

An Analysis of Female vs. Male Circumcision

Alexandra Abbott¹

Circumcision is a practice that can be performed on both males and females. While there are similarities between the two, dividing factors include physical and psychological outcomes, medical benefits, and issues surrounding human rights. Although some of these issues overlap, there are serious adverse effects depending on which sex the procedure is performed. Compared to the male practice, female circumcision carries a plethora of risk making it undoubtedly unjustifiable and non-equivalent. This paper will explore complications associated with the procedure when performed on either sex, as well as possible benefits of the practice. Finally, a conclusion will be made to express how these are vastly different practices when performed on different sexes, because of the harmful physiological and psychological effects on women.

The practice of circumcising females has received much more attention and scrutiny compared to performing the same on males. Much of this opposition stems from the fact that the procedure has no medical benefits when done to females, in contrast to male circumcision (Pearce & Bewley, 2014; Sorokan et al., 2015). This important difference has led the term “female circumcision” to be more widely referred to as female genital mutilation (FGM) by administrations such as the World Health Organization to more accurately reflect what occurs during this procedure and the harm it causes (Mulongo et al., 2014). FGM has also been categorized as a violation of human rights of the female, and in many areas of the world the practice has been banned and is considered a criminal offence (Mulongo et al., 2014; Muteshi et al., 2016; von Rège & Champion, 2017). Finally, FGM is often carried out on girls between infancy and age 15, when they are unable to provide consent to the painful procedure (Pearce & Bewley, 2014; von Rège & Champion, 2017). Although infant males also cannot provide consent, it has been argued that performing circumcision on an infant male is easier and has less adverse outcomes compared to performing a circumcision on an older male (Morris et al., 2014).

¹ alexandramabbott@hotmail.com; Written for Human Sexuality (PSYC 3010). Special thanks to Dr. Cory Pedersen for recommending this submission.

There are four types of female genital mutilation, each with different ranges of adverse effects. A clitoridectomy, or type one, involves partial or total removal of the clitoris (Muteshi et al., 2016). The second type, termed excision, requires partial or total removal of the clitoris and labia minora, also sometimes involving the removal of the labia majora (Muteshi et al., 2016). Infibulation, or type three, narrows the vaginal opening by sealing the labia minora and/or the labia majora, and may also involve the removal of the clitoris (Muteshi et al., 2016). Infibulation is considered to be the most invasive type of FGM and results in the most severe health outcomes for the female (Muteshi et al., 2016). The final type encompasses any other kind of female genitalia mutilation for non-medical reasons including cauterization and scraping (Muteshi et al., 2016).

One significant problem with the practice is that it is often performed without any anesthesia and uses non-sterile equipment, which may include razor blades or shards of glass (Muteshi et al., 2016). It is estimated that 100-140 million women around the world have undergone a variation of this terrifying procedure, with an estimated 3 million occurring annually in Africa (Mulongo et al., 2014). It may be obvious that several of the adverse outcomes associated with the procedure can be attributed to unsafe techniques (Pearce & Bewley, 2014). It has even been suggested that some of the long-term consequences may be reduced if FGM is performed by a trained professional in a sterile environment with proper surgical equipment (Pearce & Bewley, 2014).

Aside from the issues associated with performing the procedure under unsafe conditions, FGM itself carries serious short- and long-term physiological complications and psychological harm, which may vary depending on the type of FGM. In general, the first three types of FGM share similar consequences, however as mentioned, infibulation carries more risk because the procedure is more extensive (Muteshi et al., 2016). Short-term physiological consequences of FGM may include excruciating pain in the inflicted area, pain when urinating, excessive amounts of bleeding, and risk of infection (Bjälkander et al., 2012; Muteshi et al., 2016; von Rège & Campion, 2017). Long-term physiological consequences of all types of FGM may involve damage to reproductive health, complications during childbirth, difficulty conceiving, and cervical cancer (Bjälkander et al., 2012). Such consequences may be more likely to occur in prepubescent girls primarily because the vulva is more susceptible to infection, as it lacks many protective agents that develop through puberty (Bjälkander et al.,

2012). Females who have undergone FGM may suffer from childbirth complications such as low birth weight and the risk of a stillborn birth (Muteshi et al., 2016). In addition to these possible harmful physiological outcomes, FGM has also been associated with psychological and psychosexual harm (Pearce & Bewley, 2014). Decreased sensitivity in the area and psychological trauma may result in sexual dysfunction, which is another complication not typically present with male circumcision (Bossio et al., 2016; Mulongo et al., 2014; Pearce & Bewley, 2014; von Rège & Campion, 2017). Sexual satisfaction may be compromised due to more pain during intercourse in women who have undergone FGM (Pearce & Bewley, 2014). Psychological harm may include Post-Traumatic Stress Disorder (PTSD), anxiety, depression, fear of childbirth, sleep problems including nightmares, poor eating habits, and memory loss (Bjälkander et al., 2012; Muteshi et al., 2016). Since male circumcision is best performed when a child is an infant and usually in a safe sterile medical environment, these adverse psychological outcomes are not present (Morris et al., 2014; Sorokan et al., 2015).

An exploration into potential benefits of FGM was unsurprising as research did not indicate any reported medical benefits of FGM. It was alarming to discover why many women consent to FGM, and it is important to recognize the reasons FGM is performed either with or without consent of the female. As with male circumcision, the primary reasons for FGM are rooted in tradition and culture (Muteshi et al., 2016; Sorokan et al., 2015). In places such as Sierra Leone, it is seen as a transition to womanhood (Bjälkander et al., 2012). Although advocates attribute the practice to religious duty, there is absolutely no written rule it is a religious requirement (Bjälkander et al., 2012; Pearce & Bewley, 2014). Despite this, many women consent to the procedure as a result of social pressure and to avoid stigmatization from their community (Bjälkander et al., 2012; Muteshi et al., 2016). It has therefore been argued that because of these factors it may be in the woman's best interest to undergo the procedure (Bjälkander et al., 2012). Although male circumcision shares similar cultural roots, it has been argued that FGM is another way to control and oppress women where male circumcision holds no link to oppression of the male sex (Muteshi et al., 2016; Sorokan et al., 2015).

It has been suggested that because of these strong cultural forces and social pressure, rather than eradicating FGM it should be medicalized (Pearce & Bewley, 2014). However, a child still cannot give proper informed consent to the procedure and the mutilation is most often irreversible (Pearce & Bewley, 2014). Medicalization may also promote rather than ideally

eliminate the practice and lead to even more unmedicalized procedures (Pearce & Bewley, 2014). For these reasons, medicalizing FGM may not be an effective harm reduction strategy (Pearce & Bewley, 2014).

Considering that there are no reported medical health benefits and the resulting physiological and psychological adverse health outcomes of FGM (Pearce & Bewley, 2014), I do not believe the procedure is justified. I would argue that the social isolation seen in some areas from not undergoing FGM is not nearly as severe as the other associated adverse outcomes and is therefore not a valid defense.

Male circumcision has been around for thousands of years and is a more common and widely accepted practice (Sorokan et al., 2015). Circumcision of a male is performed by removing the prepuce from the end of the penis (Bjälkander et al., 2012). Its greater acceptance can be attributed to its medical benefits and less severe risk factors than FGM. Many oppositions to male circumcisions are based on beliefs that it impacts sexual functioning which may be why its rates are declining (Sorokan et al., 2015). The primary reasons for male circumcision are for religious reasons, a belief that it is more hygienic, or for aesthetics. Male circumcision is not done as a way to control a male's sexual activity, ensure virginity and marriageability, or to oppress them as seen with FGM (Bjälkander et al., 2012; Muteshi et al., 2016).

Unlike FGM, male circumcision has health benefits for the male himself, and in some cases his partner. It has been suggested that circumcised men have a lower risk of developing urinary tract infections (UTIs; Sorokan et al., 2015). The enclosed structure of the preputial sac provides an ideal environment for organisms to thrive which may lead UTI's to develop (Sorokan et al., 2015). Removal of the prepuce may, therefore, lessen this risk (Sorokan et al., 2015). Some males may be more prone to the development of UTIs due to their sexual anatomy, which is why this procedure might be a more appealing choice for parents (Sorokan et al., 2015). Circumcision may also reduce the risk of Human Immunodeficiency Virus (HIV) in males (Sorokan et al., 2015). The inner area of the prepuce contains an abundance of Langerhans cells which are subject to infection during intercourse, which is a primary factor in the development of HIV (Sorokan et al., 2015). Similar to the development of UTIs, the moist and protected environment is an ideal place for these pathogens to survive and grow. Removal of this environment, therefore, lessens the possibility of their development and survival,

reducing the risk of HIV (Sorokan et al., 2015; Wright et al., 2012). In some cases, the prepuce may also tear, providing a channel through which pathogens can easily enter the bloodstream (Wright et al., 2012). It has also been suggested that sexually transmitted infections (STIs) could lead to the development of prostate cancer (Wright et al., 2012). Lessening the risk of STI development may then lead to a lower risk of developing prostate cancer (Wright et al., 2012). These benefits also extend to female partners of these men, as it has been shown partners of circumcised males are at a lower risk of contracting cervical cancer (Sorokan et al., 2015). Considering that a circumcised male carries a lesser risk of STI transmission to their female partners (Wright et al., 2012), I reason that these findings may extend to male partners as well.

Timing is also an important factor with male circumcision (Morris et al., 2014). Although some parents advocate for the male being able to consent to the procedure when he is of age, medical professionals suggest circumcision should be performed from the time of birth up to one month of age (Morris et al., 2014). This lessens the risks and complications associated with undergoing surgery at a later age as a mature penis can be more difficult to operate on compared to an infant penis (Morris et al., 2014; Sorokan et al., 2015). Additionally, if a male is more prone to UTIs, waiting until he can consent to surgery to minimize this risk may be doing more harm than good (Sorokan et al., 2015). Costs associated with circumcision among older males include higher risk of complications, longer healing time, often a poorer aesthetic, delayed protection against STI's, and possible interference with employment due to recovery (Morris et al., 2014). In terms of FGM, timing also affects the procedure, however the opposite effect is seen (Morris et al., 2014). As outlined previously, FGM performed on a younger female can be more detrimental and it may be better to wait until she is able to consent to the procedure to avoid additional unnecessary harm (Bjälkander et al., 2012).

The main drawbacks to male circumcision have to do with post-surgery recovery and the distress it may cause a child during the healing process. Common short-term problems with neonatal circumcision may include bleeding, infection of the targeted area, dissatisfaction with the resulting aesthetic, and pain and discomfort during recovery (Sorokan et al., 2015). More severe but very rare complications that might arise are partial removal of the penis, and death caused by surgical complications such as a hemorrhage (Sorokan et al., 2015). Finally, it has been reported that males who are circumcised are less likely to engage in safe sex, possibly because of its assumed protection from diseases and infection (Sorokan et al., 2015). Given that

the potential risk of harm during male circumcision is less likely than FGM, the medical benefits of male circumcision outweigh the potential risks associated with the surgical procedures (Bjälkander et al., 2012; Muteshi et al., 2016). As such, male circumcision can be medically justified while FGM cannot; therefore, these two practices are not comparable.

Aside from the discussed benefits of male circumcision, many people still present concerns surrounding the procedure. One of the main misconceptions is that a circumcised penis is less sensitive than an intact penis because the prepuce is believed to be one of the more sensitive areas (Bossio et al., 2016). Studies have shown that circumcision undergone in the neonatal period does not affect penial sensitivity during adulthood, and there is no significant difference between circumcised and intact penises concerning sensitivity (Bossio et al., 2016). When a female undergoes FGM, it may result in pain during intercourse, psychological trauma and sexual dysfunction which can gravely affect a female's sexual health and attitudes towards the idea of coitus in general (Mulongo et al., 2014; Pearce & Bewley, 2014; von Rège & Campion, 2017).

All this being said, I believe male circumcision is a justified medical procedure even when performed on an infant who cannot consent, especially compared to FGM. My conclusion is primarily based on the reported health benefits, such as protection from STIs. Although I believe consent is an important aspect of any medical procedure, it is clear that it may be in the male's best interest to have the surgery at a younger age where there are fewer medical risks and possible disruption of everyday life (Morris et al., 2014).

Overall, the practice of FGM and male circumcision are not comparable, and it is clear that FGM is not medically justifiable. It has been said that to equate FGM with male circumcision would be the equivalent of amputating the penis and parts of the scrotum (Bjälkander et al., 2012). FGM involves a magnitude of physiological and psychological problems that are not present with male circumcision (Bjälkander et al., 2012; Muteshi et al., 2016). This is especially apparent because of the non-medical circumstances FGM is often performed under which often lacks proper equipment and pain management efforts (Muteshi et al., 2016; Pearce & Bewley, 2014). Compared to male circumcision, FGM has no medical benefit for the female and although this may help her avoid social isolation in some communities, the benefit does not overthrow the risk (Bjälkander et al., 2012; Muteshi et al., 2016; Pearce & Bewley, 2014). Although consent and autonomy are issues for both practices,

there is a greater benefit to the male when circumcision is performed during infancy, where FGM is said to be more harmful to a female when it is conducted before she reaches puberty (Bjälkander et al., 2012; Morris et al., 2014). In conclusion, FGM and male circumcision are radically different practices and the frequency of male circumcision should not be used as a justification for FGM.

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