations in neonatal circumcision

South Africa confronts an HIV pandemic of frightening proportions. Some 5.7 million people are infected, and the pandemic shows little sign of abating.⁹¹

The strategy of circumcision as an intervention in the prevention of HIV/AIDS requires a careful balancing of human rights on the one hand, and the public health necessity of stemming the spread of HIV on the other. The constitutional rights of children to bodily integrity and eventual self-determination must not be lightly interfered with. If neonatal circumcision is to be implemented, there must be adequate justification for such a measure, bearing in mind that rights are not absolute. In terms of the National Health Act, treatment can be administered without consent where failure to do so puts the public health in peril.⁹² Parents of the neonate are the final arbiters and may give informed consent on behalf of the child. This is comparable to other interventions on infants, such as vaccinations against various diseases.

The Siracusa Principles also permit the invocation of public health as a ground for limiting rights in order to address serious public health crises.⁹³ The *necessity* of the intervention is determined by whether it will adequately address the public health need; whether it is, in fact, a legitimate public health goal; and whether it is proportional to the purpose it seeks to achieve.⁹⁴ Applied to the South African context, it can be argued that an intervention such as neonatal circumcision is considered as necessary and justifiable by both the government and international agencies such as the WHO/UNAIDS; serves a legitimate public health purpose in helping reduce HIV infection; and, despite being somewhat invasive, is proportional to the achievement of that purpose.

Childress *et al.* suggest 'justificatory conditions'⁹⁵ to determine whether an intervention is required, namely the effectiveness of the proposed intervention; proportionality, which requires that the public health benefit to be gained is such that it justifies the infringement of particular rights; necessity, meaning that where there is an alternative to the suggested treatment that is less invasive of rights, it should be considered and be found wanting in order to realise the health goal; the manner of implementation must cause the least infringement on individual rights; and the intervention must be carried out in a transparent manner, which fosters public trust in order to fulfil the requirement of public justification.

Kass declares that ultimately the 'fundamental goal' of any public health measure is to reduce morbidity and mortality, therefore an intervention should be judged on how well it fulfills this aim.⁹⁶

As indicated, the surgical removal of the foreskin has been proven to be effective in the prevention of the sexually transmitted HIV by up to 60%,^{3,10,11} prompting the WHO/UNAIDS recommendation¹² and ensuring its inclusion in the South African National Strategic Plan.¹⁷ Its utility has been justified as a prophylactic intervention akin to vaccinations, which are routinely performed on healthy infants for public health reasons.

As regards necessity and proportionality Hodges *et al.* argue that before administering prophylaxis, once it is established that the intervention is effective, it must be shown to be the 'least invasive and most conservative'.⁵⁴ They contend that the beneficial result should not depend on uncertain future behaviours such as unsafe sex practices, and that the public health benefits are outweighed by the need to preserve individual liberties⁵⁴ (see also Sidler *et al.*⁵⁵).

While this may be true of low-prevalence settings, children living in high-incidence HIV contexts are especially vulnerable given the impact of mother-to-child transmission, sexual assault and adolescent sexual activity. It is submitted that the views outlined above have limited relevance in the South African context, where HIV/AIDS has reached epidemic proportions⁹¹ with the primary mode of infection being through unprotected heterosexual sexual activity.⁹¹ It cannot be regarded as speculative that children who are not sexually active will not engage in risky sexual activity, given that education campaigns on prevention have not yielded the expected reduction in new infections. A gauge of HIV prevention in South Africa⁹⁷ observes that while the epidemic appears to have stabilised, with a decrease in the rate of new infections, the national prevalence remains high. It will therefore be impossible to sustain the rising costs of treatment unless the rate of new infections drops drastically to below 50% of its current rate. The three randomised trials conducted on the efficacy of circumcision are testimony to this fact. Along with the provision of condoms, participants received intensive education and counselling.⁵⁷ That notwithstanding, a number of the adult participants engaged in unprotected sexual activity, causing some of them to be infected with the HIV. Given the catastrophic effects of HIV on both the individual and the public health system, the option to practise neonatal circumcision cannot be said to be disproportionate to the potential harm. Together with other preventive measures, male circumcision could prove to be a viable option in the fight to prevent and reduce the incidence of HIV in South Africa. Circumcising neonates will be a key component of such a public health strategy.

Conclusion

A model evaluating the impact of male circumcision in Southern Africa projected that 0.3 - 1 million infections could be prevented in the first 10 years of the intervention, while 0.5 - 1.8 million infections would be prevented in the course of 20 years.¹¹ In total 5.7 million new infections would be averted in southern Africa, South Africa alone accounting for a quarter of all infections and deaths prevented.¹¹ Yet another model estimated that one infection could be prevented for every 5 - 15 adult male circumcisions, further projecting that an uptake of between 50% and 80% could reduce the prevalence of HIV by as much as 25 - 67% with time.⁹⁷ Savings in

HIV treatment would amount to an estimated US\$ 2.3 billion over 20 years.⁹⁸

In order to ensure widespread roll-out of male circumcision, the integration of a policy of neonatal circumcision into existing health systems has been projected to be a cost-effective measure, as clinics could offer the service as part of postnatal care;⁵² adolescent and adult roll-outs would constitute 'catch-up' campaigns that would be phased out over time.²² Neonatal circumcision has been shown to be a simpler, cheaper procedure with fewer adverse events.⁹⁹ However, the problems of pain management and infection control in resource-poor settings may continue to pose significant challenges.

Notwithstanding the significant concerns about the incursion into the human rights of infants and neonates, in the face of the compelling evidence available it would be foolhardy to forego this important intervention in the fight against the rampant HIV/AIDS pandemic. Limiting the rights of neonates under such circumstances can be regarded as a justifiable measure to protect the public health.

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