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Cover Page Footnote

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FEMALE GENITAL MUTILATION: WHAT DOES THE NEW FEDERAL LAW REALLY MEAN?

Khadijah F. Sharif*

Introduction

Wake up, girl, whispers Granny, as she shakes my shoulder gently. Jolted out of my dream, I dress myself quickly in a *lappa*¹ skirt and blouse, then Granny and I join three other Fula girls and their relatives. We leave Freetown, Sierra Leone, by minibuss and drive to a remote place in the bush. As the morning mist rises, I see a gathering of women and six or seven other girls. I am 10 years old, and though I do not yet know it, the events of this day will forever alter my life.

Bare-breasted dancers shuffling bell-laden feet and shaking maracas sing Temme, Susu and Mandingo songs. They dance around a blazing fire where several kettles boil water for the cooking of pepper soup, corn and rice. Abruptly the singing and dancing stop, and I stand with the other girls in a circle. The women make a ring around us, and the eldest woman enters our circle. 'You are about to join Society', she says gravely, 'and you must never reveal the ritual that is about to take place. Do you promise to keep these events secret forever?' Solemnly we nod our heads.

Next we are led to a round thatched hut, where we are blindfolded. I feel the women grab me, gag me and lay me down upon a *matta*.² Be brave, they tell me. Crying is a disgrace. Suddenly I feel an excruciating pain. My clitoris is sliced off! I try to pull away, but the women hold me. I scream, but no sound comes [out]. Before my silent scream ends, a sharp blade has removed my labia majora and minora. As the women close my wounds with thorns and try to stanch the bleeding with scalding water, I faint from the pain.³

* J.D. Candidate, Fordham University, 1997; A.B., Columbia University, 1993. The author would like to thank Professor Joseph Sweeney for his assistance during the drafting of this Note. The author also thanks Amidah Salahuddin, Asia Sharif-Clark, Valerie D. White, Ming Avyas, Emile Milne, and Craig Drinkard for their support.

1. Cotton-like cloth.

2. Mat or bed.

3. Mariama L. Barrie, *Wounds That Never Heal*, ESSENCE, Mar. 1996, at 54.

This is the story of Mariama L. Barrie, one of almost one hundred million victims of female genital mutilation⁴ in Africa alone. It illustrates the pain and horror inflicted on young girls and women in the name of cultural rights, religion and tradition.⁵ In recent years, the practice of female genital mutilation has received widespread attention throughout the world due to the increasingly high number of incidents involving the practice.⁶ The Centers for Disease Control and Prevention recently estimated that more than 150,000 women and girls of African origin and ancestry residing in the United States may be at risk of or have undergone female genital mutilation.⁷ The practice first gained United States media attention when Fauziya Kasinga won asylum to avoid persecution in

4. The term female genital mutilation should not be confused with circumcision of any kind. While many attempt to equate this practice with male circumcision, there is no similarity. Nahid Toubia, an African specialist, states that in a man this practice would range from amputation of most of the penis to removal of all the penis, its roots of soft tissue, and part of the scrotal skin. A.M. Rosenthal, *Fighting Female Mutilation*, N.Y. TIMES, Apr. 12, 1996, at A31.

5. Many international human rights activists argue that the practice is a violation of women's human rights. Allison T. Slack, *Female Circumcision: A Critical Appraisal*, 10 HUM. RTS. Q. 437, 439 (1988). Others assert cultural and religious defenses as a reason to respect the practice. *Id.* The female genital mutilation debate exemplifies the struggle between cultural relativism and universal human rights. Cultural relativists oppose conforming to "universal" norms, arguing that majority preference should not dictate what is moral. Slack, *supra*, at 463. According to theorists, cultural relativism is complex, and seeks to question how much we can actually understand of other culturally based realities, while it simultaneously prescribes appreciation for those diversities. Conversely, universal human rights activists argue that those practices that have neither factual, historical validity nor contemporary legitimacy in terms of societal values, and that furthermore inflict harm and injury on their adherents, must be abandoned. Sandra D. Lane and Robert A. Rubinstein, *Judging the Other: Responding to Traditional Female Genital Surgeries*, HASTINGS CENTER REPORT, May-June 1996, at 31. Shelley Simms, *What's Culture Got to Do With It? Excising the Harmful Tradition of Female Circumcision*, 106 HARV. L. REV. 1944, 1960 (1993).

6. During her introduction of the Female Genital Mutilation Act of 1995, H.R. 941, 104th Cong., 1st Sess. (1995), Congresswoman Patricia Schroeder, D-Colorado, stated that millions of girls had been genitally mutilated. See Press Release from Pat Schroeder, June 7, 1995. The Female Genital Mutilation Act of 1995 was not passed; however, the contents of the bill were included in the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, §§ 644-645, 110 Stat. 3009, 3708-09 (1996).

7. Researchers have developed these rough estimates by matching 1990 Census Bureau population data on the number of girls and women whose families came from the African countries where the practice is customary with estimates of the prevalence of the rite in those countries. Although the Census Bureau and other governmental agencies have not yet determined the number of Americans who have undergone the practice, numerous anecdotal stories provide evidence that female genital mutilation occurs in immigrant communities in the United States. Celia W. Dugger, *New Law Bans Genital Cutting in the United States*, N.Y. TIMES, Oct. 12,

her native land.⁸ Her case and significant anecdotal evidence⁹ of female genital mutilation led Congress to incorporate provisions prohibiting genital mutilation in the Illegal Immigration Reform and Immigrant Responsibility Act of 1996.¹⁰

This Comment considers the growing number of immigrants who bring the traditional practice of female genital mutilation to the United States and examines the difficulty in protecting victims from the practice of female genital mutilation in insular communities. Part I outlines the three types of female genital mutilation, the cultural and religious reasons for the ritual, and the existence

1996, at A1. The inability of the Census Bureau to provide hard numbers does not mean that the practice does not occur in the United States.

8. Celia W. Dugger, *U.S. Hearing to Decide Rights of Women Who Flee Genital Mutilation*, N.Y. TIMES, May 2, 1996, at B6. Celia W. Dugger, *U.S. Frees African Fleeing Ritual Mutilation*, N.Y. TIMES, Apr. 25, 1996, at A1. Kasinga, a 17 year old girl, fled her native land of Togo to avoid being genitally mutilated. Upon her arrival in the United States at Newark airport, she was taken into custody by local authorities and detained for a period of two years in a prison in New Jersey, awaiting determination of her claim of asylum. With the exposure of her case through media coverage and illumination of the injustices she was forced to suffer, she was eventually granted political asylum, based on a finding that her fear of being genitally mutilated was sufficient grounds on which to grant her relief. David A. Martin, General Counsel of the United States Immigration and Naturalization Service, argued for asylum in narrowly defined cases, where the victims would receive political asylum only if they had not already been mutilated. Mr. Martin and his colleagues appeared to be concerned that Ms. Kasinga's case would set a precedent that would allow millions of women to become eligible for asylum. The floodgate argument, however, does not appear to be very strong in light of the fact that Canada, which in 1993 became the first country to make genital mutilation grounds for granting refugee status, did not have an overflow of emigrants applying for political asylum.

9. Congresswoman Patricia Schroeder stated in an address to the House of Representatives that she and her colleagues have received anecdotal reports that the practice is taking place in the United States. 141 CONG. REC., H1695, Feb. 14, 1995.

10. Illegal Immigration Reform and Immigrant Responsibility Act of 1996, §§ 644-645. After much debate regarding whether Congress had the power to pass such a law, members of the House and Senate agreed that it was within their power to do so. Senator Reid proposed the following to Congress:

Such mutilation infringes upon the guarantees of rights secured by Federal and State law, both statutory and constitutional; the unique circumstances surrounding the practice of female genital mutilation place it beyond the ability of any single State or local jurisdiction to control; the practice of female genital mutilation can be prohibited without abridging the exercise of any rights guaranteed under the First Amendment to the Constitution or under any other law; and Congress has the affirmative power under section 8 of article I of the Constitution, as well as under section 5 of the Fourteenth Amendment to the Constitution, to enact such legislation; it is the purpose of this section to protect and promote the public safety and health and activities affecting interstate commerce by establishing Federal criminal penalties for the performance of female genital mutilation.

142 CONG. REC. S1870-03 (statement of Sen. Gregg for Sen. Reid).

of the practice in the United States. Part II examines the provisions of the Immigrant Responsibility Act of 1996. Part III recognizes that the passage of the Immigrant Responsibility Act of 1996 is timely, but argues that its implementation remains uncertain because victims and perpetrators are insulated within their communities. This Comment concludes that the legislation must provide specific provisions and funding to enable states and localities to (1) devote significant amounts of attention to educating communities about the dangers and horrors of the practice, (2) develop culturally sensitive outreach activities for victims of the ritual, and (3) involve governmental agencies and community-based organizations in the fight to abolish female genital mutilation.

I. Female Genital Mutilation: The Practice Here and Abroad

A. The Female Genital Mutilation Procedure

Although the practice of female genital mutilation is performed on girls ranging from newborn babies to adolescents, the procedure is performed typically on girls at age seven.¹¹ Women in more than forty countries have practiced female genital mutilation for over 2,500 years.¹² In addition, estimates reveal that 100 million females of all ages in Africa alone have undergone some type of genital mutilation,¹³ and worldwide the practice affects well over 100 million women.¹⁴

11. *Report of the Working Group on Traditional Practices Affecting the Health of Women and Children* 10, 40-41, U.N. Doc.E/CN.4/1986/42 (1986); see also ALICE WALKER & PRATIBHA PARMAR, *WARRIOR MARKS: FEMALE GENITAL MUTILATION AND THE SEXUAL BLINDING OF WOMEN* 308 (1993). A description of the practice follows:

The little girl . . . is immobilized in the sitting position on a low stool by at least three women: one of them with her arm tightly around the little girl's chest; two others hold the child's thighs apart by force Then the old woman takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip The little girl howls and writhes in pain, although strongly held down. The operator wipes the blood from the wound and the mother and the guests "verify" her work, sometimes putting their fingers in. . . . The opening left for urine and menstrual blood is minuscule.

12. FRAN P. HOSKEN, *THE HOSKEN REPORT* 25 (3d ed. 1982) (listing WIN News List of Female Genital Mutilation Around the World: Population Groups).

13. HANNY LIGHTFOOT-KLEIN, *PRISONERS OF RITUAL: AN ODYSSEY INTO FEMALE GENITAL CIRCUMCISION IN AFRICA* 27-31 (1989).

14. Council on Scientific Affairs, American Medical Ass'n, *Female Genital Mutilation*, 274 JAMA 1714, 1714 (1995) [hereinafter Council Report].

There are three types of female genital mutilation: the pharaonic type, the intermediate type and the sunna type. Pharaonic circumcision or infibulation is the oldest, the most prevalent, and the most brutal type of genital mutilation. It accounts for over eighty per cent of the cases in the Sudan, one of the countries where female genital mutilation is prevalent.¹⁵ The term infibulation is derived from the name given to the Roman practice of fastening a fibula or clasp through the lips of their wives' genitalia in order to prevent them from having illicit sexual intercourse.¹⁶ There are two methods of infibulation: the classical and the modernized. The former consists of removal of the clitoris, the labia minora, and the labia majora, with the two sides of the wound being brought together by different methods. In Eastern Sudan, adhesive substances such as sugar, egg, and cigarette papers are placed on the wound, left for three to fifteen days; and removed leaving a small opening.¹⁷ In Central and Northern Sudan, thorns wrapped in palm reed are used. In Western Sudan, adhesive substances, thorns, and strings are sometimes used.¹⁸ The girl's legs are bound together at the ankle, above the knees, and around the thighs for approximately fifteen to forty days to limit movement and to facilitate proper healing.¹⁹ To ensure tightness of the hole, a thorn is inserted into the vagina so that when the tissue heals, only this opening remains. The classical type of pharaonic circumcision is practiced mainly in rural areas and is usually performed by untrained midwives without anaesthesia.²⁰ The modern type of pharaonic infibulation involves removal of the clitoris, the labia minora, and most anterior parts of the labia majora. The two sides are then brought together by stitching with catgut or silk by trained midwives in urban areas with the use of anaesthesia. Often the legs are bound together similar to the classical operation, but for no longer than seven days. Warm oil and tea are usually poured into the wound and healing time varies between seven and fifteen days.²¹

15. ASMA EL DAREER, *WOMAN WHY DO YOU WEEP?: CIRCUMCISION AND ITS CONSEQUENCES* 1 (1982). Many scholars who have studied the practice acknowledge the significance of her reports and have used her work as a springboard for their own studies. See, Lane & Rubenstein, *supra* note 5; Slack, *supra* note 5.

16. RAQIYA HAJI DUALEH ABDALLA, *SISTERS IN AFFLICTION: CIRCUMCISION AND INFIBULATION OF WOMEN IN AFRICA* 10 (1982).

17. EL DAREER, *supra* note 15, at 1.

18. *Id.* at 2.

19. *Id.*

20. *Id.*

21. *Id.*

Excision, the intermediate type of female genital mutilation, shares aspects of the pharaonic and sunna type.²² Many believed that a middle ground was needed because sunna was viewed as practically no circumcision at all and pharaonic was seen as too severe.²³ The mildest form of the intermediate type consists of the removal of the clitoris, where the surface of the labia minora is roughened to allow stitching.²⁴

The sunna type is the mildest and least performed type of female genital mutilation.²⁵ The word sunna means following the tradition of Prophet Muhammad.²⁶ This procedure consists of removing only the tip of the prepuce of the clitoris.²⁷ In some geographical areas, women apply a heated piece of stone or pearl to the prepuce of the clitoris to burn it away.²⁸ In the other communities, only the tip or half of the clitoris is removed, the labia minora are intact, and there is no stitching.²⁹

All types of female genital mutilation raise medical and hygienic issues regarding the use of unsanitary instruments including razor blades, knives, scissors, glass, stones and, in some regions, the midwife's teeth.³⁰ Other evidence suggests that instruments are used on more than one woman without proper sterilization.³¹ Doctors and activists worry that women who undergo the procedure are at a high risk of infection from hepatitis B and the human immu-

22. *Id.* at 3. It was invented in 1964, subsequent to the enactment of legislation in the Sudan forbidding the practice of pharaonic circumcision. *Id.*

23. EL DAREER, *supra* note 15, at 3.

24. *Id.* at 4.

25. ABDALLA, *supra* note 16, at 8.

26. EL DAREER, *supra* note 15, at 2. Peace be upon him should always be said after any Prophet's name is mentioned. It signifies that Muslims wish peace and blessings on all of the Messengers of God (Allah). The word Sunna also refers to the path or way of life of Prophet Muhammad (who Muslims believe is the last messenger of God (Allah) and who was sent to teach the religion of Islam).

27. While some assert that this type of mutilation resembles male circumcision, others dispute that any form of genital mutilation performed on women is comparable to circumcision performed on men.

28. EL DAREER, *supra* note 15, at 2.

29. *Id.* at 3-4.

30. *Id.* at 6-8.

31. El Dareer gives her account of such unsanitary conditions:

The problem is that these knives are not sterilized, but simply wrapped in a piece of old rag after use, without washing. Sometimes they may be wiped with oil and sometimes midwives said that they heated it. But all the knives I saw were rusty, dirty and old. These knives were also used for deliveries and some midwives said that they used them in their housework.

Id. at 8.

nodeficiency virus.³² Other immediate and long-term complications include chronic vaginal and uterine infections,³³ sterility, urinary tract infections,³⁴ dysmenorrhea,³⁵ pain during sexual intercourse,³⁶ obstetric complications,³⁷ severe agony, danger during childbirth, and early death.³⁸

B. Cultural and/or Religious Reasons for the Practice

In cultures that practice female genital mutilation, the ritual confers upon women full social acceptability, integration into the community,³⁹ and serves as a rite of passage to womanhood.⁴⁰ For many women in these cultures, the practice enables them to identify with their heritage and to enjoy recognition as full members of their ethnic group, enjoying social benefits and privileges.⁴¹

Female genital mutilation is practiced predominantly in African and Middle Eastern countries among Muslim and non-Muslim tribal communities,⁴² among the Muslim populations in Malaysia and Indonesia,⁴³ and within immigrant communities in the United States.⁴⁴ Today, these communities continue to perform female genital mutilation because of the deep cultural and religious roots of the ritual in African society.⁴⁵ Many practitioners believe that it is an Islamic custom encouraged by Prophet Muhammad but there is no textual authority for such belief.⁴⁶ Others argue that because

32. Council Report, *supra* note 14, at 1715. HIV can cause AIDS (Acquired Immunodeficiency Syndrome).

33. EL DAREER, *supra* note 15, at 29.

34. *Id.*

35. This term refers to severe menstrual pain.

36. *Id.* at 27.

37. Council Report, *supra* note 14, at 1715.

38. Rosenthal, *supra* note 4, at A31.

39. Simms, *supra* note 5, at 1949.

40. Karen Engle, *Female Subjects of Public International Law: Human Rights and the Exotic Other Female*, 26 NEW ENG. L. REV. 1509 (1992).

41. Simms, *supra* note 5, at 1949.

42. LIGHTFOOT-KLEIN, *supra* note 13, at 27-31.

43. Council Report, *supra* note 14, at 1714.

44. *See generally*, Illegal Immigration Reform and Immigrant Responsibility Act of 1996, §§ 644-645; *see also*, 142 CONG. REC. S4286-02 (1996) & 142 CONG. REC. S8972-01 (1996) (citing Senator Reid's floor debates regarding reports he has received concerning female genital mutilation being practiced in the state of California. Immigrants are found to have migrated from Senegal, Sudan, Mauritania and other countries in West and Central Africa).

45. Karen Hughes, *The Criminalization of Female Genital Mutilation in the United States*, 4 J.L. & POL'Y 321 (1995).

46. EL DAREER, *supra* note 15, at 72; *see generally*, THE HOLY QUR'AN, A. Yusuf Ali Translation.

neither the Holy Qur'an⁴⁷ nor the Islamic law⁴⁸ mention the practice, female genital mutilation has no religious or legal authority under Islam.⁴⁹ Non-practicing Muslims acknowledge that the procedure is primarily performed among Muslims,⁵⁰ but, argue that the practice of female genital mutilation predates Islam.⁵¹ The idea that female genital mutilation is not a religious practice is supported by references to Islamic history.⁵² In addition, there is no evidence in Muslim history that the Prophet's wives were genitally mutilated.⁵³

Some scholars suggest that economics underlie the persistence of female genital mutilation.⁵⁴ In many African and Middle Eastern countries, women are married off to eligible, wealthy males and, in exchange, their fathers receive substantial bride prices.⁵⁵ The bride price depends on whether the woman is highly valued and found to be chaste.⁵⁶ The bride must display her virginity as evidence of her virtue following the wedding.⁵⁷ The anxieties surrounding this occasion and its general importance are highly intensified.⁵⁸ The groom's family may examine the bride to ascertain her virginity, and only after they are satisfied that it is intact will the marriage be consummated.⁵⁹

47. Hughes, *supra* note 45, at 343.

48. Shar'ia is the Arabic term for Islamic law.

49. EL DAREER, *supra* note 15, at 72.

50. *Id.* at 21.

51. ABDALLA, *supra* note 16, at 80.

52. Critics of the practice argue that since the Holy Qur'an does not explicitly enjoin the practice on women, it is not a religious mandate. EL DAREER, *supra* note 15, at 72.

53. It can be argued that if he did not encourage his wives to undergo the procedure then he would not encourage other women to be genitally mutilated.

54. ABDALLA, *supra* note 16, at 56-61. Raquiya Haji Dualeh Abdalla conducted a study regarding the reasons for the practice. She explained that the practice is perpetual because the main contribution a woman makes to the honor of her family is the preservation of her chastity and purity.

55. While the bride's father receives money or some form of property, she receives the honor of being married and having her husband provide for her. If she is not chaste she may face the ridicule of being seen as undesirable because of her lack of purity. *Id.* at 56-61.

56. *Id.*

57. *Id.*

58. EL DAREER, *supra* note 15, at 73-74.

59. The intrusion of the groom and his family takes place even before he has married the bride, it occurs prior to the marriage proposal. The prospective groom may claim his right to ascertain that the woman is a virgin by inspecting her infibulation scar. The virginity test is a means of confirming a woman's modesty and potential fidelity. ABDALLA, *supra* note 16, at 56.

Some commentators attribute the perpetuation of the practice to the notion of the sexual domination of women by men.⁶⁰ Female genital mutilation inhibits the sexual desires of women, preserves virginity until marriage, and prevents women's outward enjoyment and sexual response.⁶¹ It hinders women from expressing sexual pleasure, protecting them from socially unacceptable behavior reserved only for men.⁶² Others believe that female genital mutilation developed as a means by which husbands could own and control women,⁶³ rendering them silent, powerless and submissive.⁶⁴

C. Female Genital Mutilation in the United States

Immigrants from countries practicing female genital mutilation often retain their cultural traditions and religious beliefs. Based on the Census Bureau's findings that large numbers of immigrants from African countries reside in metropolitan areas, i.e. New York City, Newark, New Jersey, Washington, D.C., and Los Angeles, CA, it is likely that many have undergone or are at risk of undergoing female genital mutilation. In addition, anecdotal stories of the ritual have been reported in these areas.⁶⁵ Although governmental

60. See generally *Report of the Fourth World Conference on Women, Beijing Declaration and Platform for Action*, U.N. Doc. A/Conf. 177/20 (1995). [hereinafter *Platform*]. This document was introduced and adopted at the United Nations Fourth World Conference on Women in Beijing, China. The document provides "Violence against women is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement." The author of this Comment was present at the conference and worked on the document.

61. Eugenie Anne Gifford, *The Courage to Blaspheme: Confronting Barriers to Resisting Female Genital Mutilation*, 4 UCLA WOMEN'S L.J. 329, 345-48 (1994).

62. *Id.*

63. Hughes, *supra* note 45, at 330.

64. Gifford, *supra* note 61, at 341.

65. Mimi Ramsey, a native Ethiopian and a victim of the practice who is currently a political activist against the ritual, is quoted as saying that she has recently talked to three Somali mothers here in the United States who performed female genital mutilation on each other's daughters on a kitchen table. She also stated that a father told her last year that he performed female genital mutilation on his three year old daughter because she liked to play with boys, which indicated to him that she would later run after men. Ramsey cited San Jose, California, San Francisco, California and Washington, D.C. as some of the places where stories such as these occur. Press Release, Pat Schroeder, October 12, 1995. See Rita Henley Jensen, *Mimi Ramsey: For Selflessly Striving, Despite Her Own Pain, to End the Mutilation of Young Girls*, Ms. MAGAZINE, Jan./Feb. 1996, at 51; *Womanhood Denied*, SAN JOSE MERCURY NEWS, Jan. 14, 1996 at 1H, 5H; Dugger, *supra* note 6, at A1; 142 CONG. REC. S8972-01, 142 CONG. REC. S4286-02 (Senator Reid stating that seven cases of female genital mutilation were reported in Santa Clara, California.)

agencies continue to compile statistics on the number of women and girls at risk of genital mutilation,⁶⁶ many immigrants fear disclosure⁶⁷ because the subject of female genital mutilation is taboo.⁶⁸ Female genital mutilation has received increased media exposure in the United States and internationally.⁶⁹ The practice is decried by women's rights activists worldwide, and debated in the pages of widely accepted international human rights documents.⁷⁰

II. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996

In September, 1996, Congress passed the Immigrant Responsibility Act, sponsored by Representative Schroeder and Senator Reid, outlawing the rite of female genital mutilation in the United States. The passage of the federal law followed the enactment of various state laws against the practice.⁷¹ The Immigrant Responsibility Act identifies several goals including requiring doctors to report incidences of genital mutilation, prohibiting the performance of the ritual by unlicensed medical practitioners, guaranteeing persons who have undergone the ritual freedom from discrimination by medical practitioners, recommending the development of educational curricula for medical school students, and calling for the structure and implementation of outreach activities that allow persons performing the ritual and persons trying to prevent the ritual to work collaboratively to stop the practice. The federal law also defines female genital mutilation as a criminal act. It provides that anyone who knowingly circumcises, excises, or infibulates the whole or any part of the labia majora, labia minora or clitoris of another person who is under the age of 18 shall be fined or imprisoned for not more than 5 years or both.⁷² The bill also provides that no weight shall be given to the defense that the procedure was

66. The Census Bureau and other agencies are working on compiling data on the numbers of women and girls at risk.

67. Nancy I. Kellner, *Under the Knife: Female Genital Mutilation as Child Abuse*, 14 J. JUV. L. 118 (1993).

68. Press Release from Congresswoman Pat Schroeder's Office, Oct. 12, 1995.

69. See generally *Illegal Immigration Reform and Immigrant Responsibility Act of 1996* §§ 644-645.

70. See generally *Platform*, *supra* note 60.

71. Staff of Rep. Patricia Schroeder, 104th Cong., 1st Sess., Summary of Federal and State Legislation on Female Genital Mutilation (1995).

72. *Illegal Immigration Reform and Immigrant Responsibility Act of 1996* § 645.

required as a matter of custom or ritual.⁷³ The bill further provides that whoever denies medical care or services or otherwise discriminates against any person who has undergone female genital circumcision, excision, or infibulation or because that person has requested that female circumcision, excision, or infibulation be performed on any person, shall be fined or imprisoned not more than one year or both.⁷⁴ The bill exempts the performance of medical procedures from prosecution. It provides that surgical operations are not violations of the bill where the procedure is necessary to an individual's health and if performed by a licensed medical practitioner in the place of its performance. The bill also allows the practitioners to perform genital surgery on a woman in labor or who has just given birth, for medical purposes connected with that labor or birth.⁷⁵ The medical practitioner, midwife or person in training must be licensed to practice the procedure in the place where it is performed. Congress intended that the bill eradicate the practice of female genital mutilation in people's houses without the proper equipment and supervision.⁷⁶ The bill allows students in the medical field to gain experience in treating these patients with unique medical circumstances.

In addition to providing penalties for violating the law, the bill contains an educational component. The Secretary of Health and Human Services must compile data on the number of women living in the United States who have been subjected to female genital mutilation (whether in the United States or in their countries of origin), including a specification of the number of girls under the age of 18 who have been subjected to such mutilation.⁷⁷ The Secretary must also identify communities in the United States that practice female genital mutilation, and design and implement outreach activities to educate individuals about the physical and psychological health effects of the practice.⁷⁸ The bill provides that the Secretary's outreach activities include collaboration with representatives of ethnic groups practicing female genital mutilation and with representatives of organizations with expertise in preventing the prac-

73. *Id.* The bill explicitly provides that "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 or any other person that the operation is required as a matter of custom or ritual."

74. *Id.*

75. *Id.*

76. *See generally* Illegal Immigration Reform and Immigrant Responsibility Act of 1996 §§ 644-645.

77. *Id.*

78. *Id.*

tice.⁷⁹ Finally, the Secretary must develop recommendations for the education of medical and osteopathic medical school students regarding female genital mutilation and its medical complications.⁸⁰ The bill does not mention how the law will be funded, monitored or enforced.⁸¹

III. Problems of Implementation

The Immigrant Responsibility Act is a good first step towards eliminating the ritual. The law properly requires the compilation of the number of women and girls who have been affected by and are at risk of the practice here in the United States and the development of educational components to inform immigrant communities about the dangers of the practice. In addition, the law envisions persons performing the ritual and persons trying to stop the practice to work collaboratively to abolish female genital mutilation.

Although the law is important and timely, it is merely a skeleton of the law necessary to practically limit the occurrence of female genital mutilation in the United States. Although the bill identifies a myriad of goals, it has some significant flaws. The bill (a) lacks specificity in terms of how Health and Human Services will implement, administer and monitor the law, and does not mention how the bill will be funded (b) is not culturally aware with regard to how Health and Human Services will infiltrate insular immigrant communities to obtain the information about the practice within those communities, and (c) places an unfair burden on medical personnel to report incidences of the ritual, disregarding the long-standing physician-patient confidentiality privilege. The lack of specificity in these areas leaves Health and Human Services with unbridled discretion to define the law's parameters and fails to provide detailed guidelines for the law's implementation.

79. *Id.*

80. *Id.*

81. The author has sifted through the following floor debates and reports, 142 CONG. REC. S8972-01 (1996); 142 CONG. REC. S4286-02 (1996); 142 CONG. REC. S1870-03 (1996); 142 CONG. REC. H2879-02 (1996); H.R. CONF. REP. NO. 537, 104th Cong., 2d Sess. (1996); 142 CONG. REC. S7490-02 (1992); H.R. CONF. REP. NO. 828, 104th Cong., 2d Sess. (1996); H.R. CONF. REP. NO. 863, 104th Cong., 2d Sess. (1996); 142 CONG. REC. H4187-01 (1996); 142 CONG. REC. S11886-01 (1996); 142 CONG. REC. S4401-01 (1996), to ascertain Congress' intent in funding, implementing and monitoring the law. No evidence was found regarding any of these issues.

A. Lack of Guidance for Health and Human Services to Implement the Act

The Immigrant Responsibility Act lacks specific instruction regarding how Health and Human Services should compile data on the number of females living in the United States who have been subjected to female genital mutilation. This lack of instruction is problematic because if Health and Human Services cannot identify the victims then it will not be able to serve them. One way Health and Human Services can obtain such information is by working with the United States Census Bureau. Health and Human Services should petition the Office of Management and Budget to include questions in the Census Questionnaire that is distributed once every ten years. The questions that Health and Human Services submits should seek to obtain information on the country of national origin, cultural norms that one has knowledge of, medical and health-related questions and the ethnic make-up of one's community. Examples of questions might read: What is your country of national origin? If you were not born in the United States, when did you migrate here? Did you migrate to the United States with other family members, friends, etc.? What grade in school did you complete? What if any cultural/religious traditional norms are you familiar with? (Examples include, santeria, female infanticide, branding or engraving of tribal marks, jumping the broom, female genital mutilation, leviratic⁸² or sororate⁸³ marriages, polygamy and brideprices). Have you or any members of your family participated in one or more of the above traditions? If so, which ones? What is the ethnic make-up of your community? Is your community largely populated by people from your country of national origin? List any serious health problem(s) you have or had within the last ten years. List the cause(s) of problem(s) (dietary, hygienic, genetic). With the information obtained from the Census Questionnaires, the Census Bureau should provide information to Health and Human Services regarding communities who may be at risk of or already practicing female genital mutilation. The Census Bureau has not in the past used information obtained for this type of purpose, however, it is one, if not the only efficient way to ascertain who is practicing genital mutilation and who is likely at risk. While many argue that people will be discouraged from answering

82. In this form of marriage a widow is forced to marry her dead husband's brother. WEBSTER'S THIRD INT'L DICTIONARY 1301 (1986).

83. This form of marriage is one in which a wife is replaced by her sister upon her death. WEBSTER'S THIRD INT'L DICTIONARY 2175 (1986).

census forms because they fear their privacy will be invaded, it is worth the risk to solicit such information to help as many people as possible.

The bill also fails to outline educational services that Health and Human Services must provide for victims of female genital mutilation and for victims' families. Health and Human Services must work in conjunction with Centers for Disease Control and nongovernmental organizations to establish educational seminars that are culturally sensitive to both victims of the ritual and practitioners. These dialogues should focus on the dangers of the procedure and its medical complications, including contraction of HIV and/or AIDS from the use of unsterilized equipment, various uterine and cervical infections, possible danger of death during childbirth and recurring pain and trauma throughout one's life from sexual intercourse. The focus here is on preventing health problems caused by female genital mutilation rather than on invading the autonomy of others, because to do so would be culturally insensitive.

The collaboration of Health and Human Services, Centers for Disease Control and nongovernmental organizations is key to the success of the bill. Without the concerted efforts of these agencies and community-based organizations it will prove difficult if not impossible to educate communities about the dangers of female genital mutilation. Because female genital mutilation is insulated within communities it must be confronted on many levels if it is to be abolished. The combined resources of these governmental and nongovernmental agencies will increase the chances of eradicating the practice. In addition, it is vital that nongovernmental organizations and governmental agencies confer about encouraging women and men in these insular communities to open up dialogue where they can candidly discuss female genital mutilation. Health and Human Services, Centers for Disease Control and nongovernmental organizations should create support groups for women and men who wish to discuss the subject and the effect it has had on their lives. This can be achieved through roundtable discussions, lectures or one-on-one counseling sessions for those persons who are uncomfortable with disclosing such personal information. Furthermore, Health and Human Services, Centers for Disease Control and nongovernmental organizations must specifically address the provisions of the Immigrant Responsibility Act, particularly highlighting that the ritual is a crime in the United States punishable by incarceration, fines or both. In addition, immigrant communities

must be informed that cultural defenses are not recognized as legitimate reasons for performing the ritual.

Additionally, the law omits information on how the law will be funded. Staff at Health and Human Services have stated that no dollar amount has been allocated to fund this bill as of yet;⁸⁴ however, Health and Human Services states that the bill will be implemented with monies already in existence at the Office of Public Health. In order for this bill to serve its intended purpose, to abolish female genital mutilation, significant resources must be allocated to women who have undergone the ritual and to those women who are at risk of undergoing the practice. Money is needed for staff, educational materials for purposes of distribution, outreach workers who will be responsible for working inside immigrant communities, and for training Health and Human Services staff and outreach workers in dealing with victims and practitioners. Implementing a bill that requires educational instruction, counseling services and a public relations campaign could easily require millions of dollars. Without adequate monetary resources any attempts to abolish the practice of female genital mutilation will be short-lived. Moderate amounts of money will either be allocated to prevent the ritual or larger sums of money will be needed to cure patients who have contracted diseases, to treat victims suffering from trauma and to prosecute individuals for performing the practice. Adequate funding of this bill is crucial; it is an investment in the lives of future generations and it will send a message to the world that the United States is serious about abolishing harmful and unsanitary traditions. Because the practice is so devastating to millions of women, Health and Human Services should petition for funding from Congress and from the national government.

B. Lack of Cultural Competency Awareness in the Bill

The bill fails to recognize cultural challenges regarding the difficulty of infiltrating insular immigrant communities. Immigrant communities are counseled and in some instances warned not to discuss female genital mutilation.⁸⁵ As a result, it is very difficult to persuade victims and practitioners to openly engage in discourse

84. Telephone Interview with an anonymous staffmember, Office of Public Health, Health and Human Services (Feb. 2, 1997).

85. Fitnat Naa-Adjeley Adjetey, *Religious & Cultural Rights: Reclaiming the African Woman's Individuality: The Struggle Between Women's Reproductive Autonomy and African Society and Culture*, 44 AM. U.L. REV. 1351, 1378 (1995).

with members of the non-immigrant community due to possible mistrust, fear or repercussions and the discomfort with discussing such a personal issue. For this reason, the educational component of the bill is vital to its implementation. The purpose of the educational component goes beyond providing statistical data regarding medical complications and informing communities of the legal ramifications of disobeying the law. The educational component's primary purpose is to foster a greater understanding by immigrant communities of the emotional and physical risks of female genital mutilation on its female members.

Cultural norms such as female genital mutilation, however, cannot be changed without a concerted effort to attack the problem on legal, educational and social levels.⁸⁶ The place to start is at the local level by involving practitioners of female genital mutilation and victims of the practice in dialogues with governmental agencies, along with nongovernmental agencies and other community-based organizations serving as cultural and linguistic interpreters, mediators and support networks. It is only through this collaborative and culturally sensitive effort that practitioners and victims will likely feel free to discuss the subject of female genital mutilation.

In addition to collaborative action on the local level, it would also be helpful to have international human rights activists involved in educating immigrant communities. The more heads of state, prime ministers, presidents, ambassadors and scholars collectively condemning the age-old practice, the more expeditiously victims and practitioners will be able and willing to discuss and abolish the practice. Furthermore, education of grassroots women leaders in basic human rights is essential for re-orienting the thinking of indigent women and the ways in which they perceive their own roles in society.⁸⁷

Widespread educational campaigns to transform the thinking of traditional rulers and whole communities on women's human rights, generally, is an absolute prerequisite to make communities realize the possibility and the utility of change.⁸⁸ To effectively eradicate harmful traditional practices such as female genital mutilation, traditional rulers and religious leaders who have helped maintain these practices must be educated and encouraged to become agents of education and change.

86. *Id.* at 1353.

87. *Id.* at 1354.

88. *Id.*

C. Lack of Protection for Physicians and Patients

Finally, the bill fails to appreciate the uniqueness of the doctor-patient relationship including the doctor-patient confidentiality privilege.⁸⁹ By expecting doctors to report incidences of the ritual, the bill ignores the legal obligations that doctors have to hold a patient's medical history in confidence. In addition, if doctors report patients who have undergone genital mutilation, patients will be reluctant to seek further medical treatment. Moreover, should doctors decide to disclose such information, serious legal ramifications may result for physicians should patients decide to sue. Many patients seek medical attention because they believe that their medical history will be kept confidential. The one exception where the doctor-patient confidentiality privilege is waived is in instances of public safety.⁹⁰ If the patient's life or health is at risk, doctor's are allowed to disclose a patient's medical information.⁹¹

Instead of enlisting doctors as informants, where they would be required to report incidences of the ritual, their services would be better used as collaborators on a team to study the existence and

89. Several states have statutes that protect the doctor-patient relationship. Under Kansas law, the purpose of the physician-patient statute is to encourage persons needing medical aid to seek it without fear of betrayal; in other words, the privilege encourages free and frank disclosure between patient and physician to assist physician in proper diagnosis and appropriate treatment. *Bennett v. Feiser*, 152 F.R.D. 641 (Dist. Ct. Kansas 1994); Under Pennsylvania law, no physician shall be allowed, in any civil matter, to disclose any information which he acquired in attending the patient in a professional capacity, and which was necessary to enable him to act in that capacity, which shall tend to blacken the character of the patient, without consent of said patient, except in civil matters brought by such patient, for damages on account of personal injuries. *Ferrell v. Glen-Gery Brick*, 678 F. Supp. 111, 112 (E.D. Penn. 1987); see also *Miller v. Colonial Refrigerated Transportation Inc.*, 81 F.R.D. 741, 743 (M.D. Penn. 1979); Under District of Columbia law, a physician may not be permitted to testify (except by the consent of the patient or his legal representatives) as to any matter which has come to his knowledge strictly out of his professional relationship to the patient. This includes all knowledge or information acquired by him through disclosures made by the patient, as well as information obtained through his observation or examination of the patient and to all inferences and conclusions drawn therefrom. *Sher v. De Haven*, 199 F.2d 777, 779 (Dist. Columbia Cir. 1952). Under Texas law, the purpose of the privilege is to enable a patient to secure complete and appropriate medical treatment by encouraging candid communication between patient and physician free from the fear of possible embarrassment and invasion of privacy engendered by an unauthorized disclosure of information. *Horner v. Rowan Companies, Inc.*, 153 F.R.D. 597, 600 (S.D. Texas 1994).

90. See, e.g., *Bennett v. Feiser*, 152 F.R.D. 641 (Dist. Ct. Kansas 1994); *Ferrell v. Glen-Gery Brick*, 678 F. Supp. 111 (E.D. Penn. 1987); *Miller v. Colonial Refrigerated Transportation Inc.*, 81 F.R.D. 741 (M.D. Penn. 1979); *Sher v. De Haven*, 199 F.2d 777 (Dist. Columbia Cir. 1952); *Horner v. Rowan Companies, Inc.*, 153 F.R.D. 597 (S.D. Texas 1994).

91. *Id.*

perpetuation of the practice. Doctors could provide invaluable assistance in the educational component of outreach activities by explaining to victims and practitioners the medical dangers of female genital mutilation. By requiring doctors to report occurrences of the ritual, it places doctors in jeopardy of losing the trust and confidence of their patients, it decreases the likelihood of patients seeking medical attention, and it impedes the overall progress of the bill, to abolish the harmful traditional practice of female genital mutilation.

Conclusion

With the growing number of incidences of female genital mutilation in the United States, the Immigrant Responsibility Act is an important first step toward eradicating the brutal practice. It fails, however, to consider how the Act will be implemented, administered and funded. In addition, it is not culturally aware with regard to how Health and Human Services will infiltrate insular immigrant communities, and it places an unfair and impractical burden on doctors to report incidences of female genital mutilation. Only with specific recommendations to educate communities, develop culturally sensitive outreach activities and involve governmental agencies, community-based organizations, and individual health care providers in collaborative efforts against female genital mutilation, will the Act truly make an impact on the harmful practice.