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Orientalism and the UN:

Deconstructing the Double Standard in Policies of FGM/C

Casey L. Ball

Abstract

Female genital mutilation, cutting or circumcision (FGM/C) involves removing or altering the female genitalia. The UN's Zero Tolerance Policy toward FGM disregards the cultural application of these practices and implements educational programs, while criminally prosecuting those participating in the performance of FGM/C. The UN and associated organizations reference female genital mutilation (FGM), although to maintain objectivity across genital practices, FGM/C will be used in this paper. This paper proposes that the double standard between Western-classified cultures and cultures traditionally practicing FGM/C exists as the international regime of human rights, created by the cultural hegemony, imposes a juxtaposition of acceptable and illegal practices of FGM/C. This is exhibited through Western FGM/C practices, other acceptable body alterations, male genital circumcision, and the intentionally abrasive language used to discredit the legitimacy of important and chosen cultural practices.

Since the signing of the United Nations (UN) Charter in 1945, internationalism, the idea of unifying under a single set of rules for which every state in the anarchic system lives under, has thrived. The 1948 Universal Declaration of Human Rights (UDHR) provided a framework for states to follow, instituting a regime of international humanitarianism that allowed states to critique another state's affairs. Since 1952 when female genital mutilation/cutting (FGM/C) was first addressed, advocacy groups have increasingly fought to end FGM/C. The UN's 2012 "Zero Tolerance" policy internationally condemned and pressured widespread illegalization of FGM/C. Efforts of the UN, associated organizations, and advocacy groups have criminalized and victimized people of ethnicity participating in the practice of FGM/C, striving only for its' eradication. Despite the harmful effects of FGM/C in its worst form, FGM/C has strong cultural value and is practiced around the world in nearly identical ways, although not identified as such. The double standard between Western-classified cultures and cultures traditionally practicing FGM/C exists as the international regime of human rights, created by the cultural hegemony, imposes a juxtaposition of acceptable and illegal practices of FGM/C.

THE UN'S FGM/C DEFINITION

FGM or female genital mutilation is defined by the UN as "all procedures that involve altering or injuring the female genitalia for non-medical reasons and is recognized internationally as a violation of the human rights of girls and women" (FGM). The UN and associated World Health Organization (WHO) report over 200 million females live with the consequences of FGM/C, many of which are from the Mediterranean, South Asia, and Africa. According to Sipsma et al's FGM/C prevalence survey, Sierra Leone has the largest population of cut women; 94% of women had been circumcised, 88% believed the practice is a beneficial component of their

identity and should be continued. In traditional rural African communities, village practitioners often with no formal medical background perform these procedures. They often do not sanitize themselves or their tools (razor blades or multipurpose knives). Nor do they offer anesthesia and proper wound treatment. Much of these procedures cause the majority of complications associated with FGM/C. The WHO discourages trained medical practitioners from participating in FGM/C procedures despite their knowledge on physiology and sanitation being much more advanced than traditional practitioners. In the case of FGM/C, the UN and WHO only formally recognize Western medicine as legitimate healthcare. This becomes problematic for the communities that do not believe in Western medicine and rely on culturally constructed health knowledge and practices deemed unconventional by Western states.

The WHO identifies four major FGM/C procedures, all of which are illegal and condemned by the UN/associated organizations and governments (*Eliminating female genital mutilation*, 2008). Type I is the partial removal of the clitoris, either removing the clitoral hood (prepuce) or part of the bundle of nerves. Although the latter may decrease sexual pleasure, removing the prepuce increases pleasure during sex by revealing the nerves for stimulation. In Western societies, removing the prepuce is a cosmetic surgery procedure called a Hoodectomy. Type II is trimming to the labia minora or majora, including the partial removal of the clitoris. Anatomically the labia minora is to be surrounded by the labia majora, both of which cover the vaginal orifice. Removing or trimming the one or both of the labias may reduce friction during daily activities or sex and alter the appearance so the labias form a clean slit, desirable amongst many societies. The WHO reports 90% of FGM/C cases are type I or II. Type III, often called infibulation is removing the all or part of the clitoris, trimming the labias, and narrowing the

vagina orifice by sewing it partially shut. Many women with infibulation report extreme pain during sex and can have life-threatening health complications during child birth. According to the WHO, only 10% of FGM/C cases are Type III. “Infibulation, which is the most severe form of FGM, is mostly practiced in the north-eastern region of Africa: Djibouti, Eritrea, Ethiopia, Somalia, and Sudan” (Female genital mutilation). Type IV includes burning, piercing, and/or nicking the exposed genitalia although typically, no flesh is removed. The WHO has not gathered statistics about the prevalence of type IV of FGM/C. Often times, FGM/C is considered a rite of passage, something girls must go through to become women, but may occur much before menstruation.

JUSTIFICATION FOR INTERVENTION

According to UNICEF, because most cases of FGM/C are operated on people between the ages of 0-15, legal consent is unattainable and regulators believe the intensity of informal procedures is too extreme for children to endure. Due to the health concerns, FGM/C is considered a violation of human rights and has been internationally prohibited. The UN strives to protect the universal rights of every person, pressuring states to illegalize FGM/C through conventional treaties. In response, the WHO proposed guidelines for managing FGM/C cases and decreasing their prevalence by increasing civilian health education and condemning modern healthcare participation in FGM/C procedures (Doucet, 2017). For example, EU laws prevent cut people from travelling in the Eurozone, and often criminalize them under law (Brown, 2013). These laws violate universal human rights to mobility, self determination and practice of culture. States have also criminally prosecuted those who have undergone a procedure, sought to have a procedure , and/or those assisting in the process, and led educational efforts to deter such people

(Berg, 2013). Education efforts include female empowerment through knowledge and opportunity, encouraging community discussions and FGM/C abandonment, and providing cultural alternatives/substitute rites of passage. Efforts to change the behavior of FGM/C susceptible communities have been largely unsuccessful. UN believes this lack of success is due to states not committing to the cause and organizational efforts have not yet engaged the entirety of communities, addressing the empowerment of women and sexual/reproductive health needs (Fgm). According to UN, approximately 86 million girls will be cut by 2030.

MEDICALIZED APPROACH & INDIFFERENCE

The “medicalization” of FGM/C, procedures performed by a medical practitioner has increased in recent years. Medical professionals are desired to decrease potential health risks and provide the healthcare sought after by the community under which one serves (Doucet, 2017). Medical professionals can prevent and treat most health complications such as hemorrhages, pain, vaginal and urinary tract infections, and sexual health issues (Wheeler, 2003). Thus, women and girls are even more likely to undergo type I or II when assisted by a trained medical professional (already composing 90% of FGM/C cases). Even with these good intentions, Doctor Snaedal from the World Medical Association wrote that health professionals have no place assisting in the practice of FGM “because of its serious detrimental impact on the physical and mental health of women and girls...it is in contradiction with our code of ethics, as these practices violate the human rights of women and girls” (Thread: Physicians Call For Zero Tolerance..., 2017). WHO officials also believe that allowing medicalized FGM/C, does not eliminate all risk and does not justify the benefits of FGM/C. UN Secretary-General Ban Ki-Moon said, “There is no developmental, religious, or health reason to cut or mutilate any girl or woman.” In response,

Many women living with the negative consequences of FGM/C have also begun to speak out against FGM/C in hopes of protecting later generations from the same suffering.

ANTI-FGM/C CAMPAIGNS

Sarian Karim Kamara from Sierra Leone was cut when she was 11 years old. She now leads a nonprofit called “Keep the Drums. Lose the Knives” to encourage FGM/C vulnerable communities to celebrate the rite of passage, but not the harmful cutting practices (Goldberg, 2016). In a study conducted by the Norwegian Knowledge Centre for Health Services, Dr. Rigmor C. Berg and researcher Eva Denison found that “When asked why FGM/C is performed, in almost all studies, the participants consider it a meaningful cultural tradition, which functioned both as a form of social control and identity for women, as well as a feature of the ideal girl.” Kamara works to encourage alternatives to FGM and holds workshops to empower women in their sexuality despite their condition. A woman from Somalia, where according to UNICEF 66% of girls in this country suffer from type III FGM (infibulation), says her cousin “told us, ‘remember how we got cut when we were little? Your husband has to bulldoze that’” (Lytton, 2015). Thousands of women and girls share the same story of pain and suffering from the FGM/C forced upon them by their communities. Kamara’s self-love and sexuality workshops for cut women do not use the word mutilation, but rather “bonda” to emphasize the positive implication practicing cultures sought for their women and not to deter suffering women from loving themselves. Yet, circumcised women in communities all across Africa continue to willingly practice FGM/C on their daughters to encourage positive cultural assimilation and passage to adulthood.

PROTECTING CULTURAL LEGACIES

Although some cut women wish to eliminate FGM/C from traditional practice, others still believe FGM/C is important and valuable. For Western people, even professionals like University of Washington anthropologist, Bettina Shell-Duncan, this reality may be shocking. “I thought African girls were held down and butchered against their will, but some of them voluntarily and joyfully partake in the ritual” (Khazan, 2015). Other FGM/C misconceptions include a cut woman’s inability to enjoy sexual intercourse; that sex in FGM vulnerable communities is strictly focused on male domination and pleasure. Rather than FGM/C be a means of men controlling the pleasure and power of women, some believe women are cut to align their bodies with femininity and dominate men as their creators (Ahmadu, 2009). A Tanzanian mother wrote, “Getting circumcised was one of the happiest days of my life...I felt like I was reaching a life goal” (Ellison, 2016). FGM/C does not cause negative physical and mental effects for all women and although some recognize the potential harm of being cut, the cultural and emotional benefits outweigh the physical consequences. Cut women from Kenya said, “In [our] eyes, anyone who is not circumcised is not a woman and not fit to carry out certain traditions” (Jaafari, 2014). Women around the world support circumcision and do not view it as demoralizing or abusive of an individual’s right. “So it is in my opinion that we need to remove the stigma of mutilation and let all girls know they are beautiful and accepted... lest the myth of sexual dysfunction in circumcised women become a true self-fulfilling prophecy, as Catania [OB/GYN] and others are increasingly witnessing in their care of circumcised African girls and women” (Ahmadu, 2009). Understanding the positive benefits cut women gain can aid international organizations to deconstruct the harmful double standard that has been created, and frame appropriate FGM/C policies.

DECONSTRUCTING THE DOUBLE STANDARD

Although the UN-defined FGM/C natively occurs in 27 countries and continues to spread, other or unacknowledged forms of FGM/C are widely practiced. FGM/C is any alteration to the female genitals to meet a desired image or identity. FGM/C as practiced in Western states, such as female genital cosmetic surgeries, plastic surgeries, and body art/modifications, are linguistically framed to be excluded from the UN efforts, although procedures are nearly identical. To further isolate FGM/C practices from Africa and other developing countries as UDHR violations, UN policies and advocacy campaigns have used discriminatory language. This choice language victimizes and shames cut women who choose to partake in FGM/C practices. This double standard in UN policy can be described by three theories: Edward Said's Orientalism, Gramsci's Theory of Cultural Hegemony, and Constructive Regime theory. Ideas encompassed in these three theories have constructed the double standard of acceptable and illegal practices of FGM/C despite such procedures in Western countries having the same descriptions and intentions. The double standard between Western-classified cultures and cultures traditionally practicing FGM/C exists as the international regime of human rights, created by the cultural hegemony, imposes a juxtaposition of acceptable and illegal practices of FGM/C.

THEORETICAL UNDERSTANDINGS

Intellect Edward Said said "The European encounter with the Orient, and specifically with Islam, strengthened this system of representing the Orient and it has been suggested by Henri Pirenne, turned Islam into the very epitome of an outsider against which the whole of European civilization from the middle ages on was founded" (Said, 1977). Said's Theory of Orientalism explains how Western-classified cultures see FGM/C from Africa as primitive, abusive and

unnecessary while believing their own FGM/C practices as acceptable and encouraged by many. Orientalism and the Western understanding of global cultures, or lack thereof, has led to the insistent spread of Western ideas. “The concept of hegemony, described as the domination of a culturally diverse society by the ruling class, who manipulates the culture of the society—the beliefs, explanations, perceptions, values and mores—so that their ruling class worldview becomes the worldview that is imposed and accepted as the cultural norm” (Ward, 2015). The US has been a hegemon for the last 70 years, imposing their own cultural values through diplomacy and international aid/agendas. As a leading member of the UN Security Council, the US and great European powers have become a cultural hegemony, framing global issues like FGM/C from the Western perspective. Powerful UN states, specifically the US, has led the international community in implementing a regime of human rights, focusing UN efforts and awareness on violations of the UDHR. “Dominant theories of international relations explain the role of such rights...indicating an uneasy juxtaposition of state sovereignty with ideas of a universal moral order. The growth of the UN’s international human rights regime and the rise of international non-governmental organizations and human rights activists enabled a closer insertion of human rights into state diplomatic practices” (Dunne, 2009). Policies regarding FGM/C UDHR violations have been directed almost exclusively toward traditional FGM/C practices of developing countries. Applying these theories to FGM/C policies may help deconstruct the double standard between Western and traditional FGM/C practicing states and implement appropriate international policies.

FGM/C PROCEDURES IN WESTERN STATES

FGM/C has been defined by the UN and advocacy groups as a violation of human rights, bringing awareness and raising the standards of living. Despite this, female genital alterations are widely accepted and practiced in Western states. “Although the practice is currently prevalent primarily in African and Asian countries, female genital cutting was performed on white women in Western nations as early as the 1950s, as a medical treatment for nymphomania and depression” (Boyle, 2000). In present-day US, female genital cosmetic surgery (FGCS) and body modification procedures are extremely popular.

African feminists analogize [plastic surgeries (e.g., sex change operations and breast implants), tattoos, and body-piercings, which are viewed as normal, mainstream, and generally harmless by Americans] to FGC in that both create a hierarchical ordering of sexuality and gender, and are likewise painful and extreme cultural avenues to make the woman’s body more attractive and in line with male-imposed cultural standards of beauty” (Cassman, 2007).

Such procedures practiced in the US include a labiaplasty which reduces the size of the labia minora of a woman’s genitalia so it is tucked between the labia majora. This procedure can reduce daily discomfort, sexual interference, increase stimulation, and make the vagina appear physically appealing, consistently sought after for the latter. “The 2016 ASPS [American Society of Plastic Surgeons] statistics report showed that labiaplasty is more popular than ever, with over 12,000 procedures performed by ASPS members last year (a 39% increase from 2015)” (FRCSC, 2017). Although Great Britain appears to have increasingly greater awareness of the double standard of FGM/C practices, the National Health Service (NHS) still recorded over 2,000 labiaplasty procedures in 2011. “These procedures have not led to any prosecutions, so

either the physicians are able to justify them all as medically necessary or police and prosecutors are ignoring the activity” (Avalos, 2015). Hoodectomy procedures, removing the clitoral hood to increase sexual stimulation, are also popular. Labiaplasty and hoodectomy are nearly identical in description and practice as Type I/II FGM/C. In fact, if Type I or Type II was performed by a trained medical practitioner, the procedures would be indistinguishable. Although small groups have advocated against FGCS and promoted self-love of all types of bodies, FGCS is largely unchallenged in US society. Even more so accepted, plastic surgery procedures are popular amongst American women to achieve a more desirable physical appearance.

BODY MODIFICATION IN WESTERN STATES

Plastic surgery and body modifications in the US include breast implants, facial reconstruction, skin tuck procedures and body art. Culturally, FGM/C creates female genitals that are associated with womanhood, characteristic of an ideal woman. “Cosmetic surgery is material, a carving into flesh; it is also profoundly psychological--a form of psychotherapy, aimed at providing an embodied solution to a psychological concern--the person's perception of a particular body part, and anxiety and distress that causes” (Braun, 2009). Body modifications can be extremely harmful to anyone who feels their natural body is not enough. “The cultural idealisation of a certain (typically unrealistic) bodily form is a key factor in making female embodiment problematic for many women” (Braun, 2009). In fact, comparable anthropological woman studies have focused almost exclusively on physical sexual traits (Johnsdotter, 2012). This pressure has also fallen on American women who choose to have surgeries to enhance their feminine appearance. According to the ASPS Statistics Report, 290,000 breast augmentation procedures, 235,000 liposuctions, and 223,000 nose reshaping procedures were done in 2016

(Plastic Surgery Statistics). In total, 17.1 million cosmetic surgeries were performed on patients 13 years and older. In an National Institute of Health study of England, 1.2% of people had a genital piercing from a licensed shop, which is considered Type IV of UN-defined FGM/C (Bone, 2008). It is thus the lack of understanding developing states' FGM/C practices that supports the juxtaposition of acceptable and illegal FGM/C practices. This double standard is not only exhibited across cultures, but also between genders.

MALE CIRCUMCISION

With over 200 million females affected by some type of FGM, approximately 5.5% of the global female population has been cut. According to the WHO, 90% of that 5.5% is Type I or Type II FGM. Correspondingly, the WHO predicts 30% of the global male population has been circumcised; of this number, 13% are non-muslim and non-jewish men and boys living in the United States (equivalent to 66% of all American boys) (DeLaet, 2009). Although male circumcision has a large correlation to male rite of passage of Jewish tradition, American doctor, John Harvey Kellogg, was part a movement in 1870-1920 that instituted the need for boys' sexual desires to be controlled.

A remedy for masturbation which is almost always successful in small boys is circumcision. The operation should be performed by a surgeon without administering an anesthetic, as the brief pain attending the operation will have a salutary effect upon the mind, especially if it be connected with the idea of punishment. In females, the author has found the application of pure carbolic acid to the clitoris an excellent means of allaying the abnormal excitement (Motivations for "Medical" Circumcision, 2007).

Practiced widely in the US for “medical reasons” and around the world for cultural ones, male circumcision removes the prepuce or foreskin, the equal to a female’s prepuce or clitoral hood, without anesthesia or consent. “Male genital mutilation involves a variety of basic health risks, including hemorrhage, lacerations, infection, urinary retention, the accidental amputation of the tip of the penis, and in *extremely rare* circumstances, death, in these cases, usually during complications from infection” (DeLaet, 2009). In the US, to not undergo this procedure is unusual and is sometimes seen as unclean to be uncut. Parents are also highly encouraged to have their son circumcised by a doctor soon after birth. The Danish Medical Association (DMA) has advocated against male circumcision, making much of the same argument as those against female circumcision. “In the United States, the belief that male circumcision is a medically beneficial procedure has become deeply entrenched despite much scientific evidence to the contrary” (DeLaet, 2009). Although many Americans believe circumcision reduces risk of HIV and UTI’s, the DMA believes the risk of male circumcision is still too high and a boy’s penis should only be cut for an immediate medical reason. “It is most consistent with the individual’s right to self-determination that parents not be allowed to make this decision, but that it is left up to the individual when he has come of age.” (England, 2016). This argument is largely ignored by US citizens and male circumcision continues to be heavily practiced as an important social procedure. Other procedures growing in practice and awareness in Western states include intersexed and transgender procedures.

GENDER DYSMORPHIA & GENITAL RECONSTRUCTION

According to Human Rights Watch, 1 in 2,000 children born in the US are intersexed, with ambiguous genitalia. This exhibits the double standard of FGM/C because parents are highly

encouraged by medical doctors to have surgical reconstruction of their child's genitals to match their genetic sex before 2 years of age. "In their justification of the surgical alteration of atypical genitalia, surgeons reason that were genital modification not performed, the intersex child would be ostracised by peers, family members, and even parents" (Sullivan, 2007). For the criticized FGM/C practicing cultures, logic behind FGM/C is largely the same. "For example, Saadia, a 62-year-old Egyptian woman, explains that in her culture circumcision [infibulation]: "is what makes one a woman because by removing the clitoris, there is no way that her genitals will look like a man's. The woman with a big clitoris is just like a man. How can a woman carry such a long organ between her legs and pretend that things are normal?" (Sullivan, 2007). Gender dysmorphia is a psychosocial condition that both cases are at risk of presenting. Gender dysmorphia is the discomfort one experiences when their biological sex does not align with their assigned gender. Genital reconstruction surgeries have not been exclusive to intersexed persons and women like Saadia. Transgendered men and women seek surgery to align their physical bodies with their mental ones. "The [ASPS] reported that in 2016 there were 3,200 gender confirmation surgeries—nearly a 20% increase from 2015" (Gender Reassignment, 2017). Gender confirmation surgeries require extensive alterations to the genitals and in some cases, removal of tissue to achieve a desired genital appearance. Transgender, intersexed, and ciswomen and cismen may seek genital reconstruction surgery to converge or strengthen their gender and sex under a single identity. For both men and women around the world, genital circumcision is an important contributor to one's identity and self-image.

UTILITY OF IDENTITY

Identity, or how people view themselves, plays a huge role for individuals' successfully participating in society. Identity may develop from one's family, job, sexual orientation, ethnicity or race, ability/disability, economic class, and even physical appearance. For every society, physical characteristics represent one's interests, role in the community and timemarks their position in life. Footbinding in Chinese elite, eyelid reconstruction in Asian women, menstruation seclusion of Indian women, land jumping of Vanuatuan boys, Kaningara scarification, male and female genital circumcision are rites of passages essential for constructing one's identity. To have undergone these rite of passages, allows one to healthily participate as a functional member of the community. "An important aspect of utility comes from identity, which is a function of an individual's social category...this implies that people derive satisfaction from their own behavior as well as from the emergence and strengthening of an identity that fulfills the prescription associated with a specific social category" (Coyne, 2014). For women in Western states, having FGCS and plastic surgery procedures done allows for them to associate with an identity of feminine sexuality, class and ideal American beauty, although in some severe cases, seeking the sought-after identity may be unhealthy and cause distress. UN FGM/C policies and their enforcement in the international community fail to account for similarities in the role of identity regarding FGM/C practices. The Western belief that Western cosmetic practices and male circumcision are inherently different and better than non-Western classified states practice of FGM/C delegitimizes the identity of African and other cultures practicing FGM/C. The identities of willingly cut women are also discredited because of the state and media sponsored stories of those who were unwilling and brutally cut.

THE CASE OF FREE WILL

FGM/C is a cultural reality for hundreds, if not thousands of cultures around the world. While each community may practice FGM/C with slight variations in value and ceremonies, the main reason for all is to create and/or strengthen a desired identity. As any cultural practice, some people are forced into it while others are cut willingly and even happily. “This origin theory is complicated by the fact that women are generally the actors and the most fervent advocates of female circumcision” (Johnsdotter, 2012). Thus, discourse discussing the legitimacy of FGM/C’s role for the individual and the community will probably have not condoned forced FGM/C as a form of male dominance and control over female health, safety and sexuality. The claim of UDHR violations assumes that “The notion of “FGM”, on the other hand, renders choice impossible for those involved in practices deemed “traditional”--since choice is the province of the rational subject and “mutilation” is, by definition, an irrational act...” (Sullivan, 2007). Continual use of “mutilation” and judgements on cultural practices have enticed negative consequences for cut women that was not an issue before. The identity embraced from having FGM/C is scorned by the UN and human right advocacy groups’ intentional invasive language used in policies and campaigns.

INTENTIONAL INVASIVE LANGUAGE

Western-framed perspectives and policies have used language as a form of cultural hegemony, imposing the human rights regime to exhibit a sense of otherness and violence regarding populations practicing FGM/C. Although the UN is unable to forcibly enforce anti-FGM/C policies, variations in choice language has similar effects as coercive policies. “On the other hand, actors who operate independently of the nation-state system, either because they are private individuals (feminist organizations) or they have power (the United States), are more

likely to use coercive strategies, such as embarrassment and financial penalties, to bring about reform” (Boyle, 2000). Anthropologists and other professional researchers have recognized that FGM/C discourse generalizes FGM/C practicing communities described by Said’s theory of Orientalism. “Instead [of recognizing differences amongst African woman], what emerges is the image of a homogenized, essentialized African woman who is “powerless, constrained by tradition defined by men, unable to think clearly, and [has] only problems and needs, not choices...” classified and defined by shared victimization by FGC” (Shell-Duncan, 2008).

Women and girls who have chosen to be cut are unwittingly victimized by the very international system of policies and advocacy campaigns meant to protect them by using the term mutilation rather than cutting or circumcision. This language removes the utility of one’s chosen/believed identity adopted once cut and entices an emotional response of humiliation and disgust amongst the audience. Some professionals have suggested ““those trying to eliminate it should just call it “cutting the genitals” to those they’re trying to persuade, but we should realize that it’s still mutilation”” (Khazan, 2015). Referring back to Sarian Karim Kamara from Sierra Leone, founder of the nonprofit called “Keep the Drums. Lose the Knives,” even those who struggle with the consequences of being cut choose not to use the word mutilation, but rather, circumcision, cutting, or ‘bonda.’ The double standard regarding FGM/C also extends to include language regarding male circumcision as well. “Interestingly, even the few papers and books that have been written about male circumcision as a violation of human rights typically refer to “male circumcision” rather than “male genital mutilation” (DeLaet , 2009). The use of intentionally harmful language toward cut women may provide insight as to why UN policies and advocacy efforts to eliminate FGM/C have been largely unsuccessful.

PROBLEMS WITH CURRENT POLICIES

UN policies and advocacy efforts have continued to represent a strong juxtaposition of legal and illegal FGM/C practices without making much progress toward eliminating FGM/C. The UN Development goals hope to achieve FGM/C elimination by 2030. Despite this, the UN predicts 86 million additional girls will have been cut by then (FGM). Policies have assumed an individualistic perspective, where one's identity is analyzed on a personal level rather than a societal one, while believing 'damaging' the female genitals as assumed in FGM/C discourse, disrespects self-worth (Silverman, 2004). For many FGM/C practicing communities, one's identity is reliant upon the community of which one lives and sees FGM/C as conforming to the needs and expectation of women, not self-disrespect. Community dynamics may also determine what are considered human rights as human rights are not inherently universal. "To ignore the social, cultural, political, and economic particularities of any local community is to forsake possible change undertaken by a freely persuaded community" (Gregg, 2010). Many anthropologists and other professionals regarding FGM/C have found an blatant disregard for these particularities. "All too frequently, public, legislative, and even scholarly opinions about MC and FC [male and female circumcision] lack the measured, nuanced, careful understanding that most of us value as the signature of the anthropological project. Often, it seems non-anthropologists are not interested in what we have to say, or how we say it" (Silverman, 2004). Thus, any cultural relativism one might claim when approaching culturally sensitive topics such as FGM/C is not objective.

CULTURAL RELATIVISM

Cultural relativism, or understanding another's culture by comparison to one's own is encouraged by many scientific professionals to be an extensive and mandatory practice of international organizations. Using this approach allows policies, laws, and social awareness efforts to be more effective in reaching the FGM/C practicing communities as well as identifying and managing other similar global concerns. When analyzing international issues, people, specifically those from the West use what is called a "white optic." This is a cultural lens for which includes Western belief in medicine, education, political systems, and human rights. Although UN member states adopted the UDHR and the "responsibility to protect" doctrine of 2005, not all human rights in the declaration are perceived as Western states perceive them to be (Dunne, 2009). "For a human-rights project, then, no single account of human rights is necessary for the spread of human rights...correspondingly, a human-rights frame is a distinct interpretation of the world: it deploys the specific normative term of human rights" (Gregg, 2010). When Westerners analyze FGM/C, their inherent understanding of the UDHR set of human rights as universal influences their scope of acceptable practices. One's prior worldview is unavoidable when developing policies regarding the health and safety and thus UN FGM/C policies are subjective.

PROPOSITION

Given the similarities in female genital procedures in Western-classified states and in developing states around the world, some subjectivity may be eliminated from UN policies. FGCS, plastic surgery, male circumcision, and other body alterations practices are not that different across state borders. Understanding the similar practices priorly described across cultures and admitting the systemic hypocrisy leading UN states have imposed by the human rights regime of the cultural

hegemony may assist in the development of successful policies. This paper proposes the UN's position regarding FGM/C must be adapted to eliminate the harmful double standard. This can be done by approaching Western cosmetic surgeries and male circumcision practices as equal to traditional FGM/C. "The empirical evidence suggests that there is not a clear and bright line differentiating male from female circumcision [both Western and other practices] that warrants a significantly differential international response" (Delaet, 2009). Therefore, if FGM/C is illegal, all forms, regardless of gender, are illegal and enforced including Western FGCS, sex transformations and male circumcision. If FGM/C is legalized, to maintain the "responsibility to protect" doctrine, I propose FGM/C should be legalized to the standards of modern advanced medical procedures. This protects women from the harmful consequences of having FGM/C performed by a practitioner not medically trained and encourages legal consent of the parents and/or the individual themselves while enforcing a single interpretation of human rights.

To maintain the highest level of objectivity across all types of genital circumcision and other altering procedures, I propose the UN and associated organizations abandon the terms FGM, FGC or FC. Instead, using the term "genital modifications" encompasses both male and female genital procedures not exclusive to the removal of tissue. This removes the use of harmful and invasive language, gender bias and deconstructs the double standard. Societies tend to see themselves as exclusive, containing little similarities amongst other societies when in reality the opposite is true. The UN's mission statement is to "work for the protection of all human rights for all people; to help empower people to realize their rights; and to assist those responsible for upholding such rights in ensuring that they are implemented" (Who We Are). In doing so,

protecting the uniqueness of cultures across the world, respecting their values, and helping them eliminate any of which are not beneficial to the community where one lives.

After extensive research, I have determined that there is no approach to the issue of FGM/C that entirely protects women from abuses. Other propositions may claim to protect women, and contradict mine: holding the human rights regime in the highest regard, emphasizing the particularities of Western FGM/C practices as inherently different than traditional FGM/C, and/or insisting all other genital procedures are not equivalent to FGM/C. These rebuttals attempt to justify traditional FGM/C's universal illegalization. Bans only drive abuses underground and do not stop them. I believe eliminating the double standard that puts women of developing countries at a disadvantage for seeking the body alterations that they desire, cultural tradition or not, is a step toward eliminating gender-specific human rights violations.

Sources

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