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Children's right to physical integrity

Report¹

Committee on Social Affairs, Health and Sustainable Development

Rapporteur: Ms Marlene RUPPRECHT, Germany, Socialist Group

Summary

Despite the committed legislative and policy measures which have been taken by Council of Europe member States to protect children from physical, sexual and mental violence, they continue to be harmed in many different contexts. One category is particularly worrisome, namely violations of the physical integrity of children which supporters tend to present as beneficial to the children themselves despite evidently negative life-long consequences in many cases: female genital mutilation, the circumcision of young boys for religious reasons, medical interventions during the early childhood of intersex children as well as the submission to or coercion of children into piercings, tattoos or plastic surgery.

The Parliamentary Assembly should urge member States to promote further awareness in their societies of the potential risks for children's physical and mental health of the above-mentioned procedures. Member States should take legislative and policy measures that help reinforce child protection in this context by giving primary consideration to the best interest of the child.

1. Reference to committee: [Doc. 13042](#), Reference 3912 of 5 October 2012.



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A. Draft resolution²

1. Many legislative and policy measures have been taken by Council of Europe member States in recent decades to improve the well-being of children and their protection against any form of violence. Nevertheless, children continue to be harmed in many different contexts.
2. The Parliamentary Assembly is particularly worried about a category of violation of the physical integrity of children, which supporters of the procedures tend to present as beneficial to the children themselves despite clear evidence to the contrary. This includes, amongst others, female genital mutilation, the circumcision of young boys for religious reasons, early childhood medical interventions in the case of intersexual children and the submission to or coercion of children into piercings, tattoos or plastic surgery.
3. According to the United Nations Convention on the Rights of the Child (UNCRC), in all actions concerning children, comprising every person under 18, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration and States are required to take "all appropriate ... measures to protect the child from all forms of physical or mental violence, injury or abuse ... while in the care of parent(s), legal guardian(s) or any other person who has the care of the child" (Article 3).
4. The Council of Europe has been actively promoting children's rights and child protection since 2006 through its Strategy for the Rights of the Child, and in which "Eliminating all forms of violence against children" can be found as one of four strategic objectives.
5. The Assembly itself has adopted numerous texts drawing attention to various forms of violence inflicted upon children in bad faith (sexual violence in different contexts, violence in schools, domestic violence, etc.). It continues to fight against different forms of violence inflicted upon children via different promotional activities and campaigns (domestic violence, sexual violence). However, it has never looked into the category of non-medically justified violations of children's physical integrity which may have a long-lasting impact on their lives.
6. The Assembly strongly recommends that member States promote further awareness in their societies of the potential risks that some of the above mentioned procedures may have on children's physical and mental health, and take legislative and policy measures that help reinforce child protection in this context.
7. The Assembly therefore calls on member States to:
 - 7.1. examine the prevalence of different categories of non-medically justified operations and interventions impacting on the physical integrity of children in their respective countries, as well as the specific practices related to them, and to carefully consider them in light of the best interests of the child in order to define specific lines of action for each of them;
 - 7.2. initiate focused awareness-raising measures for each of these categories of violation of the physical integrity of children, to be carried out in the specific contexts where information may best be conveyed to families, such as the medical sector (hospitals and individual practitioners), schools, religious communities or service providers;
 - 7.3. provide specific training, including on risks of and alternatives to certain procedures, as well as the medical reasons and minimum sanitary conditions that should be fulfilled when performing them, to various professionals involved, in particular medical and educational staff, but also, on a voluntary basis, religious representatives;
 - 7.4. initiate a public debate, including intercultural and interreligious dialogue, aimed at reaching a large consensus on where the limits with regard to violations of the physical integrity of children are to be drawn according to human rights standards, and at striking a balance between the rights and the best interest of the child and the rights and religious freedoms of parents and families;
 - 7.5. take the following measures with regard to specific categories of violation of children's physical integrity:
 - 7.5.1. publicly condemn the most harmful practices, such as female genital mutilation, and pass legislation banning these, thus providing public authorities with the mechanisms to prevent and effectively fight these practices, including through the application of extraterritorial "legislation or other measures to establish jurisdiction" for cases where nationals are submitted

2. Draft resolution unanimously adopted by the committee on 27 June 2013.

to female genital mutilation abroad, as specified in Article 44 of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (CETS No. 210);

7.5.2. clearly define the medical, sanitary and other conditions to be ensured for practices which are today widely carried out in certain religious communities, such as the non-medically justified circumcision of young boys;

7.5.3. undertake further research into rare phenomena such as intersexuality or DSD (differences of sexual development) to ensure that all children concerned may benefit from operations according to the highest medical and ethical standards and the current state of the medical art, and be submitted to them at an age appropriate for their specific DSD symptoms;

7.6. promote an interdisciplinary dialogue between representatives of various professional backgrounds, including medical doctors and religious representatives, so as to overcome some of the prevailing traditional methods which do not take into consideration the best interest of the child and the latest state of medical art;

7.7. raise awareness about the need to ensure the participation of children in decisions concerning their physical integrity wherever appropriate and possible, and to adopt specific legal provisions to ensure that certain operations and practices will not be carried out before a child is old enough to be consulted.

B. Draft recommendation³

1. The Parliamentary Assembly welcomes the ambitious work undertaken by the Council of Europe in favour of children's human rights, which has always followed a comprehensive approach including child protection, the promotion of children's development and child participation as the main pillars of effective child rights strategies.
2. The Assembly welcomes, in particular, the fact that the Council of Europe's Strategy for the Rights of the Child already focuses on eliminating all forms of violence against children amongst its strategic objectives, and strongly encourages the Committee of Ministers to allow this work to continue along the same lines beyond 2015.
3. The Assembly points out, however, that a certain category of human rights violations against children is not yet explicitly covered by any international or European policy or legal instrument: the medically unjustified violations of children's physical integrity as specified in Assembly Resolution ... (2013) on "Children's right to physical integrity".
4. With the purpose of reinforcing the protection of children's rights and well-being at the European level, the Assembly invites the Committee of Ministers to:
 - 4.1. fully take into account the issue of children's right to physical integrity when preparing and adopting its new Strategy for the Rights of the Child as of 2015, in particular as regards the fight against all forms of violence against children and the promotion of child participation in decisions concerning them;
 - 4.2. consider the explicit inclusion of children's right to physical integrity, as well as their right to participate in any decision concerning them, into relevant Council of Europe standards and, to this end, to examine in a comprehensive manner in which Council of Europe instruments such rights should be included.

3. Draft recommendation unanimously adopted by the committee on 27 June 2013.

C. Explanatory memorandum by Ms Rupprecht, rapporteur

1. Introduction

*“Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you yet they belong not to you.”*

Khalil Gibran, “On Children”

1. The background and yardstick for the issue covered by the present report is, amongst others, a far-reaching international human rights framework relating both to children's right to special protection and the more specific human right to health as specified, respectively, by the United Nations Convention on the Rights of the Child (UNCRC) of 1989 and the Constitution of the World Health Organization (WHO) as amended in 2005.
2. The Convention on the Rights of the Child provides that, in all actions concerning children, comprising every person under the age of 18, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration and requires States to take “all appropriate ... measures to protect the child from all forms of physical or mental violence, injury or abuse, ... while in the care of parent(s), legal guardian(s) or any other person who has the care of the child” (Article 3). It also provides that “States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children” (Article 24, paragraph 3).
3. As far as the right to health is concerned, the World Health Organization declares in the preamble of its Constitution that it is one of the fundamental rights of every human being to enjoy “the highest attainable standard of health”.
4. Despite this very clear framework, which has been translated into national legislation in many countries, the physical integrity of children continues to be threatened in many ways in Europe. This may happen in practically all settings where children spend time in their everyday lives, such as families, schools, leisure associations, religious communities, social services or others.
5. Harm to their physical integrity is inflicted upon children on the basis of various intentions: in some cases, physical harm is done in bad faith, for example when abusing, mistreating or neglecting a child. In other cases, such as in the context of corporal punishment in families or schools, it is meant to be to the benefit of children, but is often practiced without sufficient awareness or knowledge of the dramatic short-term and long-term consequences it may have on a child's mental and physical health and development. In yet another category of cases, physical harm may be inflicted upon children with entirely positive intentions, sometimes motivated by cultural or religious traditions, but often against the best interest of the child as protected by the above-mentioned international standards and according to more objective criteria.
6. As rapporteur, I am particularly concerned about the last category of specific, (well-)intended, socially accepted, but very often medically unjustified interferences with children's physical integrity. Children themselves cannot be or are not consulted on these interventions because they are too young to fully understand the intervention or its consequences, or to give their full and informed consent. I am particularly worried about those cases where these interventions are undertaken without associating qualified medical staff and based on the consent given or explicit wish expressed by parents who are not fully aware of the risks of such interventions.
7. In this respect, I would in particular like to examine the following situations which may have an impact on children's physical integrity: the circumcision of young boys in certain religions, medical interventions in the case of intersexual children, female genital mutilation (in certain cultures), the submission to or coercion of children into piercings, tattoos or plastic surgery, and the non-treatment of children facing certain medical pathologies (in certain religious communities).
8. Recent political debates, such as the one on male circumcision in my own country Germany, have made it very clear that any work on this issue needs to take into consideration children's rights, parental rights as well as cultural and religious freedoms. In particular the rights of parents (and their possible limits) need to be examined closely, as they are generally the ones giving their consent to the interventions in question.

Some of the central questions to be examined in this respect are: under which circumstances can it be justified to interfere with the physical integrity of children and under which conditions? Through which means (political or legal) shall these conditions be guaranteed, in other words should parents' possibilities to decide on behalf of their children be limited by law and how could they be made aware of risks and alternatives through other means?

9. Several experts have already been heard, to complete the review of specific literature and press articles: Dr Ilhan Ilkilic (Associate professor at the Department of History of Medicine and Ethics, Istanbul University, Faculty of Medicine, Turkey), Mr Victor Schonfeld (Producer of documentary films, London, United Kingdom) and Dr Matthias Schreiber (Paediatric surgeon, Department of paediatric surgery, Clinic of Esslingen, Germany) gave presentations to the Committee on Social Affairs, Health and Sustainable Development on the widespread practice of male circumcision.⁴ Ms Irmgard Schewe-Gerigk (President of the Executive Council of *Terre des Femmes*, Germany) was heard at a subsequent committee meeting focusing on female genital mutilation.⁵ I would like to thank all experts for their availability and most useful contributions that are reflected in the present report.

10. I am convinced that the Parliamentary Assembly should call upon member States to take committed political action through awareness-raising campaigns in favour of the utmost protection of children's physical integrity in all circumstances, and to examine further legal and political action required. As a general principle, any future action at national level should be taken without criminalising families or professionals acting in good faith for minor injuries and include criminalisation for major injuries.

11. The present report intends to draw up some of the lines along which children could be better protected in our modern world, and their best interest guaranteed while balancing their rights with parental rights and cultural and religious freedoms.

2. Threats to the physical integrity of children in Europe today

12. Several categories of procedures fall under the proposed notion of "specific, (well-)intended, socially accepted, but often medically unjustified interventions", though they certainly vary with regard to their irreversibility, gravity and actual consequences for the child. Below different types of interventions and their consequences on the physical and mental health, well-being and development of children are described, discussed and qualified in the most differentiated manner possible, in particular set against the specific cultural context in which they are taking place.

2.1. Circumcision of young boys

13. Male circumcision is the surgical removal of some or all of the foreskin (or prepuce) from the penis.⁶ It is probably the oldest identified and the most frequently performed optional surgical procedure for males throughout the world. Neonatal circumcision or circumcision on young boys may be performed for medical, cultural or religious reasons. It is a widely observed religious practice performed almost universally in Jewish and Muslim communities.⁷

14. However, the procedure is increasingly questioned and its perception is changing in the light of growing awareness for children's human rights. Even within religious communities, an increasing number of people have started questioning traditional but harmful practices and looking for alternatives. Having explored this issue in detail during the recent legislative debate in my own country, Germany, I would like to show why circumcision applied to young boys clearly is a human rights violation against children, although it is so widely performed both in the medical and in the religious context.

2.1.1. History and prevalence of male circumcision

15. Ritualistic circumcision has been carried out in West Africa for over 5 000 years and in the Middle East for at least 3 000 years. The transformation of this ancient ritual into a routine medical operation began late in the 19th century where it was recommended for a growing list of (pseudo-)medical indications, in particular as

4. Experts heard at the hearing organised by the Committee on Social Affairs, Health and Sustainable Development in Strasbourg on 24 January 2013.

5. Exchange of views organised at the committee meeting held in Berlin on 15 March 2013.

6. Centers for Disease Control and Prevention (USA), "Male Circumcision", www.cdc.gov.

7. Steadman, Ellsworth, To Circ or Not to Circ: Indications, Risks, and Alternatives to Circumcision in the Pediatric Population with Phimosis. *Urologic Nursing*, June 2006, 26(3): 181-194, Society of Urologic Nurses and Associates.

a means against masturbation, headache, strabismus, rectal prolapse, asthma, enuresis, and gout. Rates of circumcision began to drop in the 20th century when increasingly nationalised health care systems analysed costs versus benefit.⁸

16. In 2006, the World Health Organization (WHO) estimated that about 30% of males worldwide, representing approximately 665 million men, were circumcised.⁹ These are largely concentrated in the United States, Canada, countries in the Middle East and Asia with Muslim populations, and large proportions of Africa. Also according to WHO, circumcision prevalence has continued to decline in Europe to be found at less than 20% in most countries today. In Europe, neonatal circumcision is therefore predominantly related to Muslim or Jewish religious communities, medical reasons or immigration from circumcising countries.¹⁰

17. Today, Muslims continue to consider ritualistic circumcision as a pubertal rite of passage into manhood among older boys. The Jewish community usually circumcises male infants on their 8th day after birth in a ceremony called the “Brit Milah”, which is understood as an initiation rite for babies and a covenant with God.¹¹ Circumcision applied for medical reasons varies from one country to another. Whilst circumcision of boys is being critically viewed and increasingly replaced by alternatives in European countries, it continues to be promoted in the United States.

2.1.2. Arguments regularly presented in favour of male circumcision and its legal authorisation

18. According to the evaluation by the American Academy of Pediatrics (AAP) Task Force on Circumcision in 2012, the health benefits of newborn male circumcision outweigh the risks. To be found amongst the specific benefits were the prevention of urinary tract infections, acquisition of HIV, transmission of some sexually transmitted infections, and penile cancer. Accordingly, the United States remain amongst those countries where most newborn circumcisions are carried out in the western world (around the end of the 20th century, up to 80% of boys according to geographic, ethnic and socio-economic determinants, though this percentage has strongly declined in recent years).¹²

19. A similarly positive evaluation, although for other reasons, is made by WHO, which sees compelling evidence for the fact that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60% and therefore promotes circumcision as one element of comprehensive HIV prevention packages (amongst other measures, such as the correct and consistent use of condoms by sex workers).¹³ WHO also sees an indirect health benefit for women in male circumcision, in particular a reduced risk of exposure to HIV and other sexually transmitted infections, as well as reduced rates of cervical cancer.¹⁴ However, increasingly, medical experts are starting to question positive evaluations of male circumcision as a factor reducing the risk of HIV infections.¹⁵

20. In the religious context, male circumcision of young boys is considered an integral and indispensable part of religious rituals and has, for centuries, been perceived as not causing major harm to children’s health in any way if carried out according to the highest medical and hygienic standards. Moreover, the (erroneous) belief is still relatively widespread, also amongst religious communities holding up their traditional rituals, that very young children are not yet as sensitive to pain as older children or adults and that their pain can be relieved with local anaesthetic creams.

21. In the face of the arguments of those promoting children’s right to physical integrity, religious representatives would generally tend to interpret the “best interest of the child” in a broader manner, also by taking into consideration religious rights and practices. From this point of view, it is considered to be in a child’s best interest not to be discriminated against or marginalised within the own religious community. In the face of efforts undertaken to legally restrict circumcision in the religious context, such as recently in my own country Germany, religious communities would often warn against “circumcision tourism” by parents travelling to countries where such operations are more easily accessible, but not necessarily under the safest conditions

8. Steadman, Ellsworth; see footnote 7.

9. WHO, Information Package on Male Circumcision and HIV Prevention” (Insert 2), www.who.int.

10. WHO, Male circumcision Global trends and determinants of prevalence, safety and acceptability, Geneva, 2007.

11. BBC Thematic file “Circumcision” (under Religions, Judaism: Circumcision), www.bbc.co.uk.

12. American Academy of Pediatrics Task Force on Circumcision, Male circumcision (abstract), National Center for Biotechnology Information, United States National Library of Medicine (Pubmed), 2012, www.ncbi.nlm.nih.gov/pubmed/22926175.

13. WHO, “Male Circumcision for HIV Prevention”, www.who.int/hiv/topics/malecircumcision/en.

14. WHO, Information Package on Male Circumcision and HIV Prevention” (Insert 5), www.who.int.

15. Circumcision Resource Center, Circumcision and HIV: Harm Outweighs Benefit, Boston, www.circumcision.org/hiv.htm#.

for the child.¹⁶ From my point of view as a children's rights activist, these are arguments purely serving the adults who wish to avoid a confrontation with the "dark side" of their own religion, traditions and, finally, identity. Such arguments ignore both current medical knowledge about the lack of necessity and the consequences of circumcision, and the fact that children are subjects of rights and should no longer be objects and victims of harmful practices imposed on them by adults.

2.1.3. Arguments against male circumcision as a routine procedure

22. The British Medical Journal already concluded in 1949 that there was no medical justification for routine neonatal circumcision.¹⁷ From an ethical point of view, which I would like to support with the present report, infant circumcision applied in a routine manner is increasingly considered as an infringement of the human rights of a child, in particular if carried out by non-medically trained persons and in a non-sterile environment (in a private home, a religious edifice, etc.) as very often happens in the religious context.

23. Qualified medical experts who have themselves carried out many circumcisions regularly underline that the protective function of the male foreskin must not be underestimated, that any circumcision is a considerable intervention which always involves cuts around the whole penis (as the Latin name "*circumcisio*" indicates) and the need for a general anaesthetic (when applied to older children or adults). There is evidence that unprofessional circumcisions may cause infections, organ curvatures, perforated urethra and, finally, additional operations, whilst even wrongly applied bandages can have severe consequences such as necrotic tissue and other irreversible damage. Some of the complications are regularly fatal. Of course not all consequences or side effects of operations are widely known given that neither medical staff nor patients (or their families) like talking about complications. However, in 2013, 38 professors around Europe and in Canada officially contested the new policy statement published by the APP in 2012 (see footnote 12).¹⁸

24. On the other hand, recognised paediatric surgeons would argue that the benefits of newborn circumcision should not be overestimated: while circumcised infants are known to have ten times less urological infections in their first year, such infections are generally so rare that, statistically speaking, 100 circumcisions are needed to prevent a single infection. Furthermore, there is scientific evidence that the pain suppressing system of children is only operational a few months after birth, and that a newborn child feels more pain than an adult.¹⁹ Medical studies have also shown that analgesic treatment available for small children (who are too young for general anaesthetics) do generally not have the intended effect, and are not recommended for children under 12 years of age anyway. The increased pain perception by young children and the lack of effective pain treatment for infants are, from my point of view, amongst the main arguments against circumcision of young boys, as they can be traumatising for the child.

25. Even in the religious context, more and more critical voices can be heard. One of them is that of Victor Schonfeld, a British film producer and a Jew himself, who started taking a critical view when his own son was expected to be circumcised. In his well-known TV documentary "It's a Boy" (produced for Channel 4 in the United Kingdom in 1995), Victor Schonfeld shows the suffering of a Jewish baby boy, Joshua, who is circumcised according to the traditional Jewish ritual, that is to say without anaesthetic, by a rabbi who is not a doctor, in non-antiseptic conditions, including use of a sharpened fingernail and the rabbi's mouth.²⁰ The film also shows the severe infection that the little boy suffers from a few days later as a consequence of the operation, and the extreme social pressure exerted on his parents: whilst the father had tried to object to the procedure, without success, the mother was not allowed to be present, neither during the operation itself nor in the aftercare provided to her son. The documentary also shows an interview with a young mother whose son died following the procedure a few days after birth.

26. Increasingly aware of the underestimated risks of such procedures, especially when undertaken without medical professionals, of the fact that newborn circumcision is not necessarily medically required and of the pressure that is put on them, more and more Jewish families seem to question the traditional ritual of

16. Arguments put forward by Dr Ilhan Ilkic at the hearing held in Strasbourg on 24 January 2013.

17. WHO, Male circumcision Global trends and determinants of prevalence, safety and acceptability, Geneva, 2007.

18. As explained by Dr Matthias Schreiber at the hearing held in Strasbourg on 24 January 2013; see also Fritsch et al: Cultural Bias in the APP's 2012 Technical Report and Policy Statement on Male Circumcision, in: Pediatrics Volume 131, Number 4, April 2013.

19. Ballwieser, Dennis, *Kinderärzte befürworten Beschneidung* (Paediatricians in favour of circumcision), *Der Spiegel Online*, 29 August 2012, www.spiegel.de.

20. This traditional ritual carries an additional risk for the baby boy: there is clear evidence of regular deaths amongst newborn boys due to infectious diseases (for example herpes) transmitted by rabbis or *mohels* (the traditional Jewish circumcisers) – see, for example: Robbins, Liz: Baby's Death Renews Debate Over a Circumcision Ritual, *New York Times*, 7 March 2012, www.nytimes.com.

circumcision today. This can, for example, be observed with initiatives such as the Jewish Circumcision Resource Center created by Jews who question ritual circumcision and “who generally evaluate an idea not solely based on its conformance with the Torah, but also in light of its agreement with reason and experience”. They openly call on Jews to listen to and feel the intense pain of the children, and the denied pain of the adults that they become, in order to realise that circumcision does not necessarily serve the best interest of the child or the community of Jews.²¹

27. The debate is of a slightly different nature in the Muslim community where boys are generally circumcised at a later age, by medical professionals and in more acceptable health conditions involving appropriate anaesthetics. Nevertheless, the tradition is also increasingly questioned by members of the Muslim community, and the long-term physical and psychological consequences for boys having been submitted to this violation of their physical integrity are certainly the same as in other contexts. Critical Muslims regularly point out that no sura of the Koran indicates an obligation to circumcise, but that the main reference are some *hadithe*, thus stemming from prophets’ words mentioning circumcision as “an obligation to be imitated”. However, until today, Islam scientists are divided over the question of whether circumcision truly is an obligation or a simple recommendation.²²

28. The above shows that both medical professionals and religious communities are increasingly aware of the considerable harm inflicted on children through circumcision procedures, especially if performed in a routine, traditional manner. Society should launch new research projects concerning the necessity of circumcision as a medical intervention and enter into an active dialogue with religious communities to raise awareness of what circumcision really means for the physical integrity and lives of boys and men, and to foster the development of alternatives which do exist in many cases and contexts.

2.1.4. Alternatives exist

29. In reality, it is often left to families to decide on behalf of their sons who cannot yet express their wish, whether or not a circumcision should be performed. This confirms the importance of providing families with arguments for and against circumcision in the most complete and transparent manner and of accompanying them in a difficult choice, whether in the medical or the religious context.

30. In the medical context, there is increasing evidence that the operation is often applied too rapidly and alternatives are not sufficiently considered. Amongst these alternatives and for different urological problems (such as phimosis), one may for example find topical steroid therapies and variations of prepuce operations, which do not involve the removal of the entire foreskin. Paediatricians and urologists therefore need to receive adequate training on pathologies which may indicate circumcision, for example when it comes to distinguishing between physiological phimosis – prevalent with more than 90% of male newborns and very often cured by the age of 3 with specific treatment – and pathological phimosis which may require more far-reaching measures, but not necessarily straight at birth.²³

31. In the religious context, alternative rituals are regularly being considered already. They may include other ceremonial elements that are more sensitive to the child and the community. An alternative ritual, sometimes referred to as a “naming ceremony” or “bris shalom“, may or may not be led by a rabbi. To underline the acceptability of such rituals, critical Jews would point out that many Jewish circumcisions already do not meet religious standards if carried out by medical staff in a hospital. In addition, the religious ritual should be performed with the appropriate mindset. However, this is not the case if many Jews circumcise their sons with great emotional conflict, reluctance, and regret. Finally, the use of an alternative ritual has another advantage for which it is attracting growing interest amongst Jewish communities: it can be used for both male and female children.²⁴

2.1.5. Various conditions and actions required to accompany male circumcision

32. In certain countries, there is a large consensus that minimum standards need to be guaranteed to ensure that male circumcision is carried out in healthy and safe conditions. Even those strongly in favour of the operation, such as the American Academy of Pediatrics (see above), generally request that those carrying out circumcision need to be adequately trained, that sterile techniques need to be used and that effective pain

21. Jewish Circumcision Resource Center, www.jewishcircumcision.org.

22. Kelek, Necla: *Die Beschneidung – ein unnützes Opfer für Allah* (Circumcision – a useless sacrifice for Allah), Comment in *Die Welt*, 28 June 2012, www.welt.de.

23. Steadman, Ellsworth, see footnote 7.

24. Jewish Circumcision Resource Center, www.jewishcircumcision.org.

management techniques must be applied.²⁵ Moreover, the American Task Force strongly recommends that medical standards and training should be developed with regard to the circumcision procedure, that educational material should be developed both for professionals and parents (of circumcised or uncircumcised children) and that doctors should advise families, in a non-biased manner, about the potential benefits and risks and inform them about the optional nature of the procedure for which many alternatives exist today.²⁶

33. As rapporteur, I regret to have to say that such measures are not yet systematically applied in my own country Germany. Today, circumcision as a religious ritual may even take place entirely outside the medical system, and may be practised within private homes or religious edifices. According to the latest revision of the German Civil Law as amended on 20 December 2012, male circumcision of infants is now explicitly allowed if it does not endanger the child's well-being and if undertaken "according to the rules of medical art". Within the first six months after the birth of a child, circumcisions may also be performed by qualified religious representatives who are not medical doctors.²⁷ An alternative proposal moved by myself and a group of parliamentarians, that prior to the operation the child should have reached the age of 14, given his consent, and that the circumcision should always be carried out by a paediatric surgeon or urologist, was unfortunately not endorsed by a majority within the German Bundestag.

34. From the facts presented above, in favour and against male circumcision of young boys, I wish to conclude that – according to the current state of medical knowledge – the operation is not as innocuous as many used to or continue to believe, but may have serious short-term and long-term consequences for the health and well-being of boys and men. Although it has been practised for thousands of years, it should therefore be strongly questioned today, both in the medical and the religious context. Alternatives do exist and should be promoted wherever possible: if circumcision seems to be indicated for medical reasons, its necessity should be closely examined on a case-by-case basis; in the religious context, families should be systematically made aware of the risks of the procedure and be provided with full information on the alternatives.

2.2. Female genital mutilation (FGM)

35. According to European standards, such as the "Istanbul Convention" of the Council of Europe (Convention on Preventing and Combating Violence against Women and Domestic Violence, CETS No. 210) and human rights activists across Europe, female genital mutilation (FGM) is amongst the worst human rights violations against girls and women, next to domestic violence, sexual abuse, the abortion of female fetuses for cultural reasons, so-called "honour crimes", or trafficking in human beings. Numerous non-governmental organisations (NGOs), such as *Terre des Femmes* in my own country, Germany, support girls and women to ensure that they are protected from violence, may decide themselves about their sexuality and reproduction and above all are protected from severe bodily mutilations for which no medical reason exists.²⁸

36. Female genital mutilation, as defined by WHO, comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The term used by Unicef is wider and includes the notion of "cutting" to speak of "female genital mutilation/cutting (FGM/C)". This definition takes into consideration that community-based approaches, and therefore less judgmental notions, are sometimes required.²⁹ For this report, however, I would like to stick to the more restrictive notion but which clearly qualifies FGM as a violation of the physical integrity and human rights of girls.

37. WHO currently distinguishes four major types of FGM:

- clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);
- excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina);

25. Ballwieser, Dennis, see footnote 19.

26. American Academy of Pediatrics Task Force on Circumcision, see footnote 12.

27. See paragraph 1631.d on Circumcision of the male child of the German Civil Law (*Bürgerliches Gesetzbuch (BGB)*) as amended on 20 December 2012, www.gesetze-im-internet.de/bundesrecht/bgb/gesamt.pdf.

28. As explained by Ms Irmingard Schewe-Gerigk, President of the executive Council of *Terre des Femmes*, Germany, at the hearing organised by the Committee on Social Affairs, Health and Sustainable Development, in Berlin on 15 March 2013.

29. Unicef Innocenti Research Centre: Changing a Harmful Social Convention, Female Genital Mutilation/Cutting, Innocenti Digest, Florence, 2005 (reprinted in 2008).

- infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris;
- other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.³⁰

38. FGM is in particular practised in certain parts of Africa, Asia and the Middle East. About 140 million girls and women worldwide are estimated to live with the consequences of FGM, while we speak of 92 million girls of 10 years of age and older who have undergone FGM in Africa alone. Increasingly, FGM is encountered in Europe as well. Here, most often, girls and women are taken to their countries of origin during school holidays where they are confronted with the pressure to be cut. The European Parliament estimates that 500 000 girls and women living in Europe are suffering with the lifelong consequences of female genital mutilation.³¹ For Germany once again, *Terre des Femmes* estimates that more than 20 000 migrants are concerned and more than 5 000 girls are currently at risk of undergoing FGM in the near future, whilst 43% of gynecologists in Germany have already treated a woman concerned.³²

39. According to WHO, the causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities. Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice. FGM is often considered a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage. FGM is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist "illicit" sexual acts. Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.³³

40. FGM, which is, in certain cultural contexts, carried out on young girls sometime between infancy and the age of 15, has no health benefits whatsoever, but is known to have severe physical and psychological consequences for girls and women concerned.³⁴ Amongst the immediate consequences of FGM we can find severe bleeding, problems urinating, infections, or sometimes even the death of the mutilated girl.³⁵ Amongst the long-term effects are chronic pain, pelvic infections, abscesses and genital ulcers, excessive scar tissue formation, infections of the reproductive system, decreased sexual enjoyment and painful intercourse. The health consequences therefore continue throughout the woman's life, often producing repetitive trauma when she is about to give birth. FGM is also evidently linked to higher maternal and infant mortality.³⁶ Due to these severe consequences, it is widely recognised as a human rights violation.

41. The large majorities of girls and women (about 80%) are cut in poor hygienic conditions, by a traditional practitioner, a category which includes local specialists (cutters or *exciseuses*), traditional birth attendants and, generally, older members of the community, usually women. In most countries, medical personnel, including doctors, nurses and certified midwives, are not widely involved in the practice, though the "medicalisation" of FGM, whereby girls are cut by trained personnel, seems to be on the rise. According to Unicef, this trend may reflect the impact of campaigns that emphasise the health risks associated with the practice, but fail to address the underlying cultural motivations for its perpetuation.³⁷

42. As most FGM interventions are still carried out by women, women are also key stakeholders when it comes to raising awareness of the need to protect a girl's physical integrity and the abolishment of such harmful traditional practices that they were themselves submitted to as children and that they perpetuate on their daughters. The average age at which girls are submitted to FGM seems to be declining, possibly because it is then often easier to hide the procedure which is illegal in an increasing number of countries today.

43. The cruel practice of FGM violates a number of human rights: the right to physical and mental integrity; the right to the highest attainable standard of health; the right to be free from all forms of discrimination against women (including violence against women); the right to freedom from torture or cruel, inhuman or degrading treatment, the rights of the child; and, in extreme cases, the right to life. Many international

30. WHO – Media Centre, Female genital mutilation, Factsheet No. 241, February 2012, www.who.int.

31. END FGM, European Campaign run by Amnesty International Ireland in partnership with NGOs, www.endfgm.eu.

32. According to Ms Schewe-Gerigk, see footnote 28.

33. WHO, see footnote 30.

34. Ibid..

35. Ibid..

36. Amnesty International: Ending Female Genital Mutilation. A Strategy for the European Union Institutions. www.endfgm.eu/content/assets/END_FGM_Final_Strategy.pdf.

37. Unicef Innocenti Research Centre, see footnote 29.

organisations and child protection agencies have started taking action against FGM, including the European Union, agencies of the United Nations and many NGOs. Amnesty International launched the END FGM European Campaign in 2009 to ensure that the European Union and its national governments act now to end this practice and protect women and girls.³⁸

44. The Parliamentary Assembly adopted its first report on FGM in 2001, clearly condemning it as torture, inhuman and barbaric treatment of girls and young women and a violation of human rights and bodily integrity, thus asking the governments of Council of Europe member States in its [Resolution 1247 \(2001\)](#) to take committed action against it at different levels (legislative, judicial, political, educational, etc.). The Assembly is currently pursuing its action against FGM in the framework of its activities aimed at promoting the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), which clearly condemns female genital mutilation and establishes extra-territorial legislation for such crimes. The Istanbul Convention, opened for signature on 5 May 2011 (but which has not yet entered into force), clearly condemns FGM in its Article 38 by criminalising its performance or any behaviour inciting the procedure or coercing a girl into it. On 6 February 2013, a joint statement to mark the International Day of Zero Tolerance for Female Genital Mutilation was made public by José Mendes Bota (Portugal, EPP/CD), general rapporteur on violence against women, and myself as general rapporteur on children of the Parliamentary Assembly.

45. Juan E. Méndez, United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, regularly underlines that FGM/C amounts to torture and cruel, inhuman or degrading treatment or punishment as set forth in Articles 1 and 16 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). According to him, many States in which FGM is practised, including those with immigrant communities, have enacted laws that specifically prohibit FGM, or apply general provisions of their criminal codes.³⁹

46. Nevertheless, the practice and social acceptance of FGM persist in many countries and effective mechanisms to enforce prohibition are often absent. A formal prohibition of FGM by law is thus not sufficient to conclude that State protection is available. States are obliged to take effective and appropriate measures to eliminate FGM. These obligations include the prohibition through legislation, backed by sanctions, of all forms of FGM, at every level of government, including medical facilities.

47. Not only must States ensure that perpetrators are duly prosecuted and punished, they are also required to raise awareness and mobilise public opinion against FGM, in particular in communities where the practice remains widespread. States should ensure that victims of torture or other cruel and, inhuman or degrading treatment or punishment obtain redress, are awarded fair and adequate compensation and receive appropriate social, psychological, medical and other relevant specialised rehabilitation.⁴⁰

48. It is not because FGM is mainly carried out outside Europe, that European stakeholders should not feel concerned by this issue. Evidence shows that, in the face of a globalised world and increasing migration flows, girls are confronted with this human rights violation in many countries, even though the operation itself sometimes takes place abroad, in their families' countries of origin. Moreover, female genital cutting seems to be increasingly developing in Europe and is openly promoted by some mass media. Especially the reduction of the labia minora and the tightening of the vaginal opening are regularly presented as operations with beneficial outcomes for aesthetics and sexuality. Young girls should be made aware, through sexual education within their families and at school, that although such operations may be fashionable, they may have major and irreversible consequences for their health.⁴¹ With regard to FGM, migrant families and in particular women need to be convinced to spare their daughters such painful and unnecessary procedures and mutilations.

2.3. Sex-determining operations on intersex children

49. The term "intersex" refers to atypical and internal and/or external anatomical sexual characteristics, where features usually regarded as male or female may be mixed to some degree. This is a naturally occurring variation in humans and not a medical condition. It is to be distinguished from transsexuality, a

38. Amnesty International, see footnote 36.

39. Statement by Juan E. Méndez, United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment: Female Genital Mutilation: Progress-Realities-Challenges, Geneva, June 2011, Source: Women's UN Report Network, WUNRN, www.wunrn.com.

40. Ibid.

41. Essén, Birgitta/Johnsdotter, Sara, Female genital mutilation in the West : traditional circumcision versus genital cosmetic surgery, *Acta Obstetricia et Gynecologica Scandinavica* 83 (2004).

phenomenon where someone has an evident sex, but feels as if he or she belongs to the other sex and is therefore ready to undergo a medical intervention altering his or her natural sex. The notion of intersex however, does not clearly indicate whether one needs to speak about a third sex between the two others or if a clear indication of a sex is simply renounced.

50. From the late 1950s onwards, starting in the United States, intersex infants and children were increasingly subjected to cosmetic surgery intended to ensure that their genital appearance and internal gonads were in conformity with the assigned gender, as well as to accompany hormonal treatment. Such treatment was often justified by the assumption that intersex children and/or adults would be subjected to discriminatory behaviour because of their bodily differences, which was not necessarily correct because differences are not always evident or visible.⁴²

51. From the early 1990s, numerous intersex adults have come forward to say that these medical practices had been extremely harmful to them, both physically and psychologically. This public debate was initiated at the time when intersex persons first federated in the Intersex Society of North America (ISNA) in 1990. Today, relevant advocacy organisations strongly recommend that genital operations and other forms of treatment should be avoided until a child can fully participate in decision making.⁴³ Both on legal and ethical grounds, the determination of the sex should be postponed until an age at which affected individuals can make fully informed decisions for themselves.

52. In Germany, the Ministries for Education and Research and for Health have jointly mandated the German Ethics Council (*Deutscher Ethikrat*) in 2010 to examine the situation of intersexual persons based on an invitation by the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) to the German authorities to take appropriate measures to protect intersex persons' human rights. Sex-determining operations undertaken without the consent of the person concerned are indeed increasingly perceived as a violation of personal rights given that the latter include the right to live one's life according to the subjectively perceived sexual identity.

53. Advocacy organisations further criticise the perception of an intersex condition as a pathology and plead for its understanding as an individual sexual variation and a medically complex situation. Different perceptions are reflected by the terminology used: amongst intersex persons themselves this very notion is controversial, whilst many experts today use the internationally recognised notion of DSD, originally standing for "disorders of sex development" but today increasingly understood as "differences" or "variations of sexual development". Without further developing the issue of medical differentiations and expressions of intersex characteristics of any kind, it may just be said that these terms generally cover endocrinal, metabolic disorders on the one hand, and inborn deformations and chromosome abnormalities on the other. In particular, the term also covers girls and women with the so-called androgenital syndrome (AGS) who have masculine expressions in their outer sexual organs, although they are genetically female. According to Europe's leading intersex organisation "Organisation Intersex International (OII) Europe", "intersex" is the best available, least stigmatising and simplest way of describing atypical sex characteristics.⁴⁴

54. Different empirical studies in Germany have shown that until now 96% of all intersex persons across different categories had received hormonal therapy. 64% of persons concerned had received a gonadectomy, 38% a reduction of their clitoris, 33% vaginal operations and 13% corrections of their urinal tract. Many had been submitted to a series of operations and were confronted with post-operative complications. Relevant treatment was traumatising for them and often involved humiliating procedures such as being exposed to large groups of medical professionals and students studying this curious phenomenon. For many, the interventions linked to their syndrome had long-term effects on their mental health and well-being.⁴⁵

55. Some may wonder why, with relatively few numbers of children concerned by this phenomenon, so much public attention is currently given to it. Indeed, very few people are statistically concerned by intersex conditions.⁴⁶ For Switzerland for example, the National Advisory Commission on Biomedical Ethics, in its own opinion No. 20/2012 on the "Handling of Variations of Sex Development", estimates that between 20 and 30 children per year are born without evident sexual assignment.⁴⁷ Estimates by the organisation OII Europe

42. Genital Autonomy: Intersex Children, Intersex Variations and Genital Autonomy, www.genitalautonomy.org.

43. Ibid.

44. According to a written submission forwarded to the rapporteur in July 2013 by OII Europe, <http://oiieurope.org>.

45. *Deutscher Bundestag* (German parliament): *Stellungnahme des Deutschen Ethikrates, Intersexualität* (Opinion of the German Ethics Council, Intersexuality), Drucksache 17/9088, 14 February 2012.

46. According to American experts, a child is born so noticeably atypical in terms of genitalia in about 1 in 1 500 to 1 in 2 000 births. But a lot more people than that are born with subtler forms of sex anatomy variations, some of which will not show up until later in life; source: Intersex Society of North America (ISNA), www.isna.org.

indicate that intersex phenomena concern between 1% and 2% of the population.⁴⁸ In any case, where such conditions appear, they have a considerable impact on people's lives, especially if sex-determining operations are undertaken at an early age and without asking children's consent. Next to medical complications and subsequent suffering, there are cases where the "wrong" sex had been assigned to children at an early age, which did not correspond to their own feeling.

56. The empirical surveys quoted above have shown that, whilst certain persons affected by the AGS syndrome consider that early childhood operations may be useful, most of the persons with other intersex characteristics find it important that operations be made at an age where children can give their consent. Legal loopholes therefore need to be overcome in most countries, now that more medical knowledge about the phenomenon is available, in particular to differentiate between the few cases where operations in early childhood are acceptable or appropriate and the great number of cases where the children concerned must participate in decisions concerning their sex in order to be heard about their personal perceptions and feelings. Finally, specific information and training are required for families of intersexual children, medical professionals of different categories and staff in charge of childcare, allowing them all to handle the situation of intersex children in the most sensitive manner.

2.4. Further violations of the physical integrity of children

57. The interventions quoted above are certainly amongst the most far-reaching interferences with the physical integrity of children, even though they vary in severity according to their specific expression and the context in which they take place. Many of them are decided by families who have never known anything other than these practices, who have good intentions in principle or who are not sufficiently aware of the risks linked to the described procedures.

58. Further violations of the physical integrity of children, in most cases having a minor impact, may occur outside of these main categories, such as, for example, piercings, tattoos or plastic surgery performed on children in an irresponsible manner, or authorised by parents without making their children aware of the risks.

59. A recent case in Germany has drawn attention to parents' responsibility even in cases of small operations such as ear piercings: a girl of 3 had her ears pierced in a Berlin tattoo studio and suffered pain for several days afterwards. When the parents sued the owner of the studio (who was finally condemned to pay compensation of 70 euros), the judges tended to examine whether the parents had acted in a responsible manner. The debate on this case has shown that even minor operations of this kind are controversial. Whilst those who offer ear-piercing services, including on children, consider that this is a minor intervention, medical experts consulted in this context stated that earrings on small children were an interference with the physical integrity of a child, that they are mainly meant to please parents and that children should decide on such bodily decorations or modifications at their own age of legal responsibility (14 in Germany).⁴⁹

60. In the same manner, plastic surgery on children has been debated controversially in recent years. In this context, it will firstly be important to distinguish between medically or psychologically indicated operations, such as the reparation of bodily damage after severe accidents or the correction of prominent ears, and operations applied for purely aesthetic reasons or to escape bullying at school, such as breast enlargement on minors or large tattoos.⁵⁰ It will secondly be essential to protect minors from irresponsible decisions taken by their parents in this context and to raise awareness amongst medical staff and service providers so as not to carry out such operations on young children.⁵¹

61. Finally, isolated religious communities, such as Jehovah's Witnesses, promote the omission of certain medical treatments, in particular blood transfusions, which may cause serious health risks for children in need of such treatments. Under the criteria applied here, this must also be perceived as an undue interference with the physical integrity of children who enjoy the full right to the highest attainable standard of health, just like any other human being. This context is a complex one and should therefore be considered on a case-by-case basis. A recent case reported from the United Kingdom has shown that it may not always be the parents who

47. Swiss National Advisory Commission on Biomedical Ethics, *Zum Umgang mit Variationen der Geschlechtsentwicklung* (On the Handling of Variations of Sex Development), *Stellungnahme* No. 20/2012, Bern, November 2012.

48. OII Europe, see footnote 44.

49. *Sind Ohrlöcher für Kinder Körperverletzung?* (Are ear piercings for children a personal injury?), *Stern* magazine, 31 August 2012, www.stern.de.

50. Braunmiller, Helwi, *Schnippeln an Kindern* (Snipping on Children), Focus Online, 23 April 2008, www.focus.de.

51. Sims, Paul, Children having cosmetic surgery to escape school bullies, surgeon reveals, *Daily Mail*, 28 August 2008, www.dailymail.co.uk.

decide themselves against such interventions but the children themselves under the influence of the sectarian beliefs that their parents have drawn them into: in 2010, a teenage Jehovah's Witness declined the blood transfusion advised by doctors and, not being overruled by his family, finally died at the age of 15.⁵²

62. Such cases create a complex legal situation: whilst a doctor could be sued for non-assistance to persons in danger, doctors who administer blood in the face of refusal by a patient could also be considered as acting unlawfully. There have been cases where doctors have gone to court to get permission to give blood to children against the wishes of parents who are Jehovah's Witnesses. In the light of such ethical and legal complexity, raising awareness for this specific human rights violation, violating children's most fundamental right to life, is therefore of utmost importance in the national context.

3. Conflict and balance between different categories of human rights

63. As already seen above, political and legal responses to the above-mentioned situations are very complex and vary from one country to the other. Every national situation has its own rules and complexity to be taken into account when defining national strategies for the protection of children's physical integrity.

64. For me as rapporteur, the highest standards in the field of child protection, of the human rights to life and security as well as of "the highest attainable standard of health" are clearly the highest priorities and "yardsticks" to be universally applied when it comes to the issue of children's right to physical integrity. These are clearly laid out in the United Nations Convention on the Rights of the Child (UNCRC), the Universal Declaration of Human Rights of 1948, as well as the preamble of the World Health Organization's Constitution, as described in the introduction.

65. Nevertheless, I am aware that there might be categories of human rights which are conflicting with the above-mentioned categories, such as the right to respect for private and family life or the right to freedom of thought, conscience and religion as respectively laid out in Articles 8 and 9 of the European Convention on Human Rights (ETS No. 5). Both articles provide respectively that there shall be no interference by a public authority with the exercise of the right to respect for private and family life and that the right to freedom of thought, conscience and religion shall only be subject to limitations as are necessary ... "for the protection of the rights and freedom of others".

66. In other words, this would mean that the parental right to private and family life and the right of parents to freedom of thought, conscience and religion may be limited in so far as the protection of children's rights would require it. Although we should not create an abstract hierarchy of human rights judging the "best interest of a child" independently from a specific situation, I would like to insist on the fact that the physical integrity of children is a value that should not be too easily undermined. Every adult having some kind of power over or influence on a child's physical integrity, be it as a parent, medical doctor or religious representative should first of all feel responsible for protecting a child against physical and moral harm. Especially in the light of the current knowledge of consequences of the mentioned procedures, such as medically unjustified circumcision, FGM or sex-determining operations on intersex children, adults should strongly question whether their freedom of thought, conscience or religion is to be valued higher than the physical integrity and well-being of their own child.

67. I do, however, also understand that families may be subjected to social pressure in their own cultural and religious contexts which simply does not allow them to renounce very old rituals from one day to the next or which make them take certain decisions on behalf of their children that they believe to be in their child's best interest. In such situations, parents should be provided with a maximum amount of information, receive advice and support, and be provided with alternative solutions allowing them to protect their children against any physical harm or life-long consequences for their health. I am convinced that children, if they were given a choice, would not decide to be harmed by a medical operation, which is not entirely beneficial to them. Their parents should therefore be enabled to become the spokespersons of what their children would wish for their own development.

52. Roberts Laura, Teenage Jehovah's Witness refuses blood transfusion and dies, *The Telegraph*, 18 May 2010, www.telegraph.co.uk.

4. Conclusions and recommendations

68. Thanks to the many efforts and years of commitment of child protection activists, as well as the overall recognition of children's vulnerability and special need for protection, children's rights are already secured in many circumstances and many different ways across Europe today. Nevertheless, violence and harm is still inflicted upon children in different contexts, and it is of utmost importance that legal and political action in this respect be pursued and reinforced.

69. In this respect, we need to differentiate between some of the procedures concerning the physical integrity of children described above. There is certainly a clear line to be drawn between male circumcision which may have certain medical benefits for boys and men, and female genital mutilation (FGM) which evidently has no medical benefit whatsoever, but is a procedure intended to control the sexual behaviour of girls and women throughout their lives.

70. The legal framework to be referred to when it comes to protecting the physical integrity of children is very clear: the Universal Declaration of Human Rights determines that everyone has the right to life, liberty and security of person (Article 3) and that no one shall be subjected to degrading treatment (Article 5), whilst Article 24 paragraph 3 of the UNCRC provides that States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

71. It is widely recognised – and the Council of Europe has been promoting this idea for many years – that “children are not mini human beings with mini human rights” but enjoy the full set of human rights just like any adult person, and that, additionally, they benefit from the right to special protection and support for their development as set out by various international standards and national legislations. However, the problem is one of ensuring implementation.

72. I therefore call upon the Parliamentary Assembly, and my fellow parliamentarians represented herein, to launch an appeal for more awareness for the need to protect children against various types of physical injuries, and their consequences for children's physical and mental integrity and well-being, as described in this report.

73. Both short-term and long-term actions are required to effectively protect children. In the short term, the most evident legal loopholes should be filled, for example by prescribing that only qualified medical staff be allowed to undertake certain operations, such as circumcision, in sterile conditions. Comprehensive and understandable information should be provided to families more systematically, to make them understand the risks of certain operations. In the long run, awareness of the child's right to physical integrity as a fundamental human right should be better promoted, with a view to changing deeply rooted and unquestioned but very often harmful religious and cultural practices concerning children.

74. Against this general background, the Assembly should in particular convey clear recommendations to member States by asking them, *inter alia*, to:

- carefully consider the prevalence of the different operations and interventions impacting on the physical integrity of children in their respective countries, as well as the current practices, according to the categories presented in this report and in light of the best interest of the child in order to define in which areas action is immediately required;
- initiate and suggest in particular awareness-raising measures as regards violations of the physical integrity of children, to be carried out in various contexts where information may be conveyed to families, such as the medical sector (hospitals and individual practitioners), schools or religious communities;
- provide specific training, for example on risks of and alternatives to certain operations as well as the medical reasons and conditions that should be fulfilled when undertaking such procedures, to various categories of professionals involved, in particular medical and educational staff, but also, on a voluntary basis, religious representatives;
- initiate a public debate aimed at reaching a large consensus on where the absolute limits with regard to interventions with the physical integrity of children are to be drawn according to human rights standards;
- publicly condemn the most harmful procedures, such as female genital mutilation (FGM), and pass legislation banning these, thus providing public authorities with the mechanisms to prevent and fight these practices;

- for practices which may be considered acceptable under certain circumstances and in certain contexts, such as the male circumcision of young boys or sex-determining operations of young children in some cases, clearly define, also by legislation, the medical and other conditions and proceedings under which relevant operations must be undertaken, including in the religious context, and to implement procedures and structures which allow all families to access such operations in a legal manner;
- facilitate and promote an interdisciplinary dialogue between experts and representatives of various professional backgrounds including medical doctors and religious representatives so as to overcome some of the prevailing traditional beliefs which do not take into consideration the best interest of the child and the latest state of medical art, and to ensure that all children may benefit from the latest scientific knowledge and highest medical standards for any operation performed on them;
- raise awareness, in particular, about the need to ensure the participation of children in decisions concerning their physical integrity wherever appropriate and possible, and to adopt specific legal provisions to ensure that certain operations will not be carried out before a child is old enough to be consulted.