

Case No. 07-2080

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IN THE UNITED STATES COURT OF APPEALS  
FOR THE FOURTH CIRCUIT

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ALIMA TRAORE  
Petitioner,  
v.

MICHAEL B. MUKASEY,  
U.S. ATTORNEY GENERAL,  
Respondent.

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On Petition for Review of an Order of  
the Board of Immigration Appeals

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BRIEF FOR AMICI CURIAE IN SUPPORT OF PETITIONER

ON BEHALF OF

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## OTHER AUTHORITY

- American Heritage Dictionary of the English Language* 1415  
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- Erika M. Baron & Florence L. Denmark, *An Exploration of Female Genital Mutilation*, 1087 *Ann. N.Y. Acad. Sci.* 339–55 (2006) ..... 21
- A. Behrendt & S. Moritz, *Posttraumatic stress disorder and memory problems after female genital mutilation*, 162 *Am. J. of Psychiatry* 1000 (May 2005)..... 18
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(July 9, 2004).

## STATEMENT OF INTEREST OF AMICI

*American College of Obstetricians and Gynecologists (“ACOG”)* is a non-profit educational and professional organization founded in 1951. With more than 49,000 members in the United States, ACOG is the leading professional association of physicians who specialize in the health care of women. ACOG opposes all forms of medically unnecessary surgical modification of the female genitalia. ACOG has developed guidelines and educational materials to assist its members in treating patients who have undergone FGM.

*Boston Center for Refugee Health and Human Rights (“BCRHHR”)* is a clinical center located within Boston Medical Center, providing comprehensive care to refugees, asylum seekers, asylees and victims of torture. The Center offers medical, mental, and dental care—coordinated with legal and social services—to over 300 individuals from over 50 countries each year. The Center is a member of the National Consortium of Torture Treatment Programs and operates as an interdisciplinary collaboration among clinicians and experts from Boston Medical Center (Departments of Psychiatry, Departments of Obstetrics and Gynecology, Medicine, Family Medicine, Pediatrics, Social Work, and Interpreter Services), Boston University (Schools of Medicine, Public Health, Dentistry, and Law), Global Lawyers and Physicians—a non-governmental

organization, and the National Center for Post-Traumatic Stress Disorder. The Center was founded in 1998 to provide comprehensive health care for refugees and survivors of torture and related trauma, to educate and train agencies and professionals who serve this patient population, to advocate for the promotion of health and human rights in the United States and worldwide, and to conduct clinical, epidemiological, and legal research for the better understanding and promotion of health and quality of life for survivors of torture and related trauma.

*Global Lawyers and Physicians (“GLP”)* is a non-profit non-governmental organization, founded in 1996, that focuses on health and human rights issues. GLP was formed to reinvigorate the collaboration of the legal, medical, and public health professions to protect the human rights and dignity of all persons, and is founded on the premise that people collaborating in these professions can be a much more effective force for human rights than either profession working separately. The organization works at the local, national and international levels with NGOs and governments on the implementation of the health-related provisions of international law obligations, with a focus on health and human rights, patient rights and patient experimentation.

*Michael A. Grodin, M.D.*, is a psychiatrist and Professor of Bioethics, Human Rights, Philosophy, and Psychiatry at Boston University,

specializing in the treatment of refugees and persons suffering from trauma. He has treated, supervised, or consulted on the treatment of more than 1000 patients, and personally treated fifteen FGM survivors.

***Kelley Saia, M.D.***, is a board certified obstetrician and gynecologist at Boston Medical Center, an instructor of Obstetrics and Gynecology at Boston University, and an Obstetrician and Gynecologist for the BCRHHR. She specializes in caring for female survivors of rape and torture and has personally cared for and treated over 80 women who have been subjected to FGM.

***Sondra Crosby, M.D.***, is a general internist and Associate Professor of Medicine at Boston University, specializing in the treatment of refugees. She has personally treated, supervised and consulted on the treatment of over 1500 patients, 75 of whom suffered problems as a consequence of having undergone FGM.

### **SUMMARY OF ARGUMENT**

*Amici curiae* submit this brief in support of reversal of the decision of the Board of Immigration Appeals (“BIA”), in order to explain the medical, legal, and factual errors in the BIA’s determination that past female genital mutilation (“FGM”) does not cause ongoing or future harm.

In this case, the BIA denied refugee protection to a woman whose entire clitoris and vulva were removed.<sup>1</sup> She suffered, continues to suffer, and in the future is likely to suffer a variety of debilitating physical and psychological harms in Mali that are the natural and intended result of being subjected to FGM. As a result of undergoing FGM as a child, Ms. Traore suffers painful intercourse, emotional trauma, and sexual dysfunction in the form of mental and physical scars she will bear throughout her life. Were she to be removed to Mali, her psychological and emotional scars would be exacerbated by proximity to the people who committed the act and the society and government which permitted it. Moreover, Ms. Traore would likely suffer additional harm if she bore children in Mali, as would the children themselves. (Their births would likely be complicated by her FGM.) Significantly, in Mali, Ms. Traore would be unable to treat these ongoing and future harms, which would be exacerbated in Mali.

The BIA incorrectly found that for a woman who has suffered past FGM, the presumption of a well founded fear of persecution is generally

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<sup>1</sup> As indicated in the medical report submitted with the record. *Amici*, medical doctors themselves, find the use of the anatomical term “vulva” by Ms. Traore’s examining physician to be non-specific, and assume from the examination report that the FGM carried out on Ms. Traore constituted partial or extensive excision of the vulvar tissue, in addition to excision of the clitoris and clitoral hood.

overcome because FGM cannot be repeated. In distinguishing forced sterilization from FGM, the Board incorrectly argued that Congress carved out a statutory exception for forced sterilization claims due to the nature of harm entailed, while no such exception was made for past FGM claims. The Board went on to devise a medically inappropriate and legally unfounded analogy, comparing FGM to the severing of a limb.

The Board's analysis is legally and morally wrong. It deprives victims of past FGM the right to seek asylum on those grounds. Its analysis is also inconsistent with Congress's purpose in criminalizing FGM in the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, and requiring all visa applicants to be made aware of the impacts and consequences of FGM. *See* 63 Fed. Reg. 13,433-04 (Mar. 19, 1998). Then INS explicitly recognized both the short and long term health consequences of past FGM:

The World Health Organization and other United Nations organizations, as well as the United States Government, recognize that FGM has very serious effects on the health of women and girls. . . . Long-term consequences of FGM include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, painful intercourse, and sexual dysfunction. The most extreme forms of FGM can cause infertility, and may also cause an increase in the risk of stillbirths and maternal deaths.

Psychological consequences of FGM in childhood can include behavior disturbances and loss of trust and confidence in caregivers. As adults, these women may suffer feelings of

incompleteness, anxiety, depression, chronic irritability, and frigidity, and may experience marital conflicts.

63 Fed. Reg. at 13,434. Clearly, the government agency responsible for regulating immigration matters and asylum has long been aware of the ongoing and future health problems that follow FGM.

In short, *amici*, organizations and medical doctors (gynecologists, obstetricians, internists, and psychiatrists) and clinical psychologists who regularly treat women subjected to FGM, or are otherwise familiar with the harms arising from it, wish to clearly set forth the multitude of well-documented ongoing and consequent harms these women suffer.

Specifically, *amici* will set forth the physical and psychological harms FGM causes women and their infants. All of these consequences are consistent with Ms. Traore's explanation of how FGM continues to affect her. Further, *amici* argue that should Ms. Traore be removed, she could not find treatment for the serious and life threatening medical conditions that arise from her past FGM.

## ARGUMENT

### **I. The Board Erred in Concluding that Having Already Been Subjected to FGM, Ms. Traore No Longer Has a Well-Founded Fear of Persecution**

The Board erroneously concluded that victims of FGM are not entitled to a presumption of future persecution on the basis of their past FGM. It reached this decision without analyzing Ms. Traore's specific circumstances.

#### **A. The IJ and Board Erred in Failing To Ascertain the Future Harm Faced by Ms. Traore on Account of FGM on This Petitioner.**

On direct examination during the hearing, the Petitioner was asked, "Are there any effects or problems presently because of that circumcision to you?" She responded "yes," but was immediately cut off by the Immigration Judge ("IJ") who found the question irrelevant. (A126:17–22.) Nevertheless, in her affidavit, Ms. Traore describes that genital cutting left her "with both physical and mental scars that [she] will bear for all [her] life. [She] will have complications at childbirth, and sexual intercourse is painful and devoid of pleasure. . . . This is something that [she] cannot change, but it has become a motivation not to endure [her] family's degrading customs." (A307.) A letter from a medical doctor who examined her describes that FGM left Ms. Traore with a "complete absence of clitoris and vulva which have been surgically excised." (A182.) The IJ failed to properly consider the evidence of the devastating continuing and future impacts of FGM on

Ms. Traore.<sup>2</sup> The Board then failed to properly assess this omission and erroneously concluded that victims of FGM, generally, are not entitled to a presumption of future persecution on the basis of their past FGM.

On the basis of the erroneous conclusion, the Board wrongly concluded that past FGM precludes Ms. Traore's ability to establish future harm.

**B. The Board Erred in Finding that Past FGM Yields No Future Harm, and that the Act of FGM Itself Rebutts a Presumption of Future Harm.**

Rather than making a determination based on the evidence, as the regulations require, 8 C.F.R. § 1208.13(b)(1)(i-ii), the Board “assume[d] arguendo that [Ms. Traore] is a member of a particular social group who has suffered past persecution.” *In re A-T-*, 24 I. & N. Dec. 296, 299 (B.I.A. 2007). Because the Board never made a finding as to Ms. Traore's social group, it failed to consider whether her continued status in that social group renders her vulnerable to future harm.<sup>3</sup>

Had it properly assessed Ms. Traore's individual claim, the Board would not have applied its inappropriate severed “limb” analogy, *In re A-T-*, 24 I. & N. Dec. at 301. Instead it would have considered—as discussed

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<sup>2</sup> FGM is committed with the purpose of abating a woman's sexuality throughout her life, as will be discussed in this brief.

<sup>3</sup> See Ms. Traore's brief on appeal to the Fourth Circuit.

below—that FGM is one element of an array of gender-based oppression to which Ms. Traore will be subject upon return, based on her social group membership. To the degree that the severed limb analogy has any relevance, the Board should have considered that even the severing of a limb is evidence that its victim could again be targeted by his or her persecutors. The regulations require a case by case, contextualized analysis of conditions relevant to the applicant’s circumstances when determining whether changed circumstances exist. *See* 8 C.F.R. § 1208.13(b)(1)(i)(A). In Ms. Traore’s case, however, the Board made a blanket assumption that in the case of past FGM, changed circumstances exist. Finally, the Board does not consider whether those persecutors, in severing limb or clitoris and vulva, only intended to inflict harm for that moment, or indefinitely throughout the victim’s life.

FGM is not performed solely for the purpose of cosmetically altering the genitals, but rather to control the chastity, lifelong sexuality and social and cultural behavior of the girl on whom it is performed. C. Braddy, MD & J. Files, MD, *Female Genital Mutilation: Cultural Awareness and Clinical Considerations*, 52 *J. of Midwifery & Women’s Health* 158 (Mar./Apr. 2007) [hereinafter *J. of Midwifery & Women’s Health*].<sup>4</sup> FGM is not performed

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<sup>4</sup> *J. of Midwifery & Women’s Health* at 159-60 (“the specific rationale for the practice [is] maintaining virginity and fidelity,” “for social and sexual

with the intent of a one-time cutting of a girl, but—crucially—to control the woman she becomes.

## **II. The Board Erred in Failing To Properly Consider Well-Established Medical Findings Already Recognized by Courts and the BIA, Regarding the Continuing and Future Harms Caused by Past FGM**

The Board failed to consider the extensive medical information regarding the reasons for inflicting FGM, as well as the practice’s long-term effects. This is a crucial omission, given that the Board and numerous federal courts have recognized that FGM can serve as the basis of an asylum claim, whether a woman fears future FGM or has already been subjected to FGM and has a presumptive well-founded fear of further harm.<sup>5</sup>

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control of women, to decrease sexual pleasure for women while enhancing sexual pleasure for men.”).

<sup>5</sup> See, e.g., *In re Kasinga*, 21 I. & N. Dec. 357 (B.I.A. 1996); *Hassan v. Gonzales* 484 F.3d 513, 517-19 (8th Cir. 2007) (finding that past FGM created presumption that alien possessed well-founded fear of future persecution and remanding to shift burden to DHS to show changed conditions); *Niang v. Gonzales*, 422 F.3d 1187, 1197, 1202 (10th Cir. 2005) (explaining that FGM constitutes persecution and remanding to agency to consider alien’s asylum claim); *Mohammed v. Gonzales*, 400 F.3d 785, 795, 802 (9th Cir. 2005) (same); *Balogun v. Ashcroft*, 374 F.3d 492, 499, 507-08 (7th Cir. 2004) (noting FGM constitutes persecution under the INA but affirming denial of asylum claim on credibility grounds); *Abay v. Ashcroft*, 368 F.3d 634, 638, 643 (6th Cir. 2004) (explaining that FGM “involves the infliction of grave harm constituting persecution on account of membership in a particular social group that can form the basis of a successful claim for asylum” and remanding to agency to consider eligibility for asylum and withholding).

There are four types of FGM. *World Health Organization (“WHO”) Factsheet* [hereinafter *WHO Factsheet*].<sup>6</sup> Type I consists of the excision of the prepuce (skin covering the clitoris) with partial or total clitoridectomy (removal of the clitoris). Type II, the most common, consists of clitoridectomy and partial or total excision of the labia minora. This is the form Ms. Traore most likely suffered, given her doctor’s assertion that her clitoris and vulva had been entirely removed. Type III, also called infibulation, is the most extreme form of FGM, and consists of clitoridectomy, excision of the labia minora and labia majora, and the sewing together of remaining tissue to form a small hole for the passage of urine and menses. Type IV refers to all types of FGM that do not fit into the first three categories, and can include cauterization of tissue or the introduction of corrosive substances or herbs into the vagina to cause tightening or narrowing. *WHO Factsheet*. Neither the IJ nor the Board made any reference to the medical facts contained in the record regarding the physical and psychological consequences of FGM.

**A. FGM Is Not a Discrete Act, but Is Carried Out with the Purpose of Limiting a Woman’s Autonomy Throughout Her Life.**

It is well established that FGM is not a discrete act carried out for the sake of cosmetic alteration. To the contrary, FGM is incorrectly believed by

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<sup>6</sup> Available at <http://www.who.int/mediacentre/factsheets/fs241/en>.

some Muslim communities to be “sunna,” an act prescribed by the prophet Mohammed. H. Rushwan, *Female Genital Mutilation Management During Pregnancy, Childbirth and the Postpartum Period*, 70 *Int’l J. of Gynecology & Obstetrics* 99–104 (2000) [hereinafter *Int’l J. of Gynecology & Obstetrics*]. Communities which practice FGM do so for the following stated reasons: enforcing virginity and controlling chastity and fidelity (because sex is painful for cut girls), securing marriage prospects within the prescribed group (because men expect to have sex with a woman who has had her external genitalia removed), and to increase her future husband’s sexual pleasure. *Id.*

The reasons families give for performing FGM on girls include psychosexual<sup>7</sup> reasons. By eliminating or reducing the sensitive tissue of the outer genitalia, particularly the clitoris, families believe they will diminish or extinguish sexual desire in girls, thereby insuring their chastity and virginity before marriage, and maintaining and securing their fidelity during marriage. *WHO Factsheet*. Where young women are cut so that they feel (and seek) less sexual pleasure, their future husbands feel more secure in their belief that the children born to them are indeed their own. The Board understands that FGM is committed for the purpose of maintaining the

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<sup>7</sup> Psychosexual means “of or relating to the mental and emotional of sexuality.” *American Heritage Dictionary of the English Language* 1415 (4th ed. 2000).

chastity of a woman, and controlling her sexual, social and familial fidelity. *Int'l J. of Gynecology & Obstetrics*. Nonetheless, in this case, the Board erroneously considered only whether the identical form of persecution—the excision of a clitoris and vulva—could once again be inflicted upon Ms. Traore. A proper inquiry would have led the Board to consider the myriad present, continuing and future harms to which Ms. Traore is vulnerable and continues to suffer based on her past FGM.

**B. Serious Continuous, Ongoing and Future Medical Harms Arise from Past FGM**

A multitude of severe continuous and future harms arise from past cutting, plaguing women at various stages of their lives: after the cutting, at puberty, when sexually active and at childbirth. *J. of Midwifery & Women's Health*. These harms include structural damage as well as increased risk of infection, disease, and infertility.

For example, women who have undergone Types I and II experience periurethral tears (tears in the lining of the urethra) because the urethral meatus (opening) is frequently injured during the FGM procedure and later during labor and delivery. *J. of Midwifery & Women's Health* at 160. The urethral meatus can be blocked by scar tissue, which can lead to the accumulation of urine and menstrual blood, facilitating the entry of bacteria into the urinary tract. *Id.* at 161. Long-term urinary health issues for women

who have undergone FGM also include urethral strictures, meatal obstruction, chronic UTI's, meatitis (inflammation of the opening of the urethra), and urinary crystals. Nawal M. Nour, MD, MPH, *Female Genital Cutting: Clinical and Cultural Guidelines*, 54.4 Obstetrical & Gynecological Survey 272–79 (2004) [hereinafter *Obstetrical & Gynecological Survey*].

The formation of epidermal inclusion cysts is another common long-term complication associated with FGM. These cysts may progressively expand over time and can range in size from several centimeters to the size of the head of a fetus. They may become infected and require drainage and/or surgical removal. *J. of Midwifery & Women's Health* at 161.

Chronic pelvic infections and pelvic inflammatory disease result from the progression of acute infections and/or poor wound healing at the time of the FGM and can lead to infertility. *Id.* Other treatable infections commonly found in women who have undergone FGM include recurrent vaginal candidiasis (fungal infection in the vagina), trichomoniasis (parasitic disease in the vagina) and bacterial vaginosis (bacterial disease in the vagina). *Id.*

FGM is also linked to transmission of HIV. *Journal of Midwifery & Women's Health* at 161. Because the vaginal opening is reduced in size, especially with Type III FGM, increased bleeding, inflammation, or abrasions due to sexual intercourse facilitate the transmission of HIV. *Id.*

HIV is also a concern due to the questionable adequacy of the blood supply screening processes in many African countries. Women who have suffered FGM endure increased complications in childbirth, resulting in a greater need for blood transfusion at that time. *Id.* HIV can also be transmitted perinatally, from mother to unborn baby. *Id.*

Women subjected to FGM have a multitude of associated local and pelvic pain. *Obstetrical & Gynecological Survey* at 275. The obstructed vaginal environment encourages overgrowth of pathogens (diseases which cannot escape the obstructed vagina) such as candida and bacterial vaginosis. *Id.* Foreign bodies and neuromas (tumors in the cut nerves) can also form under the scar leading to severe point tenderness. *Id.* Sixty-five percent of cut women suffer severe dysmenorrhea (painful menstrual cycles) due to obstructed vaginal outflow of menstrual fluid. *Id.*

Additional long-term complications of FGM include a variety of scarring which causes pain and medical complications, such as fibrosis, keloids (hardened tissue), partial fusion, complete fusion, hematocolpos (accumulation of menstrual blood in the vagina), inclusion/sebaceous cysts (fluid filled sacs), and vulvar abscesses (open wounds). *Obstetrical & Gynecological Survey* at 274. Such scars can lead to debilitating keloids that interfere with daily activity, such as walking and dressing. Scarring from all types of FGM can also form partial or complete labial fusion. These scars

can obstruct the vaginal opening and become painful cysts or abscesses requiring complete surgical excision and “deinfibulation” (surgical re-opening of the hardened scar tissues). *Id.* at 275. As documented in her affidavit, and as Ms. Traore attempted to explain in court before being stopped short by the IJ, the cutting she suffered has left her with physical effects that she will bear for life.

**C. Serious Continuing and Future Psychological Harms Arise from Past FGM.**

Extensive evidence exists linking past FGM with ongoing and future psychological harm. Psychological harm resulting from past FGM includes: post-traumatic stress disorder (“PTSD”), anxiety, depression, fear of sexual intercourse, and suicide from inability to consummate marriage due to the pain of intercourse. United Nations Children’s Fund, *Eradication of Female Genital Mutilation in Somalia* [hereinafter *UNICEF*].<sup>8</sup> These psychological effects “are a consequence of the trauma of the procedure and the short- and long-term physical complications that ensue.” *UNICEF*.

Undergoing FGM leaves a lasting mark on the life and mind of a girl. The psychological complications may be submerged deep in the child’s subconscious and may trigger behavioral disturbances. In the longer term, women may suffer feelings of incompleteness, anxiety, depression, loss of

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<sup>8</sup> Available at [http://www.unicef.org/somalia/SOM\\_FGM\\_Advocacy\\_Paper.pdf](http://www.unicef.org/somalia/SOM_FGM_Advocacy_Paper.pdf).

trust, chronic irritability and fear of intimacy. Many women and girls, traumatized by their experience but with no acceptable means of expressing their fears, suffer in silence. Womenaid International, *Female Genital Mutilation Information Paper* [hereinafter *Womenaid*].<sup>9</sup>

When a child is mutilated by adults as part of a community-sanctioned practice, the procedure constitutes a sexual assault because the child does not understand it, has no control over it, and cannot consent to it. Janet Menage, *Psychological Damage Is Immense*, 333 *British Med. J.* 260 (July 2006) [hereinafter *British Med. J.*].

For many girls, genital mutilation is a major cause of later experiences of fear, submission, inhibition, and suppression of feelings and thought. *British Med. J.* at 260 (citing WHO, *Female Genital Mutilation, Report of a WHO Technical Working Group* 10 (1996)).

This experience becomes a vivid landmark in their mental development, the memory persisting throughout life. For some, nothing they have subsequently gone through, including pain and stress in pregnancy, has come close to the painful experience of genital mutilation. Their tension and tears reflect the magnitude of emotional pain they silently endure at all times; the resulting loss of confidence and trust in family and friends can affect the child-parent relationship and has implications for future intimate relationships between the adult and her own children.

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<sup>9</sup> Available at <http://www.womenaid.org/press/info/fgm/fgminfo.htm>.

*Id.* (citing WHO, *Female Genital Mutilation, Report of a WHO Technical Working Group* 10 (1996)).

It is clear that women who have been subjected to FGM suffer a significantly higher prevalence of PTSD and other psychiatric syndromes than uncut women. A. Behrendt & S. Moritz, *Posttraumatic stress disorder and memory problems after female genital mutilation*, 162 *Am. J. of Psychiatry* 1000 (May 2005). If removed to Mali, proximity to those who either performed or sanctioned the cutting would exacerbate Ms. Traore's fears and psychological wounds.

**D. Severe Sexual Dysfunction Arises from Past FGM.**

FGM often results in ongoing and future sexual dysfunction, which is consistent with Ms. Traore's experience that sexual intercourse is "painful and devoid of pleasure." (A307.)

FGM frequently results in keloid scar formation and damage to the urethra, resulting in urinary incontinence, painful sexual intercourse, and hypersensitivity of the genital area, all of which can be physical causes of sexual dysfunction. United Nations Population Fund, *Calling for an End to Female Genital Mutilation/Cutting* [hereinafter *UNFPA*].<sup>10</sup>

FGM also interferes with women's sexuality. Socio-psychological aspects of body image form a complex pattern of self knowledge and how

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<sup>10</sup> Available at <http://www.unfpa.org/gender/practices1.htm>.

one is perceived by others. *British Med. J.* at 178–81. The disfiguring and mutilating operations to the genitals and reproductive organs frequently have a deleterious effect on a woman’s self image and sexuality. *Id.* Women who have been subjected to FGM often develop vaginismus, a physiological response following genital or sexual trauma causing involuntarily flexing of vaginal muscles such that vaginal penetration cannot occur. *Id.* Anxiety, fear, depression, and problems with non-consummation of marriage are common years after FGM. *Id.*

Moreover, repressed memories of the traumatic cutting often surface, creating sexual dysfunction due to feelings of anger, helplessness, and fear. Dyspareunia (painful intercourse), infertility, and anorgasmia (inability to achieve orgasm) may also result. D. Woolard & R. Edwards, *Female Circumcision: An Emerging Concern in College Healthcare*, 45.5 J. of Am. Coll. Health 230 (Mar. 1997).

**E. FGM Increases Risks to Mother and Child in Childbirth.**

When a woman who has undergone FGM gives birth, both mother and child are at greater risk of life-threatening complications. Past FGM creates a substantially higher risk for cesarean section, postpartum hemorrhage, episiotomy (cutting between vagina and anus), extended maternal hospital stay, need for resuscitation of the infant, and stillbirth or early neo-natal death than exists for births to women who have not undergone FGM. WHO,

*Eliminating Female Genital Mutilation* 11 (2008)<sup>11</sup> [hereinafter *Eliminating Female Genital Mutilation*]; *J. of Midwifery & Women's Health* at 161. The risks of dying in childbirth are substantially increased for women who have been subjected to FGM, as well. WHO, *Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries* 6 (2006) [hereinafter *WHO African Study*].<sup>12</sup>

Women who have been subjected to FGM can have a prolonged second stage of labor due to the scar tissue surrounding the perineum. This, in turn, increases the risk of birth trauma to the infant. “The infibulated scar does not interfere with stage I of labor, [but it] significantly prolongs stage II by inhibiting fetal descent.” *Obstetrical & Gynecological Survey* at 275. “The presence of scar tissue, which is less elastic than the perineal and vaginal tissue would normally be, might cause differing degrees of obstruction and tears or episiotomy.” *WHO African Study*, at 6. A prolonged or obstructed second stage of labor can lead to an increased need for infant resuscitation and an increased risk of neonatal injury or death. *Obstetrical & Gynecological Survey* at 275; *Eliminating Female Genital Mutilation* at 11. The number of miscarriages also increases, perhaps due to upper genital

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<sup>11</sup> Available at [http://www.who.int/reproductive-health/publications/fgm/fgm\\_statement\\_2008.pdf](http://www.who.int/reproductive-health/publications/fgm/fgm_statement_2008.pdf).

<sup>12</sup> At <http://www.who.int/reproductive-health/publications/articles/lancetfgm.pdf>.

tract infections and urinary fistula formations (tears or abnormal formations in urinary tract) which can cause urine to seep into the female organs. Erika M. Baron & Florence L. Denmark, *An Exploration of Female Genital Mutilation*, 1087 Ann. N.Y. Acad. Sci. 339–55 (2006).

The risk of bearing an infant who requires resuscitation at delivery or suffers perinatal death is significantly higher for mothers who have suffered Type II or III FGM than for those who have not. *WHO African Study* at 1838. The number of perinatal infant deaths in Mali is 115 per 1000 births, as compared to the United States, which is 6.85 per 1000 births. *Id.* at 1839. This is an increase of 1 to 2 additional perinatal deaths per 100 deliveries where the mother has suffered FGM. *Id.* at 1841. These outcomes suggest that the substantially increased risk to infants during childbirth is linked to FGM-related complications such as hardened scar tissue formations and increased likelihood of urinary tract and vaginal tears. *Id.* at 1840.

Infants born to women who have undergone FGM are also substantially more likely to contract HIV. As discussed in section II.B, *supra*, the increased likelihood of FGM-related complications necessitating blood transfusion during a baby's birth increases its risk of HIV infection from a poorly-screened blood supply. *Obstetrical & Gynecological Survey* at 162.

### **III. Medical Facilities in Mali Are Not Adequate for Treating the Future Harms Ms. Traore Would Likely Suffer There**

If removed to Mali, neither Ms. Traore nor her future children would receive sufficient care for complications caused by her FGM. The complete lack of sufficient or adequate health care centers, medical professionals, and pharmaceuticals in Mali make it difficult to receive treatment for even common ailments. The quality of obstetric and gynecological care is very low. Int'l Insulin Found., *Mali's Health System* [hereinafter *Int'l Insulin Found.*]<sup>13</sup>.

The pyramidal health care system in Mali, which requires patients to be treated in small clinics before ever being treated at a hospital, is insufficient. Only 30% of the population has access to health care, and many of those who do receive care obtain it at expensive private facilities. *Int'l Insulin Found.*

In practice, the majority of clinics and resources are in Bamako, and the regional hospitals and clinics vary greatly in accessibility and distance. There is an average of one clinic per 20,593 people, and fewer than 10,000 hospital beds in the country.<sup>14</sup> *WHO Factsheet Mali 2006*. Furthermore, maternal and child care is exclusively performed by clinics, mostly at the

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<sup>13</sup> Available at [www.access2insulin.org/html/mali\\_s\\_health\\_system.html](http://www.access2insulin.org/html/mali_s_health_system.html).

<sup>14</sup> By contrast, the United States aimed in the year 1960 to provide 4–5 hospital beds per 100 persons. Roemer, *Distribution of Hospital Beds in the United States*, 1 J. of Health & Hum. Behav. 94-101 (1960).

hands of NGOs, and is rarely referred to the hospitals. Seydou Coulibaly & Kafing Diarra, *Financing of Recurrent Health Costs in Mali*, 5.2 *Oxford J. of Health Pol'y & Planning* 126–38 (1990) [hereinafter *Oxford J. of Health Pol'y & Planning*].

There are only 1053 doctors in Mali, which is one doctor for every 12,500 patients. The average for other countries in this region of Africa is one doctor for every 4,608 patients. *WHO Factsheet Mali 2006*. There are also very limited resources available for childbirth, with only 573 midwives in the country. *Id.* These midwives are often traditional practitioners who have been trained in hygiene and sterilization by NGOs, but are not medically qualified to handle obstetric emergencies. Canadian International Development Agency [CIDA], *Relief for Health Care in Mali*.<sup>15</sup>

While accessibility to healthcare and drugs is limited in general, the resources available specifically for women's care are worse. The drugs needed to treat common long-term effects of FGM, like urinary and vaginal infections, are hard to find. G. Hutton, *User Fees and Other Determinants of Health Service Utilization in Africa*, Swiss Tropical Institute (2002). An estimated 25% of women who have been subjected to FGM in Mali die due to these infections. Having undergone the procedure doubles the risk of

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<sup>15</sup> Available at <http://www.acdi-cida.gc.ca/CIDAWEB/acdicida.nsf/En/NAT-63010109-JME>.

death in childbirth. UK Dep't for Int'l Dev., *The Impact of FGM*, Developments Magazine.<sup>16</sup>

In one study of the moderately sized rural town Kouitala, one hundred women in need of obstetric care died in 1999 because they could not reach a hospital. *Oxford Health Policy Plan 2004*, vol. 19 supp. 1, i87–i95 (Oxford Univ. Press 2004).

Childbirth is a dangerous procedure in Mali. Out of every 100,000 births, 1,200 women die from complications, which is significantly higher than the average in this region of Africa. The childbirth mortality rate has *increased 52%* since 1995, and only 41% of births are attended by a “skilled health care professional.” *WHO Factsheet Mali 2006*. Childbirth in Mali, among women who have undergone FGM, is complicated by unsterile techniques and FGM-related bleeding, which increases the risks of contracting HIV, tetanus, local and systemic infections, particularly when de-infibulation (cutting the scar tissue open) is necessary to allow the infant to pass through the vaginal opening. *Id.* Sixty-eight of every thousand babies die due to neonatal causes. *Id.*

One study found that one-quarter of the Malian women studied had labor complications, with women experiencing episiotomies and perineal

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<sup>16</sup> Available at <http://www.developments.org.uk/articles/the-impact-of-fgm/?searchterm=sex>.

tears. H. Jones et al., *Female Genital Cutting Practices in Burkino Faso and Mali and Their Negative Health Outcomes*, 30.3 *Studies in Family Planning*, 219–30 (Sept. 1999). This study also recorded non-childbirth related complications. Fifty-two percent of women in Mali experience hemorrhage from the scar tissue caused by FGM. Thirteen percent have stenosis (abnormal narrowing of urethra or vagina), 7% have a keloid or dermoid cyst, 8% have a vaginal obstruction, and 5% experience urinary incontinence. Genital infection rates were not available in Mali, but a concurrent study by the same scientists found that 72% of women in the same geographical region with Type II FGM will have a genital infection.

*Id.*

**IV. The Board Erred in Failing To Consider the Expanding Recognition by Courts that FGM Is Not a Discrete Event, but Rather Is an Act Carried Out with the Objective of Impacting the Women on Whom It Is Practiced in Lasting Physical, Psychological, and Sexual Ways**

Multiple federal circuit courts and the BIA have granted review of petitions for asylum based on the long-term physical and psychological effects of FGM. The BIA addressed the practice of FGM as a basis for asylum in *In re Kasinga*, 21 I. & N. Dec. 357 (B.I.A. 1996), and in granting relief specifically considered the long term effects, ruling that FGM

permanently disfigures the female genitalia. FGM exposes the girl or woman to the risk of serious, potentially life-threatening complications. These include, among others, bleeding,

infection, urine retention, stress, shock, psychological trauma, and damage to the urethra and anus. It can result in permanent loss of genital sensation and can adversely affect sexual and erotic functions.

21 I. & N. Dec. at 361.

The Fourth, Sixth, Ninth, and Tenth Circuits have followed the BIA's lead, citing to *In re Kasinga*. In *Mohammed v. Gonzales*, 400 F.3d 785 (9th Cir. 2005), in considering the BIA's denial of a Motion to Reopen based on the petitioner's past FGM, the Ninth Circuit acknowledged the short and long-term physical and psychological consequences of FGM, citing to United States law criminalizing FGM and *In re Kasinga*. The Court found that "persecution may be emotional or psychological, as well as physical" and that "the extremely painful, physically invasive, psychologically damaging and permanently disfiguring process of genital mutilation undoubtedly rises to the level of persecution." *Mohammed*, 400 F.3d at 795–96 (citations omitted). The court then went on to compare FGM to forced sterilization citing *Qu v. Gonzales*, 399 F.3d 1195 (9th Cir. 2005) and *In re Y-T-L-*, 23 I. & N. Dec. 601 (B.I.A. 2003). Specifically:

Like forced sterilization, genital mutilation permanently disfigures a woman, causes long term health problems, and deprives her of a normal and fulfilling sexual life . . . even the least drastic form of female genital mutilation can cause a wide range of complications such as infection, hemorrhaging from the clitoral artery during childbirth, formation of abscesses, development of cysts and tumors, repeated urinary tract infections, and pseudo infibulation. Many women subjected to

genital mutilation suffer psychological trauma. In addition, it can result in permanent loss of genital sensation and can adversely affect sexual and erotic functions. Thus, [i]n addition to the physical and psychological trauma that is common to many forms of persecution [female genital mutilation] involves drastic and emotionally painful consequences that are unending.

*Mohammed*, 400 F.3d at 799–800 (alterations in original) (citations, internal quotation marks, and footnote omitted). The court found that the multitude of physical and psychological consequences were sufficient to show that FGM is a permanent and continuing act of persecution that “cannot constitute a change in circumstances sufficient to rebut the presumption of a well-founded fear.” *Id.*

Both the Sixth and Ninth Circuits have recognized the physical and psychological effects of FGM on children. In both *Abay v. Ashcroft*, 368 F.3d 634 (6th Cir. 2004) and *Abebe v. Gonzales*, 432 F.3d 1037 (9th Cir. 2005), parents petitioned for asylum in an effort to avoid returning to Ethiopia where FGM is “nearly universal.” *Abay*, 368 F.3d at 639 (quotation marks omitted). Each court emphasized the permanent consequences of FGM. With the percentage of those inflicted being so high (90% of women are subjected to FGM in Ethiopia), both courts granted the petitions for review.

Additionally, in *Niang v. Gonzales*, 422 F.3d 1187 (10th Cir. 2005), the petitioner filed a petition for review of the BIA’s denial of asylum.

Niang sought asylum on the ground that she had suffered past persecution—FGM—in Senegal. *Id.* at 1192. Due to FGM, she could no longer have normal sexual relations and her marriage in the United States had fallen apart as a result. *Id.* Her family in Senegal also informed her that if she returned, she would be murdered as an adulteress. At the asylum hearing, a doctor testified that she had been a victim of FGM and that she would not be able to conceive or deliver children naturally or even engage in normal intercourse due to the permanent injuries from the mutilation. *Id.* The Tenth Circuit took the doctor’s findings into consideration and cited previous cases (i.e., *In re Kasinga* and *Mohammed*), which recognized the permanent physical and psychological consequences of FGM. It reversed and remanded. Finally, the Fourth Circuit in *Haoua v. Gonzales*, 472 F.3d 227 (4th Cir. 2007) granted a petition for review for a woman from Niger based on the permanent psychological and physical consequences recognized in *In re Kasinga*. *See also Hassan v. Gonzales*, 484 F.3d 513 (8th Cir. 2007).

Until this case, the Board had granted protection to women who suffered past FGM. In *In re Anon.*, 34 Immig. Rptr. B1-22 (Aug. 8, 2006) (Tab 1), the BIA granted asylum to a woman forced to submit to an arranged marriage and subjected to FGM, recognizing that her “experiences clearly had a profound and lasting impact” on her, citing the Ninth Circuit’s decision in *Mohammed v. Gonzales*. In *In re Anon.*, 27 Immig. Rptr. B1-93

(May 23, 2003) (Tab 2), the BIA rejected the IJ's finding that FGM was a one-time occurrence and that the respondent would not face future harm were she to return to Nigeria, and granted her asylum. Disagreeing with the IJ, the BIA stated that "[f]orced female genital mutilation is better viewed as a permanent and continuing act of persecution that has permanently removed from a woman a physical part of her body, deprived her of the chance for sexual enjoyment as a result of such removal, and has forced her to potential medical problems relating to this removal." Based on the respondent's well-founded fear of persecution upon returning to Nigeria, the BIA awarded her asylum. The BIA in *In re Jainaba Awumme Quist*, 29 Immig. Rptr. B1-68 (July 9, 2004) (Tab 3), also utilized this basis for asylum. Citing *In re Kasinga*, the BIA recognized that FGM "results in permanent disfiguration and poses a risk of serious, potentially life-threatening complications." Based on those consequences and the respondent's fear of returning to Gambia and being subjected to FGM, the BIA granted her asylum.

## **CONCLUSION**

Prior to the BIA's decision below, the federal courts and the BIA itself had acknowledged FGM to be an act which causes lasting and future physical, psychological, and sexual harms to the women and girls who are subjected to it. Now, with this case, the Board has changed course and concluded that while the risk of future FGM is grounds for asylum, past

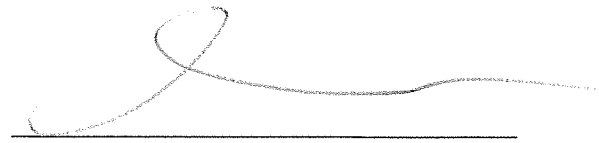
FGM is not. In so concluding, the Board incorrectly characterized FGM as a one-time discrete act. All previous rulings, and the widely available medical facts clearly establish that the act of FGM is not a discrete act, but rather perpetrates ongoing harm and is designed to control a woman's autonomy, sexual and otherwise, and to maintain male dominance over essential aspects of a woman's life and freedom.

Contrary to the Board's conclusion, infliction of FGM in the past does, in fact, work ongoing and serious future physical, psychological and sexual harm on a woman, limiting her in the most crucial and private decisions available to her, namely her sexuality, marriageability, intimate relations, her autonomy and personal freedom. Furthermore, past FGM has already worked serious, ongoing physical and psychological harms on Ms. Traore. If she is able to develop and maintain any sexual intimacy, and to become pregnant, she is likely to suffer during childbirth, as is the child born to her. Furthermore, as country conditions demonstrate, if she were returned to Mali, she would receive inadequate medical care in the process, leading to a significant increase in the risk of death.

This Court should vacate the BIA's decision, rule that past persecution has been established and that the government cannot rebut Ms. Traore's presumption of a well-founded fear of future harm simply because she has already been subjected to FGM, and grant her asylum.

Dated: April 14, 2008

Respectfully submitted,



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