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The impact of empathy on the realisation of human rights in general and female genital mutilation in particular

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To TMAE

ABSTRACT

More than 130 million girls and women have undergone female genital mutilation (FGM). FGM is an act violating human rights (HR) involving many actors, most importantly children, mothers and fathers. This notwithstanding, WHO estimate that 2 millions will undergo FGM each year, despite FGM being a punishable act on international as well as on national levels. What is the impact of empathy on the realisation of HR in general and FGM in particular? Empathy i.e. to understand another person's feelings is, compared to sympathy, a neutral word i.e. free of value. To use sympathy instead of empathy might if misguided give the feeling of pity, and yield resentment, thus hampering the eradication of FGM. Furthermore, empathy is easily lost e.g. by numbing, distancing, demonising, and intellectualising "them" into being so different as for "us" not to believe "them" to have the same feelings as "we" have. Most importantly, the majority of the children and some of the women undergoing FGM are non-autonomous, non-consenting, hence it is of great importance not to forget that the realisation of their HR requires that the individuals making the decisions on their behalf can afford to feel empathy, and acknowledge HR.

“The first female circumcision I witnessed was in 1978 in Kenya, and it was a shocking and deep-felt experience, chiefly because it did not proceed “normally”, as the Maasai would have it. This account, I think, brings out issues of hegemonic power and subjugation of women, which, although they are profoundly significant aspects of female circumcision, are seldom overtly contested in places where the practice is socially accepted.

The girl to be circumcised was a young and athletic woman of fourteen to fifteen years of age. I noted that she was tall with a particularly well shaped body and beautiful face. She was operated upon in the house of her mother, which is common both among the Barabaig and the Maasai (as well as among the Somali described later). As soon as the circumciser began cutting her flesh the girl started to fight back. That is the point in time when “normality” took its own course. The women who participated in the operation did not manage to hold her down in spite of the fact that they were several who thronged around her.

Finally, the elder brother and guardian of the girl (her father had passed away) approached the house with long and resolute paces – in atypical masculine Maasai way – and shouted at his sister to stop crying for “nothing”. Pain is something Maasai must learn to tolerate and be proud to endure from an early age. From a male perspective, circumcision constitutes the ultimate sign of courage and bodily control. The brother told the women that if they could not hold the girl by their own strength, they would have to use ropes to bind her. The operation had to be executed immediately because the cattle were restlessly waiting to get out to the pastures, and all the guest who had gathered were eager to begin the feasting. [...] The struggle continued for a while before the girl tired and the rope loops were securely fastened around her ankles. It was, however, difficult to hold her legs stretched out inside the narrow house. One of the men watching the scene from a distance and waiting for the women to get finished with the work approached the house to offer his assistance (it is likely that her prospective husband was also among the men, and he, as is common among the Maasai, probably had paid for part of the expenses for the celebration of her circumcision). [...] At last, the circumciser could proceed with her work. With tiny movements she carved away the clitoris and the labia minora, while the women in loud voices instructed her how to cut. The blood rushed forward, and for us outside the actual scene, it was as if the excited voices of the women and the heavy breathing of the girl would never come to an end.

I had been invited inside, but to come so close to the operation had seemed threatening. The Maasai house is small and the entrance low, and I knew that if I stayed inside, I risked being squeezed between bodies, without being able to move in or out. Besides, I had experienced the invitation partly to be a polite gesture toward a foreigner (*ekashumpai*) who had come to participate in the celebration. Intuitively, I felt a great resistance to fulfill the role of observer. [...]

When I gathered courage, I peeped through the opening in the roof that the women had made beforehand to lighten up the room. There were others, in particular children and boys of the same age as the girl, who tried to get a peek at the scene through the roof. The man, all the time holding tightly on to the rope, gazed into the narrow room to check that the women did a proper job. The spectators outside said nothing; glances were exchanged and some broke into uncertain smiles. The nervousness of the women who executed the operation had spread to the observers, and it was as if we sought support in each other’s glances and presence. The smell of blood and sweat forced itself through the wall and incorporated us into what was happening inside. My own pulse beat more quickly than normal. Instantly, I understood what a personal challenge anthropological fieldwork could be. I was witnessing “torture”, and the fact that I remained standing with the others outside somehow sanctioned what happened inside the house.”

From the chapter “Female circumcision in Africa and beyond” written by A Talle, pp 94-95, “Transcultural bodies”, eds Hernlund & Shell-Duncan, 2007.

ABBREVIATIONS

AI	Amnesty international
FC	Female cutting
FGC	Female genital cutting
FGM	Female genital mutilation
HR	Human right
MC	Male circumcision
MD	Medial doctor
NGO	Non-governmental organisation
WHO	World Health Organisation

MEDICAL DICTIONARY (translation into Swedish)

Anaesthesia	bedövning
Cervix	livmoderhals
Clavicle, femur, humerus	nyckelben, lårben, överarmsben
Coitus	samlag
Cystitis	blåskatarr, inflammation i urinblåsan
Fracture	benbrott
Glans penis	främre delen av penis
Insomnia	sömnlöshet
Labia minora/ labia majora	inre/små respektive yttre/stora blygdläppar
Ligament	ligament
Pelvic bones	benen i bäckenet
Phimosis	förhuden kan inte föras över ollonet pga en förträngning
Prepuce	förhud
Pubis	kroppsområdet runt yttre könsorganen
Scrotum	pungen
Sepsis	sjukdomsframkallande bakterier i blodet
Uterus	livmoder
Urethra	urinrör
Vagina	slida

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1 INTRODUCTION

"Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons" (Abusharaf, 2006, p 6; Rahman & Toubia, 2000, p 4). WHO (World health organisation) has estimated that over 130 million girls and women have undergone some type of female genital mutilation (FGM), and this figure is added with 2 million each year (Abusharaf, 2006, p 3). None has been able to trace the origin of FGM with certainty. One explanation would be that FGM is a Pharaonic ritual from ancient Egypt and texts describes the practice AD 502-575 (Abusharaf, 2006, p 2; Dorkenoo, 1995, p 33; Hadi, 2006, p 106).

Human rights (HR) can be mentioned in various situations. Some live in the illusion that HR means that everyone is entitled to get tickets to sport events "it's a human right to have tickets to the European Championship in football", others use the term in a more serious manner regarding e.g. famine, racism, genocide or gender issued violence. FGM is classified as a violation against HR in several conventions and campaigns against FGM has been going on for several decades, resulting in new laws on national and international levels. This notwithstanding, too few campaigns ends with the implication of HR in reality, thus the frequency of FGM is diminishing slowly. Furthermore, FGM is for various reasons introduced to new societies, thus creating new "traditions".

Personal descriptions of FGM are often on best-selling book charts, but are sometimes described as "chic-literature", and as exaggerated or ethnocentric**,** thus trivialising the girls and women's experiences of how it felt to undergo FGM. How does the lack of empathy influence the implementation of HR? For whom do we feel empathy? For whom should we feel empathy?

1.1 Subject

I chose this particular subject, i.e. the impact of empathy on the realisation of HR in general and FGM in particular, due to my strong wish to understand how an intelligent, rational, caring, loving, and warm person can react totally differently as regards empathy, solely depending on the individual who's HR has been violated.

My intentions have been to focus on the various actors and their empathy as regards girls and women undergoing FGM. I have deliberately chosen to use rather many quotations, because I wish to give a voice to the individual actors, and I believe them being fully capable of transmitting their own views of FGM.

I am an opponent to FGM, and I do consider the act a mutilation. Nevertheless, I wish to emphasise that I differ between the act in itself and the various actors, i.e. I do not find it ethical to stigmatise an individual e.g. to call someone mutilated, especially considering the girls and women who have undergone FGM without consenting. My point of view in general is that kindness and respect as well as indifference and cruelty is to be found within all individuals, no matter which nationality, religion, culture, generation or gender one has chosen to belong to.

1.2 Method and theory

The text is based on the analyses of literature regarding FGM and empathy. I have chosen recently publicised books and articles about FGM, based on numerous interviews performed by established researchers within different fields, as well as a model of how to develop empathy by Mark H Davis (Holm, 2001, p 81).

FGM is performed within various countries and societies, and is described as a cultural, not a religious practice, although Christian, Muslim and Jewish girls and women undergo FGM. Needless to say, the individual experiences as regards undergoing FGM might be more or less similar (Hale, 2005, p 211; Rahman & Toubia, 2000, p 6). Vast amounts of literature have been published about FGM, and I didn't have the intention to fully cover all aspects.

This notwithstanding, mutilations, modifications and reductions of genitalia have been, and are still, applied not only in the countries usually mentioned when discussing women undergoing FGM, and I found it of value to compare these entities.

2. FEMALE GENITAL MUTILATION

2.1 Definitions and implications of female genital mutilation

To discuss FGM is also to discuss terminology e.g. female genital cutting/ surgery/ operations, female genital mutilation, or female circumcision, and I have chosen to use female genital mutilation i.e. FGM.

The following descriptions of FGM are used by WHO to define the most common types of FGM:

A/ cutting of the prepuce, with or without amputation of parts or the entire clitoris;

B/ clitoridectomy, i.e. cutting of the clitoris with partial or total amputation of the labia minora;

C/ infibulation; cutting of part or all of the labia minora and labia majora, and stitching or narrowing of the vaginal orifice; and
D/ all other forms of FGM e.g. pricking, piercing, stretching clitoris or labia, cauterising the clitoris by burning, scraping or cutting the vagina, or inserting substances into the vagina with the purpose of causing bleeding and thereby tightening and narrowing the vagina (Abu-Sahlieh, 2006, p 61; Abusharaf, 2006, p 6; Rahman & Toubia, 2000, p 4).

Although there are many variations of FGM (as described above) – with different consequences depending on short-term and long-term investigations, the circumstances, and the circumciser e.g. a trained or untrained midwife, traditional healer, barber, medical doctor (MD), or nurse – *all* are defined as FGM and thereby a violation against HR. It is worth to emphasise that it is extraordinarily difficult to remove "only" the prepuce and Toubia has stated that she has not seen a single case of "type A" (see above), where the clitoris hasn't been damaged as well. Furthermore, undergoing FGM is often a traumatic experience with other physical implications as well e.g. fractures on the clavicle, femur or humerus from the attempts of handling the objecting child. WHO states in a report that although the girl or woman may receive support from her family after the FGM, they "may have feelings of anger, bitterness and betrayal at having been subjected to such pain. The resulting loss of confidence and trust in family and friends can affect [...] relationships between the adult and with their own children". Another point worth mentioning is that children of both genders are present during the FGM, standing among the spectators. These children witness the act of mutilation. They see the blood, they hear the girl, and these child guests are described to gather around the recently cut girl, persuading her to eat and trying to comfort her. Deaths due to complications of FGM are sometimes registered, but are to a large extent hidden from health authorities, thus making an estimation of casualties uncertain, but authors have estimated that 7-15% die due to the initial bleeding or infections. The long-term complications of FGM are most often several (especially with infibulation) e.g. frequent cystitis due to the difficulties to empty the bladder, loss of sensation, hypersensitivity, psychological implications, painful menstruation, and difficulties during coitus and deliveries, as the women have to be de-infibulated i.e. "opened up", and sometimes will be re-infibulated i.e. "closed" again (Abdalla, 2006, p 196; Abusharaf, 2006, pp 4, 10; Berggren et al, 2004, p 307; Boddy, 2007, p 50; Dorkenoo, 1995, pp 14-16; El Guindi, 2006, p 45; Grassivaro Gallo, Aralid, Vivani & Gaddini, 1999, p 249; Morrison et al, 2001, p 643; p Rahman & Toubia, 2000, p 7-9).

2.2 FGM - a violation against human rights?

FGM is a violation against human rights, and HR and FGM intertwine several important, although controversial topics e.g. children's rights, gender discrimination, bodily integrity, the right to enjoy tradition, cultural values and religious freedom, as well as minority rights (for details see appendix) (Rahman & Toubia, 2000, p 22, 24, 27, 31, 33, 35-37, 45, 47, 48).

The age at which FGM is performed differs depending on the customs and circumstances of the families involved. Some girls are a few days old, some are teenagers, some girls or women undergo FGM a few months before marriage, and some are infibulated when becoming widows or before being buried. However, it ought to be emphasised that the majority of the individuals undergoing FGM are between the ages 4 and 12. Two major issues divide FGM as regards the HR. Firstly, the issue of consent, and secondly the intent. The definition of a child is "every human being below the age of 18 years, unless, under the law applicable to the child, majority is attained earlier" (Children's Rights Convention, article 1), and the international community question if a child enjoys the autonomy needed in order to give consent as to undergo FGM, even if the child is a mature minor. Furthermore, some women's' rights groups support the view that FGM should be considered as a crime against HR, even when the adult woman has given consent. The given reasons are social pressure, the lack of equal access to education and financial opportunities for these girls and women, giving that they might need to submit to FGM if not wishing to be social outcasts. Thus, in reality, they do not enjoy the autonomy to chose and give consent. Rahman and Toubia stated that "under no circumstances should governments criminalize the practice of FC/FGM in the absence of a broader governmental strategy to change individual behaviour and social norms" Needless to say, the laws are important in affirming social policy, but a law in itself will not ensure a social change, and a poorly-timed law might even yield social resentment, thus giving the opposite results compared to the intentions. United Nations has regarded FGM as an act of violence against women, thus FGM is considered as an act of gender-based violence, resulting in the suffering and harm of women (Berggren et al, 2004, p 304; Dorkenoo, 1995, pp 11, 12; Rahman & Toubia, 2000, p 25, 26, 30, 42, 62, 65, 66; Toubia, 1999, p 6).

It is established that the parents and the circumcisers who are proponents to FGM do not have the intentions to inflict harm, even if they know that undergoing FGM is painful. Furthermore, Abusharaf express that besides the rights of bodily integrity, spiritual integrity should also be remembered i.e. "banning the practice may therefore generate a sense of spiritual vulnerability. In light of this set of cultural understandings, the practice is hardly

thought of as a human rights issue, let alone as discrimination" (Abusharaf, 2006, p 9; Rahman & Toubia, 2000, p 25, 26, 62).

3. EMPATHY

Empathy is to observe an individual and to understand his or hers feelings and psychological situation. The word empathy is originally a neutral term, free of value, and Holm illustrates empathy with the statement that one can love a person without feeling empathy towards him or her, as well as feeling empathy towards someone whom one dislike. Empathy is often used equivalent to sympathy i.e. to observe someone and to feel for him or her e.g. with compassion, support, friendliness, or pity (Holm, 2001, pp 47, 68, 71, 105-107).

3.1 How to develop empathy

Mark H Davis developed the following model as regards empathy:

1. Preconditions characteristic for the observer and the situation. The first part, the empathic capacity of the observer, requires that the observer is able to use facial expressions, gestures, voice characteristics, behaviours etc and combine this information given by the observed in order to evaluate the observed individuals feelings and thoughts. The observer needs to have acquired emotional maturity, self-esteem, trust in other people and a responsible behaviour. Studies have shown that the major obstacles to succeed is firstly the observer lacking the above-mentioned necessary traits, and secondly the resistance of the observed to avoid empathetic understanding. The second part, is dependent on the strength of the situation i.e. if and how the situation will invoke an emotional response, e.g. compassion, within the observer. Factors affecting the response are the degree of emotional state, the helplessness of the observed person, and the relationship between the observer and the observed. People who know one-another, or people who connect with each other have greater empathetic precision, partly because they have had possibilities to observe each other behaviours and perhaps been engaged in situations with previously experienced emotional responses. A general phenomenon is to define the behaviour of people whom one likes or believes are similar to oneself in a more compassionate manner, e.g. to explain their failures as due to outer circumstances, compared to defining the behaviours and failures of the ones whom one dislike as due to personal traits. As a conclusion, the more the observer believes that he or she has in common with the observed, the greater the efforts to understand and to feel compassion and intensity in the emotional response (Holm, 2001, pp 81-86).

2. Processes i.e. the specific mechanisms yielding the empathic result are to a large extent dependent on the efforts to receive and understand emotional messages when communicating. If the observer "know" what the observed feels, the greater correlation with the drive to help the person in need. The observer doesn't have to have experienced the feeling together with someone else, instead it is enough that the observer has experienced a similar feeling as the observed (Holm, 2001, pp 81, 87-102).
3. Intrapersonal effects. A parallel effect can be considered as the reproduction of the observed person's feelings within the observer. These responses can transform to reactions towards the observed persons condition e.g. compassion or personal discomfort because of the hardships of the observed (Holm, 2001, pp 102, 103).
4. Interpersonal effects, which are the observers behaviours towards the observed, as a response to the observed persons emotional expression e.g. helping behaviour, tolerance to other peoples opinions and handling of conflicts (Holm, 2001, pp 80,103, 104).

3.2 Actors involved in FGM

Female genital mutilation is often a decision within the family and includes many different actors, as illustrated by the quoted text on page 3, which was written by Talle. Many mothers who decide that their daughters should undergo FGM are themselves infibulated, i.e. they know the act from "within" and yet FGM is inherited from generation to generation. Williams & Sobieszczyk refer to a study where almost 90% of the interviewed women already had or had planned to perform FGM on all of their daughters, and about half of the mothers preferred infibulation (Talle, 2007, pp 94, 95; Williams & Sobieszczyk, 1997, p 966).

As described above, mothers do play a crucial role in the process of FGM, but there are many other actors in the lives of the girls and women undergoing FGM e.g. fathers, guardians, siblings, elderly family members, friends, class mates, fiancées, husbands, circumcisers (of various professions as described above), health workers, anthropologists, politicians, religious leaders, society at large, as well as HR activists from various backgrounds.

4 THE IMPORTANCE OF FGM

Ardo was seven years old when she was infibulated: "I refused to urinate as well, but even when I tried to on the second day, I could not as it was so painful. My bladder was so full and hard and I was crying. Because of this my father decided that I should be taken to the hospital. When the doctor examined me, he took the thorns out of the wound and then helped me to urinate. After all the urine was out I felt relieved of my pain. After two days, my mother

insisted that I would be sewn again and called another midwife. I cried and resisted, but they were stronger than I was and the midwife sewed me up again. [...] My mother nursed me, cleaned the wound, applied herbs, burned some incense under my legs, and used to feed me with traditional mug mad [dried meat], porridge, and milk" (Abdalla, 2006, p 196).

This description is consistent with the belief that if the opening left after the infibulation is too big (some families/women/men prefer the size of a match-stick), or if the inspection after the removal of tissue is non-satisfactory, the girl ought to be de-infibulated and re-infibulated as many times necessary in order to remove the "right" amount of tissue. Furthermore, both of the parents can take an active part in the decision, initiation, and fulfilment of FGM, and many parents nurture and care for the girls during the girls' healing stage (Abdalla, 2006, pp 190, 191).

Descriptions of FGM induce strong emotions and some authors describe how the parents are thought of as sadists with no empathy for their daughters, but others believe that it can be beneficial to undergo FGM. Mackie describe how mothers love their daughters and decides that they should undergo FGM with the thought of their daughters gaining something crucial by their pain. This feature is underscored, as some women don't associate their parents with evilness. They describe their pain and suffering during the FGM, but pictures their mothers as good, their fathers as good or just absent from the event, and the circumcisers as just performing their job (Ahmadu, 2007, p 308; Johnsdotter, 2007, p 129; Obiora, 2007, p 78).

4.1 Reasons for undergoing FGM

There are several explanations as to why girls and women undergo FGM e.g.: contact between the clitoris and the baby's head will cause the death of the baby; the clitoris will otherwise grow and turn into a penis; a man will be killed by the poisonous secretion from the clitoris; without FGM women isn't fertile; it is a form of contraceptive; otherwise the woman will have urine shooting far forward like a man when urinating; or the smell of sweat or blood - indicating physical openness - is claimed to be damaging to the health. Although commonly described, the explanations mentioned above are rare if comparing to the following: without having undergone FGM the girl will not become a woman, she receives a higher status and becomes acknowledged as respectable, i.e. marriageable, and the mutilation is thought to improve fertility. Women undergoing FGM is said to promote social cohesion and is seen by cultural custodians as an "essential traditional practice" by e.g. purification of the body, or as

a religious statement. Furthermore, women who have undergone FGM are believed to become normal, as they are thought of as being born unfinished, with the FGM completing the social and spiritual definition of the child's gender. Furthermore, it is believed that women undergoing FGM are humanised, feminised, and gain an aesthetic bodily ideal, as well as making the woman a more obedient, respectful, clean, polite, mature, moderately sex-interested woman i.e. a better wife. Although not commonly described, FGM is also used as a health promoting cure e.g. an ailing toddlers was infibulated in order to make her well. Others describe that to invoke pain is to teach the children to suffer, which is thought to strengthen their perseverance and self-enhancement. Another explanation is because WHO is trying to eradicate FGM (Abusharaf, 2006, p 9; Ahmadu, 2007, p 307-308; Ahmed, 2006, p 171; Boddy, 2007, pp 48, 51, 60, 64, 65; Dogenoo, p 34; El Guindi, 2006, pp 32, 40; Johnson, 2007, p 208; Meyer, 2000, p 473, 478; Mohamud, Radeny & Ringheim, 2006, pp 77, 81; Rahman & Toubia, 2000, 2000, p 38; Talle, 2007, p 97).

4.2 No gain without pain

The parents and grandparents, who are proponents to FGM, do often look forward to their daughters undergoing FGM. This might be a time when the mother is at the centre of attention, but FGM can also represent the culmination of her efforts to make her daughter ready for marriage, her skills in organising the FGM, as well an opportunity to present financial status e.g. by paying the midwife well. Fathers can use this period of time to display their daughters, to negotiate about bride prices with potential husbands, and the grandparents take pride in the new generation following their footsteps. It is worth to emphasise that many of the women gain their social status through their children as they marry and reproduce. Grandmothers in turn achieve the respect and authority over the family, and as far as FGM being a request in order to become married or maintain married and thereby having "respectable" opportunities of reproduction, this partly explains these women strongly supporting FGM and their influence of the younger generations (Boddy, 2007, pp 62, 63; El Guindi, 2006, p 45; Mohamud, Radeny & Ringheim, 2006, pp 88, 89).

Marriage arranged by parents, subordination of men and women and their sexuality by their elder relatives make the sexual restrictions a matter of the family's honour. A family loosing its honour risks having their members deemed as unmarriageable, social outcasts, which in turn endanger the economic, political, and social status of the entire family, i.e. the continuity of the family. Boddy describes how the honour mainly is invested in the conduct of women, and that the lives of daughters and sisters are more restricted than the males. The

failure i.e. if not being able to marry can be catastrophic to the individual, even if the girls and women most definitely aren't powerless. No matter if marriage and reproduction is the only way, or yet another possibility, to be able to gain status, the pressure of impeccable morality is absolute crucial. In societies where the husband's family has the right to claim inspection of the bride's "closed" genitals, mothers regularly investigate the infibulation in order to ensure that the unmarried daughter is properly "closed ", and a girl – if provoked – has been described to publicly expose her genitals as a proof of her chastity. In short, the girl's body has become a symbol of the village society (Boddy, 2007, pp 62, 64).

Another struggle of power is the social pressure and expectations to perform intercourse during the wedding night. Husbands have committed suicide due to their shame of not being able to penetrate, i.e. not completing coitus due to the infibulation, or for other reasons. Thus, the cultural and psychological factors can give an infibulated woman an "advantage", since if the husband fails to penetrate, he "comes under the mercy of the wife" not to be exposed as having a "sexual weakness" (Bashir, 2006, p 165; Boddy, 2007, p 52). Another example is Xeero, a ritual held by the bride's female relatives and the groom's male relatives some societies. Xeero is a figure filled with special dishes, covered with cloth and bridal attire by the attending females. The men are invited to untie the Xeero and the opening process is a competition where the man who fails is teased and hit by the women. Since this ceremony is thought to be performed at the same time as the de-fibulation, its symbol has been interpreted as the women's success in tying the bride for the men to struggle to untie. By inflicting pain on the men, the women parallel the pain both men and women experience during de-fibulation. Both female and male attendants consider the entire ceremony as hilariously funny (Johansen, 2007, p 262).

5. USING AND ABUSING EMPATHY

Rosenaue stated that it is reasonable to assume that individuals' skills are different compared to our predecessors' e.g. due to the influence of today's information technology. He claims that the change in skill of people everywhere matters, and is crucial to world affairs due to the following premises: firstly, increased analytical, emotional and imaginative skills enable people to participate in organisations of their interest and to engage in collective actions. Secondly, processes on the micro level are more important to the decisions made on the macro level, and thirdly the macro system of the world politics is presumably more easily influenced by micro inputs due to the turbulence in the world today. This skill evolution would thereby influence the work of NGOs (non-governmental organisation) in a positive

manner. However, both Amnesty International (AI) and Doctors without borders are facing a battle with a "numb" public, i.e. numbness due to empathy fatigue or compassion fatigue. People make a conscious effort not to know what is really going on in the world, "knowledge generated guilt", i.e. if one remain ignorant one doesn't have to make moral choices. The HR workers difficult tasks are firstly to prevent people to behave like ostrich i.e. hiding their heads in the sand, and secondly to cultivate empathy (Dean, 2004, pp 1, 76, 77, 85; Rosenau, 1997, pp 279-280; Rosenau, 2002, pp 277-279).

Changing the views of FGM from cultural practice to violations of HR has been a long process, and the step to expand the definition as to include FGM as a violation of HR has recently been taken by AI. Nevertheless, there are many examples of prosperous projects against FGM e.g. the Tostan project, a successful informal education program based in Senegal, aiming to provide skills as well as information, thereby helping people to define and pursue their goals in general. Villagers determine their goals, by themselves and for themselves, as well as the obstacles needed to be overcome in order to reach the goals. The eradication of FGM was not a goal or even a preliminary concern, but rather became a bonus. This change came about after the rural women had learnt to read and write, and their empowerment and newly gained self-confidence made them interpret how health and human rights could be applicable in their own society. Meyer outlined how successful educational programs encourage the women to use their imagination skills and introspective empathy i.e. to acknowledge their emotional lives, empathise with the suffering individuals "instead of rationalizing the pain and dismissing the sorrow as passing". Furthermore, Mhamud, Radeny & Ringham have described a project to end FGM, and how the growing awareness of the fact that girls ought to be included when speaking about human rights had triggered a social change, with the result that the majority of young boys were willing to marry an uncut girl. The authors claim that this recognition of "girls and women as full human beings endowed with rights to bodily integrity and freedom from harm " will be beneficial to the entire society (Bob, 2002, pp 137, 145; Meyer, 2000, pp 485, 487, 488; Mhamud, Radeny & Ringheim, 2006, p 77; Nnaemeka, 2005, pp 36, 41; Obiora, 2007 pp 75, 76, 81).

Dean discusses the emotional numbing of an audience, as well as how suffering can be transformed into pornography when the uninvited viewer looks at something as private as suffering. Displaying people's bodies, their misery, fears and grief in the most intimate manner creates a delicate balance between empathising identification for a good cause, and voyeurism and humiliating the victims in the name of doing them justice. An example is according to Dean the seemingly compassionate interviewer whom in his or hers quest,

forgets about the vulnerable position of the observed individual (Dean, 2004, pp 19, 32, 52). Johnsdotter states that various actors achieve power and gain advantages in their careers by opposing FGM e.g. politicians condemning FGM gain moral capital, researchers receive grants more easily if being anti-FGM, and that journalists and historians gain prestige by upgrading human tragedy. Western "anti-FGM media" have given money and used other influences in order to get pictures of the mutilation process for their magazines, newspapers, books and documentaries. A woman, being the head of an anti-FGM organisation, used to serve Western crews by arranging FGM for footage. She did not see any contradiction between her work against FGM and her own part in arranging for girls to undergo FGM for footage. Comparable, El Saadawi and Nnaemeka describe how conferences regarding e.g. FGM are transformed into exhibitionistic spectacles of arrogance and hypocrisy, where African women are doubly victimised "and these voyeurs want me to believe that they are fighting for the human rights and dignity of African females!" (Ahmadu, 2007, pp 307, 308; Ajayi-Soyinka, 2005, pp 69, 70; El Saadawi, 2005, p 25; Johnsdotter, 2007, pp 118, 119; Korieh, 2005, p 122; Nnaemeka, 2005, pp 30, 32).

The pain during the de-fibulation at the wedding night is often excruciating, no matter if the husband is brutal or not. Marriages between family members with mutual interests to make the marriage last, might have a positive empathic effect according to Boddy, who also claims that the genetically closeness of the couple might heighten the cerebral component during sex, thereby compensating the lack of e.g. the clitoris (Boddy, 2007, pp 51, 52, 58).

6. THE HISTORY OF WESTERN FGM

Gynaecology was born at the approximate time when references to the female body were used to legitimise standpoints regarding women's rights. It was stated that pain was something natural for women and that woman as a group had a higher tolerance for pain compared to men. The quest of the female genitalia was compared to the expeditions and discoveries of the Nile, and it was important for a woman to obey all medical advises in order to maintain her own health, as well as the health of the future generations. Dr Sims, sometimes called the "father" of American gynaecology and the architect of the vagina, developed his skills and techniques of surgery on black female slaves. Notably, these surgeries were performed during 1845-1849, before the invention of anaesthesia. Dr Baker Brown was also among the first prescribing radical clitoridectomies. He described that every single one of his patients were eternally grateful, had married, conceived children and lived happy family-lives after undergoing FGM. Nevertheless, Dr Brown was excluded from the medical society due to

several reasons e.g. he had forced his patients to agree to undergo FGM, cut without explaining the consequences of the FGM, performed FGM on married as well as unmarried women, and lacked to inform and collect the acceptance from the husbands of his married patients. The Church of England supported the work of Brown and encouraged the clergies to bring FGM to the attention of other male physicians, and the diagnoses motivating infibulation and clitoridectomy was of various types e.g. hysteria, insomnia, irritations of the spinal cord, headache, depression, loss of appetite, lack of obedience, masturbation, and sterility, as well as cases of the woman registering to divorce from her husband. The results of the FGM were among others described to be that the unmanageable wives became more co-operative and had returned to their respective husbands, and a nine-year-old nymphomaniac was also described as successfully cured (Dorkenoo, 1995, p 30; Korieh, 2005, p 114; Nilsson, 2005, pp 13, 76, 79, 98, 99, 106).

Daughters to well-established families in New York were cut in the 1950s on the recommendation of the family physician to prevent masturbation, Church social workers advocated FGM as a kind of rehabilitation to prostitutes. Women in general were inclined to undergo FGM due to them supposedly being unable to keep a proper hygiene, and FGM was the universal cure of frequent vaginal infection, painful intercourse and frigidity. Moral panic due to the increase of the moral threat to society i.e. masturbation, resulted in widespread campaigns, among which John Harvey Kellogg, father of the popular breakfast cereal, had great influence. Clitoridectomy, as well as “surgical operations like infibulation, castration, and circumcision” of men as well as women was the given answer. The expectancy of female chastity, especially the girls and young women from higher classes in society, contributed to this fashion. The women were often unaware of their own physiology, reproduction issues, and sexually transmitted diseases. As late as 1979 “the medical license of James C Burt was revoked for performing clitoridectomies and a form of infibulation on five hundred unconsenting, and frequently unconscious US women” (Abu-Sahlieh, 2006, p 65; Dorkenoo, 1995, p 30; Hodges, 1999, p 44; Nilsson, 2005, pp 191, 199, 211, 228, 278).

7. ANALYSIS AND DISCUSSION

7.1 Terminology

Is it inappropriate to use the term female genital mutilation? Some say yes, and prefer a more neutral term e.g. female genital operation/ cutting/ surgery or female circumcision. Others do not use the words FGM due to the reason that this term can not be translated directly into

African languages, compared to circumcision (Abusharaf, 2006, p 6; Rahman & Toubia, 2000, p X).

My reasons for using the term FGM are several; firstly I agree with Meyer that the term female genital operations or genital surgery gives an association to conditions which are not always fulfilled, and the act in itself is a violation of HR no matter if it is performed at a hospital with anaesthesia and antibiotics, or under unsanitary conditions with a non-officially educated circumciser. Furthermore, alarming studies have shown that the FGM is more extensive during anaesthesia, probably due to the fact that the girl/woman does not fight back as extensively. FGM performed by Western-trained medical staff at hospitals medicalise FGM, and this will not only perpetuate but also legitimise FGM. Therefore, WHO has stated that health professional shouldn't perform FGM under any circumstances (Diop & Askew, 2006, p 131; Dorkenoo, 1995, pp 9, 10; Hadi, 2006, p 109; Johnson, 2007, p 202; Meyer, 2000, p 470). Secondly, no matter the terminology or degree of FGM e.g. clitoridectomy or infibulation, the words describe a punishable violation against HR. Thirdly, the argument of the necessity to apply a term readily translated to African languages neglects the fact that FGM is applied not only in Africa. FGM is unfortunately found in far too many countries around the world and will, due to migration and other circumstances, become an increasingly global issue. Fourthly, female circumcision indicates equivalence to male circumcision (MC). Both FGM and MC include removal of healthy tissue and the arguments as regards content are often the same. However, the physical implications, and the sexual and social messages as regards subordination are too large extents different. Furthermore, there are variants of male circumcision e.g. male infibulation, flaying i.e. peeling the skin of the penis and the hair-bearing skin of the pubis to the navel, or slitting open the male urethra from scrotum to the glans penis, which are also termed circumcision, yielding the same terminology issues as described above (Abu-Sahlieh, 2006, pp 60, 61; Aldeeb Abu-Sahlieh, 1999, p 162; Rahman & Toubia, 2000, pp X, 21; Toubia, pp 2, 4, 5; Zwang, 1999, p 202).

Many choose not to use the words FGM in order not to offence the proponents to FGM i.e. not to stigmatise women by calling them mutilated and not to insult cultural values. I use the term FGM, but I have chosen to describe the individuals who have undergone FGM as having been cut, thus I agree that it is not ethical to stigmatise girls and women. Nevertheless, I do find the act in itself a mutilation, and I wonder if one, by not using the term FGM, betrays the children and women by not acknowledging what they have been through? A social anthropologist described a conversation regarding FGM with one of her contacts: "I commented to Sarah that I preferred the more relativistic circumcision for the practice. Sarah

turned against me and said but it is mutilation. Her sharp answer surprised me. I could do nothing but agree." (Hadi, 2006, p 108; Mohamud, Radeny & Ringheim, 2006, p 79; Rahman & Toubia, 2000, p X; Talle, 2007, p 99).

7.2 Autonomy and the need for empathy

- "She was invited by her paternal aunt to spend her holidays with her cousin. [...] No sooner did Miami enter the house when all the women grabbed her and stripped her" (Dorkenoo, 1995, p 25).
- An infibulated, immigrated child will not have a sympathetic environment, but will instead be treated as abnormal and different (Boddy, 2007, p 51).
- "That day I was warned that if I refused to submit to the midwife, they would call men to de-infibulate me by force." (Abdalla, 2006, p 200).
- "I had an uncle who used to rub me there and I liked it. He would give me money and tell me to keep quiet. When my grandmother found out the next month they took me for circumcision" (Ahmadu, 2007, p 287).

The quotes and statements above, as well as Talle's anthropological description of how a girl, age 14 or 15 is undergoing FGM (on page 3), emphasise the lack of autonomy and the definite need to feel empathy when implicating HR in everyday life. The author herself states that the FGM was a "shocking and deep-felt experience", but claim that this was due to the FGM not being normal, i.e. the girl fought back and was tied up and held by force in order for the FGM to continue. Nevertheless, descriptions of how force is used on girls and women undergoing FGM are common, perhaps with the exceptions when anaesthesia is used. This notwithstanding, I do believe that painless operations in the genital area ought to be rare, especially when no anaesthesia is used i.e. one ought to think about the issues of consent as well as the intents not to inflict deliberate harm and what a "normal" FGM inflicts on an individual. Furthermore, the portrayal of this particular FGM described by Talle e.g. how people said "stop crying for "nothing"", were "eager to begin the feasting", and the picture of the girl's heavy breathing, the excited voices and how the blood is rushing, makes a sharp contrast to the authors own fear of the risk to be squeezed between the bodies if she had entered the house. Nevertheless, the author concludes, "I was witnessing "torture"", and that she herself had sanctioned the event by her presence. It is important to emphasise that torture is not applicable to FGM, as the intentions of the perpetrators are not to inflict harm on the

child or the woman. Furthermore, FGM has also been described to establish solidarity, as the intensity of the common experience blurs the boundaries between observers and the observed, thus making it difficult to interpret the impact of empathy (Meyer, 2000, p 482; Rahman & Toubia, 2000, p 26; Talle, 2007, p 92, 94, 95).

Although some children do express their wish to perform FGM i.e. give their consent e.g. “when she was seven, she had run to the shop and bought the razor blade herself in order to speed up the operation”, this ought to be interpreted as for what it is i.e. the actions of a child, and this shouldn’t (according to me) erase the responsibilities and obligations of the adults to feel empathy with the child and acknowledge that she is a minor. The children wish to show bravery, desire to attend the promised festivities with gifts and privileges, and feel a strong social pressure from bullying classmates or family members e.g. “when I came home they were laughing at me and accused me of being a coward for not daring to have a small operation like circumcision”. I do not find this a decision that a child should have the possibility to make. Firstly, the child will not be able to change her mind, i.e. if running away from the mutilation she will often be hunted down and held down by force until the circumciser has finished. Secondly, a child lacks the understanding of what FGM means as regards the short-term, or the long-term consequences. This is further enhanced by the fact that FGM is a subject of taboo, i.e. isn’t addressed publicly, partly because to retell the pain is somehow to arise it anew. Thirdly, the decision is irreversible, and shouldn’t be taken as lightly, as to be the responsibility of a child. Fourthly, parental support regarding the girl’s choice not to perform FGM is critical in many cases. Nevertheless, El Gundi argues that the girls’ autonomy ought to be equally damaged by one parent encouraging compared to a parent prohibiting FGM. I do find this remarkable considering that FGM is permanent, but if being denied to undergo FGM as a child, the girl may perform FGM when she is an adult and understands what FGM means. Fifthly, strong girls, being able to physically resist are sometimes cut more extensively than those who obey quietly. This is in line with the thought that FGM disciplines individuals, rendering them fit for the social role which is reserved for them due to their gender. Sixthly, and (according to me) most importantly, the agreement to undergo FGM is described by the girls to be an opportunity to show respect to their parents, as well as their willingness to do whatever their elders required them to do. I interpret this as a child’s desperate wish to please her parents, and I find this heartbreaking (Abdalla, 2006, p 194; Ahmed, 2006, p 171; Bashir, 2006, p 164; El Guindi, 2006, pp 35, 37; Johnson, 2007, p 208; Lionnet, 2005, p 107; Mohamud, Radeny & Ringheim, 2006, pp 79, 81, 100; Rahman & Toubia, 2000, p 23; Talle, 2007, pp 97, 98, 101).

The increased focus on FGM as regards legislation, restrictions and punishments were made in order to protect the children and women at risk undergoing FGM. However, studies have shown that FGM is performed on even younger girls than before the new laws, and this is largely explained by the attempts of the parents or guardians to overcome legislative pressures against FGM within ones home-country or when immigrating (Ahmed, 2006, p 176; Dorkenoo, 1995, p 12; Mohamud, Radeny & Ringheim, 2006, p 86).

7.3 Do adults need empathy?

FGM influence the daily lives of daughters, wives, mothers, sisters and grandmothers, as well as their relations with other close family members. I do not doubt the importance of empathy as regards the realisation of human rights in general and FGM in particular. However, to feel sympathetic towards adults, who in most cases possesses autonomy compared to the children described above, might give the results of individuals feeling pitied, patronised, disrespected, and objectified. Thus, many campaigns to eradicate FGM have failed due to various reasons. The roles of the many actors are intimately entwined, and I do agree with Hancock who stresses that "without recognizing and challenging each group's position as both victim and oppressor in society, the agency for social change is muted" (Hancock, 2005, p 264), with the reservation that children most often are only victims.

7.3.1 Empathy for the women undergoing FGM?

If being an adult shouldn't one be able to use ones autonomy and should not ones bodily integrity be respected? Needless to say, many women are opponents and many women are proponents to FGM. Some of these women base their decisions on correct pretences, others on false ones, e.g. when understanding that an uncut clitoris wasn't several centimetres long or elongated, a woman shouted "If it is that small what is the point of cutting it. Many women analyse their experience as "dehumanising and painful", "my opinions were dismissed", "absolutely terrifying", "humiliation...as if it happened yesterday", "it felt undeniably like rape", or "assaulted and then abandoned" (Johansen, 2007, p 262, 265; Menage, 1999, p 217; Rahman & Toubia, 2000, p 65;).

Sudanese women belonging to the age-group 18-25 years chose to undergo FGM in an increasing frequency. Many of these women are attending high school or university, and it is common that they request FGM in connection with them being betrothed or some months before getting married. Other women continue to be infibulated since a woman not "recircumcised" after delivery fears the accusation of slackness. To re-infibulate and tighten

the vagina is seen as a guarantee in order to keep the husband from taking another wife, due to her fear to loose her husband, or a way to please the husband. Nevertheless, reports of divorces and broken engagements are frequent due to the husband or fiancée noticing the change and finding this suspicious. At the same time, Sudanese women being interviewed by Berggren and colleagues described that the woman seldom was the one taking the initiative to be re-infibulated after the delivery. Often the midwife convinced the woman or didn't even ask before re-infibulating her. A Sudanese midwife: "Last week a woman came to me, asking for decircumcision after being recircumcised, because her husband did not want her to be like that. She had done it because the midwife had insisted. Poor woman, then she had to pay double!" (Bashir, 2006, pp 162-165; Berggren et al, 2004, p 306).

Even if I wish that none had undergone FGM, I do believe that all need empathy and that Toubia is right when stating that if adult women do chose to undergo FGM, then this is their choice, i.e. their right to bodily integrity. On the other hand it is worth to remember that choices made by adults, men as well as women, might be influenced by social pressure, as well as by not having equal access to education and economic opportunities (Toubia, 1999, p 4). Furthermore, if the rights of sexuality and fertility of a woman is transferred to another lineage after marriage, when will she enjoy autonomy?

7.3.2 Empathy and the elders

- "My grandmother was circumcised, I am circumcised. Why shouldn't my daughter be? How can we tell our elders, the people who gave birth to us that we no longer want to follow their customs" (Johnson, 2007, p 219).
- "Mothers often avoided watching the procedure for their own daughters, finding the pain unbearable to watch. Ironically, however, this form survived for hundreds if not thousands of years because women insisted on it" (El Guindi, 2006, p 41).
- "I was the first one to be circumcised among the three, because I was the youngest and my mother did not want me to see what would happen to the other girls" (Abdalla, 2006, p 194).
- "I was infibulated when I was nine years old. [...] He cannot enter me. [...] My husband unfortunately emotionally abuses me. He says I am a useless woman. It hurts me so much. I cannot speak about this to my family or to any members of my community. This will bring shame on my family." (Dorkenoo, 1995, pp 23, 24)

Did the elders suffer in vain if the younger generation do not continue to undergo FGM? Will the status of the elders' change if FGM is eradicated? Is FGM the spiritual bond connecting the generations? Clearly, the continuity of FGM is partly a way to show respect and honour the elders and their traditions, and perhaps also a way to show empathy e.g. to understand their lives and to suffer like they have suffered, as well as to gain the status which the elders have gained. Obviously, the generations know FGM from within. They are fully aware of the short and long term experiences and yet FGM seems to be very difficult to discuss, due to the fear of the family honour being lost. Nevertheless, there are countless families who have made the decision not to force the girls to undergo FGM, and these families are most definitely prominent within the society (oral communication).

WHO stated that the feelings of betrayal when undergoing FGM had long lasting consequences as regards the girls' confidence in their families, and that this also might affect the relationship with their own children (Grassivaro Gallo, Aralid, Vivani & Gaddini, 1999, p 249). Perhaps this has an impact on the empathy and sympathy between the generations. What is known is that it is not only FGM in itself, which is influencing the behavioural patterns within families. Toubia states that FGM, together with the social messages following FGM is greatly endangering women's autonomy i.e. "additional messages enjoining women to assume a role of subservience and provide unquestionable services to in-laws, men, and the elderly, often accompany the training that is part of the initiation ritual. Women internalise these messages as part of their social adaptation and emotional adjustment"(Toubia, 1999, p 5).

7.3.3 Empathy and the men

"I was afraid and worried about everything because I was young, and my father made all the arrangements for my marriage to a man 20 years older than myself. Later I discovered that he had given a large number of camels to my family as a bride-price. [...] My husband used a knife to cut the infibulation and when I tried to run away and struggled, he accidentally cut the sides of my legs and the whole area was messed up with blood. [...] My family decided to keep me with them until I regained my strength and grew mature enough for the marriage burden and responsibilities. I stayed with them for two complete years before they took me back to my husband. [...] After I stayed with my husband for two nights of painful intercourse and fear, I decided to run away and I went back to my family. [...] This time also I was separated from my husband for another two years. At the age of 18 years, I was returned to my husband, still against my will. When I stayed there for a few weeks, tolerating my dislike

of the man and his sexual desires for the sake of my family, I discovered that I was pregnant and I stayed with him and stopped running away." (Abdalla, 2006, p 195).

Men are needless to say, crucial actors within societies. Fathers, uncles, guardians, brothers, husbands, friends, elders etc are most often described as a group instead of individuals, and frequently stigmatised as to be ignorant bystanders or villains (Nnaemeka, 2005 p 42). I do believe that they are neither. Clearly, there are men who benefit from and prefer girls and women undergoing FGM for various reasons, and obviously men suffer from FGM, although not to the same extent as women. Are men able to feel empathy and sympathy? Of course they are, and many men are active in campaigns to eradicate FGM, together with their wives, sisters, daughters, female friends among others. Both men and women are involved as regards FGM, and both men and women need to be included in the process to eradicate FGM, and I do find it dangerous to neglect the impact of empathy in the realisation of HR, as this will slow the process.

Some men are very emotional, but say that they had to stop feeling sympathy in order for them to fulfil their duties as a groom. "Every time I approached her sexually, she bled. […] I felt horribly guilty. […] The thought that I was hurting someone I loved so dearly troubled me greatly. I felt like an animal". Needless to say, individuals are different and another husband had his own interpretation of pain and honour: "pain for the girl is part of it, otherwise why did she get married. Also your mates are waiting for you every morning to find out if you have done it, so it is a matter of honor to do it as quick as you can". Furthermore, men opposing FGM do also marry women who have been cut, thus perhaps fulfilling the society prophecy of men preferring to marry women who have undergone FGM. The reasons are several e.g. empathy and sympathy "how can I reject a good woman just because she has undergone FGM", but also a fear that their own female family members will rejected for being cut (Boddy, 2007, p 51; Dopico, 2007, p 239; Dorkenoo, 1995, pp 23, 24; Mohamud, Radeny & Ringheim, 2006, p 95; oral communication).

As regards all men being innocent bystanders "We did not know that women had genitals as such or any sexual feelings. We just felt it, circumcision, was a simple solution to preserve their chastity", both the innocence and the passivity ought to be questioned. Even if there are fathers who are unaware of their daughters being cut, many men are both aware and active when girls and women undergo FGM, e.g. in the anthropological description by Talle where the prospective husband, brother and several other men were encouraging and active participants when FGM was performed. Furthermore, Almroth and co-workers described the

physical damages of men e.g. psychological problems as well as wounds and infections on the penis due to difficulties to penetrate the infibulation, and that most of the men in this study were aware of the female complications of FGM. This notwithstanding, understanding the physical implications, is not the same as feeling empathy and sympathy. One woman described her honeymoon: “It hurts like hell and I cried my heart out. He did not take pity on me [...] it took him seven days of chipping to get there. His penis swelled and they treat him, but not me”. In this case, the husband did indeed understand the medical problem induced on him, but seems to fail to recognise the suffering of his wife. Some might argue that one of the obstacles for the observer to be able to achieve empathy is the inability of the observed individual to convey emotions, and authors describe how women often rationalise and neglect their pain, thus perhaps preventing the process of empathy. However, “I cried my heart out” fails to be included within this category, at least according to me (Almroth et al, 2001, p 170; Johansen, 2007, p 249; Talle, 2007, pp 94, 95).

Dopico asked a man if he thought that his wife enjoyed intercourse and him replying: “Why would she lie under a man night after night if she gets nothing out of it”. Dopico answered “one response might be because he is the main or sole ware earner and she would be hungry and homeless if she did not perform this role” (Dopico, 2007, p 238, 245; Meyer, 2000, pp 485, 487, 488). Needless to say, the subject of intimacy and FGM is sensitive and difficult to discuss, however, I do find that Dopico points at an important aspect of autonomy, even if the question might have been frustrating.

Other ways to avoid the issue of empathy, as well as HR altogether, is to trivialise the consequences of FGM e.g. one man “compared female circumcision to a decorative flower arrangement on his coffee table i.e. not essential to daily life but make the house more pleasant, or romanticise the fact that women undergo FGM or “In our grandmothers’ time, hundreds of girls were circumcised at the same time without the use of any “white” (Western) medicines. Those same women all grew up and gave birth to us without ever going to the hospital”. One researcher even compared FGM with snails i.e. “I was pleasantly surprised that snails, towards which I felt a certain cultural horror, in fact, tasted so good”, i.e. showed empathy towards “strange eating habits” (Johnson, 2007, pp 214, 215; Tangwa, 1999, 1999, p 184), thus wondering why the big fuss about FGM.

Furthermore, some men are seemingly ambivalent to FGM i.e. oppose FGM on a theoretical level (and often officially), but nevertheless express their desire to marry a woman who have undergone FGM, as they doubt the virginity and moral standards of a non-cut woman. Other men who were both officially and unofficially proponents to FGM showed

disbelief and discomfort when discussing post-menarche infibulation (i.e. waiting to perform FGM until the girl has had her first period), since they claimed it to be more difficult to prove the girls virginity if waiting to cut her (Johansen, 2007, pp 258, 259). This implies them preferring children undergoing FGM, thus entirely disregarding the rights of the child and favouring a HR violation.

7.3.4. Empathy and the circumcisers

An infibulated woman giving birth need to be attended by a midwife in order to cut the woman, thus allowing delivery, and infibulation made midwives socially indispensable. The status of a midwife in the Old Kingdom of Egypt was rather high, and they were even considered as to be a member of their clients' families, but nowadays, the status of a circumciser is among the lowest in many societies. Furthermore, traditional circumcisers, whose sole family income is generated through FGM, are now out of business due to the competition from health professionals (Bell, 1998, p 295; Fischer, 2000, p 70; Kirby, 2005, p 93). Many circumcisers have undergone FGM, their daughters have undergone FGM and they know that they inflict pain and suffering, although claiming to feel empathy for the women. Interestingly, Berggren and colleagues describe how the midwives direct the women to hide their expressions, thus concealing their pain, when giving birth, being de-infibulated or re-infibulated, thus trying to prevent the preconditions for empathy. Furthermore, when asked why they performed FGM, despite the risk of being punished, some of them claimed that if they didn't perform FGM on the girl, then somebody else would and perhaps they would perform a lousy job. Others describe "It was, frankly, quite appealing to circumcise girls". Lastly it is worth to emphasise that both the traditional circumcisers, as well as the health workers and MDs perform FGM despite the fact that national law prohibits such acts. Interestingly, the most commonly quoted motive by all of these groups is the one described above, i.e. if I do not do it, then someone else will. Nevertheless, it is important to realise that FGM is a lucrative business (Bashir, 2006, pp 154, 160; Berggren et al, 2004, pp 304, 305, 307; Holm; 2001; pp 81-86); Mohamud, Radeny, Ringheim, 2006, p 97).

7.3.5 Emphatic confusion?

There is a risk of empathic confusion if discussing for whom we feel empathy, and for whom we should feel empathy. I find that discussions regarding the status of the actors, or comparing the consequences of undergoing clitoridectomy or infibulation, who is the real victim, more victimised, most victimised, more deserving of empathy etc diminish the HR to

enjoy autonomy and bodily integrity. Furthermore, the danger in requiring “them” to be like “us” in order for “us” to be able to feel for “them” is obvious, just as the jeopardy to feel on their behalf instead and thereby silencing them (Ajayi-Soyinka, 2005, p 64; Dean, 2004, p 13; Hancock, 2005, p 251; Holm, 2001, p 81-86). Furthermore, I do find arguments like ”it is better to perform FGM at a hospital with antibiotics and anaesthesia ” very disturbing, considering that FGM on a minor, or a non-consenting adult always ought to be a violation against HR.

The campaigns to eradicate FGM are not as successful as one could hope, and perhaps the lack of empathy is one part of the problem. Firstly, and according to me most importantly, somewhere on the way the children, the non-consenting women, the social implications and messages are forgotten. Secondly, the observer needs to listen to the observed in order to be able to achieve empathy. Thirdly, the observed individual needs to feel confidence and strength in order to be able to express their feelings and experiences. Fourthly, I do agree with many authors who believe that it is crucial not to neglect the importance of including all the actors in the process for change as regards FGM, i.e. not to stigmatise and exclude anyone. Although, I do find stigmatisation appalling, these considerations ought never to be at the expense of the most vulnerable individuals i.e. the children and I do find this as to be the true empathic confusion.

7.4 Hegemonic empathy - “us” versus “them”

Davis state in his model regarding empathy that it is easier for “us” to feel empathy for “them” if “they” are similar to us and if “we” like “them”. Thus, Toubia declares that hegemonic status and political, cultural, historical situation has made it easier to vilify and condemn what is common in Africa and sanctify what is popular in America (Holm, 2001 81-86; Toubia, 1999, p 5).

Dehumanisation and loosing empathy can be achieved by using stereotypes e.g. by ignoring the multiple roles women play in Africa, diminishing their role in preserving African traditions, controlling the forms of communications and knowledge, and by neglecting how culture might strive to “test, gain and retain dominance through the bodies of their women”. Interestingly, many of the first campaigns to eradicate FGM weren’t focusing on the health and sexual rights of women, instead “women became the convenient and safe site for the manifestation of imperial power”. Furthermore, the initial focus on the health and psychological aspects of FGM failed and the campaigns are nowadays more focussed on the

overall context of girls' and women's rights i.e. focussing on social messages (Rahman & Toubia, 2000, p 3; Toubia, 1999, pp 5, 6).

Although operating girls with ambiguous genitalia (e.g. medical conditions where the clitoris is enlarged due to the hormonal imbalance) is considered a routine in many societies e.g. in the USA, critical voices are raised against the assumption that if left untreated, the girl's elongated clitoris would yield long-lasting effects on their social life and psychological development. I would like to stress that these operations are made for therapeutic reasons i.e. not defined as FGM, however some of the arguments to operate are based on the same arguments about aesthetics as the ones mentioned when talking about FGM. Furthermore, Meyer states that the mothers, whose daughters have ambiguous genitalia, are not thought of as having evil intentions when authorising these procedures onto their daughters, while the empathy is clearly lacking with many contemporary women in other societies (Meyer, 2000, p 470).

Furthermore, Hodges describes that many MDs have rarely seen a penis with its foreskin intact, especially if studying and working in countries where MC is performed on the majority of the men. This results in phimosis*(see below), despite being rare, "has achieved mythical dimensions". In England, 62% of MC are performed on boys less than 16 years of age, and about 1% is for "routine" or social reasons and 4% on religious grounds. Hence, the vast majority is indicated on medical grounds, of which close to 90% are indicated due to phimosis. Health workers describe how fathers, when looking at their new-born son, are shocked due to their belief that the " penis was grossly "abnormal", deformed, and in urgent need of surgical correction". I find it somewhat interesting to compare this quote from an English father with the quote of a mother who used this argument when defending FGM "Had this been your face, would you leave it as is?" (Donnell, 1999, p 63; El Guindi, 2006, p 27; Hodges, 1999, p 54, 56).

One can discuss the intentions to do harm when girls and women undergo FGM. As regards pain and neglecting the pain of the observed, procedures and surgeries have been performed on new-borns without anaesthesia, due to the mistaken belief that children were not neurological complex enough to experience pain. Researchers have studied the duration and pitch of the cry, as well as cardiac activity, blood pressure, respiratory rates etceteras, and van Howe expressed that these studies "of extreme pain in experiments that would not have been allowed on laboratory animals" undoubtedly proved that the children felt pain. The standard excuse for the circumciser to neglect the pain of the child was that the male baby was "not feeling pain from the surgery, but that he was crying from being strapped into the

restraining board", however experiments have not confirmed this notion. Howe expresses his views that the proponents of MC have changed their arguments from discussing pain towards anaesthesia during MC, with the intentions to "deflect public scrutiny of circumcision away from the more significant consequences of the surgery, such as the unavoidable loss of the most neurologically complex portion of the penis, and the human rights violation of being subjected to unnecessary surgery" (van Howe, 1999, pp 67, 68, 74, 88).

Needless to say, I do not believe that the social messages and the physical consequences of the three examples above are to be compared with FGM. However, some of the arguments are the same, e.g. aesthetic thoughts, the thoughts of children not feeling pain, how the loving parent's strongly wishing that their children should not be social outcasts, and that many of the children having ambigious genitalia and undergoing surgery, as well as children undergoing FGM and MC, grow up feeling that their parents ought to have respected their bodily integrity (oral communication).

*phimosis= förträngning av förhud så att den ej kan föras over ollonet

7.5 Distancing and pathologisation

Distancing is to completely dissociate ones thought and actions from emotional evaluation, thereby transforming the observed individual into an object. Many authors conclude that too many individuals, both men and women, find it difficult to understand that human rights ought to include women. I do believe that thoughtlessness, objectification, and pathologisation can influence the process of empathy, perhaps even turning empathy and sympathy into hypocrisy e.g. when some western photographers paid for the arrangements of girls undergoing FGM. One of the girls, whose nudity has been displayed in several newspapers by a western photographer, is Seita Lengila. She has never given her consent to this display of her pain, but the crew gained huge success and was pleased regarding the "very, very positive and compassionate response" (Ajayi-Soyinka, 2005, pp 69, 70; Holm, 2001, p 50; Korieh, 2005, p 122; Nnaemeka, 2005 p 32).

Pathologisation is a way to further distance oneself from feeling empathy towards human being e.g. by pathologise human behaviours as not normal. One example is how Dr Cartwright, in 1851, defined drapetomania as "the disease causing slaves to run away". He stated that this disease had been described in ancient Greece, the treatment i.e. whipping was "supported by the Bible, as he puts it, by the "will of the Creator" (Hodges, 1999, p 38), i.e. geographical, ethnical and social difference can distort compassion, and self-protective dissociation can function as a psychological form of numbness.

7.5.1. Loosing empathy

Part of the explanation for loosing empathy and feeling empathic numbness is according to Dean that visual media might give you so many images that you in the end don't register anything. Do we identify with the victims or the perpetrators? Do we use suffering as entertainment? Institutionalised variations of everyday violence will normalise the process towards dehumanisation and yield the sufferings of the observed individuals invisible to the observers. I do agree with Dean that indifference in this extent might be far more dangerous compared to numbness, or unconscious unwillingness to think. The author claims that it might not be the indifference in itself, but the uncanny banality with which extraordinary cruelty is displayed. The cruelty can be manifested both through the best intentions and the most banal ones. Dean states that indifference is a symbolic erasure, whether or not bystanders have a guilty conscience or not and whether they are ignorant or educated, or aim to help but regrettably cannot (Dean, 2004, pp 3, 5, 8, 9, 11; 95, 99, 103, 104).

Many projects with the aim to eradicate FGM use empowerment, i.e. to encourage the participants' skills in imagination and introspective empathy in order for them not to rationalise or dismiss their pain. Whether not acknowledging pain is some kind of personality trait or a socially implemented behaviour, the need of education, or perhaps more accurate empowerment is emphasised as crucial (Meyer, 2000, pp 485, 487, 488). I do not doubt that many women and men feel empowered by this education, however, it needs to be remembered that highly educated women and men are proponents as well as opponents to FGM. Thus, I do not conclude that education is the only way to eradicate FGM, and considering that many information campaigns have failed, perhaps due to people feeling patronised or pitied, which is by many considered very offensive (Ahmadu, 2007, pp 307, 308; oral communication). Furthermore, education is not an automatic diploma of empathy or empathic behaviour. Alarmingly, medical students in the USA showed more empathy towards their patients in the beginning of their education, compared to when becoming MDs (Holm, 2001, pp 57, 139). Another example is how Ntarangwi, an opponent to FGM, transforms numerous of American students from being opponents to FGM towards proponents after attending Ntarangwi's course in anthropology. The author describes how this is achieved by pushing the students to separate themselves from their emotions, and stressing the need to see the other culture from the inside. Many students could not go beyond what they claimed to be to deny women their rights, nevertheless, they learnt to wish avoiding to be considered as ethnocentric, which they learnt to be a negative trait (Ntarangwi, 2007, p 94, 101, 103). The

students of Ntarangwi read a description of how a naked women is chained and held down by several men, in order for the husband, who she obviously doesn't wish to have any relations with, approach her with the intentions to have intercourse with her without her content, and with the assistance of several men. The students question the role of the anthropologist in such a context, i.e. for him or her not to intervene and help the woman. Ntarangwi replies that "I remind students that this practice, just like FGC is but a piece in a large block of culture. To eradicate it would require not only an understanding of the relationships it has to other cultural realities in the community but also the instigation of such a change from the inside the culture itself and by the cultural practitioners themselves" (Ntarangwi, 2007, p 96). I do believe that Brière is correct when expressing the view that the "most dangerous positions are those that intellectualize the oppression and mutilation of women on the basis of tradition" (Brière, 2005, p 176). This can be exemplified with following quotes**:

- "After two periods of field research [...] Female and male circumcisions [...] were part of the order of the day and a cultural phenomenon that *no longer raised feelings of anxiety or indignation*" (Talle, 2007, p 93).
- "some girls find the experience traumatic, and some young women *construct* the memory of their particular childhood circumcision experience in this fashion" (El Guindi, 2006, p 37)
- "Somali women in general encounter perpetual gynecological problems, real and *imagined*" (Talle, pp 102, 103)
- Ntarangwi comments that his students never "questioned their own assumptions of what constitutes sexual pleasure and if such pleasure is achievable for all, *or even at all desirable*" (Ntarangwi, 2007, p 101).

**I have altered the quotes by emphasising words in italics

Pathologisation, to medicalise, and intellectualise are various ways to distance oneself from human suffering, and are according to me rather crucial "tools" if wishing to avoid the issue of empathy. Western FGM can be interpreted to begin with vivisection. Vivisection, i.e. scientific experiments on living animals was a highly controversial method around 1900, and critical voices regarding the necessity, the usefulness, the brutalising influence and the distancing objectivity which the opponents deemed necessary in order to perform these experiments. The opponents to vivisection claimed that the researching MDs did no longer hear the cries of the animals, did not see the blood flowing, but was only occupied with the

idea and the biological mechanisms associated to his experiments. The opponents to vivisection were also against the distancing and pathologisation of gynaecology. Several MDs refused to perform vivisection, as well as painful gynaecological treatments e.g. uterus massages, or placing electrodes with 250-300 mA on the stomach and in the vagina, for up to 10 minutes, and encouraged their colleagues to imagine how their patients felt, thus feeling empathy (Abu-Sahlieh, 2006, p 65; Dorkenoo, 1995, p 30; Hodges, 1999, p 44; Nilsson, 2005, pp 191, 199, 211, 228, 278).

Supporters of FGM stress the symbolism and state that the suffering and pain will subside and be replaced by joy and pride, as well as emotional bonding both between the girls and the bystanders i.e. “seldom are we shown the smiling faces of their mothers and sisters, even the girls themselves, rejoicing at their accomplishment” (Abusharaf, 2006, p 8; Boddy, 2007, p 54). But as Dorkenoo argues: “Clearly, if in a community sufficient pressure is put on a child to believe that her clitoris or genitals are dirty, dangerous or a source of irresistible temptation, she will feel relieved psychologically to be made like everyone else” (Dorkenoo, 1995, p 25).

7.6 Empathic fashion?

Nowadays, women undergo painful surgeries e.g. where the clitoris is tailored according to the individuals aesthetic preferences, pelvic floors adjusted to look more like the ideal of pornographic magazines, vaginas tightened in order to become narrow like virgins as being part of an aesthetic ideal. Ahmadu express how women from western countries perform the surgeries described above, which are much similar to the aesthetics of some types of FGM, and El Guindi describes how some compare FGM with breast enlargements, and that they refer this procedure as “breast mutilations” i.e. a way to make women feel good about themselves, yielding increased value and increased male attraction. Many women do see FGM as cosmetic surgery, as a way to increase their beauty and femininity, and many claim not to have any complaints as regards the FGM in itself, despite urine retention, painful intercourse, and obstructed labour. This can partly be explained by the fact that they don’t even associate their health problems with them having undergone FGM (Ahmadu, 2007, p 284; El Guindi, 2006, p 27, 33; Mohamud, Radeny & Ringheim, 2006, p 81).

A common theme when loosing empathy is to play with the human wish to belong and to be considered as normal i.e. the wish of being fashionable and “normal”. Is it fashionable to use the skill evolution like Rousenau suggested, i.e. to be interested in HR, to be an activist, or will the aesthetics of cultural fashion include the change of our thoughts about HR? Does

hegemonic fashion exist, and how will this implement the eradication of FGM? Will fashion have an impact on the works of NGOs and our ability to feel empathy? I do not claim to have answers to the questions above, but I find it interesting to learn from history. Ventrofixation was a frequent surgery, almost fashionable, where the uterus was claimed to be "tilted" and in need of correction. The "tilted" uterus, which most certainly was a normal variation in shape and position, was considered to prevent hysteria and sterility and was "cured" by cutting the ligaments holding the uterus, and pin them into the pelvis bones. The life-endangering side-effects e.g. infections, blood loss, or sepsis were almost exclusively seen as due to carelessness of the patient i.e. this was the fault of the woman for not obeying orders as regards how to behave after the operation. The patients diagnosed themselves as having a "tilted" uterus, and it was almost impossible to convince the patient that she was completely healthy, thus the operation created a placebo effect. These surgeries "curing" the "tilting" uterus, were very dangerous, often followed by serious complications e.g. a third of the women who went through the operation had miscarriages, and the ones who could fulfil the pregnancy had extremely dangerous deliveries as the cervix often did not open (Nilsson, 2005, pp 170-173, 176, 177, 182).

Personally, I do find that there are many similarities between adult consenting women undergoing FGM, breast implants and genital surgeries, both the ones performed several centuries ago and today. I do believe that the implications of empathy and social pressure are essentially the same, no matter if comparing within ones own society or between societies, and no matter the generation. However, I do find it dangerous to thoughtlessly compare FGM with plastic surgery, as one ought never to forget that the majority of the individuals undergoing FGM today are minors, and they have neither given consent, enjoyed autonomy, received correct information, nor are given the chance to change their minds.

8 CONCLUSIONS: FASHION, FEAR AND FAITH

Needless to say, it is not sufficient to preach about child labour to the mother who sends her child to work, if the very existence of this child or the rest of her children is dependent on the labour of the child (Meyer, 2000, pp 485, 487, 488; Nnaemeka, 2005, p 40).

I. The children and the non-consenting adults are often forgotten when discussing HR in general and FGM in particular.
II. Empathy is a fragile luxury, which many people can not afford, especially if there is no other possibility for them to secure the future of their children.

III. When men and women from various different societies make “business-arrangements” in order to gain power, or social and financial benefits, there is a great risk of turning individuals (men and women) into items lacking the right to receive empathy. Do we buy the cheap jacket thinking about sweatshops or are we ignorant bystanders?

IV. Education can be empowering, but is most definitely not a guarantee as regards being able to feel empathy.

V. Empathy is easily lost e.g. by numbing, distancing, demonising, and intellectualising “them” into being so different as for “us” not to believe “them” to have the same feelings as “we” have i.e. demonising them or patronising them. Thus, by ignoring our similarities, empathy can easily be lost within societies, between societies, within families and between genders.

VI. Women of age, undergoing FGM for cultural, religious or esthetical reasons ought to be respected as adult individuals, but the impact of social pressure should never be disregarded.

VII. To men and women who do not find FGM a big deal i.e. nothing to be upset about: How much do you value your penis or clitoris?

VIII. To men and women who think that FGM is a small prize to pay in order to gain status within the society: Which body part do you wish to loose in order to gain the right to vote?

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APPENDIX I

Conventions & Charters cited when discussing FGM and HR are e.g.:

1. The Universal Declaration of Human Rights (articles1- 3, 18, 25, 27 (1), 28 & 30)
2. United Nations Charter (articles 1 and 55)
3. Civil and political rights convenant (preamble and articles 2 (1), 3, 5 (1), 8, 9 (1), 18 (1), 18 (3) & 27)
4. Economic, social and cultural rights convenant (preamble and articles 2 (1), 2 (2), 5 (1), 12 & 15 (1)(a))
5. Banjul Charter (articles 4, 5, 8, 16, 18 (2), 27 (2), 28 & 29 (7))
6. American convention (articles 1, 5 (1), 12 (1) & 12 (3))
7. European convention (articles 8 (1), 9 (1), 9 (2) & 14)
8. The United Nations Convention on the Rights of the Child (article 2 (2), 19, 24 (1) & 24 (3))
9. The African Charter on the Rights and Welfare of the Child (articles 4 (1), 5 (2), 10, 14 (1), 14 (2) & 21)
10. The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (articles 1, 2, 5 (a) & 12)
11. The United Nations Declarations on Violence Against Women (article 1 & 2(a))
12. Declaration on race and racial prejudice (article 5)
13. Declaration of the principles of international cultural co-operation (articles 1 (1) & XI (2))
14. Declaration on the rights of persons belonging to national or ethnic, religious and linguistic minorities (articles 2 (1) & 8 (2))
15. Declaration on religious intolerance (articles 1 (1), 1 (2) & 1 (3))
16. Programme of action, world conference on human rights (paragraph 38, 49)
17. Programme of action of the international conference on population and development (paragraph 5.5)
18. Platform for action, fourth world conference on women (paragraphs 39, 106 (c) & 224) (Rahman & Toubia, 2000, pp 22, 24, 27, 33, 35-37, 45, 47, 48).