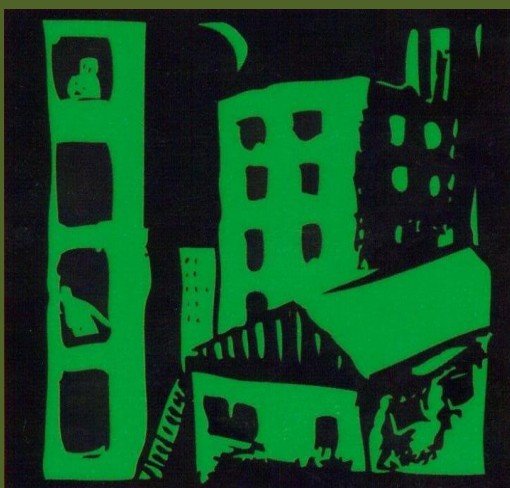


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A foreskin too far? Religious, “medical” and customary circumcision and the Children’s Act 38 of 2005 in the context of HIV/Aids

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1. INTRODUCTION

South Africa’s Children’s Act 38 of 2005, which was under development over the period of 1997 to 2005 and which was finally fully promulgated on 1 April 2010, is consciously respectful of cultural rights. Throughout, sections of the Act affirm the need for respect for a child’s cultural attachments,¹ including requiring consideration of culture as a general indicator relating to the best interest of the child.²

The South African Law Reform Commission (SALRC) which spear-

¹ Section 12 of Act 38 of 2005 regulates certain social, cultural and religious practices to which a child may be exposed. The chapters on adoption (Chapter 15, section 228 specifically), foster care (Chapter 9 of the Act) and in norms and standards appended to the Act, which set guidelines for programme development.

² See Chapter 2, section 7 specifically, of Act 38 of 2005.

headed the investigation into the review of the Child Care Act 74 of 1983,³ the then legislation providing for the welfare of children,⁴ identified “children growing up under customary law”⁵ as an explicit constituency to be addressed in the law reform process.⁶ A chapter on children growing up under customary law regimes is to be found in the 2001 Discussion Paper that was issued by the SALRC.⁷ From the outset, the Commission posed questions as to which dimensions of customary law and culture could be assimilated in the omnibus children’s legislation that was forthcoming; which customary practices posed risks to children’s rights or violated constitutional principles; as well as how best to deal with identified practices which could not be tolerated in protective rights based legislation.

Based on the responses the Commission received to the Discussion Paper, the final Report of the SALRC recommended that “harmful or potentially harmful cultural practices be prohibited, that male circumcision be regulated, that female genital mutilation be prohibited, that an educative and criminal law approach to virginity testing be adopted, and expansion of the grounds for refugee status to include the threat of female genital mutilation”.⁸

The focus of this article will be only on the male circumcision provisions, and not the provisions related to other harmful or potentially harmful cultural practices now provided for in the Act. This is in light of the reality that social attitudes and views on male circumcision have changed in the period since the legislation was formulated and debated. It will be asserted, below, that this is due to changes in health policy in relation to prevention of HIV/Aids (see section 4).

It is recorded that no submissions were received from the public in response to these earlier proposals from the SALRC. It is not clear from available evidence that medical circumcision and religious circumcision were ever fully canvassed before the legislation was finalized in Parliament.⁹ Section 19 of the draft Children’s Bill which accompanied the Discussion Paper contained a fairly limited provision giving effect to the SALRC’s view. It provided that “every male child has the right to ... refuse

³ In 1997, the SALRC was asked to investigate and review the Child Care Act of 1983 and make recommendations to the Minister for Social Development for reform of this law. From the outset, the Commission viewed its mandate as one that included a review of all statutory, customary, common, and religious laws affecting children.

⁴ The Child Care Act of 1983 dealt with matters such as, protection of children from mistreatment; adoption; custody; and the prohibition of the employment of certain children. *See* Child Care Act 74 of 1983.

⁵ *See* SALRC Report Review of the Child Care Act, 1 (December 2002), [hereinafter SALRC Report] Chapter 9 which deals with ‘Child Protection’ and ‘Harmful Cultural Practices’ at para. 9.6. *See also* SALRC Report, Chapter 20 which deals with ‘Customary Law Affecting Children’.

⁶ There were various other identified groups, such as migrant and refugee children, children being cared for outside families, children affected by cross border disputes, and so forth.

⁷ *See* Chapter 21 of the Discussion Paper 103 of 2000. *See also* Chapter 8 of the First Issue Paper: Review of Child Care Act (Issue Paper 13, Project 110), 18 April 1998.

⁸ SALRC Report, Vol. 1, para. 9.6.

⁹ The author was a member of the SALRC project committee which produced the Discussion Paper and the SALRC Report.

circumcision and not to be subjected to unhygienic circumcision".¹⁰ In the original section in the draft Bill dealing with criminal offences (Clause 353), this clause was excluded from reach of criminal sanctions, although the preceding clause prohibiting female genital mutilation or the circumcision of girl children was coupled with a criminal sanction.

As has been recorded,¹¹ the provisions on virginity testing in particular were highly controversial in the law reform process, and the provisions on circumcision also underwent changes. Notably, the opposition to the virginity testing prohibition came in the National Council of Provinces, the second chamber of Parliament. Many representatives from amongst traditional leaders from various provinces serve in this chamber. It is likely that some of the changes to the male circumcision clause that eventuated were drawn into the arena via the debates on virginity testing. This is because the two were linked in one clause, which was subjected to detailed attention. The National Council of Provinces delayed debates on the bill as a whole to host a two day workshop on virginity testing before resuming deliberations.¹²

The backdrop to the child law reform process was the ratification of international treaties such as the UN Convention on the Rights of the Child (1989) and the African Charter on the Rights and Welfare of the Child (1990). Both treaties contain provisions which proscribe harmful cultural practices, and it was therefore incumbent upon the law reformers to address potentially harmful cultural practices in domestic legislation on child protection.¹³ These specific provisions will briefly be outlined in the first part of this article. Thereafter, the approach of the legislature towards traditional practices decided to be in violation of constitutional principles¹⁴ and international law as set out in provincial legislation and in the (nationally applicable) Children's Act will be analysed. The inclusion of religious and medical circumcision in an article on social, cultural and religious practices will also be reviewed in the third part of the article. The focus will turn to male circumcision practices in South Africa, and current initiatives to promote circumcision as a way of reducing HIV infections will be discussed.

The final part of the article will explore whether, with hindsight, the legislature took the correct approach in regulating religious and medical circumcision, on the one hand, and traditional or customary circumcision, on the other. Whether or not male circumcision does in fact constitute harmful cultural practice is contested. Nevertheless, current public health policy is advocating male circumcision as a critical tool for HIV prevention.

¹⁰ Section 19(4) of the Bill.

¹¹ Le Roux 'Harmful Traditional Practices (Male Circumcision and Virginity Testing of Girls) and the Legal Rights of Children (Unpublished LLM Thesis, 2006, University of the Western Cape, copy on file with the author) 60 et seq.

¹² The Public hearings were hosted by the Select Committee on Social Services, and a substantial submission was made by the National House of Traditional Leaders. Le Roux, note 11 above at 62.

¹³ The question as to whether medical and religious circumcisions constitute harmful practice will be dealt with subsequently in this article.

¹⁴ At issue are a range of constitutional principles such as the right to dignity, the right to health, the right to life, and so forth.

2. THE INTERNATIONAL LAW CONTEXT

The United Nations Convention on the Rights of the Child¹⁵ refers to cultural practices in article 24,¹⁶ which deals with the right to health. The standard set in article 24(3) is that State Parties are required to take all effective and appropriate measures with a view to abolishing traditional practices which are prejudicial to the health of children. No specific practices are enumerated or described, and the explicit reference to traditional practices which are deleterious for children's health limits the usefulness of this section considerably, in the view of this author. It leaves out of the equation traditional and customary practices which violate equality rights, or dignity, or invade children's privacy.

The formulation raises from the very outset the potential of disputes about the meaning of "prejudice" to children's health – must the prejudice be real or merely possible? Must it be prejudice of a weighty nature, or is minor, non-serious, short-lived prejudice (such as that incurred when a small wound heals) also covered? What if the child consents to the traditional practice, exercising his or her participation and agency in an informed manner as an expression of his or her right to culture? Given the importance of article 12 of the Convention,¹⁷ which provides for the child's right to express views freely in all matters concerning the child, and to have those views given due weight in accordance with the age and maturity of the child, the issue of voluntary

¹⁵ Nov. 20 1989, 1577 U.N.T.S. 3. [hereinafter CRC].

¹⁶ Article 24 of the CRC reads:

'1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.'

¹⁷ Article 12 is regarded as being one of the four 'pillars' of the CRC, and has also formed the basis for a General Comment of the CRC Committee (GC 12 'The Right of the Child to be Heard' (CRC/C/GC/12 (20 July 2009)).

submission to a practice which may be regarded only by some as harmful cannot be dismissed. Article 24 provides no answers to these questions.¹⁸

Far more nuanced is the wording of the African Charter on the Rights and Welfare of the Child (1990), the regional children's rights treaty now ratified by 45 of the 53 member states of the African Union.¹⁹ The Charter privileges the enjoyment of culture in several ways. For instance, the Preamble refers to the need to take into consideration the virtues of (African) cultural heritage, the historical background and the values of the African civilization which should inspire and characterise States Parties' reflection of the concept of the rights and welfare of the child. However, the Preamble also alludes to the negative impact of (amongst others) culture, traditional and developmental circumstances as affecting the situation of children in Africa. It has frequently been observed that one rationale for the drafting of a regional treaty on children's rights was the view that African cultural values had not been sufficiently accommodated in the CRC.²⁰

Turning to the substantive text of the Charter, article 1 is headed "Obligations of States Parties". Article 1(3) provides that "any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations contained in the present Charter shall to the extent of such inconsistency be discouraged".²¹ This formulation is superior to that in the CRC for two reasons. First, by including a broader array of practices, customs and religious traditions, it is obvious that a wide variety of practices outside the health arena may be at issue. Thus practices which imperil girls' equal access to their rights, or infringe dignity, or limit the implementation of the right to education, must fall foul of article 1(3). Second, whereas the CRC requires abolition, a blunt instrument at times, the ACRWC requires careful consideration, in the context of each specific practice, of the extent of inconsistency with other Charter rights, in order for positive cultural practices to be preserved. The use of the verb "discouraged" could be regarded as letting states parties off the hook, imposing a lower threshold for

¹⁸ Note that the CRC Committee's General Comments on adolescent health (GC 4), on HIV/AIDS and the rights of the child (GC 3) and on implementing child rights in early childhood (GC 7) all make a specific reference to harmful traditional practices as a serious violation of the Convention. They do not, however, elaborate what harmful cultural practices are. Nor has the CRC Committee yet opined in general terms on their understanding of harmful cultural practices, though a General Comment is reportedly under development.

¹⁹ South Africa ratified the African Children's Charter in 2002. An initial report to the Committee monitoring the implementation of the Charter (the African Committee of Experts on the Rights and Welfare of the Child) – due within two years of ratification – is yet to be submitted.

²⁰ Chirwa 'The merits and the Demerits of the African Charter on the Rights and Welfare of the Child' (2002) 10 *international Journal on Children's Rights* 157; Olowu 'Protecting Children's Rights in Africa: A critique of the African Charter on the Rights and Welfare of the Child' (2002) *International Journal on Children's Rights* 137; Viljoen 'The African Charter on the Rights and Welfare of the Child' in Boezaart, T(ed) *Child law in South Africa* (Juta, Cape Town, 2010) 331; Sloth-Nielsen 'Children's Rights in Africa' in Ssenyonjo, M (ed) *30 years of the African human rights system*, Brill publishers: The Netherlands (2011).

²¹ Article 1(1) contains the general obligation of States Parties to recognise the rights, freedoms and duties contained in the body of the Charter and to undertake the necessary steps to give effect to the provisions of the Charter. Article 1(2) contains the proviso that Charter provisions shall not affect any provisions of other domestic law or international treaties which have been ratified that are more conducive to the realisation of the rights and welfare of the child.

abhorrent practices, and permitting states to respond only weakly to egregious violations of rights to life, dignity, bodily integrity and so forth.²² A counter argument to this, though, is that custom, tradition, cultural and religious practices are referred to right at the outset in the article dealing with implementation of the Charter. This is, at least, indicative of the degree of priority given to abhorrent cultural practices and customs by the drafters.

The Charter also contains a positive affirmation of the child's right to culture, which is contained in article 12(2): "States Parties shall respect and promote the right of the child to fully participate in cultural and artistic life..." Cultural respect and sensitivity also provides the rationale for the inclusion of an article dealing with the duties of the child, found in the concluding substantive article, article 31.²³

The African Children's Charter additionally contains a dedicated article headed "Harmful social and cultural practices". States parties are required to take "all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular, customs and practices prejudicial to the health or life of the child, customs and practices discriminatory to the child on the grounds of sex or other status".²⁴ Further, child marriage and betrothal of girls and boys is to be prohibited, and effective action, including legislation, shall be taken to specify the minimum age of marriage at 18, and to make registration in an official registry compulsory.²⁵ As with the CRC provision, outside of the marriage issues which are mentioned *eo nomine*, no other specific cultural practices are referred to by name. The African Committee of Experts on the Rights and Welfare of the Child has not laid down any guidelines regarding the interpretation of this treaty provision, but in engagement with country reports has recently commented on positive cultural practices which promote children's enjoyment of their rights, such as celebrations which encourage chastity in school going girl children (E.g. in relation to Togo, the State party report of which signatory state was considered at the May 2011 meeting).²⁶

The international and regional treaty provisions clearly mandate State parties, including South Africa, to take the necessary legislative steps to ensure that harmful cultural and religious practices are prohibited. Despite differences in wording of their texts, neither treaty gives authoritative guidance on what harmful cultural practices are, more specifically in relation to the practice of circumcision which is the topic of this

²² Gose, M (2002) *The African Charter on the rights and welfare of the child: an assessment of the legal value of its substantive provisions by means of a direct comparison to the Convention on the Rights of the Child* (Bellville: Community Law Centre, University of the Western Cape).

²³ For a detailed discussion on article 31 see Sloth-Nielsen and Mezmur, 'A dutiful child: Article 31 of the African Children's Charter' 2008 (2) *Journal of African Law* 159-189.

²⁴ African Charter, Article 21(1).

²⁵ African Charter, Article 21(2).

²⁶ Personal observation from attendance at the meeting.

article.²⁷ However, it is against the backdrop of the need to provide in municipal legislation for binding treaty provisions that the child law reform process took place.

3. THE SOUTH AFRICAN LEGAL FRAMEWORK

The Children's Act 38 of 2005 is not the only South African legislation regulating male circumcision. In an effort to curb the well-known deaths and amputations that occur each year during the circumcision cycle in traditional communities,²⁸ several provincial legislatures have responded with laws to regulate traditional circumcision. The provincial laws have not been repealed with the coming into operation of the Children's Act nationally on 1 April 2010. They are regarded as still in effect.

What this article refers to as traditional circumcision²⁹ is a rite of passage in most African cultures in South Africa.³⁰ Boys are sent away or sequestered for a period of weeks whilst the ceremonies of transition to manhood are undertaken. Every year, newspaper reports of botched circumcisions and deaths from exposure to the elements, dehydration and septicaemia are recorded.³¹ However, not all traditional communities practice circumcision, hence not all provinces are equally affected by the harmful consequences of circumcisions which go wrong. Those provinces which have taken legislative initiatives are amongst the worst affected, and the relevant provisions will be discussed next.

3.1 Northern Province Circumcision Schools Act 6 of 1996

The Northern Province Circumcision Schools Act was passed in 1996 and came into operation in March 1997.³² It provides for a prohibition on holding of a circumcision school without a permit issued by the premier of the province, who may issue such permits upon conditions as he or she may deem desirable.³³ The police are further authorised, upon receipt of a complaint or oath that a person is reasonably believed to have been abducted or forcefully taken to a circumcision school, "to rescue such person in an orderly manner".³⁴ Regulations are mandated by the Act concerning the issue of permits, and, notably, the determination of the age of initiates and the duration of any circumcision school (the maximum period for which boys and young men are to be sequestered during the rites of passage, which sometimes runs to a few weeks). It is not

²⁷ There appears to be universal consensus that female circumcision (also known as Female Genital Mutilation (FGM) or cutting) is a harmful cultural practice.

²⁸ In the Eastern Cape alone, between January 2008 and December 2009, 144 circumcision-related deaths were recorded. See J Lazarus "Traditional circumcision - the unkindest cut of all" (2010) 100(9) *South African Medical Journal* 544; Le Roux (note 11) 71-74.

²⁹ In contrast to medical and religious circumcision, as noted in the title to this article.

³⁰ Van der Zalm 'Protecting the Innocent: Children's Act 38 of 2005 and Customary Law in South Africa-conflicts, consequences and possible solutions' (2008) 22 *Emory Int'l Law Review* 891 at 906.

³¹ Note 30 above.

³² The province was subsequently renamed Limpopo.

³³ See section 2 and 3 of the Northern Province Circumcision Schools Act 6 of 1996 [hereinafter Act 6 of 1996].

³⁴ See section 5 of Act 6 of 1996.

clear that the regulations envisaged by the principal Act have ever been issued or whether the permit system is up and running. The definition of “circumcision school” in the Act is also inconsequential, insofar as it merely refers to a circumcision school as “including a circumcision school for either male or female initiates”. It must be assumed that at minimum, such schools entail groups of initiates.

3.2 Application of Health Standards in Traditional Circumcision Act

The Application of Health Standards in Traditional Circumcision Act 6 of 2001 of the Eastern Cape Province is considerably more detailed. Rather than requiring a permit, the Act envisages the designation of medical officers to exercise functions in terms of the Act; it is then required that any circumcision in the province to be performed only after written permission has been obtained from the medical officer designated for the area in question.³⁵ The medical officer may impose conditions prescribing or supplying a proper surgical instrument where the use of a particular instrument has been disallowed.³⁶

Within one month of applying for written permission to perform a circumcision, the applicant is required to submit proof of compliance with the conditions imposed by the medical officer, failing which the permission lapses.³⁷ Other provisions ensure that no person other than “the traditional nurse, medical practitioner, medical officer or person authorized by the medical officer may, within a traditional context, treat an initiate at any stage during the circumcision process”.³⁸ The Act periodically refers to circumcision schools, like the Limpopo counterpart, and the definition is slightly more instructive. A circumcision school is defined as “a place where one or more initiates are treated”, from which can be deduced that a circumcision school refers to both a group activity and to a dedicated venue or place. Circumcision is also defined as the “circumcision of a person as part of traditional practice”, which is then in turn defined to “include a practice according to custom, religion or any other rules of a similar nature”.³⁹

Section 7 of the Act provides specifically for consent by a parent or a guardian where an initiate is aged below 21 years.⁴⁰ The consent must be furnished in writing on a prescribed form. According to Annexure A to the Act, which sets the conditions for obtaining permission to perform circumcisions, proof in the form of a birth certificate or an ID document of the initiate is required. This proof is to show that the prospective initiate in respect of whom permission to circumcise is requested is at least 18 years old or, if the parents so specifically request, is at least 16 years old. No provision is made for consent of the initiate, and this conflicts with the participation provision contained in the Children’s Act (see section 12(9)(a) and section 12(10), discussed below).

³⁵ See Act 6 of 2001 Sections 2 – 5.

³⁶ See Act 6 of 2001 Section 4(1).

³⁷ Section 5(4).

³⁸ Section 6(2).

³⁹ Why religion is referred to, as in the last phrase, in an Act the title of which refers to ‘traditional circumcision’ is not clear.

⁴⁰This was the then applicable age of majority, which has been lowered to 18 years by the Children’s Act 38 of 2005.

The health standards are also provided for in Annexure A. It provides that the traditional surgeon must be known to the parents of the prospective initiate, and must use instruments approved by the parents or guardians, unless the medical officer has authorized the use of another surgical instrument. Further, a traditional surgeon must have experience of circumcising or must operate under the supervision of a traditional surgeon with experience. Furthermore, instruments used on one initiate must not be used again to perform a circumcision on another initiate, and instruments must be kept clean at all times. The traditional surgeon shall use any substance prescribed by a medical officer for the sterilization of such instruments.

According to Annexure B which lays down conditions for obtaining permission for holding a circumcision school or treating initiates, the traditional nurse (which is not defined in the Act) must, at least within the first eight days of the circumcision, allow the initiate a reasonable amount of water to prevent dehydration. The traditional nurse must not expose the initiate to any danger or harmful situation and shall exercise reasonable care in the holding of the circumcision school. The traditional nurse must stay with the initiates at the circumcision school 24 hours a day during the first eight days of the initiation process, and after the lapse of the first eight days must be available to the initiate at least once every day until the initiation process has come to an end.

The Act provides for criminal penalties: up to R1000 or six months imprisonment are prescribed for contravention of the provisions concerning consent, and R10 000 or ten years imprisonment for performing circumcisions without a permit or failing to comply with any condition imposed by a medical officer is the penalty set.

3.3 Free State Initiation School Health Act 1 of 2004

The most recent piece of legislation dealing with circumcision is found in the Free State province. The Free State Initiation School Health Regulations 2008, which came into effect from June 2008, were published under the Free State Initiation School Health Act 1 of 2004. This Act too regulates both medical and environmental aspects of initiation,⁴¹ as well as local authority, traditional authority⁴² and parental consent⁴³ where a prospective initiate is less than 18 years of age, as well as proof of experience and expertise in holding an initiation school.⁴⁴ A consent form for parents is provided for in the form of Annexure A where the prospective initiate is aged below 18 years. Parents are also required to “render the assistance and cooperation as may be prescribed in the interest of the health of the initiate”.⁴⁵ The consent of the Initiate is not expressly covered.

An initiation school means a place where one or more initiates are initiated, according to section 1. The period of initiation is restricted to a maximum of two

⁴¹ Section 2(2)(d).

⁴² Section 2(2)(a) and (b).

⁴³ Section 2(2)(c).

⁴⁴ Section 2(2)(e).

⁴⁵ Section 3(1) and (2); a parent is widely defined to include also any person legally entitled to custody of an initiate.

months.⁴⁶ Initiates are prohibited from treating one another at any stage during the holding of an initiation school,⁴⁷ and only a traditional surgeon, medical practitioner or person authorised by the District Medical Officer may treat an initiate.⁴⁸ Permission to perform a circumcision as part of initiation must be obtained if it is to be performed by a traditional surgeon, in the manner provided for in Annexure A, which includes a requirement of a pre-circumcision medical examination by a medical practitioner or primary health care nurse to determine whether an initiate is fit to undergo circumcision.

Instruments used to perform circumcisions are also regulated in some detail, and an instrument used on one initiate may not be used to perform a circumcision on another initiate.⁴⁹ Instruments are to be kept clean, and substances prescribed by the District Medical Officer must be used for the sterilisation of the instruments.⁵⁰

Amongst the environmental factors regulated by the Free State Act include inspections by an Environmental Health Officer of initiation schools to ensure that there is an adequate supply of clean water, acceptable ablution facilities, hygienic preparation of food, adequate shelter against the natural elements, and that instruments used are kept, prepared and used in a manner that will not place an initiate at risk of injury, disease or death.⁵¹ Criminal penalties for violations of certain sections are provided.

The Regulations to the Act are somewhat more prescriptive: regulation 4 deals with the personal requirements of the applicant for a permit, who must be at least 45 years of age, be a South African citizen, must have 10 years' experience in performing circumcision, have the support of 5 graduated initiates (with confirming letters of support), and submit a report of good health. The regulations establish a Provincial Initiation School Health Committee, with mirror District Initiation School Health Committees, which have defined functions and responsibilities, which are largely advisory, coordinating, awareness raising and information dissemination, and which consider reports and prepare annual reports.

It can be deduced that provincial enactments have become ever more detailed in their endeavours to protect initiates from adverse medical consequences and environmental dimensions of initiation schools, as well as to ensure that proper consent procedures are followed for initiates who are minors. Keeping of registers of initiates, requiring permission to operate an initiation school and providing for inspections of initiation schools are amongst the other protective regulatory mechanisms that have been devised and incorporated in the respective provincial enactments. As noted, the Children's Act 38 of 2005 does not, on the face of it, abrogate the provincial laws, although to the extent that they may be inconsistent with national legislation, they may in future be determined to be invalid.

⁴⁶ Section 4(4).

⁴⁷ "Treating one another" presumably refers to various dimensions of post-operative care.

⁴⁸ Section 5.

⁴⁹ Annexure A: 6.

⁵⁰ Annexure A: 8.

⁵¹ Section 10.

3.4 The Children's Act 38 of 2005

The Children's Act and Regulations regulate male circumcision in three main ways.⁵² The applicable title to section 12 of the Act is "Social, Cultural and Religious Practices".⁵³ First, section 12(8) prohibits circumcision of male children under the age of 16 years, with two exceptions, namely religious and medical circumcision, which are dealt with in more depth below. Thereafter, section 12(9) provides for a general age of consent to circumcision at 16 years. This is not limited to what is often termed traditional or customary circumcision, as discussed above, but applies to all forms and kinds of circumcision (i.e. including religious and medical circumcision, for instance, where the child is of sufficient age and maturity to furnish consent). The child's decision is paramount here, and the consent must be given in the prescribed manner (in writing, on the prescribed form⁵⁴ and after proper counselling by a parent, guardian, caregiver or social service professional). No reference is made in the body of sections 12(8) or 12(9) to "customary" or "traditional" circumcision. It is submitted, however, that the general floor of 16 years for consent to circumcision applies to traditional circumcision.

Second, the Children's Act and Regulations provide for certain health standards and safeguards during the circumcision process, as outlined in Regulation 5(2), which

⁵² Female circumcision is completely proscribed by section 12(3).

⁵³ The regulation of circumcision in the South African Children's Act corresponds a great deal with those provisions found in the Botswana Children's Act, 2009. Section 62 of that Act reads:

'62. Harmful social, cultural and religious practices

(1) Subject to section 61 (3), and section 90, every child has a right not to be subjected to social, cultural and religious practices which are detrimental to his or her well-being.

(2) A child shall not be subjected, by any person, to-

(a) a forced marriage;

(b) a child betrothal;

(c) genital mutilation or female circumcision; or

(d) any other cultural rite, custom or tradition which may inflict physical, emotional or psychological pain or harm to the child, or otherwise violate or endanger his or her bodily integrity, life, health, dignity, education or general well-being.

(3) Unless it is in the interest of the child, no person shall circumcise a male child except where-

(a) the circumcision does not expose the child to any harm and does not conflict with any regulations made under this or any other Act;

(b) the circumcision is performed for medical reasons on the recommendation of a medical practitioner; and

(c) proper counselling of the child is obtained, subject to the child's age, maturity and level of understanding.

(4) A child above the age of 16 may be circumcised only if he consents thereto, has received proper counselling, and it has been certified by a medical practitioner that the procedure is unlikely to cause him any harm taking into consideration his maturity and state of health.

(5) Any person who coerces, pressures or deludes a child into participating in any of the practices referred to in this section shall be guilty of an offence and liable to a fine of not less than P10 000 but not more than P30 000, or to imprisonment for a term of not less than 12 months but not more than three years, or both.'

⁵⁴ See Children's Act Regulation 5, and Form 2 (Consent to Social or Cultural Circumcision).

applies to circumcision for social and cultural purposes, and Regulation 6, which applies to circumcision for religious purposes.⁵⁵

Echoing some of the provincial circumcision provisions discussed previously, these health standards include the use of sterile surgical instruments (to prevent the transmission of HIV Aids or other STDs), safe disposal of instruments and gloves after each circumcision, unless the instruments are appropriately sterilized, prevention of direct blood contact or contact with any other bodily fluids, again an HIV prevention measure, and the disposal of any human tissue in accordance with appropriate medical standards.

Third, as noted previously, the Children's Act provides for two exceptions to the 16 year age limit set for the prohibition on circumcision, namely circumcision for religious purposes in accordance with the practice of the religion concerned,⁵⁶ and circumcision for medical reasons on the recommendation of a medical practitioner.⁵⁷ As regards religious and medical circumcisions, a child older than 16 years must furnish consent independently and parental consent is not required. As regards children aged below 16 years, consent must be given by a parent or guardian and where more than one person has parental rights and responsibilities towards that child, both holders of parental rights and responsibilities must provide permission.⁵⁸ Section 12(10) of the Children's Act also provides for the right of any male child to refuse to be circumcised, taking into consideration the child's age, maturity and stage of development. This provision clearly applies to children below the age of 16 years able to express their refusal.⁵⁹

It has been noted above that provisions aimed at addressing religious and medical circumcision were not envisaged by the South African Law Reform Commission. Their inclusion in the Act did not come about through the deliberations of the draft in the National Assembly, but only when it was subsequently considered by the National Council of Provinces. Since the weight of focus was on virginity testing and amelioration of the proposed outright ban on cultural circumcision, it is not clear from where the drive to include religious and medical circumcision in the ambit of the Act came.⁶⁰

Without wishing to single out any particular religion, aspects of this provision, i.e. the exemption for religious circumcision, appears specifically to target circumcision

⁵⁵ General Regulations Regarding Children (published under GN R261 in GG 33076 of 1 April 2010). There are no provisions in the Regulations regarding circumcision for medical purposes.

⁵⁶ Children's Act Section 12(8)(a).

⁵⁷ Children's Act Section 12(8)(b).

⁵⁸ Regulations 6(3)(a).

⁵⁹ Where the line would be drawn is not clear, but in a very recent judgment, a South African Court accepted the refusal of a child to be returned to his mother's care in Australia in a return application under the Hague Convention on the Civil Aspects of International Child Abduction (*Central Authority v B*, case no 2011/21074, South Gauteng High Court, unreported judgment of 7 December 2011) where the child concerned was 13 years old.

⁶⁰It is not referred to at all in Le Roux (note 11 above), nor in the Children's Institute summary 'Children's Bill Progress update, 13 March 2006 available at (http://www.ci.org.za/index.php?option=com_content&view=article&id=632%ASubmissions-to-national-council-of-provinces (accessed 7 June 2012).

performed by adherents of the Jewish faith,⁶¹ although it is well known that adherents of other faiths, including Christians and Muslims, routinely circumcise infant boys. This assertion is proffered because, despite the fact of Christians and Muslims practicing infant circumcision, it is not self-evident that these circumcisions are the result of religious adherence, or whether they are simply based on the past practice of the parents. It is not clear, therefore, whether routine infant circumcision (RIC) performed shortly after birth by Christians and Muslims falls within the scope of legitimacy conferred by the Act's exception based on religion. They may well rather be characterised as medical circumcisions, which would then have to fall within the justification of medical circumcision elucidated above, i.e. they have to be recommended by a medical practitioner.⁶² Usually, Christian and Muslim circumcisions are effected in medical settings, rather than in religious ceremonies, and it is therefore submitted that in order for Christian or Muslim circumcision to qualify under the religious circumcision exception, a detailed justification on religious grounds would have to be manifested.⁶³

The Children's Act provides that social and cultural circumcision may only be performed in accordance with the social and cultural practices of the child concerned,⁶⁴ and then by a medical practitioner or a person with knowledge of the social and cultural practices concerned and who has been properly trained to perform circumcisions;⁶⁵ similar provisions govern religious circumcision which may be performed by a medical practitioner or by a person from the religion concerned who has been properly trained to perform circumcisions.⁶⁶

The Act does not further regulate any training of social, cultural or religious circumcisers, or provide any further detail pertaining to the qualifications or experience of the traditional or religious circumcision practitioners. Moreover, no provisions (except the nude exception referred to in section 12(8)(b)) cast any further light on what meant by "circumcision performed for medical reasons or upon the recommendation of a medical practitioner". Whether neonatal circumcision (RIC) performed shortly after birth without a "recommendation of a medical practitioner" as a result of parental preference and family tradition (leaving aside social health policy, as discussed in sections 4 and 5 below) is legal in the face of the prohibitions and explicit exceptions outlined in the Children's Act above, is questionable. It is the assertion of this

⁶¹ See Le Roux (note 11) at 18-20.

⁶² Since the Regulations do not cover medical circumcision at all (there is no enabling clause in the principal Act requiring or permitting regulations), it would appear that this 'recommendation' may be either verbal or written, and no particular format is prescribed.

⁶³ As was advocated in the leading Constitutional Court decision on the right to religion by the girl who argued that the right to wear a nose ring was a manifestation of her right to religion (*MEC for Education KwaZulu Natal and Ors v Pillay (Governing Body Foundation; Natal Tamil Vedic Society Trust: Freedom of Expression Institute as Amici)*, 2008 (1) SA 474 (CC)).

⁶⁴ Children's Act Regulation 5(1)(c).

⁶⁵ Children's Act Regulation 5(1)(d).

⁶⁶ Children's Act Regulation 6(1).

author that such routine neonatal circumcisions were not intended to be authorised by the Act.⁶⁷

To summarise, there is now quite a complex interplay of South African legislation, at various levels, attempting to regulate particularly circumcision practiced in accordance with customary rites, but also addressing religious and medical (infant) circumcision. The legislation spans provincial enactments, with accompanying Regulations and even Annexures which also purport to contain direct legal provisions, the national Children's Act, and the Regulations to that Act. The Children's Act does not deal with exactly the same issues covered by the provincial laws, notably issuing of permits and establishment of registration systems. However, some of the health protective provisions are clearly duplicated, notably in the Free State provincial provisions which, insofar as the Regulations of 2008 are concerned, post-dated the passage of the Children's Act in the national Parliament and seem to have been developed contemporaneously with the development of the Regulations to the Children's Act. The fact that there is co-existing provincial and national legislation creates the possibility of conflicts, for instance in relation to the consent of the initiate. National legislation would in such instance triumph.

Yet traditional or customary circumcisions continue apace outside the bounds of the Acts, and deaths and botched circumcisions of young initiates continue to be recorded. Since the Children's Act became operational only on 1 April 2010, it is unknown whether the provisions of the Act are being strictly followed in relation to religious circumcision.⁶⁸ Further, it remains unknown whether widespread elective circumcision of neonates continues, in apparent violation of the provisions of the Act. It is worthy of note, perhaps, that contravention of section 12 (8) of the Act (the prohibition on circumcision of children aged below 16 except for religious or medical reasons) constitutes a criminal offence in terms of section 306, for which severe penalties are prescribed.

However, as will be shown below, it is rather more likely that circumcision, including infant circumcision, is on the overall increase.⁶⁹ The reasons for this deduction are provided next.

⁶⁷ The author does not provide any view on the ethics or medical desirability of neonatal circumcision performed to the wishes of the parents, although this has recently become a topic of some debate in medical and legal circles. See, for instance, Fox, M and Thomson, M 'Short Changed? The Law and Ethics of Male Circumcision' in Freeman, MDA (ed) *Children's Health and Children's Rights* (Marthinus Nijhoff publishers, The Netherlands, 2006). The preliminary view expressed here is that elective infant circumcision without medical justification as a result of parental preference contravenes the Children's Act.

⁶⁸ In particular, the requirement that sterilized instruments be used, which is not always the preferred method in the Jewish tradition. See also the requirement in the Regulations about the safe disposal of any human tissue, which is not always a feature of orthodox Jewish circumcision practice: see www.wikipedia.org/brit_milah (accessed 30 May 2012) for a detailed description of the Jewish tradition.

⁶⁹ See for a similar tale of increased circumcision in neighbouring Lesotho, 'Lesotho: boys quite school to become men' www.irinnews.org/report/report.aspx?reportID=94228, 17 November 20011 (accessed 19 December 2011). The 'spike' in initiation schools is attributed to the widely reported research that men could dramatically lower the risk of contracting HIV by being circumcised.

4. CIRCUMCISION IN THE CONTEXT OF HIV/ AIDS

Whilst the provisions enumerated above were largely debated and drafted before 2008,⁷⁰ a new dimension has emerged in the male circumcision debate. This is recent data (randomized trials)⁷¹ indicating that male circumcision offers up to 60% protection against HIV transmission to men (heterosexual transmission).⁷² There is not yet evidence that male circumcision offers any protection to women who may acquire HIV through heterosexual intercourse, nor to men who may be vulnerable to contracting HIV through intercourse with men.

There is limited empirical research which suggests that there may be some “behavioural risk compensation”, i.e. that circumcised men stop using condoms, but it is argued by public health analysts that this can be mitigated by intensive counselling which accompanies male circumcision. The evidence appears to suggest that the removal of the foreskin through circumcision reduces the ability of HIV to penetrate the skin on the penis, and there are some suggestions that HIV targets cells from the inner surface of the foreskin.⁷³ The initial studies were stopped early due to the overwhelming evidence of the link between circumcision and reduction of transmission of the virus, and since 2007, male circumcision has been recommended by the World Health Organization (WHO) as a prevention method for HIV.⁷⁴

Scientists record that thereafter, several sub-Saharan countries with low circumcision prevalence and high HIV prevalence scaled up circumcision for HIV prevention. One such country is Swaziland, where approximately 8% of men are circumcised and adult HIV prevalence is 26.1%.⁷⁵ Swaziland's HIV epidemic is predominantly heterosexually driven, and it disproportionately affects younger adults in urban areas.⁷⁶ King Mswati has publically come out in favour of the campaign for male circumcision.⁷⁷

⁷⁰ The Regulations to the Act as a whole were drafted over the period February 2007 until December 2007 and were introduced to Parliament in late 2008. The author of this article led the drafting team.

⁷¹ Auvert, Taljaard, Lagarde et al. 'A randomized, controlled intervention trial of male circumcision for reduction of HIV infection risks: The ANRS 1265 Trial'. *PLoS Med* 2005;2(11)e298:1112-1122

⁷² Three major studies were done at the Bophelo Pele Center and also known as the Orange Farm trial. After the Orange Farm trial, two more studies done in Uganda and Kenya in 2006 supported the results that circumcision reduces HIV transmission by about 60 percent. See, in general, Vawda and Maqutu 'Neonatal circumcision – violation of children's rights or public health necessity? (2011) vol 4(1) *South African Journal of Bioethics and the Law* 36-42.

⁷³ *South Africa Considers Male Circumcision as Part of HIV Prevention Plan*, PBS Newshour available at http://www.pbs.org/newshour/updates/health/jan-june09/circ_0320.html

⁷⁴ WHO/UNAIDS Conclusions and Recommendations 2 reads: “The trials...carried out in Kisumu, Kenya, and Rakai District, Uganda revealed that 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’.

⁷⁵ Joint United Nations Programme on HIV/Aids, 2008a.

⁷⁶ Central Statistical Office, 2008.

⁷⁷ Africa's last absolute monarch said men and boys needed to get circumcised to help fight the ‘terrorist’ virus, which infects one in four adults in the kingdom of nearly 1.2 million. The US-funded circumcision

Malawi had decided that the evidence for mass circumcision was not convincing,⁷⁸ and one detractor from Malawi suggested that the WHO data entailed that 16 men may have to be circumcised to prevent 1 HIV transmission.⁷⁹ Other critics have called the mass circumcision claims a charade “that is stoked by people who are not themselves at any risk of being infected by the virus”⁸⁰; they note that mass male circumcision campaigns can have serious consequences such as infections with other diseases, and potentially even the failure to achieve a meaningful reduction in HIV transmission.⁸¹ There are suspicions that, as with other public health interventions, business and profit interests may be at stake, e.g. with well-known money spinners promoting new Klamps designed to speed up the circumcision in the public health system.⁸²

Notwithstanding opposition, since 2007, the powerful PEPFAR (US Presidents Emergency Plan for Aids Relief) which dominates the donor agenda, has pledged money to countries willing to undertake mass male circumcisions.⁸³ Countries who benefit must have a clear policy in place as to how the exercise will be carried out, indicating the health facilities where the circumcisions will be carried out. (It is not proposed that the funds benefit or be deployed to traditional circumcision schools or traditional surgeons). Kenya and Rwanda provide examples of two countries where comprehensive national roll out plans are underway for mass circumcision.⁸⁴

A new website (www.malecircumcision.org) aims to share information on best practices in public health relating to circumcision in the African context (where public health facilities are limited as is the availability of sufficient expertise in the form of trained health personnel). Operated by Family Health International, it has WHO, UNAIDS and various other major actors supporting the site. The WHO and UNAIDS have recently set a target of 80% coverage for male circumcision in Eastern and Southern Africa.⁸⁵

campaign aims to circumcise 80 percent of Swazi males aged 14 to 49 within a year. See *Launch of a National Accelerated Male Circumcision Program by King Mswati III*, available at http://sa.usaid.gov/southern_africa/content/launch-national-accelerated-male-circumcision-program-king-mswati-iii (accessed 6 September 2011)

⁷⁸ “Malawi rules out circumcision for Aids Prevention” at www.mg.co.za/article/2010-09-16-malawi-rules-out-circumcision-for-aids-prevention (accessed 21 December 2011).

⁷⁹ Note 78 above.

⁸⁰ HIV in Kenya: Public Health, Private Interests, HIV and Circumcision, blog post available at <http://hivinkenya.blogspot.com/2011/08/if-you-dont-have-time-to-read-articles.html> (accessed 6 September 2011)

⁸¹ Note 77 above.

⁸² See *Tara KLamp director faces extradition*, Mail and Guardian, 25 October 2010 available at <http://mg.co.za/article/2010-10-25-tara-klamp-director-faces-extradition> See also *The blunt truth about new circumcision device*, Ilham Rawoot, Mail and Guardian 4 October 2010 available at <http://www.thoughtleader.co.za/amabhungane/2010/10/04/the-blunt-truth-about-new-circumcision-device/#comment-144395> (accessed 6 September 2011).

⁸³ For example, in Swaziland the US government is spending \$30 million (21 million euros) on the campaign -- nearly \$30 per inhabitant of the tiny kingdom.

⁸⁴ See for instance ‘Rwanda aiming towards 2 million medical male circumcisions’ Plusnews 9 January 2012.

⁸⁵ <http://www.plusnews.org/report.aspx?reportid=94404> (accessed 9 January 2012).

In South Africa, calls have gone out for mass circumcision of both adults and babies.⁸⁶ It has been noted that the KwaZulu Natal Department of Health has said that from April 2012, circumcision would be offered as an option to 10% of the mothers of male babies born in public hospitals.⁸⁷ This announcement caused some controversy, as some argued there may be commercial reasons for trading in human tissue which is used for several industrial purposes, including in the cosmetic industry and for plastic surgery.⁸⁸ This was denied, and it was said that safe waste disposal methods would be implemented.

Already each day at the Bophelo Pele Male Circumcision Centre in Orange Farm, Johannesburg, a medical team of three doctors and sixteen nurses perform about one hundred circumcisions daily on adult men in the community.⁸⁹ All the literature suggests that the circumcision debate has moved suddenly and very rapidly. Current discourse contextualizes male circumcision (infant and adult) as a public health intervention in the context of HIV. It is a discourse which postdates the development of the legislation alluded to in the first half of this article, and therefore questions arise as to how public health policy and child protection legislation are going to mesh, what the human rights implications of the trend towards mass male circumcision might be, and what possible consequences for culture and custom might unfold. These three issues will be addressed in conclusion, with the last issue dealt with first.

5. A FORESKIN TOO FAR?

It is not clear what effect public health programmes for mass circumcision will have upon traditional circumcision: for some cultural groups such as the Xhosa, not being circumcised is unthinkable.⁹⁰ Yet the circumcision contemplated in Xhosa culture is not a medicalised procedure but the “the most resilient of all African practices within the urban industrialised environment”.⁹¹ It is disputable that for groups who practice traditional circumcision (add the Shangaan, Tsaong, Tswana and Sotho to the Xhosa in South Africa), the rites of passage and socialisation functions associated with the attending circumcision schools entail that “hospitalisation is strongly resisted”.⁹² Dr

⁸⁶ WHO/UNAIDS recommendation is included in the South African National Strategic Plan. Department of Health. HIV and AIDS and STI National Strategic Plan for South Africa, 2007-2011. <http://www.doh.gov.za/docs/misc/stratplan-f.html>. According to an UNAIDS report, about 35% of South African men are already circumcised.

⁸⁷ See *New move to circumcise infant boys*, 7 December 2010 The New Age available at <http://thenewage.co.za/5010-1010-53-New-move-to-circumcise-infant-boys> (accessed 9 January 2012).

⁸⁸ See *Babies' foreskins could be sold: Ethics watchdog*, 8 August 2011 Times Live available at <http://www.timeslive.co.za/local/2011/08/08/babies-foreskins-could-be-sold-ethics-watchdog>

⁸⁹ www.tac.org.za/userfiles/TK%20fliers%202.pdf (accessed 30 May 2012).

⁹⁰ Mandela, *Long walk to Freedom* (1994) at 22: ‘An uncircumcised Xhosa man is a contradiction in terms, for he is not considered a man at all...’ “When a man is not a man” UKZN press 2009

⁹¹ Stinson, *Male Circumcision in South Africa: How does it Relate to Public Health* available at <http://africanvoices.co.za/culture/circumcision.htm> (accessed 21 December 2011).

⁹² As above. See too van der Zalm ‘Protecting the Innocent: Children’s Act 38 of 2005 and Customary Law in South Africa- conflicts, consequences and possible solutions’ (2008) 22 *Emory Int’l Law Review* 891 at 906 confirms that amongst some cultures, a medically performed circumcision does not officially confer the rite of passage status that the ritual circumcision does.

Fidel Hadebe, spokesperson for the Minister of Health has gone on record as saying that male circumcision is more than just a male reproductive health issue, it is a cultural issue as well. Mass infant circumcision of neonates in the present day is going to have long term implications for cultural rites (and rights?⁹³), when traditional circumcision either becomes superfluous to designate entry into adulthood, or transforms over time into a purely ceremonial event (as the medical aspect will have been effected years previously).

As regards the human rights dimensions of infant circumcision, Vawda and Maqutu⁹⁴ argue that an incursion into various rights is occasioned by infant circumcision (rights to culture, religion, equality (vis-a-vis the girl child) and to bodily integrity are mentioned explicitly by them), but they appear to conclude that the public health threat occasioned by HIV/Aids in South Africa presents sufficient justification for a limitation of the rights concerned.⁹⁵ Further, the new circumcision policy, supported internationally at the highest level, certainly seems to imply that infant male (medical) circumcision cannot be regarded as a harmful cultural practice falling within the prohibition contained in the CRC and the African Children's Charter, and that future elaborations of harmful cultural practices are going to have to be sensitively and narrowly defined.

The paediatric profession is heavily split on infant circumcision, with about 30% of doctors campaigning against the practice, usually on rights-based grounds; yet 70% of doctors are quite happy to perform it upon request. Questions abound as to whether, in the light of public health policy, one can still differentiate between medically indicated circumcision⁹⁶ (as provided for in the Children's Act, as discussed) and routine infant circumcision (RIC), performed at the request of the parents. If this view is correct, then the earlier conclusion that elective circumcision of neonates is not consistent with the provisions of the Act must give way: ALL infant circumcision is then "medically" indicated for prophylactic reasons in the era of HIV/Aids.

Public health statements seem to imply that the official circumcision campaigns, at least in South Africa, involve persons over 18, i.e. who are no longer children.⁹⁷ But the fact that public health statements appear to imply that only adult males are being drawn into the mass circumcision campaigns is no guarantee that children below 18 will not similarly be caught up in the circumcision campaigns, which raises complications about consent issues, for instance, where teenagers are concerned. Traditionally Xhosa boys get circumcised from about 15 years of age. The lack of birth certificates which can provide actual proof of age raises yet another set of problems. It is likely therefore that

⁹³ Eg autonomy rights of adults who, on the basis of decisions made when they were infants, are denied their right to culture.

⁹⁴ Note 72 above.

⁹⁵ They do not appear to view elective neonatal circumcision as contrary to the Children's Act, as argued above, adopting a stance that circumcision of babies (at least in the public health sector) is justified by the dictates of public health policy.

⁹⁶ For instance, where a child is born with a defect such as hypospadias, which needs to be corrected.

⁹⁷ See, however, note 77 above indicating that the age threshold for circumcision in Swaziland is from 14 years, ie before boys become sexually active.

young persons below the age of 18 years might get/be? circumcised in the new attempts to control the HIV epidemic. That brings the public health sector directly into the sphere of operation of the Children's Act provisions, as discussed in detail above.

The public health consortia and the lawyers have not consulted each other in this debate until now. It must be recalled that the Children's Act was drafted before the discoveries of medical science occurred. It appears that conflicts are going to arise in future between the dictates of public health policy (advocating mass circumcision to combat HIV) and children's law which envisages narrowing circumcision practices (religious, medical and customary circumcision on the basis that they may constitute harmful practices).

It is concluded that the Children's Act was probably premature in attempting to narrow the circumstances in which circumcision is permitted, and that the independent consent provision - at 16 - may have been set too high, in retrospect (even though the age of 16 emerged as a compromise to an intended ban on all circumcision of persons under 18). Moreover, given the inability of anyone to police the performance of religious circumcision to ensure compliance with the Act and Regulations, and the overall concurrence now that male circumcision is a public good in any event, it was probably unwise, with hindsight, to attempt to regulate religious circumcision by law as well. It may be advisable to amend the Act to give effect to these recommendations.

As regards traditional or customary circumcision, the cultural significance is seemingly not being raised in the campaign for mass circumcision; the campaign remains explicitly aimed at medical circumcision, and the long term consequences for the cultural practice remain to emerge. It remains possible that with mass neonatal circumcision, traditional circumcision will in future become superfluous. Nevertheless, given the serious risks to young men's health posed by traditional circumcision practices, it is arguable that regulation of traditional or customary circumcision in the Children's Act remains necessary, and, indeed, required by international human rights instruments. However, a final observation is that the provincial legislation discussed in some detail is somewhat unrealistic in the increasingly complex approach to health protection that has taken shape, and that permits, written applications, inspections, disposal of human tissue, committees and the involvement of a series of government officials, to mention a few of the identified provisions, are not usefully placed in legislation, delegated otherwise, accompanied by criminal provisions. The reach of the law can extend too far: and it is this final thought that has inspired the title of this article.

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