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On 4 February 2015, Ms. Koonce was invited to the American Graduate School in Paris (AGS) to give a lecture as part of the AGS's continued work on violence against women, with a discussion on female genital mutilation (FGM). The following is the transcript of her speech.

On February 6, 2003, Stella Obasanjo, the First Lady of Nigeria and spokesperson for the Campaign Against Female Genital Mutilation, made the official declaration on "Zero Tolerance to FGM" in Africa during a conference organized by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children. The UN Sub-Commission on Human Rights adopted February 6th as an international awareness day.

In some African countries African women live in societies where the demands of their male dominated culture necessitate literal mutilation of the most crucial sign of womanhood- their external genitals. Female genital mutilation, often known as FGM, refers to the various degrees of cutting on the external female genitalia for non-medical reasons. FGM raises a host of complex issues and is not at all straightforward. Within the subject itself are:

- Psychological issues
- Reproduction and health issues
- The rights of the child issues
- Cultural and anthropological issues
- Accusations of Western imperialisms
- Medicalization of FGM(In Egypt, about a third of the procedures
- took place at a doctor's office, hospital or clinic.
- Societal issues on the legal system and criminality
- And even linguistic concerns: ought we call this FGM or FGC

More than 125 million girls and women alive today have been subjected to FGM in the 29 countries in Africa and the Middle East in which it is concentrated, and 30 million girls are at risk of being cut within the next decade. FGM is routinely practiced as tradition in twenty nine African nations, many of them distributed more or less across a zone running from Senegal in the west to the Horn of Africa (the region containing Eritrea, Djibouti, Ethiopia, and Somalia). However it is not uniquely confined to Africa. It has been practiced in, the Middle East, amongst diaspora communities round the world and in many immigrant communities in Australia, Canada, and the United States. Due to civil wars that have been caused major refugee movements from the horn of Africa, it can be plausibly assumed that FGM is now being performed in refugee camps. There have also been documented cases in France, Britain, Sweden and Germany.

Due to the growing number of emigrants who are bringing this time-honoured tradition with them when they emigrate, the augmentative vocalisation of women who had been mutilated as children and the rising chorus of international condemnation of this age old practice European and Western countries have forced to respond to FGM. Thus, FGM addresses three groups - those who perform it, those who have observed it and those who are aware of it.

THE OPERATION ITSELF

FGM is a collective term used for the various degrees of cutting on the female external organs; but despite the degrees of cutting, women and girls are subject to excruciating pain. The female genital organ normally is constituted by the vulva, which comprises the labia majora, the labia minor or nymphae, and the clitoris that is in front of the vestibule to the urinary meatus and the vaginal orifice. When normal, there is absolutely no reason medical, moral or aesthetic, to suppress all or any part of these exterior organs. It takes one of three forms: Sunna, Clitoridectomy and Infibulation or commonly a form of each three. Sunna, which means tradition in Arabic involves the removal of the clitorical prepuces with part of the clitoris remaining intact. It is also the rarest form. Type II Clitoridectomy mutilation is the removal of the clitoris and all or part of the labia minora. This is more extensive that Type I This form of FGM causes profound bleeding in the artery and is extremely painful due to the sensitivity of this area that is constituted by the special receptacles of nerve endings that are clustered in the clitoris. Type III Infibulation or excision, the most harrowing and common, involves the removal of all the genital parts. The vaginal introitus is obliterated except for a small posterior opening to allow the passing of urine and menstrual blood. The skin of the inner surface of the labia majora is scraped and stapled with strings and dwarf acacia thorns. It must be reopened for sexual intercourse and childbirth, a procedure known as 'defibulation'. In some instances, this is followed by reinfibulation. The vast majority (85%) of FGM performed in Africa consist of clitoridectomy or excision. This particular practice affects essentially the entire female population of Somali, Djibouti and the Sudan (except for the non-Muslim population of southern Sudan) Southern Egypt, the Red Sea coast of Ethiopia, northern Kenya, northern Nigeria and some portions of Mali. However, whatever the form of the cut, women are subjected to intense pain. It is estimated that worldwide eighty million women and girls are harmed or deformed by at least one of the above cuttings. Type IV: pricking, piercing, incising, and scraping but no removal of tissue and no permanent alteration of the external genitalia. This is sometimes called 'symbolic circumcision', and some communities have described it as a traditional form of FGM.

FGM is usually carried out in the girl's home, or the home of a relative or neighbour, in a specially designated site, such as a particular tree or river. The girl is forcibly held down, either by a woman lying underneath her to pin down her arms and legs with her own, or by several women. Young weak girls are held down by four women. Strong ones require five women, one to sit on their chest, and one for each arm and leg. The girls must be kept still. Fractures can result due to the heavy-handed restraint on the struggling child. To begin a female's legs are opened, often forcibly by other women, while a chief operator does the cutting. Once the initial cut is made, the operator takes her own sharp fingernail and makes a hole the length of the clitoris. By doing this, she is able to manually pull out the entire clitoris.

Traditional birth attendants, typically a woman with no medical training, perform FGM under appalling hygienic conditions, using unsterilized razor blades, pieces of glass, kitchen knives and sometimes sharp stones. It is usual that these unsterilised instruments are used on all the girls in succession. Amongst some tribes in Mali, a saw-tooth knife is the instrument. In the Sudan, a special razor called a Moos el Shurfa is used. Cauterization (burning) is practiced in some parts of Ethiopia. In some parts of Gambia, the fingernails have been used to pluck out the clitoris of babies. Herb mixtures, earth, cow dung, ashes and engine oil are rubbed on the wound to stop bleeding. Among some ethnic groups in Cameroon, after the mutilation, the girl's vagina is packed with cow dung or salt. Needles, thorns, catgut or threads are used to stitch the wound. In some communities there is no stitching, but to facilitate healing, the raw edges of the wound are brought together with

adhesive substances such as eggs, sugar or acacia tar. In rare cases, animal excreta is placed on the wound, as found among some people in Western Sudan. The insertion of a small sliver of wood or a match stick prevents the hole from completely closing.

FGM is usually carried out in traditional settings and rarely, if ever, in hospital settings. The traditional practitioner is favoured amongst the parents as not only does it lend itself to the feeling of passing on tradition but it is also less expensive. Anaesthesia is rarely, if ever used unless performed in hospitals. However, some groups practice traditional forms of anaesthesia such as having the girls bathe in very cold water prior to the mutilation, and applying compresses to soothe and heal the wound, in some cultures, girls will be told to sit beforehand in cold water, to numb the area and reduce the likelihood of bleeding. In general it is more common that no steps are taken to reduce the pain.
Given the circumstances under which FGM is performed, the smoothness of the organs and the lack of anaesthesia, naturally there is struggling, which sometimes causes more mutilation to take place than was originally intended. In essence the degree of hygiene under which the mutilation is performed, the expertise of the practioner, the general health of the female, and the amount of struggling she does influences the outcome. The FGM procedure lasts about fifteen to twenty minutes, according to the ability of the older women and the resistance of the girl.

The girl may be taken to a specially designated place to recover where, if the mutilation has been carried out as part of an initiation ceremony, traditional teaching is imparted. After the mutilation, the girl is bound from her waist to her toes. Since her legs are bound together down to the ankles in order to insure that the area is closed as it heals, urine and faeces remain trapped. She is placed on a mat until she urinates in order to ensure that the opening is adequate. Often the girl is immobilized for an extended period, varying from fifteen to forty days while the wound heals whilst her faeces accumulates. In Upper Volta (now Burkina Faso) the girls are isolated for four weeks and taught their adult responsibilities. Their diet is often restricted. Once the wound has healed a mutilated female's husband will often come immediately to consummate the marriage.

PHYSICAL COMPLICATIONS

The pain inflicted by FGM does not stop with the initial procedure, but often carries as ongoing torture throughout a woman's life. Indeed there is no single practice which has such a dramatic negative effect on health in the broadest sense as FGM. Surviving FGM without complications is rare for a woman. The secrecy surrounding FGM, and the protection of those who carry it out, make collecting data about its physical complications. However, there is statistical verification of the complications from FGM and the evidence is damming.

What is known are the insidious complications immediate or long-term. The major immediate complications are, of course, haemorrhage shock and urinary infection due to retention. This often occurs within the first week, because you must remember that the girl's legs are tied together. The specialized sensory tissue of the clitoris is concentrated in a rich neurovascular area of a few centimetres. Thus, the removal of a small amount of tissue is dangerous and has serious and irreversible side effects. This haemorrhage may lead to serious collapse and if bleeding is not adequately controlled, either at the time of the mutilation procedure or later, the female can bleed to death. Cutting the outer labia further damages arteries and veins.

The traditional medicine and instruments that are used to heal wounds, such as tree thorns, unhygienic knives and razor blades, also place the female's health at a greater risk. As in any surgical procedure,

infection to the wound can result either from the unsterilized instruments or hands, or from the contamination from the girl's bodily wastes during her recovery that can cause infection.
Mutilation is often performed without anaesthesia which in itself is very often the cause of atrocious pain that can last for weeks, particularly when the female has undergone the more severe form of FGM. A female naturally writhes in pain and agitation which can lead to clumsy operations and lead to additional bleeding.

The late and long-term complications that have been observed are urinary incontinence, cysts, urogenital tract infections, severe dyspareunia, pelvic inflammatory disease, infertility, and problems during birth such as delayed or obstructed second stage labour because the tissue is hard and stiff -because it no longer has the elasticity- trauma, and haemorrhage and severe tearing. Haemorrhage was also seen as a late complication especially in the newly married girl who have been tightly mutilated and subjected to forcible sex by the husband who used various instruments such as scissors, blades or knives to penetrate her. A mutilated woman no longer has an inner or outer labia and a clitoris. What remains is massive knotty scar tissue that has keloid. The pain is reinforced when they urinate drop by drop, on a monthly basis when they suffer the pain of menstruation and when they endure sexual intercourse and the agony of childbirth. Dahabo Musa, a Somali woman, described mutilation in a 1988 poem as the "three feminine sorrows": the procedure itself, the wedding night when the woman is cut open, then childbirth when she is cut again.

THE AGE
FGM is performed on infants, girls, and women of all ages. The age at which FGM is performed varies from country to country as it often depends upon the girl's country of origin and can vary widely even within countries. Sometimes, it is done just before marriage or during a woman's first pregnancy. In some areas it is carried out during infancy (as early as a couple of days after birth), in others during childhood. In Yemen, more than 75 percent of girls undergo FGM whilst they are still neonates at the age of 2 weeks old. The most typical age is before the age of 7, although there are indications that the age is decreasing in some areas. This decrease in age can be seen in Burkina Faso, Côte d'Ivoire, Egypt, Kenya, and Mali. This has been attributed to making it easier to hide it from authorities in countries where there may be laws against it, younger girls are less able to resist, to reduce the trauma to the child and to avoid government interference and/or resistance from children as they get older and form their own opinions.

More recent surveys expose some wrenching statistics. In eight countries in which more than 80 per cent of girls and women of reproductive age have undergone FGM: Somalia (98 per cent), Guinea (96 per cent), Djibouti (93 per cent), Egypt (91per cent), Eritrea (89 per cent), Mali (89 per cent), Sierra Leone (88 per cent) and Sudan (88 per cent).

WHY
African women's involvement in FGM must be acknowledged. There is no single explanation for the practice of the many forms of FGM. Rather, the reasons are numerous and are splintered economic, social and political rationales: the predesignated inferior status of African women, the preventing of women wanting to engage in illicit sex by making sex impossible for women until the vulva is again cut or forced open, the high emphasis on the physical state of virginity, the economic consequences that await an unmutilated woman and the erroneous belief that FGM is scripturally mandated by the Qu'ran. Sometimes it is a mixture of all of the above cited. Of all the rationales that justify FGM's

existence, perhaps none are as pervasive and powerful as the stranglehold rationale of TRADITION. It is tradition that is the source of FGM. As cited by one woman

> *It's true that god created us that way, but when we woke up to ourselves we found this custom handed down to us from our grandfathers and theirs and from those of whom we are not even aware of and those we no longer know. We emerged in this world and found this had already existed. It's just so. My people do this, and so I must do like they do.*

It is clear that by Western standards FGM is an unacceptable cultural practice. The very concept of crudely removing the external genital carries a shock value and a reaction of repugnance. It is also clear that the media coverage tends to be sensation prone, focusing upon the process and symptoms of FGM, rather than focusing on the multiple layers of reasons that underlie this cultural practice.

What is important to remember is that amongst African girls, they live in communities where FGM carries a high social value. It is important to remember that the African tradition of FGM has solidified over many generations. An unmutilated girl is the target of ridicule. No one will marry her. In many African communities marriage is an African woman's primary source of economic survival. In a tightly-knit village mutilation is the rule. During the traditional ritual there are references to the special clothes and good food associated with FGM, to the pride in being like everyone else, in being made clean, and in suffering without too much screaming. Some scholars view FGM as an initiation rite of passage to a girl's entrance into womanhood. FGM is typically proceeded by singing and celebration as among the Klikuya in Kenya, the Tagouna in the Ivory Coast, and the Bambara in Mali. It is also seen as a celebration, being the center of attention and acceptance by the community where a girl's rite of passage culminates in a day of joy, including the lavish gifts, the applause of the villagers and the feast. There are special songs, dances, and chants that are intended to teach the girl her duties, and the desirable characteristics of a good wife and mother.

In the period preceding FGM the girls are the focus of elaborated attention. A joyous festive atmosphere prevails. Parental supervision is lax, and new and permissive wardrobes -in essence advertisements to potential husbands- are usually provided. Although a girl may be given only a few weeks or days' notice of the ceremony, she grows up knowing that she will someday be initiated into society. In Man, Ivory Coast, it is part of a girl's dream of womanhood, a father's desire to show off with a big party, and a family's way of proving its conformity to social convention. Some tribes perform FGM in groups during the warm weather in August. This reinforces cultural unity and cohesion. The FGM ritual is rich in ritual and symbolism, with special convalescent huts for girls attended, where the girls are isolated until they emerge, healed as marriageable women.

FGM or FGC

Cutting, excision, infibulation and circumcision are euphemisms used by English-speaking Westerners and African women activists that may reflect the unease in discussing female genitalia. The term female circumcision may also come from an attempt to analogise FGM to the rite of male circumcision. Many Africans activists have objected to the term mutilation because of its implication of a deliberate attempt by practitioners to hurt or disfigure members of their own families and communities. Others strongly opposed the word mutilation, stating that the term was disrespectful to African women who have undergone it. Critics of the term mutilation have also argued that it elicits inappropriate reactions from those who misconstrue mutilation's ritual purpose. Even at the community level, the term can be problematic. Local languages generally use the less judgmental

'cutting' to describe the practice as parents understandably resent the suggestion that they are 'mutilating' their daughters. It is obvious this delicate linguistic march must not trample on alienating communities by finger pointing. Indeed in 1999, the UN Special Rapporteur on Traditional Practices called for "tact and patience" regarding FGM drew attention to the risk of "ostracising and alienating cultures by condemnation." Some organisations and some UN organisations mindful of alienating communities do use the term FGM cutting to emphasis a non-judgmental terminology.

The term FGM started to be used in the late 1970s. In the 1990s the term FGM was adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, in Addis Ababa, Ethiopia. In 1991, WHO recommended that the UN adopt this term. Subsequently, the term FGM has been widely used in UN and WHO documents. The rationale was that the word 'mutilation' reinforces the idea that this practice is a violation of girls' and women's human rights, and thereby helps promote national and international advocacy towards its abandonment. This clear linguistic distinction must be made as the term FGM emphasis the gravity of the act and reinforces the idea that FGM is a human rights violations. FGM draws attention to the stark gravity of this ritual procedure.

I use the mutilation rather than cutting, excision, infibulation and circumcision because the word mutilation emphasizes the ritual's acute physical pain and damaging physical and psychological consequences. FGM is not just a nick. Mutilation scars African women for life. It entails removal of body parts, often without anaesthesia, gloves and trained medical personnel, under appalling conditions and lack of medical facilities for non-medical reasons. The procedure often involves the use of unsterilized makeshift or crude tools, blade or razor. FGM is usually performed by traditional practioners who have no medical training and minimal knowledge of the female anatomy. By using the terms cutting and or circumcision, these euphemisms dilute the stark reality that FGM is essentially the amputation of a healthy organ. The male equivalent would be the cutting and/or amputation of the penis and its surrounding tissues. Lancet, one of the world's oldest, best known and prestigious medical journal, describe FGM as the amputation of the clitoris.

The term FGM also focuses attention on the lack of choice African women must make in order to be married and accepted in their society. There is no choice/no consent at the age of 5. Any contribution FGM may make to a group's identity is glaring outweighed by FGM horrific physical and psychological cost to females, who are often forcefully held down and restrained.

FGM is so physically horrific that those crusading against FGM have equally expressed their disapproval of the euphemisms cutting or circumcision. "It is the equivalent of whacking off the entire penis." This linguistic war to replace FGM with a milder terminology has also been sharply condemned by The Inter-African Committee (hereinafter IAC) at the 6th General Assembly. The Australian Medical Association issued a policy statement rejecting the term "female circumcision" because it "trivializes the severe and irreparable physical and psychological damage occasioned to girls and women by these practice." The organisation Foundation for Women's Health Research and Development (hereinafter FORWARD) an UK-registered campaign and support charity dedicated to advancing and safeguarding the sexual and reproductive health and rights of African girls and women, has also rejected the term female circumcision as it does not depict the true nature of FGM and implies that the practice and the consequences of FGM are far less severe than is the case.

The euphemisms " cutting, excision, infibulation and circumcision » obscure and trivialize the underlying degradation that FGM imposes on African woman and its senseless attack on African women's genitals for no other reason than that they are female.

CONCLUSION

Changes in one custom can be compensated for by adjustments in another. Culture is not static, but inherently dynamic. Cultures can and do change. Cultural change can be an adaptation to structural change. FGM can no longer remain immune to scrutiny merely because it is labelled a "tradition." «Tradition» cannot be used as a defence for human rights abuses. Cultural values and practices are as legitimately subject to criticism from a human rights perspective as any other structural aspect of society. By wanting to eradicate FGM is not a statement that one wants to deny ones culture. Women can learn that "I love my culture, but not this. This is torture hiding behind culture." No matter how well entrenched this custom is, FGM should not be a woman's destiny.

Lorraine Koonce Esq is an English Solicitor of England and Wales and a New York attorney. Currently, she is an international law professor in the Anglo American Law degree program at the Université de Cergy-Pontoise where she lectures on public international law, advanced constitutional law and human rights. She also lectures at AGS' summer program on UNESCO's infrastructures, policies and its influence in the sphere of international relations. Her area of speciality is gender and the human rights of women.