

FEMALE CIRCUMCISION IN THE UNITED STATES:
AN ANALYSIS OF LAWS AND POLICIES

By

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With the recent influx of immigrants to the United States, it is important to analyze some of the laws and policies that affect them. This work focuses on United States laws and policies regarding female circumcision. Chapter 1 gives an overview of female circumcision—its definition, history, and prevalence throughout the world. Chapter 2 provides an overview of existing legislation in the United States in regard to female circumcision. Chapter 3 analyzes how female circumcision is affecting asylum law in the United States and provides some of the most influential female circumcision asylum cases in the U.S. Chapter 4 summarizes the main points in this work and provides possible policy implications. Furthermore, sociological issues are examined and applied to these findings. The analysis in this work brings to light that there may be some bias in United States laws and policies regarding female circumcision. Reasons for such biases must be analyzed and changes to U.S. legislation should be enacted to better address the concerns of immigrants.

CHAPTER 1 INTRODUCTION

With increasing immigration, female circumcision is becoming an international practice. The issue of female circumcision was first raised as a matter of concern at the United Nations Commission on Human Rights in 1981 (Center for Reproductive Rights, 2004). Since then, legislation criminalizing female circumcision has been adopted in 16 countries, including nine African countries (Center for Reproductive Rights, 2004). Many individuals believe the practice of female circumcision is a human rights violation, specifically feminist groups in western nations. In the United States, female circumcision is often called female genital mutilation (FGM). This paper will use the lesser morally charged term, female circumcision (FC).

With the practice entering the United States through immigration, the already controversial topic is becoming even more of a contentious subject. Western feminists look to eradicate the procedure, not only in the West but also in the procedure's countries of origin. Because FC is becoming a global phenomenon, the United States has begun to address the topic with policies and law. This study will explore these laws and policies as well as the court cases in the United States pertaining to FC. Chapter 1 will give a brief overview of the history, definitions, and prevalence of FC. Chapter 2 will cover federal and state laws in the United States pertaining to FC. Chapter 3 will summarize the main cases in the United States that address granting refugees asylum based on their fears of female circumcision in their country of origin. Finally, Chapter 4 will summarize possible policy implications for the United States and how they relate to several sociological issues.

Types of Female Circumcision

There are several types of female circumcision. Type I, known as *clitorectomy*, is the procedure when the hood of the clitoris (the prepuce) is removed, with or without the excision of

part or all of the clitoris. This type of circumcision is the least severe and the least common (Dorkenoo and Elworthy, 1992). Type II, *excision*, is the removal of the clitoris and all or part of the labia minora. Type III, *modified infibulation*, is the removal of the clitoris, labia minora, and most (usually around two thirds) of the labia majora. Type III is a milder form of the last, Type IV, leaving a larger posterior opening. Type IV, known as infibulation or pharaonic circumcision, is the most common and severe form of female circumcision (Gruenbaum, 2001). This type of circumcision includes the removal of the clitoris, labia minora, and labia majora. The remaining parts of the labia majora are sutured together to cover the urethra and the vagina.

After the last three forms of circumcision, the girl is sutured, leaving only a small hole about the size of a matchstick for urination and menstrual flow. When sutures are not used, other adhesive substances such as sugar, eggs, and in rare cases, animal excreta are placed on the wound to allow the formation of scar tissue (Report of Female Genital Mutilation, 2001). Because of the highly invasive process, the girl's legs must be bound together and she must remain immobile for 40 days to permit the formation of scar tissue (Dorkenoo and Elworthy). Once healed, the female is left with a perfectly smooth vulva of skin and scar tissue. Reinfibulation is done after childbirth to restore the small vaginal opening. In addition to these types of circumcision, there are also symbolic circumcision rituals. These circumcision rituals include pricking, piercing, or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterizing by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; or the introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it (Abu-Sahlieh, 2001).

The circumcision of the female is usually done without anesthetic. Depending on the culture, a wide variety of instruments have been used; knives, razors, scissors, and sometimes even sharp stones have been used to perform the procedure—most of which are not sterile. In many cases, several girls are circumcised during a single ritual ceremony and the instrument used for the circumcision is used on a number of girls. The age at which a female will undergo circumcision varies by region, country, and community. Girls are usually circumcised between the ages of four and twelve, but in some cultures females are circumcised as early as a few days after birth or as late as immediately prior to marriage, during pregnancy or after the first birth (Report on Female Genital Mutilation, 2001). However, there has been an overall decrease in the age at which girls are undergoing the practice in recent years (Yoder et al., 2004; Report on Female Genital Mutilation, 2001).

History of Female Circumcision

Although the origins of female circumcision are unclear, the practice dates back to antiquity (Lightfoot-Klein, 1989). Herodotus, a famous historian, reported female circumcision among Egyptians, Ethiopians, Hittites, and Phoenicians during the 5th century B.C. (Lightfoot-Klein). In addition, many Nile Valley people who practice infibulations believe the practice originated in the society of the pharaohs, hence the name given to the most severe form of circumcision- pharonic circumcision (Gruenbaum, 2001). It is unknown at what time the practice became associated with virginity and chastity or religion.

There are many theories as to why female circumcision continued as a custom. First, female circumcision was believed to be a way for men to gain mastery over women's sexuality. Circumcision was believed to take women's sexual freedom from them and make them the private property of their husbands. Watson (2005) noted that since men would be away from their homes for long periods of time, they wanted reassurance that children born during their

absence were their own. Most forms of circumcision allow only a small hole for urination and menstrual flow. When the woman has intercourse for the first time, her husband must cut the hole wider to allow for penetration. This hole was sewn up when the husband departed for long periods of time. In addition, slave girls in Africa were infibulated to keep them from getting pregnant (Lightfoot-Klein, 1989). In ancient Egypt, girls could not marry, inherit property, or enter a mosque unless they were circumcised (Lightfoot-Klein). This was related to the Pharaonic belief in the bisexuality of the gods (Gruenbaum, 2001):

humans were thought to reflect [the bisexuality of the gods] in their anatomies, with the feminine “soul” of the man being situated in the prepuce and the masculine “soul” of the woman being in the clitoris. Male circumcision and female clitoridectomy and labia removal are thus needed for one to become fully a man or fully a woman. (p.43)

Furthermore, circumcision was intended to make a woman pure, clean, and smooth (Boddy, 1991); many who live in these cultures find the smooth, infibulated vulva highly feminine and aesthetically pleasing (Boyle, 2002).

Many countries practicing female circumcision believe their religion, specifically Islam, sanctions the practice. Egypt is predominantly Muslim; Islam being the official state religion (Boyle, 2002). One of the most prominent Islamic clerics in Egypt, Sheikh Gad el-Haqq, issued a religious decree stating that female circumcision, although not required by Islam, was a religious ritual and an honorable deed for women (Boyle, pp.3– 4). Furthermore, according to the grand mufti, Fadilat Allam Bey Nassar (1951):

female circumcision is an Islamic practice mentioned in the tradition of the prophet, and sanctioned by Imams and Jurists, in spite of the difference on whether it is a duty or a *sunna* [tradition]. We support the practice as a *sunna* and sanction it in view of its effect on attenuating the sexual desire in women and directing it to the desirable moderation. (Quoted in Gruenbaum, 2001, p.63)

Scholars of the Islamic faith deny that the religion condones such practices (Gruenbaum) and it is important to note that female circumcision is in no way endorsed by *any* religion. Still, many Muslims use religion to legitimize the practice.

Prevalence of Female Circumcision

The World Health Organization estimated that in 2000, the number of girls and women who have undergone female circumcision was between 100 and 140 million. Just in Africa, it is estimated that up to 3 million girls in sub-Saharan Africa, Egypt and Sudan are at risk of genital mutilation annually (Yoder et al., 2004). The topic of female circumcision is taboo in most of the cultures that practice FC. For this reason, it is difficult to obtain accurate statistics on circumcision rates. Ellen Greunbam (2001) believes that the fear of outsider's condemnations is a large reason many people in these cultures do not talk about female circumcision: "people dealing with foreigners were well advised to keep their female circumcision practices quiet or, when discussed, downplay their extent" (16). Therefore, data on the prevalence of female circumcision should be analyzed with caution.

In Africa

Female circumcision is most common in Africa and is widespread in 28 of its countries. Female circumcision is not found in southern Africa or in the Arabic speaking nations of North Africa, with the exception of Egypt (Althaus, 1997). Countries in the northeast of Africa (Egypt, Eritrea, Ethiopia, and northern Sudan) have higher rates, ranging from 80 to 97 %, than countries in the eastern part of Africa (Kenya and Tanzania), ranging from 18 to 38 % (Yoder et al, 2004).

The prevalence of FC at the national level among women 15-49 years of age in African countries varies from 5 % in Niger (1998) to 99 % in Guinea (1999) (Yoder et al, 2004). Among the 15 African countries for which FC prevalence data were available by the end of 2002, 8 had prevalence levels between 71 and 99 %, and 7 were between 5 and 45 % (Yoder et al., 2004).

According to Gruenbaum (2001), Somalia, Djibouti, Egypt, Mali, Sierra Leone, Ethiopia, and Eritrea contain half of the circumcised women and girls in Africa.

In all countries except for the ones with prevalence rates above 90 %, FC varies widely within countries by ethnicity (Yoder et al., 2004). For instance, prevalence may be 1 % in one ethnic group and 95 % in another within the same country (Yoder et al).

The most recent Demographic and Health Surveys on the prevalence rates of female circumcision in Africa indicated that the practice of female circumcision has changed in the past years. Data showed that girls are being circumcised at younger ages and there is less cutting than in the past. Furthermore, there has been a trend towards the medicalization of female circumcision, specifically in Egypt (Yoder et al., 2004); females are being circumcised more often under sterile conditions by professionals.

In Asia

There are speculations, but no studies or concrete data, on the practice of female circumcision in Asian countries. It is thought to occur throughout the coastal areas in The Republic of Yemen and Oman, and among a small number of women in a few Bedouin tribes in south Israel. (Report on Female Genital Mutilation, 2001). It is also believed to occur among individuals in the Bedouin tribes and residents of the Hejaz in Saudi Arabia and among a very small number of women in a few Bedouin groups in Israel. (Report on Female Genital Mutilation, 2001).

According to Sami A. Aldeeb Abu-Sahlieh (2001), a recent United Arab Emirates survey indicated that FC takes place in this country “in secret, far from men, who are rarely informed about it” (14). Eighty-five percent of people questioned for an investigation regarding FC in United Arab Emirates maintained FC continued to be practiced in the country (Abu-Sahlieh).

According to Abu-Sahlieh, several of his interviewees in 1999 indicated that the rate of FC was higher than 90 % in Oman.

In Indonesia, the most common form of “circumcision” is a symbolic pricking, scraping or touching of the clitoris (Report on Female Genital Mutilation, 2001). Lynda Newland (2006), witnessed an infant girls circumcision in West Java, Indonesia. This circumcision, she wrote, included the scraping of the clitoris with a needle until the baby began to cry. Newland went on to explain that many people in Indonesia believe that this type of “circumcision” enhances a woman’s sexual pleasure rather than impairing it. In Malaysia, Muslim groups also practice this less severe type of “circumcision”; a symbolic prick, a tiny ritual cut to the clitoris or simply brining a blade close to the clitoris (Report on Female Genital Mutilation, 2001). This type of “circumcision” also occurs among the Bohra Muslims in the largest cities of Sindh and Punjab provinces in Pakistan (Report on Female Genital Mutilation, 2001).

Other countries in Asia that have not been mentioned here either have a very small prevalence of FC or information is not available on the prevalence of FC within the country. It is believed that Morocco, Algeria, Tunisia, Palestine, Jordan, Lebanon, Syria, Iraq, Kuwait, Turkey, and Iran do not practice FC (Abu-Sahlieh). However, nothing guarantees that these countries do not practice FC. There is some evidence that the Bedouin in Jordan practiced FC in the beginning of the 19th century. The custom was called *sirr*, meaning a hidden and mysterious thing (Abu-Sahlieh).

In the United States

Increasingly, female circumcision is seen in Europe, Australia, the United States, and Canada because of immigration from countries that practice FC (World Health Organization, 2000). Little is known about the current prevalence of female circumcision in the United States. In 1994, the World Health Organization (WHO) declared that female circumcision had become a

public health issue in the United States (Bashir, 1997). Eyega and Conneely (1997) surveyed health care providers in New York City in hopes of determining the prevalence of female circumcision in the area. They surveyed a total of 40 nurses, 48 physicians, 43 registered nurses, 8 resident physicians, 6 nurse practitioners, and 3 physician's assistants. Eighty-seven percent of the respondents reported having knowledge of female circumcision, gained mainly by patient contact (76 %), general media (63 %), medical journals (50 %), other providers (36 %), and training or conferences (29 % and 17 %). Out of these 87 % of respondents, 100 % of the nurse-midwives, 85 % of the physicians, and 77 % of the registered nurses reported having knowledge of female circumcision. Almost two-thirds of the respondents had treated circumcised women.

The Secretary of Health and Human Services was required by legislation to undertake a study of female circumcision in the United States to determine who was at risk. They estimated that approximately 168,000 girls and women (mostly from Africa) in this country were with or at risk for female circumcision (Rahman and Toubia, 2001). Of these, 48,000 were under the age of 18. Forty-five percent of the 168,000 girls and women live in 11 metropolitan areas including New York City, Washington, DC, Los-Angeles-Long Beach, Houston, Chicago, and Philadelphia (Jones et al., 1997). These figures are based on the 1990 U.S. Census (summarized in the U.S. Secretary of State Report, 2001). In addition to performing this study, the Department of Health and Human Services (DHHS) was required to carry out an educational outreach program for communities at risk of female circumcision. According to Rahman and Toubia (2001), between February and September 1997, the DHHS held community consultation meetings in Washington DC, New York, Boston, San Diego, Houston, Atlanta, and Chicago. The department was also required to survey medical schools, medical osteopathy schools, nursing schools, midwifery

schools, and schools of social work to attempt to determine the prevalence of female circumcision (Rahman and Toubia, 2001).

The Medicalization of Female Circumcision in the United States

In the United States from the 1880s to the 1950s, excision was performed to supposedly prevent, frigidity, hysteria, depression, epilepsy, kleptomania, and melancholia in women (Watson, 2005). Circumcisions were also performed to cure masturbation, lesbianism, nymphomania (desiring excessive amounts of sex), and any other form of abnormal sexual behavior. In 1910, De Forest Willard, in his book *The Surgery of Childhood*, claimed that an irritated clitoris—one whose hood bound it down too tightly and therefore caused irritating adhesions to remain trapped—could cause a woman or girl to masturbate in order to quell the discomfort (as cited in Webber, 2003). Willard claimed that a girl's prepuce should therefore be circumcised to relieve this discomfort. In 1948, a five-year-old girl in the United States underwent a clitoridectomy to cure masturbation (Ehrenreich and English, 1978).

Beginning in the late nineteenth century and extending into the 1970s, circumcisions in America were also used to assist women who lacked an orgasmic response from missionary sex with their spouse (Webber, 2003). Doctors believed women who had difficulty achieving an orgasm had a tight clitoral hood, which could be fixed with surgery. Elting and Isenberg (1976) noted that up to 10 % of women “found relief in female circumcision” (as cited in Webber, 2003). Webber notes, “Female circumcision, whether used to suppress sexual behavior or to promote it, was an operation used to direct female sexual desire toward sex with a man, namely her husband. . . . Circumcision surgically directed women's sexual behavior. Sexual energy not specifically addressed toward one's husband was considered deviant (p.66).” Into the 1970s, 3,000 circumcisions were performed in the United States, and their costs were covered by Blue Cross Insurance until 1977 (Watson, 2005).

The International Consumption of Female Circumcision and Western Interventions

Many western countries have spoken out against the consumption of female circumcision without adequate knowledge of the history, significance, or prevalence of the procedure. Without understanding the fundamental reasons for the consumption of female circumcision or the prevalence of consumption, no changes will successfully be made. For example, Egypt has one of the highest rates of female circumcision in Africa. As a result, they have encountered significant international pressure to eliminate the practice. Egypt has been forced to conform to international desires for financial reasons; the United States began refusing financial aid to countries that had not yet taken steps to eradicate female circumcision. According to Boyle (2002), “states in countries where [female circumcision] occurred would have to develop policies to eliminate the practice or face reductions in foreign aid from the International Monetary Fund and the World Bank” (p. 5). Furthermore, in 1995, the United Nations declared female circumcision a violation of women’s rights (Newland, 2006). In 1998, the United Nations launched a campaign to eradicate female circumcision worldwide (Newland). Because Egypt is highly dependent on the International Monetary Fund and the World Bank for resources, they were unable to evade the persistent pressure from the international community and the Egyptian health minister was forced to forbid female circumcision in government medical facilities (Boyle, 2002).

It is because of this external pressure that the Egyptian government’s attempts to eradicate female circumcision have not been successful. Without acknowledging the importance of the tradition to many Egyptians, the government has passed laws prohibiting the custom. Because of this, the legislation in Egypt banning the practice of female circumcision has driven the custom underground (Lightfoot-Klein, 1989). As Boyle (2002) explains, “Egypt is one nation caught between contradictory perspectives towards [female circumcision]. The Egyptian case

highlights the fact that national policy making does not simply mirror local values or conflicts” (p. 2). National policy-making, as it applies to Egypt is therefore an interplay between local and international considerations (Boyle). Boyle also points out that if local laws were merely reflections of the desires of citizens, laws would be passed ensuring the safe implementation of female circumcision. In contrast, the laws in Egypt have banned the practice, proving that these new laws against female circumcision are not reflecting the desires of Egyptian citizens.

The consumption of female circumcision has reached beyond borders and is occurring more frequently within the international community. The US has used its authority over the World Bank and the International Monetary Fund as leverage to eradicate what they believe to be an immoral tradition. These sorts of financial threats do resemble colonialism, especially because Egypt (and many other countries) depends on financial aid from the World Bank and the International Monetary Fund. Any people would feel threatened when their culture is vilified, and Egyptians are no exception. The Egyptian government is trapped between threats of reducing financial aid and upholding the customs of their people. Despite the United State’s perceived good intentions, their intervention in Egypt’s customs has only led to more tensions within Egypt.

Concluding Remarks

The practice of female circumcision is a complex procedure with a complicated past. With its increasing prevalence in the international community, understanding the procedure is essential. When Westerners vilify the procedure, they also vilify and isolate circumcised women. Chapter 2 will explain the various laws and policies the United States has enacted regarding female circumcision within its own borders. Chapters 3 through 5 will explain some of the problems outlawing the procedure have created.

CHAPTER 2
UNITED STATES LEGISLATION RELATING TO FEMALE CIRCUMCISION

Changes in attitudes and behavior of immigrants concerning [female circumcision] cannot be viewed as a separate problem from the rest of the community...[female circumcision] should be seen as an issue that is addressed by involving the whole community.

-Williams, Acosta, and McPherson, 1999, p. 51

Federal Legislation

In 1994, the World Health Organization declared that female circumcision had become a public health issue in the United States (Bashir, 1997). As was noted in Chapter 1, the Secretary of Health and Human Services estimated that approximately 168,000 girls and women (mostly from Africa) in the United States were with or at risk for female circumcision (Rahman & Toubia, 2001). As a result of increasing immigration, the United States government enacted federal legislation in regard to female circumcision. The Federal government enacted this legislation under Section 116 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. It reads as follows:

- (a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both.
- (b) A surgical operation is not a violation of this section if the operation is--
 - (1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or
 - (2) performed on a person in labor or who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such a practitioner or midwife.
- (c) In applying subsection (b)(1), no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual.

In this Act, Congress deemed female circumcision to constitute a criminal act prohibited by law. Furthermore, anyone, other than a medical practitioner, midwife, or person in training to become such a practitioner or midwife, who performs the surgery for any reason other than for medical purposes will be fined and/or imprisoned for up to five years.

State Legislations

In addition to the United States federal legislation, 18 states have passed some sort of legislation making female circumcision illegal. In general, most states define female circumcision as the act of knowingly circumcising, excising, or infibulating any part of the labia majora, labia minora or clitoris of another person for nonmedical purposes. The states differ slightly in the age at which circumcision is illegal. Of the 18 states criminalizing female circumcision, 7 states criminalize female circumcision for women under the age of 18. Five states (Illinois, Minnesota, Rhode Island, and Tennessee) prohibit female circumcision upon all women, including those over 18 years of age (Rahman & Toubia, 2001). Five states (California, Colorado, Minnesota, New York, and Oregon) have additional provisions for educational outreach to immigrant communities.

Of the 18 states criminalizing female circumcision, sixteen states define female circumcision as a felony. One state (Minnesota) leaves the punishment and crime category of female circumcision up to the judge and reads, “judges should exercise their discretion by assigning an offense a severity level which they believe to be appropriate” (MINN. STAT. § 609.2245, 2005). Four states (Arkansas, California, Colorado, and Illinois) define and punish female circumcision as a form of child abuse. All eighteen states criminalize the performer of female circumcision.

Ten of the 18 states criminalizing female circumcision take into consideration that girls are circumcised as a result of their culture. These state legislations, like the federal legislation,

argue that no account shall be taken of the belief on the part of any individual that the operation is required as a matter of custom or ritual.

Until 2006, there had been no prosecutions of female circumcision in the United States. In 2006, Khalid Adem, an Ethiopian immigrant, was sentenced to 10 years in prison and five years of probation for cutting off his 2-year-old daughter's clitoris with a pair of scissors in 2001. He was convicted of aggravated battery and cruelty to children. He was arrested in Georgia which, at the time, had no provision against female circumcision. He also received a fine in the amount of \$5,000, with an additional \$32 a month for a probation and supervision fee (Brock, 2002). After Adem's arrest, Georgia passed a law making female circumcision a felony with a minimum penalty of five years in prison and a maximum of 20 years (Mungin, 2006; GA. CODE ANN. § 16-5-27, 2006).

Other Legislations

In 1991, the American Medical Association (AMA) declared its opposition to all forms of “medically unnecessary surgical modification of female genitalia” (American Medical Association, 1991, as cited in Rahman & Toubia, 2001, p.239). The AMA characterized female circumcision as a form of child abuse. The AMA advised doctors to provide “culturally sensitive counseling to inform the patient and to refer patients to social support groups” (Rahman & Toubia, p.239).

In 1993, the US Agency for International Development (USAID) began working on prevention strategies for female circumcision in Egypt and in other countries where circumcision is regularly practiced. Prevention strategies included data collection, support for local organizations working to eliminate the practice, and the training of medical providers and community based health workers on methods for dealing with the consequences of female circumcision (Rahman & Toubia, 2001, p.240).

The United States Congress has also passed three other measures relating to female circumcision. First, Congress passed a law requiring the Secretary of Health and Human Services to undertake a study of female circumcision in the United States to determine who was at risk. Congress told the Department of Health and Human Services (DHHS) to “compile data on the number of females living in the United States who have been subject to female genital mutilation (whether in the United States or in their countries of origin) including specification of the number of girls under the age of 18 who have been subject to such mutilation” (Congress, 1996 as cited in Jones et al., 1997). The DHHS commissioned the Centers for Disease Control (CDC) to carry out the study to determine the prevalence of female circumcision in the United States (Rahman & Toubia, 2001). The CDC used data from the 1990 U.S. Census and estimated that there were approximately 168,000 girls and women in the United States who were “with or at risk for FC/FGM” (as cited in Rahman & Toubia, 2001). Furthermore, they estimated that 45 % of women who were “with or at risk for FC/FGM” lived in 11 metropolitan areas (Jones et al., 1997). Sixty-five percent of the estimated number of girls under 18 with or potentially at risk for female circumcision lived in 35 metropolitan areas in the US; 72 % of these girls were born in the US (Jones et al., 1997).

In addition to studying the prevalence of female circumcision in the U.S., the Secretary of DHHS was also required to provide educational outreach programs for communities with at-risk populations (Rahman & Toubia, 2001). Furthermore, the DHHS was required to develop and distribute recommendations for students in medical and osteopathic schools on how to work with circumcised women (Rahman & Toubia).

Second, as part of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, the Immigration and Naturalization Service was required to provide information to

immigrants and nonimmigrant from countries where female circumcision is common. The information included the health and legal consequences of practicing female circumcision in the United States (Rahman & Toubia, 2001). The legislation required that information be presented to the immigrants in a culturally appropriate manner (Rahman & Toubia). Strangely, however, the topic of female circumcision is a taboo topic in most countries and bringing it up in *any* context would be inappropriate. Eyega and Conneely (1997) note, “our respondents indicate that circumcision is a very sensitive and private subject, and discussion is frowned upon and considered disrespectful to the whole community, so women are not only embarrassed by such questions but also do not want to embarrass their families and communities” (pp.177– 178). Therefore, it is difficult to determine to what extent this information has impacted immigrants. In addition, a simple pamphlet will likely not have the capacity to deter immigrants from practicing female circumcision.

The most current legislation against female circumcision was passed in 1997. Congress enacted legislation requiring the U.S. executive directors of international financial institutions to oppose non-humanitarian loans to countries where female circumcision was practiced and whose governments had not implemented any educational programs to prevent the practice (Rahman & Toubia, 2001, p.239).

Is Legislation Enough or Too Much?

Despite efforts to be “culturally sensitive” to immigrant’s culture, legislation in the United States remains culturally naïve. As Williams et al. (1999) noted, “whenever a government prohibits the practice of FGM, whether in the country of origin or in the other European countries to which groups immigrate, the practice continues, but in greater secrecy. This is mainly because those formulating the legislation and prevention strategies ignore the rationale for the practice” (p.48). The Research, Action & Information Network for Bodily Integrity of

Women (RAINB♀), an international advocacy organization, noted that the “well-being and status of entire communities could be threatened by the overzealous investigation and prosecution of immigrant groups believed to practice [FGM/FC].” Furthermore, RAINB♀ raised the concern that “broad criminal prohibitions run the risk of driving [the] practice underground or the growth of an overseas travel industry to provide services” (RAINB♀, 1997, as cited in Jones et al., 1997, p.376). Similarly, Williams et al. (1999) noted that because of the criminalization of female circumcision, many circumcised women might not seek medical assistance for complications resulting from the practice.

Williams et al. (1999) explained that the rationales for female circumcision “cannot merely be explained in terms of ‘culture’ or ‘tradition’, because that implies that people follow these rationales without conscious reasoning when in reality, complex decision making processes are involved” (p.50). Western culture and law cannot merely be instilled into immigrants coming from countries practicing female circumcision. Williams, et al. believed, “if female genital mutilation is to be prevented in the U.S., an understanding of the immigrant groups’ cultural rationales for this practice must be researched and acknowledged when planning prevention strategies” (p. 48). Similarly, Jones et al. (1997) believed that to successfully eradicate the practice of female circumcision in the United States, policies must involve the immigrant communities themselves. For example, the DHHS was attempting to set up “town meetings” with immigrant communities across the country for purposes of developing education and outreach programs (Jones et al., 1997). Eyega and Conneely (1997) noted, “since circumcision is carried out with the best intention for the child within the cultural context, this criminalization without education will not lead to a change in attitude, and may serve to disrupt families already struggling in a new country” (p.178).

The DHHS was forming recommendations for the education of health professionals by reviewing existing medical curricula (Jones et al., 1997). Eyega and Conneely (1997) believed that training and educating healthcare professionals is a crucial step in decreasing the prevalence of female circumcision within immigrant groups in the United States. Healthcare professionals need education regarding the physical and mental health consequences and clinical management of female circumcision as well as counseling guidelines, interdepartmental linkages, referrals and integrated service delivery, and the provision of translators and information in African languages (Eyega and Conneely).

Eyega and Conneely (1997) found that it was not uncommon for women to feel that their circumcision defined who they were once they immigrated to the United States:

many women only begin to think about what their circumcision means to them upon immigration to a new country where the practice is not the norm... African women believe that a narrow focus on one part of the anatomy objectifies and disempowers them, so [American] physicians need to see them as full human beings, not merely as 'circumcised patients'. (p.178)

Furthermore, circumcised immigrants often feel that westerners belittle their status and culture. Eyega and Conneely explained, "many [circumcised] women object to their portrayal as 'victims' as well as to the attitude of western feminists involved in this issue, who, they believe, want to define their oppression for them and then liberate them from it" (p.178). Similarly, Watson (2005) noted, "while [American anti-circumcision legislations] are touted as representing a serious American response to an international human rights issue affecting women, many African women living in this country who are concerned about and connected to the targeted communities have had their voices excluded" (p.434). More worrisome, William et al. (1999) believed that the criminalization of female circumcision would prevent many

immigrants from seeking medical assistance for any complications they may have because of their circumcision.

Eyega and Conneely (1997) found that many of the circumcised African immigrants in the United States exhibited fear of the American laws against circumcision, but did not change their attitude towards circumcision. Eyega and Conneely noted, “some of the respondents support FC/FGM, and said they would circumcise their daughters if there were no legal repercussions, to honor tradition and to keep their daughters from becoming promiscuous in a sexually unrestricted society” (p.178). Because of this mindset, Eyega and Conneely believed that merely criminalizing female circumcision in the U.S. would have no effect. They propose that educating immigrants about the procedure will better deter them from circumcising their own daughters in the U.S.. Watson (2005) most adequately explained the situation of anti-circumcision laws in the United States:

criminalizing, on its surface, seems a justifiable response for practices that are thought to harm or maim another. Nevertheless, the history of criminalizing, particularly of cultural practices, tends to divert the practice underground, and therefore, lead to more rather than less concerns. Criminalization of such practices is also seen as paternalistic—one society’s attempts to evaluate their own practices as the correct or moral ones and negate another culture’s practices as lesser or immoral. Statutes requiring educational initiatives rather than criminalization initiatives might be the most appropriate compromise. (p.435)

As was noted in earlier in the case of the United States’ financial threats to Egypt, understanding rather than vilifying the procedure and circumcised women is key when instituting legislation regarding the practice. Without this, interventions will likely remain unsuccessful.

CHAPTER 3:
FEMALE CIRCUMCISION AND ASYLUM IN THE UNITED STATES

I asked her if she would want this tradition continued on her daughters. She replied, "Never." Asked if she were sent back to Sudan, "Could anyone do this to them?" She responded, "Yes. They would take them when I wasn't home." "Who would?," I inquired. "My grandmother," she replied.
-Anonymous Health Care Provider, 2002 as cited in Oxford, 2005, p.28

Brief Overview of Asylum Law in the United States

Throughout the years, United States asylum laws have been modified through a series of international and national policies and laws. Many of these laws and policies have influenced cases regarding women seeking asylum in the United States. Seven, in particular, have been frequently cited in these asylum cases. First, in 1954, the United Nations approved the Convention Relating to the Status of Refugees. The convention defined who was a refugee and outlined who should be granted asylum. Act 1 of the convention defined a refugee as a person who had a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." Furthermore, Section 208 of the Immigration and Nationality Act guaranteed alien refugees' asylum in the United States, provided that the refugee show well-founded fear of persecution on account of their "race, religion, nationality, membership in a particular social group, or political opinion" (p.195).

Third, in the 1985 Board of Immigration Appeals (BIA) decision *Matter of Acosta* (1985 BIA LEXIS 2; 19 I. & N. Dec. 211), "persecution on account of membership in a particular social group" referred to persecution directed toward an individual who was a member of a

group of persons sharing a common, immutable characteristic. Such characteristics are either beyond the power of the individual members of the group to change or are so fundamental to their identities or consciences that it ought not be required to be changed.

Also of importance is the Refugee Act of 1980. The act is a federal law that reformed United States immigration law to admit refugees for humanitarian reasons. The act also introduced national legal standards for adjudicating refugee and asylum claims based on the definition of a refugee found in the Immigration and Nationality Act, outlined above (Oxford, 2005).

Fifth, in 1987, the Supreme Court ruled in *INS v. Cardoza-Fonseca*, 480 U.S. 421 (1987), that an asylum applicant need not show that it is more probable than not that he or she would be persecuted if they returned to their home country. Furthermore, the court in this case noted, “One can certainly have a well-founded fear of an event happening when there is less than a 50% chance of the occurrence taking place.” *INS v. Cardoza-Fonseca*, 480 U.S. 421 (1987).

Sixth, the Illegal Immigration Reform and Immigrant Responsibility Act was passed in 1996 requiring an applicant to apply for asylum within one year of their entry into the United States. If an applicant failed to apply within one year, they were barred from doing so unless they could establish changed or exceptional circumstances.

Lastly, and of importance in asylum cases regarding female circumcision, the United Nations passed the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 1987. The Convention stated the term ‘torture’ meant “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person... for any reason based on discrimination of any kind, when such pain or suffering is inflicted... with the consent or acquiescence of a public official or other person acting in an

official capacity.” Article 3 of this convention stated, “No State Party shall expel, return (‘refouler’) or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.”

Influential Asylum Cases

There have been very few asylum cases in the United States regarding female circumcision. Fauziya Kasinga had the first successful asylum case in the United States in 1996. The second successful asylum case, for Adelaide Abankwah, was two years later in 1999. The four following cases are a few of the most important asylum cases regarding female circumcision in the United States and have paved the path for future cases.

In re Kasinga (1996)

Fauziya Kasinga, a 19-year-old native and citizen of Togo, fled Togo before she was forced to undergo circumcision. Her husband in Togo was well known in the country and was a friend of the police. She feared the Togolese police could locate her in Togo or in countries surrounding Togo, specifically Ghana where she initially fled. She traveled to Germany from Ghana where she bought a fraudulent passport. With the passport, she fled to the United States, where she immediately requested asylum.

In this case, the court established that female circumcision could be the basis for a claim of persecution. The court believed there were six main points as to why Kasinga should be granted asylum based on her fear of circumcision. First, the court found Kasinga to be a credible witness. The court established that her testimony as to what had led her to the United States “reasonably could have happened to a teenage girl in the applicant’s situation.” Second, female circumcision, as practiced in her tribe in Togo, constituted persecution. The court recognized that “persecution can consist of the infliction of harm or suffering by a government, or persons a government is unwilling or unable to control, to overcome a characteristic of the victim.” Third,

Kasinga was a member of a social group consisting of young women who were members of a specific tribe in Togo who have not been circumcised and who opposed the practice. Fourth, Kasinga had a well-founded fear of persecution based on a “reasonable person” standard. Fifth, the persecution Kasinga feared was on account of her social group. Sixth, Kasinga’s fear of persecution was country-wide. The court established Kasinga would be unable to avoid circumcision by moving to some other part of Togo. Furthermore, Togo is a small country and the police would not protect her.

Based on Kasinga’s testimony and knowledge of Togo, the court found that (1) female circumcision was widely practiced in Togo; (2) acts of violence and abuse against women in Togo are tolerated by the police; (3) the Government of Togo had a poor human rights record; and (4) most African women could expect little governmental protection from female circumcision. The court concluded that female circumcision was a form of “persecution” that could entitle a woman to political asylum in at least some cases. In Kasinga’s case, since the above six points were met, she was granted asylum.

Abankwah v. INS (1999)

Adelaide Abankwah, a 29-year-old native and citizen of Ghana, argued that she should be granted asylum based on her fear that her tribe would circumcise her as punishment for having engaged in premarital sex. She felt that members of her tribe would continue to search for her since she had “sinned against their God.” She did not believe anyone in Ghana could protect her from the tribal authorities that would force her to be circumcised. For this reason, she bought a falsified passport and fled to the United States. She was apprehended upon her arrival at John F. Kennedy Airport and imprisoned.

Abankwah petitioned for review or order of deportation and denial of asylum by BIA. The Immigration Judge denied her request because he believed she had failed to establish that

her fear of circumcision as punishment for her lack of virginity was objectively reasonable. The Judge described Abankwah's situation as a "personal problem" rather than a "matter of general practice imposed upon a particular social group." The Judge believed that because female circumcision was criminalized in Ghana in 1994, Abankwah would be able to seek protection from the Ghanaian government and from non-governmental institutions.

The appeals court ruled that the BIA "was too exacting both in quantity and quality of evidence that it required." The court cited *Melendez*, 926 F.2d at 215: "In the absence of documentary proof, the applicant's testimony will be enough if it is credible, persuasive, and refers to specific facts that give rise to an inference that the applicant has been or has good reason to fear that he or she will be singled out for persecution." In her testimony, Abankwah said that she did not believe that the government of Ghana could or would prevent her tribe from circumcising her. She also said that she did not know that the government had outlawed female circumcision since "people are still practicing it."

Abay v. Ashcroft (2004)

Yayeshwork Abay and Burhan Amare, both natives and citizens of Ethiopia, sought refugee status in the United States based on fear of female circumcision. Abay, mother of nine-year-old Amare, was circumcised at a young age. Abay's mother had already attempted to circumcise Amare and Abay believed she would not be able to override Amare's future husband or in-law's wishes to circumcise Amare.

The court noted, "females who live in a culture where female genital mutilation is the norm and who do not undergo the procedure will be persecuted, subjected to ostracism, and considered unworthy of marriage" (p.6). Furthermore, the court found "Abay's fear of taking her daughter into the lion's den of female genital mutilation in Ethiopia and being forced to witness

the pain and suffering of her daughter is well-founded” (p.8). As a result, both Amare *and* Abay were granted refugee status.

Mohamed v. Gonzales (2005)

Khadija Ahmed Mohamed, a native and citizen of Somalia, fled Somalia during the civil war with her family. She sought to reopen her asylum, withholding of removal, and Convention Against Torture (“CAT”) claims on the basis of her first attorney’s failure to present evidence that she suffered female circumcision in the past and could constitute past persecution and torture. Mohamed had her clitoris and prepuce cut off when she was a child.

Because Mohamed had previously been circumcised, in order to be granted asylum, she must establish eligibility for asylum on the basis of past persecution. To do so, the courts argued Mohamed “must show: (1) an incident... that rise[s] to the level of persecution; (2) that [wa]s ‘on account of’ one of the statutorily-protected grounds; and (3) [wa]s committed by the government or forces the government is either ‘unable or unwilling’ to control” (Navas v. INS, 217 F.3d 646, 655-56 (9th Cir. 2000), as cited in Mohammed v. Gonzales, p.3077). The court agreed that female circumcision could constitute past persecution: “in sum, the extremely painful, physically invasive, psychologically damaging and permanently disfiguring process of genital mutilation undoubtedly rises to the level of persecution” (p.3080).

The court argued that although females as a social group had never been previously recognized, the “recognition that girls or women of a particular clan or nationality (or even in some circumstances females in general) may constitute a social group is simply a logical application of our law” (p.3082). The court explained, “there is little question that genital mutilation occurs to a particular individual *because* she is a female” (p.3083).

The court also disagreed with the BIA’s ruling that Mohamed could not be eligible for asylum because she had already suffered circumcision and therefore, “there is not chance that

she would be personally tortured again by the procedure” (p.3084). The appeals court held that female circumcision, like forced sterilization, “must be considered a continuing harm that renders a petitioner eligible for asylum” (p.3085). The court continued, “like forced sterilization, genital mutilation permanently disfigures a woman, causes long term health problems, and deprives her of a normal and fulfilling sexual life” (p.3086).

The appeals court also explained that under the humanitarian exception, a victim of past persecution may be granted asylum even without fear of related future persecution, if the applicant could establish (1) compelling reasons for being unwilling or unable to return because of the severity of the past persecution, or (2) a reasonable possibility that she may suffer other serious harm upon returning to that country. The court argued Mohamed could establish both—female circumcision is a particularly severe form of past persecution because of its many continuing side effects, and Mohamed’s clan in Somalia had been decimated by violence, specifically towards females, which leaves Mohamed at risk for further harm.

Lastly, the appeals court established that Mohamed’s claim for protection under the Convention Against Torture was possible: “In light of Mohamed’s past experience with female genital mutilation and the widespread practice of mutilating females in Somalia, the possibility of related harm occurring in the future, and the overall human rights conditions in Somalia, Mohamed may well be able to demonstrate that she is entitled to relief under CAT...Mohamed may be entitled to protection under CAT on the grounds that genital mutilation is a permanent and continuing harm” (p.3091).

Significance of Female Circumcision Asylum Cases

There are several reasons why these asylum cases have been significant milestones in United States asylum law. First, these cases are the first to use asylum provisions for cultural rather than strictly political human rights issues (Gruenbaum, 2001). Second, Kasinga’s asylum

case was the first to recognize “women” as a social group; it was the first successful gender-based asylum case in the United States (Gunning, 1999). This step is an important one for asylum law because many women flee their countries for gender-related reasons such as rape, sexual torture, sexual mutilation, sexual discrimination, abortion, and forced sterilization (Abu-Sahlieh, 2001). The recognition of women as a social group will serve many women, not only women escaping circumcision.

In general, the success of these asylum cases has enabled many other women from countries practicing female circumcision to also seek asylum. The Immigration and Naturalization Service (INS) was concerned that if Kasinga were granted asylum, another eighty million African women would also become eligible (Boyle, 2002). The INS went so far to caution the BIA that “the Board... cannot simply grant asylum to all who might be subjected to a practice deemed objectionable or a violation of a person’s human rights” (In re Kasinga, as cited in Boyle, 2002, p.110). The court in Mohamed’s case established that female circumcision constituted persecution, and as a result was grounds for asylum.

CHAPTER 4 CONCLUSIONS

Every age, every culture, every custom and tradition has its own character, its own weakness and its own strength, its beauties and cruelties; it accepts certain sufferings as matters of course, puts up patiently with certain evils. Human life is reduced to real suffering, to hell, only when two ages, two cultures and religions overlap.

-Hermann Hesse

This thesis has covered many new problems the United States government faces regarding immigration and the customs of female circumcision. Possible solutions for these problems seem, at first glance are monumental. To implement effective strategies for resolving problems associated with circumcising, policy makers must begin by understanding and being sensitive to the traditions that prescribe the practice. Possible policy implications will be discussed in the remainder of this thesis.

Legislation Implications

The last part of Chapter 2 discussed the problems with anti-circumcision legislation in the United States. Among these is the problem that by outlawing female circumcision, entire immigrant communities have been isolated. Furthermore, anti-circumcision legalization runs the risk of driving the practice underground. Many women may not seek medical assistance from complications resulting from their circumcision for fear of disapproval.

Although a few states have enacted educational legislation, more educational programs must be made available to immigrants coming from countries with high rates of female circumcision and to those already living in at risk communities in the U.S. Steps *have* been made to educate health professionals about complications associated with female circumcision. These steps should continue. A study in New York conducted by Eyega and Conneely (1997) found that 87% of health care providers (including nurse-midwives, physicians, registered nurses, resident physicians, nurse practitioners, and physician's assistants) reported having knowledge of

female circumcision gained mostly through patient contact (76%). However, only 50% of these respondents had learned of female circumcision through medical journals. Only 29% learned of the procedure through training and only 17% learned of it through conferences. It is clear through these statistics that more emphasis needs to be placed on training medical professionals about how to handle female circumcision. Familiarity with female circumcision should not derive solely from patient contact. Medical professionals should learn of the procedure before encountering it in their practices.

Asylum Law Implications

The progress of asylum law in the United States regarding female circumcision has not only been a huge step for immigrant populations, but for women as a social group as well. There is no doubt this progress has been substantial, but further improvements in asylum law are necessary. This is not to say that all forms of female circumcision are “wrong.” United States’ law should represent, to the best of its abilities, global human rights. If female immigrants are seeking refuge in the United States because they do not want to be circumcised, United States’ asylum law should protect these rights. Furthermore, as part of the United Nations, the U.S. has an *obligation* to protect human rights. This creates a dilemma for the U.S. How can the U.S. protect human rights while still being culturally sensitive? There is no easy or simple solution to this conundrum. However, advances in asylum law, like the ones outlined in Chapter 3, help alleviate this problem.

Last, it is necessary to solidify women as a “social group” in the Refugee Act of 1980. The Refugee Act of 1980 currently defines a refugee as one who can show well-founded fear of persecution on account of their “race, religion, nationality, membership in a particular social group, or political opinion” (p.195). It is important that this definition also include gender. More

generally, it is important for United States' asylum law to recognize female circumcision as grounds for asylum.

The Value of Language

“Words, when well chosen, have so great a force in them that a description often gives us more lively ideas than the sight of things themselves”

-Joseph Addison, 1712

The importance of language in society is undeniable. Language and words allow humans to communicate and understand one another. Words help explain things; their sole purpose is to carry meaning. Anthropologist Marvin Harris explained, “human languages are unique among communication systems in possessing *semantic universality*... A communication system that has semantic universality can convey information about all aspects, domains, properties, places, or events in the past, present or future, whether actual or possible, real or imaginary” (as cited in Wilden 1987, 138). Emile Benveniste noted, “language is the interpreting system of all other systems, linguistic and non-linguistic” (p.239). Because of the significance of language in conveying information, attaching negative or positive- sounding words to certain practices or traditions can often result in the development of preconceived notions about the practice.

Many different terminologies have been used to explain female circumcision. Female genital mutilation, female genital cutting, female genital modifications, female genital operations, and female genital surgeries are commonly used to denote the same practice. Female genital mutilation has become more widely accepted since the 1990s (Gruenbaum, 2001). However, for most people, the term “mutilation” implies intentional harm with evil intent (Gruenbaum). Many African scholars and feminists have argued that the term female genital mutilation is ethnocentric (Boyle, 2002). Furthermore, using female genital mutilation implies that all female circumcisions are mutilating, which is not the case. For instance, some of the less sever forms of female circumcision have no long term health consequences and inflict no real

damage to the woman's genitalia. Likewise, using the term female circumcision has its inadequacies. The word "circumcision", to many, seems to trivialize the practice by linking it to male circumcision. This paper has used the term female circumcision in order to avoid any bias or evil connotations the term "mutilation" brings with it. Furthermore, the term female circumcision seems to hold the least negative implications.

Many problems have arisen in the United States when legislation makers and researchers attach the term "female genital mutilation" to the practice. It is important for researchers and legislation makers to choose terminology carefully; the expression chosen often denotes a standpoint on the issue and may ostracize many people. For instance, while researching female circumcision, Gruenbaum (2001) noted, "some of my Sudanese friends have been deeply offended by the term [female genital mutilation], and it is their reaction as much as the connotations of that term that have influenced my preference for the term... female circumcision" (p.3). By subscribing a negative term to explain female circumcision, US legislation makers and researchers have not only vilified the tradition, but have also isolated and offended many circumcised immigrants.

Ferdinand de Saussure (1910) spent much of his career researching and explaining the value of words and terms. He postulated that words are completely interconnected with the society in which they are spoken: "the faculty of articulating words is put to use only by means of the linguistic instrument created and provided by society" (p.11). Furthermore, he noted, "a community is necessary in order to establish values. Values have no other rationale than usage and general agreement. An individual, acting alone, is incapable of establishing value" (p.112). Language is a social product—it presupposes the collectivity. Language is a system of signs that express ideas; this system is fixed by an agreement between members of a given society. The

sign (or signifier) is arbitrary—there is no natural reason why certain signs are attached to certain concepts (signified). For instance, if signs were inextricably bound to a concept, there would be equivalent signs for all things in all languages. However, this is not the case. For instance, we refer to the practice of female circumcision in the United States many ways. The Arabic word for the practice is tahara, tihar, or tuhur. Tahur is usually translated as “purification” and connotes the achievement of cleanliness through a ritual activity (Gruenbaum, 2001). The signifier attached to the signified is a result of social agreement. Researchers and activists have reached no agreement about the practice—this problem surfaces when the social world attempts to settle issues on paper that have not been settled in reality. The values of the different terms denoting the same practice lay within the society doing the defining. Society assigns values by attaching signifiers to the signified. Because the “value” of female circumcision in the United States has not been settled, there are many signifiers to define the practice. Which signifier we choose to use as individuals places us in a camp of like-minded people, but the signifier itself is merely an arbitrary way of articulating ourselves. Like Saussure explains, “a language is a system of pure values, determined by nothing else apart from the temporary state of its constituent elements” (p.80).

The Significance of “Cultural Practices”

The significance of what we deem to be a “cultural practice” is important when we attempt to analyze traditions such as female circumcision. Merriam-Webster dictionary (1999) defines “culture” as the “customary beliefs, social forms, and material traits of a racial, religious, or social group.” The same dictionary defines “practice” as a “customary action.” Alexander (1990) explained the complexities inherent in culture and society:

we cannot understand culture without reference to subjective meaning, and we cannot understand it without reference to social structure constraints. We cannot interpret social behavior without acknowledging that it follows codes that it does not invent; at the same

time, human intervention creates a changing environment for every cultural code. Inherited metaphysical ideas form an inextricable web for modern social structures, yet powerful groups often succeed in transforming cultural structures into legitimating means. (p.26).

Alexander goes on to explain the society and culture are complex affairs. In regard to female circumcision, the tradition is so deeply embedded in culture that many complexities arise when trying to legislate against it. Furthermore, the tradition of female circumcision did not derive from nothing—the practice has roots and reasons fixed within the culture. Without acknowledging these and understanding the subjective meaning for the practice, outsiders (Western feminists and legislation makers) will never fully understand what the tradition means to these cultures.

The concept of “cultural practices” has influenced our legislative and judicial ways of thinking of female circumcision. As was noted above, the United States is attempting to settle something on paper that has not yet been settled in reality. The significance and morality of female circumcision has not been settled in our society, and as a result there is still a tremendous amount of disagreement about how the United States should handle this cultural practice. The significance of female circumcision as cultural practice becomes increasingly important when the West is forced to make judgment calls about it. For instance, in the case of granting refugees asylum, the United States must define some cultural practices as human rights violations eligible for asylum under the Refugee Act of 1980. Other cultural practices, such as human sacrifice, cannibalism, polygamy, or consumption of dog meat have established a general consensus among United States citizens; most US citizens have agreed these things are immoral. Because we have settled these issues in reality, we are able to settle them on paper with little or no debate. Still, there is a dilemma in categorizing some cultural practices as moral and legal and labeling others as immoral and illegal. Gruenbaum (2001) explained this dilemma, “if these practices are

based on deeply held cultural values and traditions, can outsiders effectively challenge them without challenging the cultural integrity of the people who practice them?” (p.25). This dilemma brings to the forefront some interesting issues, one of which will be discussed below.

The issue of multiculturalism arises from this dilemma and is an important issue to discuss. Multiculturalism is the view that all cultures are equal in value. Although this view sounds appealing, there have been many critiques of it. For instance, Okin (1999) posed the question, “what should be done when the claims of minority cultures or religions clash with the norm of gender equality that is at least formally endorsed by liberal states” (p.1)? Okin argued that many cultural practices “make it virtually impossible for women to choose to live independently of men, to be celibate or lesbian, or not to have children” (p.4). She explained, “but perhaps the primary concern is that, by failing to protect women and sometimes children of minority cultures from male and sometimes maternal violence, cultural defenses violate their rights to the equal protection of the laws” (p.8). Once foreigners immigrate to the United States, their culture is no longer a legitimate defense for behaving in certain ways; ignorance of or disagreement with US law is not a valid excuse for breaking it. The view of multiculturalism is more lenient on this point; if all cultures are equal, then all cultural practices have something unique and important to add to society. For example, Horrace Kallen believed that “individuality was enhanced when each individual functioned both as a member of his ethnic-cultural group and as a member of the larger American society that embraced all the divergent ethnic cultural groups within the United States” (Ratner, 1984, p.187). Kallen did not refer to the United States as a melting-pot, but rather as an orchestra, “with each instrument linked to a cultural group making its unique contribution to the symphony of civilization” (Ratner, p.187). As the United States faces increasing immigration, and as a result, increased diversity in cultural practices, this

view must be analyzed more stringently. What cultural practices add value to American society? What cultural practices are in opposition with American laws and morals? Where do American legislatures draw the line between cultural respect and limiting cultural freedom? These are all questions entirely relevant to the kinds of issues Americans face when attempting to conform each culture to fit into what Kallen calls the “orchestra” of American society.

Many researchers argue that culture can serve as a valid excuse for immigrant’s behavior and actions. Tunick (2003) poses the question, “Are there certain actions one couldn’t have helped undertaking because of culture (what philosophers call the inability thesis), in which case perhaps our criminal law should permit a cultural defense?” (p.216). The inability thesis, as Tunick (2004) explains, “holds that one’s culture determines behavior and can make one unable to comply with the law and therefore less deserving of punishment” (p.395). Ikuenobe (1998) describes that the inability thesis allows for people being “rendered morally ignorant by their culture” (p.109). United States federal and state legislation have considered this point and have included this in their code. Section C of US federal legislation outlawing female circumcision reads, “no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual.” Furthermore, most state laws include this section in their legislation. Even if immigrant’s behavior and actions render them morally ignorant by US standards, they are still held accountable for their actions in the case of female circumcision; immigrants cannot circumcise their daughters on account of custom or ritual.

With increasing immigration and the current trend of globalization, America is being forced to integrate foreign cultural practices into US law. By challenging the practice of female circumcision by legislating against it, the US also seems to be inadvertently challenging the

cultural integrity of circumcised women. With the rising prevalence of issues relating to female circumcision occurring in the United States, it is clear *something* more must be done. Female circumcision is no longer solely a foreign “problem”—it is now a domestic “problem” that needs settling. United States laws and policies have not been well suited, thus far, for dealing with female circumcision within its borders. Laws and policies must find a way to be culturally sensitive while also protecting human rights. Without attempting to do both, many immigrants well-being may be threatened.

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BIOGRAPHICAL SKETCH

Katie Schubert attended University of California— Irvine (UCI) as an undergraduate and graduated with three Bachelors of Arts: anthropology, psychology, and criminology. After graduating from UCI, she was admitted into the sociology department at the University of Florida. As a graduate student, Katie's main focus was on female circumcision in the United States.