Imagine yourself as a fifteen year old girl. You are just starting to go through puberty and are beginning to feel changes happening to your body. You are slowly adjusting to these changes, and are uncomfortable and awkward about the physical and physiological transformation you are experiencing. One day, the elder women in your village, maybe even your own mother or aunt, gather around you. They lay you down and spread your legs open. The women surround you, holding you down. Then, the most respected woman comes towards you with a pair of scissors, a knife, or perhaps even a rock, and starts to cut away at your genitalia. You have been told not to show emotion or to cry out, but the fear and pain overwhelm you. For hundreds of millions of young girls all around the world, female genital mutilation is not just a nightmare: it is reality.

More and more women from countries where genital mutilation is prevalent are immigrating to the United States, making female circumcision a problem Americans need to acknowledge and address head-on. These women are seeking political asylum in the United States to avoid deportation back to the countries they are trying to escape from and the vicious custom they fear most of all. However, the asylum laws currently in place in the United States unfairly restrict the ability of these brave women to flee from the physical persecution they inevitably face if they remain in their home countries. Although some FGM victims are able to complete the asylum process successfully, the current legislation is full of challenges that hinder the efforts of the victims to legally reside in America. The U.S. asylum laws need to change to include past persecution, thus including women that have already been mutilated, as well as including a social group that addresses victims of female genital mutilation to make it easier for these women to be granted asylum. Although it is sometimes possible for women to meet the extreme requirements for legal asylum, it does not occur nearly enough. The laws need to be changed in this way to include all women and girls fleeing FGM, not on an individual and subjective basis. These changes
would not only protect future generations of women but would serve to internationally discourage female genital mutilation from occurring worldwide.

Female genital mutilation (FGM) is a term that defies exact definition. To women in Middle Eastern countries, it may invoke silence, sadness and loss. To many young girls around the world, it may invoke fear. For people in the United States, it may be a term they have heard on the news, or not at all. The World Health Organization (WHO) defines female genital mutilation as, “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons” (Mousette 359).

The World Health Organization has organized female genital mutilation into four different categories (WHO Student Manual 7). Type I is partial or total removal of the clitoris (also called a clitoridectomy). Type II is known as removal of the clitoris and the labia minora, with the possible excision, or cutting out of the labia majora. Type III is classified as infibulation with excision, and includes narrowing of the vaginal orifice by creating a seal that covers it. Type IV is more general, consisting of “all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.” (WHO Report 1). The cutting usually takes about fifteen to twenty minutes, after which the wound is wiped with anything from alcohol to cow dung, and the girl’s legs are bound together for up to forty days, or until the “healing” is complete. Clearly the level of brutality and viciousness found in the carrying out of this procedure is unimaginable and horrific.

The consequences for young women who suffer female genital mutilation are infinite, and can last a lifetime. The physical effects alone are enough to traumatize a young girl forever. The cutting is usually done without anesthetics or sterilization, or any proper medical equipment. This can result in immediate lethal shock from the pain, excessive bleeding, and infection (UNICEF 1). Long-term health consequences include increased risk of bloodborne diseases such as HIV, permanent disfigurement of the female genitalia, harm to the urethra and anus, hemorrhaging, urinary and reproductive tract infections,
incontinence, pelvic infections, keloids (scar tissue), vulval abscesses (collections of pus), fistulae (holes or false passages between the bladder and the vagina), severe scarring, dyspareunia (painful sexual intercourse), and infertility (Little 33). These serious and life-threatening conditions that come with FGM require specific and advanced medical technology that only a developed and wealthy country can provide, forcing these women to seek medical attention in America.

Although the physical consequences are sometimes the easiest to focus on, the emotional and psychological remnants of female genital mutilation leave a different kind of scar. For many, the mutilation is initiated or arranged by people they trust, such as parents, relatives or friends. The feelings of betrayal and deception can linger for years after (Burstyn para 53). Humiliation and embarrassment are usually followed by anger and resentment towards their insistent family members, which can have long term implications for the family unit. Many times girls must watch another girl being mutilated before or after them. Victims can suffer from anxiety, depression, psychosis, among countless other psychosocial problems (WHO Student Manual 69). Since they are encouraged to suffer “silently” and not show any emotion while being mutilated, the experience usually leaves them with inescapable and horrible memories of suppression, physical coercion, violence, and submissiveness (Slack 454).

Psychosomatic consequences of female genital mutilation include “sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, panic attacks, difficulties in concentration and learning, and other symptoms of post-traumatic stress” (WHO Report 31). Loss of self-esteem, feelings of incompleteness and worthlessness, phobias, and the development of psychotic disorders are linked to the experience of excision. The young women who suffer through FGM are usually unable to come forward to anyone about their feelings and are haunted by their experience for years to come. A World Health Organization manual describes helpful procedures that counselors can do to make FGM victims more comfortable and more willing to speak about their experiences, like always placing emphasis throughout sessions on, “privacy, confidentiality…and creating a trusting relationship” (WHO Student Manual 68).
America has historically been known for its open door policy towards immigrants of all backgrounds, accepting all nations’, “…huddled masses yearning to breathe free,” and creating a cultural mixture not to be duplicated anywhere else in the world (Lazarus). Priding itself on its humanitarian stance, the United States has been especially receptive to those fleeing certain persecution, imprisonment or death. However, legislation currently in place in the United States is actually detrimental to women fleeing physical persecution. The restrictions the Immigration and Nationality Act (INA) places severe restrictions on women seeking asylum based on the fear of FGM (Collopy 468). Instead of being shown mercy and compassion, American asylum legislation forces women fleeing FGM to make an impossible choice: either remain in a country where they and their children will certainly be physically tortured and scarred, or be deported and abandon their children in America alone and terrified.

In the United States today, 14 million individuals are part of families in which the head of the household is an unauthorized immigrant. In 2003, the Department of Homeland Security's Office of Immigration Statistics reported that almost one million of those people were deported or voluntarily left the country (Collopy 469). This left tens of thousands of children without parents or relatives, in a foreign country completely alone and isolated. When mothers of female children apply for asylum, they must not only prove that FGM is a serious danger to their daughters, but to themselves as well. Without meeting this burden of proof, the female child would have the legal right to remain in the United States, but the mother would not. Because FGM is not explicitly named a specific kind of gender-based persecution, it is extremely difficult for mothers to ensure political asylum for both themselves and their children. It is usually easier for the daughters of FGM victims to be granted asylum than their parents (Collopy 472). In order to decrease the number of abandoned children in the United States and protect the mothers who are risking everything to save themselves and their daughters from the cruelest fate, FGM must be included as a specific gender-based form of persecution, as well as an amendment added to safeguard and show mercy to women who have already suffered FGM and will be coping with the physical and psychological ramifications for the rest of their lives.
According to the Immigration Nationality Act, the definition of a refugee is,

“Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion” (Stern 97).

Therefore, in order to be granted asylum, a refugee must prove persecution, a well-founded fear, and a claim that is incorporated in one of the “enumerated grounds” above. Persecution is basically harm that will be inflicted upon them inevitably, and without a doubt. A well-founded fear of persecution must be proven both objectively, by showing that it is reasonable, and subjectively, that it is legitimate and genuine (Stern 93). The social group requirement is not as easy to define. The Board of Immigrant Appeals (BIA) calls for all members of a social group to share an “immutable characteristic” (Stern 100). Being a woman at risk of FGM or already a victim of FGM should be a part of the social group requirement, but the ambiguity of the requirements are hard to decipher and therefore hard to satisfy, which usually makes it, "impossible for a woman to qualify as a member of a social group based on her gender alone” (Setareh 144). However, over ten years ago, one woman did.

In her home country of Togo, Fauziya Kassindja’s influential father had protected her from the widely practiced ritual of genital mutilation. His untimely death resulted in Kassindja’s family arranging a forced marriage with a polygamous man more than twice her age (she was 17 at the time), who insisted on her being circumcised. Terrified, Kassindja fled to the United States using a false passport. When she arrived in America, she presented her false identification to Immigration and Naturalization Services (INS) and explained that she had been forced to use it to flee from her country in fear of being genitally mutilated. Instead of being received justly and compassionately, Fauziya was jailed like a criminal in an INS detention center for over seventeen months (Althaus 1). After her first request for asylum was denied, lawyers from human rights organizations worldwide united in the fight for Kassindja’s asylum.
Fauziya Kassindja made history in June of 1996 by becoming the first woman to receive asylum from the Board of Immigration Appeals because of the imminent threat of genital mutilation (Kassindja’s Story). Her victory set a national precedent in the United States and served to help others win the same battle. Her plight was nationally covered and opened the eyes and minds of America to female genital mutilation worldwide. Ultimately, Congress passed a law that criminalized female genital mutilation and brought the issue to the forefront of international attention. However, since she had won an based on the individual and specific circumstances of her situation, the law was still not amended to include all women like Kassindja, who were at risk for FGM, and women who had already suffered FGM and were seeking asylum.

Women who have already suffered FGM should be granted asylum in the United States because the persecution they face by remaining in their home countries does not end with the physical torture they have already endured. The psychological, mental, and further physical persecution they suffer after they have been circumcised continues throughout their lifetimes. The INS and current asylum legislation ignore the desperate pleas of the women and children suffering from FGM. The current process and regulations make it almost impossible for immigrants legitimately seeking asylum. Once the applicant has proven past persecution, the INS usually argues that there is little threat of present or future persecution in order to block the victims receiving asylum. The Immigration Judge, typically different in each case, must examine the conditions in the applicant’s home country to determine whether future persecution is probable if they were to return (Bashir). The subjectivity and prejudice of each judge is different, which may affect their ruling on the validity of the FGM claims. If the judge finds that the conditions in the woman’s country do not merit enough concern to be granted asylum and the woman cannot provide a claim of well-founded persecution, she will be denied asylum. An amendment that is written into the asylum legislation and is part of both the INS and BIA bylaws is critical to guarantee just and impartial decisions for all FGM victims seeking asylum.
Women that have already been mutilated should be granted asylum in the United States simply because of the fact that they have already been mutilated. The physical and psychological consequences of FGM are life-threatening and extremely critical. The primitiveness of the countries’ health systems where these women are from are clearly illustrated in the way they practice the ritual of FGM; without anesthesia, and usually without any sanitary medical equipment or medically trained staff present in case of emergency (UNICEF 1). Therefore, the physical condition of the women even years after they have been mutilated may continue to deteriorate, even after the immediate effects have worn off. Almost 35% of FGM victims die prematurely as a result of the ghastly procedure (Dudones 29). Mimi Ramsey, a forty-three year old nurse and immigrant from Africa, searched for years for a doctor who would help her with the “aftereffects” of her FGM (Burstyn para 39). As a result of her FGM, Mimi is forced to constantly carry a tube of cream with her to help soothe her nerve endings. She still feels burning and irritating discomfort from the torturous mutilation she endured at just 6 years old. She still does not enjoy sex because she is numb, and feels no sensations at all (Burstyn para 40). The physical aftereffects of FGM last for decades, if not lifetimes, and these women need the healthcare available in the United States to help them.

Women who have been mutilated and then impregnated need the most care of all. The WHO has documented countless complications that come with being excised and pregnant, including a tight introitus interfering with normal vaginal exams, chronic pelvic infections interfering with the normal process of the pregnancy and even causing abortions and miscarriages, and cysts and keloids, which could be obstructions during delivery. (WHO Student Manual 81) In addition, there are the psychosexual problems many of these women face, because of the embarrassment of their condition and their fear of being judged or reported, if they are not legal immigrants. According to a WHO study of women in six different African countries who had and had not been subjected to any type of FGM prior to their pregnancies, the number of FGM victims suffering from postpartum blood loss (500 ml or more), extended hospital stay, or a forced Caesarian section were triple the number without FGM. The study
also found that the risk of adverse infant outcomes such as lower birth weight, the infant having to be resuscitated and inpatient perinatal death, were also about triple in number of incidences among FGM women versus women without FGM (WHO Study 1835-1841). According to another WHO study done in June 2006, it was estimated that 10 to 20 thousand babies die during delivery as the direct result of their mothers being mutilated.

Opponents of granting women asylum based on the past persecution of having already been genitally mutilated will argue that once a woman has been genitally mutilated, she cannot be mutilated again, and therefore, should not be granted asylum. There is no threat of present or future persecution. This is easily debunked, however, by examining the cultural ramifications that emerge once a female is genitally mutilated. The actual cutting only symbolizes the beginning of the psychological subordination and submission of the women and the complete domination and control by the men. One of the main reasons for the mutilation is the aesthetic value for the men, as well as providing them with ultimate sexual pleasure, while usually both denying women sexual satisfaction and causing them extreme pain and discomfort (Corbett 69). Also, reinfibulation may occur after marriage. Once a woman has intercourse, the opening becomes enlarged and many times she is forced to undergo mutilation again in order to close her vaginal opening again (Setareh 129). So even though a woman may already have been mutilated, she must be granted political asylum in order to prevent the cycle of FGM to continue in her life as well as the lives of her daughters.

Others argue that only young girls should be granted asylum, since they are usually at greater risk of being circumcised. This is also untrue, since females are at risk of being mutilated throughout their childhood and into their adult years. Although most circumcisions happen at a young age since it is easiest to coerce the youngest and most innocent without a struggle, mutilation can happen at any time. Due to her personal circumstances, Fauziya Kassindja was not in jeopardy of being mutilated until she was 17. Clearly women of all ages require the safety that comes with being granted asylum in the United
States because of this risk, as well as the fact stated above, that women are often mutilated more than once in their lifetimes (after having intercourse and after childbirth (Setareh 129).

Another contrasting view is that we should be decreasing the number of immigrants that are eligible for legal residence in America, not increasing it. However, according to the Migration Policy Institute, over 60,000 more immigrants from Mexico arrived in the United States in 2006, compared with those that emigrated from Africa, where over half of all females are mutilated. Mexico has also been ranked the number one top sending country of immigrants since 1986 through 2006 (MPI). If opponents want to cut down on invalid and unwarranted immigration into the United States, their focus should be on our neighboring country of Mexico, not those of Africa. No African nations made it into the top ten sending countries since before 1986, and it is the country in which female genital mutilation is highest. Clearly, if the laws are changed to show mercy and allow more women to be granted asylum from the countries where female genital mutilation is most prevalent, it will not result in a radical or extreme increase in the number of immigrants legally living in the United States. Some would argue that since such a huge number of women undergo FGM worldwide, changing the asylum laws would be like opening the floodgates to a whole new immigration population. However, only a few thousand of FGM victims have the means or the opportunity to escape to America. It is estimated that only 7,000 women and girls emigrate to the U.S. from countries dominated by FGM (Burstyn para 28). Therefore, including FGM as a valid reason for seeking asylum in the United States would not significantly impact the numbers of immigrants coming to the United States.

If the asylum laws were changed to include more women affected by FGM, the positive results would be huge, possibly including the decline of female genital mutilation in the United States and around the world. If America were to offer its protection to this very vulnerable population and strongly voice its new policies, perhaps other countries would follow suit, changing the face of this issue around the world. The United States must take a strong position and offer its protection to women currently facing genital mutilation. If we are to pride ourselves on our compassionate and just immigration policy,
we must offer the protection and support to those most cruelly victimized by gender, poverty and ignorance. We cannot neglect the victims of FGM who are coming to the United States begging for help, and for a new start, free from persecution or violence. Mimi Ramsey, the victim who is still suffering the physical consequences almost forty years after her FGM, says it best: “I was angry and still am…after…I got up and called all the African women from my address book who live in the United States. I asked them, 'Are you a victim too?' And they said yes. I said, 'Let's talk about it. I'm not going to shut up anymore'” (Burstyn para 20).
Works Cited


