DIGNITY

Dignity: A Journal on Sexual Exploitation and Violence

Volume 4 | Issue 2 Article 9

May 2019

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Recommended Citation

Chesler, Phyllis (2019) "Female Genital Mutilation in the United States: Estimating the Number of Girls at Risk," *Dignity: A Journal on Sexual Exploitation and Violence*: Vol. 4: Iss. 2, Article 9.
DOI: 10.23860/dignity.2019.04.02.09
Available at: https://digitalcommons.uri.edu/dignity/vol4/iss2/9https://digitalcommons.uri.edu/dignity/vol4/iss2/9

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Abstract
Female genital mutilation (FGM) destroys the capacity of women to experience sexual pleasure. It causes serious medical complications such as bleeding, painful urination, cysts, dangerous and recurrent bladder and urinary tract infections, the growth of scar tissue that make marital intercourse a nightmare and that turns childbirth into an experience of danger and torture. Due to immigration, FGM now poses a potential health crisis in the West, both in Europe and in the United States. To estimate how many girls who live in the West are at risk, one can measure the prevalence of FGM in the non-Western countries where it is practiced and then calculate how many immigrants from such countries are living in the West. The highest number of girls and women at risk in the United States immigrated from three countries where the practice is the most prevalent: Egypt, Ethiopia and Somalia. It is estimated that the following numbers of girls are at risk: 65,893 in New York-New Jersey-and Pennsylvania; 51,411 in Washington-Arlington-Alexandria, WV; 37,417 in Minneapolis-St. Paul-Bloomington-Wi; 23,216 in Los Angeles-Long Beach-Anaheim; and 22,923 in Seattle-Tacoma-Bellevue, WA. Including seven other locations in the U.S., the number of girls at risk in the U.S. is 506,795. The largest at-risk populations (216, 370) live in large metropolitan areas in New York, Washington, Minneapolis-St. Paul, Los Angeles, and Seattle.

Keywords
Female genital mutilation, FMG, girls, United States, immigrant communities, risk, genital cutting, ban

Acknowledgements
The author would like to acknowledge the assistance of Emily G. Feldman. Dignity thanks Eleanor Gaetan for her review and comments on this article.

DIGNITY
A JOURNAL ON SEXUAL EXPLOITATION AND VIOLENCE

Volume 4, Issue 2, Article 9, 2019 *https://doi.org/10.23860/dignity.2019.04.02.09*

FEMALE GENITAL MUTILATION IN THE UNITED STATES: ESTIMATING THE NUMBER OF GIRLS AT RISK

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ABSTRACT

Female genital mutilation (FGM) destroys the capacity of women to experience sexual pleasure. It causes serious medical complications such as bleeding, painful urination, cysts, dangerous and recurrent bladder and urinary tract infections, the growth of scar tissue that make marital intercourse a nightmare and that turns childbirth into an experience of danger and torture. Due to immigration, FGM now poses a potential health crisis in the West, both in Europe and in the United States. To estimate how many girls who live in the West are at risk, one can measure the prevalence of FGM in the non-Western countries where it is practiced and then calculate how many immigrants from such countries are living in the West. The highest number of girls and women at risk in the United States immigrated from three countries where the practice is the most prevalent: Egypt, Ethiopia and Somalia. It is estimated that the following numbers of girls are at risk: 65,893 in New York-New Jersey-and Pennsylvania; 51,411 in Washington-Arlington-Alexandria, WV; 37,417 in Minneapolis-St. Paul-Bloomington-Wi; 23,216 in Los Angeles-Long Beach-Anaheim; and 22,923 in Seattle-Tacoma-Bellevue, WA. Including seven other locations in the U.S., the number of girls at risk in the U.S. is 506,795. The largest at-risk populations (216, 370) live in large metropolitan areas in New York, Washington, Minneapolis-St. Paul, Los Angeles, and Seattle.

KEYWORDS

Female genital mutilation, FMG, girls, United States, immigrant communities, risk, genital cutting, ban

CERTAIN FAMILY-OF-ORIGIN-BASED crimes against children in the West still remain secret, hidden, and hotly denied. We usually find out about them only when a whistleblower, who has chosen to risk everything, finally speaks out. Invariably, that brave soul is disbelieved, blamed, defamed, and often punished. For example, incest still remains an under-the-radar family crime and one that is rarely prosecuted anywhere in the world.

Unbelievably, in the United States, if a child dares come forward, or a mother does so in the context of a custody battle, that mother will frequently lose custody to the allegedly sexually abusive father (Chesler, 2011; Goldstein & Hannah, 2010, 2016).

Many Americans, including judges, lawyers, police officers, teachers, and mental health professionals, are themselves too psychologically threatened by such evil and prefer to believe that no father, the man who is supposed to protect his

children, is instead routinely torturing and ruining them. It is psychologically more comfortable to discount the claim and to punish the whistleblower.

There are other family-of-origin crimes against children in non-Western countries, and in immigrant communities in the West that are also shocking, such as the honor killing of a teenage daughter or the genital mutilation of a very young daughter (aged 4–12), a procedure which will condemn her to a lifetime of agony, but which alone may render her marriageable (Chesler, 2009; Chesler, 2010; Chesler, 2012; Chesler, 2015a).

Female genital mutilation (FGM) is not at all like male circumcision. Despite the politically correct preference for calling it "genital cutting," FGM is usually far more than a mere cut. It is a procedure that involves removing part or all of the external female genitalia (or any other injury to the female genitals) for non-medical reasons. There are four types of FGM that have been identified. Type 1 is a clitoridectomy, which removes part or all of the clitoris. Type 2, excision, removes part or all of the clitoris and inner labia, with or without removal of the labia majora. Type 3, infibulation, is a narrowing of the vaginal opening by creating a seal, which is formed by cutting and repositioning the labia, and type 4 involves any other non-medical procedures to the genitals, such as pricking, piercing, incising, scraping, stretching, and cauterizing the genital areas (National Health Service, 2016).

Not only is the capacity for sexual pleasure destroyed, serious medical complications are routine and include bleeding, painful urination, cysts, dangerous and recurrent bladder and urinary tract infections, the growth of scar tissue that make marital intercourse a nightmare and that turns childbirth into an experience of danger and torture (World Health Organization, 2018). It increases the likelihood of newborn deaths. In addition, some girls and women develop fistulas and become incontinent. They are doomed to defecate and urinate without control. Absent effective surgery, this is a lifelong condition which leads to the woman being shunned by her family.

In addition, a lifelong post-traumatic stress disorder routinely accompanies the experience of having been subjected to such pain and long-term suffering—by your own mother or grandmother, and traditionally, at the hands of a female butcher, or today, perhaps, at the hands of someone more expert.

The World Health Organization confirmed that this hellish procedure renders absolutely no health benefit and, on the contrary, harms its victims beyond measure and violates their human rights (World Health Organization, 2018). This practice is common in Africa, the Muslim Middle East, and increasingly in the Muslim Far East (Asian Pacific Resource and Research Centre for Women, 2019; Kine, 2016).

Despite the cultural reasons given to justify this atrocity, in my view, FGM is a crime against humanity. We may not be able to prevent or prosecute such a crime if it takes place in Somalia, Sudan, Kenya, Eritrea, or Egypt. But we can and must stop this crime if it takes place in the West, especially in the United States.

Due to immigration, FGM now poses a potential health crisis in the West, both in Europe and in North America.

What steps might we take to abolish this practice? First, we must understand the size and scope of the problem both here and abroad. To do so, we need a plausible way to estimate ongoing and potential incidence rates. What do we really know?

DOI: 10.23860/dignity.2019.04.02.09

In the 21st century, numerous surveys, studies, reports, memoirs, resolutions, declarations, and statements were published about FGM, and by the World Health Organization (Ali, 2007; World Health Organization, 2016). Non-enforceable resolutions have been repeatedly passed by UNICEF, the UN Population Fund (UNFPA), and by the UN General Assembly (Ki-Moon, 2012; OHCRH, 2008; UN Children's Fund, 2013; UNFPA-UNICEF, 2017; UN General Assembly, 2016; UN General Assembly, 2018; UN Population Fund, 2018; World Health Organization, 2004).

The guesstimates of FGM prevalence varies greatly and ranges from 3 million to 70 million girls at risk for FGM worldwide (at any given moment in time), and between 125 million to 200 million girls and women who have already been genitally mutilated (Ali, 2019; UN General Assembly, 2016; UNICEF, 2018; World Health Organization, 2016). Most researchers agree that this atrocity is underreported and that their guesstimates are possibly only the tip of the proverbial iceberg.

None of the studies or surveys employ the same methodology (UNFPA-UNICEF, 2017). Also, researchers and advocates have done surveys or interviews in different countries and in different years.

For example, in 2004, based on a survey, UNICEF reported that "1,367 communities representing 20% of the practicing population (in Senegal) were contacted or educated" (UNICEF, 2004). However, we do not know what this educational outreach achieved. There is no way to compare this to other communities in Senegal or to any country other than Senegal.

In 2014, the British Health Service released a study that documented "467 newly identified cases" of girls and women who had been genitally mutilated. Half live in London. Previously, 1,279 girls and women were known to be receiving post-mutilation treatment (British Department of Health, 2014). Estimates suggest that up to "170,000 women and girls living in the UK have undergone FGM." Again, there is no way to compare this to any country other than the UK, and only for the years sampled.

In 2016, another UK study released by the National Health Service (NHS) and published by Plan International UK reported that between April 2015 and March 2016, "there were 8,656 times when a girl or woman was assessed at a doctor's surgery or hospital" (British National Health Service, 2016; Plan International UK, 2019). They report that a patient was assessed on average every 61 minutes. Among those, a case of FGM is newly recorded "every 92 minutes on average." This is a promising and plausible way of trying to measure incidence in the West but it may only be true for the UK and for the year sampled.

According to a 2016 report issued by UNFPA, "more than 3,000 communities, involving nearly 8.5 million individuals, made public declarations of abandonment of female genital mutilation and cutting (FGM/C). This brings the total number of public declarations to more than 6,000, and the number of individuals reached to more than 18 million since the start of Phase II in 2014. In addition, more than 1,000 Egyptian families have declared abandonment of FGM" (UNFPA-UNICEF, 2017).

However, it is unclear whether these "public declarations" were actually honored.

In 2018, UNICEF stated that "there has been an overall decline in the prevalence of the practice in 29 African countries and two Middle Eastern countries over

the last three decades" (UNICEF, 2018). Countries with the highest prevalence of FGM, according to this report, are Somalia, Guinea, Sudan, Egypt, Sierra Leone, Eritrea, and Mali.

According to the UNFPA (2018), fourteen European countries (UK, France, Spain, Norway, Austria, Italy, etc.) have banned FGM (UNFPA, 2018). Thus far, twenty-eight American states have also done so. Despite all these bans, to date, to the best of my knowledge, there have been very few prosecutions. One was in the UK, one was in Egypt, and one was in the United States (BBC, 2015; Chesler, 2018a; Equality Now, 2018; Friedman, 2018; Ly, 2018; Victor, 2017; Yore, 2019).

In 2001, in Atlanta, Georgia, a father, Khalid Adem from Ethiopia, cut off his 2-year-old girl's clitoris with a pair of scissors. He was arrested and, in 2006, tried and convicted of "aggravated battery and cruelty to children." He was not convicted for FGM because the crime had occurred before Georgia had criminalized FGM. After serving ten years in federal prison, he was deported to Ethiopia in 2017. Please note that he was jailed and deported but not for an FGM violation. While I am in favor of banning FGM in the remaining American states, such bans alone may be necessary but are not be sufficient.

In 2018, a rather sophisticated study was released by bio-statisticians, mathematicians, epidemiologists, and public health experts at six universities in the UK, Norway, and South Africa (Kandala, 2018). They stated that, "Recent estimates show that more than 200 million women and children around the world have undergone female genital mutilation and cutting (FGM/C)" and that there is "... an emerging consensus that more than three million children in Africa are now at risk each year." This is based on their meta-analyses of data originally collected by UNICEF. However, there is no way to mix and match these and similar findings in order to draw a more comprehensive conclusion.

This minimal sampling of reports demonstrates how difficult it is to measure the incidence of FGM in a way that can be generalized to many countries or to other areas in the same country. The reports are more suggestive than conclusive. In part, this is because the subject itself seems to be both a hidden and moving target. There is no sure way of estimating incidence rates in the West based on surveys in non-Western countries. Or is there? A recent and very sensible approach may allow us to do so.

One creative way of measuring incidence rates has been to measure the prevalence of FGM in the non-Western countries where it is practiced and then to calculate how many immigrants from such countries are living in the West.

In the 2018 Kandala study: "Accurate, up-to-date information on prevalence of FGM/C among children is necessary for the development of national and international health policies for prevention of these practice; and would allow international public-health policy-makers to assign sufficient priority and resources to its prevention.

The United States

In 2016, an American Centers for Disease Control-based Public Health Report concluded that as of 2012, "an estimated 1.1 million women and girls living in the United States were born in FGM/C-practicing countries or were born in the United States to women born in such countries. Thirty-six percent were younger than 18 years of age. According to this Report, the total represents an increase of about 863,000 women and girls from the 1990 estimates" (Holdberg, 2012).

DOI: 10.23860/dignity.2019.04.02.09

According to a 2016 Report issued by the Population Reference Bureau (PRB), "there were up to 507,000 U.S. women and girls in the United States who had undergone FGM/C" or were at risk of the procedure (PRB, 2016). This figure is more than twice the number of women and girls that Brigham and Women's Hospital estimated to be at risk in 2000 (228,000) in the United States (Brigham and Women's Hospital, 2000).

The PRB report states that the "rapid increase" in girls at risk in the United States "reflects an increase in immigration to the United States... The estimated U.S. population at risk of FGM/C is calculated by applying country- and age-specific FGM/C prevalence rates to the number of U.S. women and girls with ties to those countries. A detailed description of PRB's methods to estimate women and girls at risk of FGM/C is available" (PRB, 2013).

PRB found that "55 percent of all girls and women at risk in the United States immigrated from three countries: Egypt, Ethiopia and Somalia." These countries have a high FGM/C "prevalence rate for women and girls." Since "ninety one percent" of girls and women are genitally mutilated in Egypt; 74 percent in Ethiopia, and 98 percent in Somalia," the PRB estimated that about 97 percent of U.S. women and girls at risk were from these African countries, while just 3 percent were at risk from the Arab Middle East (Iraq and Yemen)." (See Table 1.)

Based on their knowledge of which specific countries the girls or women have immigrated from and the prevalence of FGM in that country, the PRB estimated that in 2013, 65,893 girls and women were at risk in New York-New Jersey-and Pennsylvania; 51,411 were at risk in Washington-Arlington-Alexandria, WV; 37,417 were at risk in Minneapolis-St .Paul-Bloomington-Wi; 23,216 were at risk in Los Angeles-Long Beach-Anaheim; 22,923 were at risk in Seattle-Tacoma-Bellevue, WA. They estimate risk in seven other locations and conclude that as of 2013, 506,795 girls and women were at risk of FGM in the United States. Important to note that the largest at-risk populations (216, 370) live in large metropolitan areas in New York, Washington, Minneapolis-St. Paul, Los Angeles, and Seattle. (See Table 2.)

This comparative demographic work is the most promising guesstimate thus far. It helps us understand how many girls may be at risk in a particular state and city and allows us to focus outreach program there. Interestingly, most of the states in which at-risk girls live—have banned FGM.

Table 1: U.S. Women and Girls Potentially at Risk for FGM/C from Top Ten Countries Where FGM/C Is Practiced (2013 Data)

	Number of U.S. Women and Girls at Risk of FGM/C
All Countries of Origin	*506,795*
Egypt	*109,205*
Ethiopia	*91,768*
Somalia	*75,537*
Nigeria	*40,932*
Liberia	*27,289*
Sierra Leone	*25,372*
Sudan	*20,455*
Kenya	*18,475*
Eritrea	*17,478*
Guinea	*10,302*
Other Countries of Origin	*69,981*

Source: Population Reference Bureau. Estimates are subject to both sampling and nonsampling error.

Europe

In terms of Europe, German researchers (2018) took a similar demographic approach and found that the majority of girls and women at risk for FGM (or who had already been genitally mutilated) had immigrated to Germany from Egypt, Ethiopia, Eritrea, Somalia, Indonesia, etc. (Terre Des Femmes).[1]

[1] According to a website titled EndFGM.com, in an undated and sadly anonymous report, similar estimates were obtained for six countries in Europe. In France, of 205,683 girls, 12-21% were at risk of FGM; in Italy, of 76,040 girls 15-24% were at risk of FGM; in Belgium, of 22,544 girls, 16-27% were at risk of FGM; in Greece, of 1,787 girls, 25-42% are at risk of FGM; in Cyprus, of 758 girls 12-17% are at risk of FGM; and in Malta, of 486 girls, 39-57% are at risk of being genitally mutilated.

Table 2: U.S. Women and Girls Potentially at Risk for FGM/C, by Metro Area, Top 10 Metropolitan Areas (2013 Data)

	U.S. Women and Girls at Risk of FGM/C
All Areas	*506,795*
New York-Newark-Jersey City, NY-NJ-PA	*65,893*
Washington-Arlington-Alexandria, DC-VA-MD-WV	*51,411*
Minneapolis-St. Paul-Bloomington, MN-WI	*37,417*
Los Angeles-Long Beach-Anaheim, CA	*23,216*
Seattle-Tacoma-Bellevue, WA	*22,923*
Atlanta-Sandy Springs-Roswell, GA	*19,075*
Columbus, OH	*18,154*
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	*16,417*
Dallas-Fort Worth-Arlington, TX	*15,854*
Boston-Cambridge-Newton, MA-NH	*11,347*
Other Metro Areas	*216,307*
Outside of Metro Areas	*8,780*

Source: Population Reference Bureau. Estimates are subject to both sampling and nonsampling error.

Decline of Female Genital Mutilation in Africa

Based on the UNICEF surveys, which were conducted between 2000 and 2017, and which dealt with 208,195 children (0-14 years old), the six researchers (Kandala, 2018) found a "huge and significant decline" of FGM in 29 countries in Africa and in some countries in the Muslim Middle East." They believe that this "decline" may be due to the "legal ban on FGM/C among children currently in place in most of these countries."

But even if Kandala, Ezejimofor, and Uthman (2008) admit that there is a "...possibility of (a) reverse trend in some countries." The "risk factors include lack of, or poor education, poverty, and continued perception of FGM/C as a potential marriage market activity." Further, they concede that their "findings" may be

"distorted" due to the fact that "FGM/C may be under-reported. In fact, a recent body of evidence suggests that under-reporting of FGM/C cases could occur."

Banning Female Genital Mutilation

If Kandala et al. are right, banning FGM, state by state, in the United States is important. Even if their conclusion is premature, criminalizing FGM is still a necessary if not sufficient first step.

Recently, a United States' Federal District Judge ruled that the federal ban against FGM was "unconstitutional" (Friedman, 2018). The Department of Justice (DOJ) refused to appeal this to the Supreme Court and instead suggested new legislative guidelines for an anti-FGM federal ban (Department of Homeland Security, 2017; Ryan, 2019). As of this writing, Congressional leaders have "asked the U.S. 6th Circuit Court of Appeals for permission to intervene in the case" (Baldas, 2019).

However, does criminalizing a human rights atrocity truly abolish it? While criminalization is a necessary first step, it is far from sufficient in terms of deterrence, prevention, prosecution, or abolition.

To date, there has been a total absence of political will and funding in terms of combatting violence against women and children in general.

Thus, while bans have existed for 37 1/2 years in parts of the West and in Egypt, as noted above, only two prosecutions have taken place—one in the UK and one in the United States, which failed.

Despite all that we have gained in terms of American women's rights—and we have gained a great deal—we still have not managed to abolish such violence. Prosecutions of incest, rape, and domestic violence are minimal (Fontaine, 2013; Leins, 2015; The National Domestic Violence Hotline). Rescue and refuge for the female and child victims of violence are less than minimal (The National Network to End Domestic Violence, 2016).

Do some judges and police officers still subconsciously believe that family and community dissolution is worse than incest or woman-battering and that society will collapse if the family does not remain intact? Perhaps they do. But the toll on society is already great given the costs in terms of prison, mandated education, lifelong medical care for the victims—as well as the loss of potentially productive citizens due to trauma-caused disabilities.

If Americans lack the will (and, arguably, the means) to prosecute violence against American women and children who live in fully integrated communities, imagine the reticence when it comes to American *immigrant* communities. A misplaced "sensitivity" to immigrant customs (such as FGM, the Burqa, polygamy, child marriage, honor-based violence, etc.) and a fear of inflaming both the immigrant and politically correct "street," might also explain why FGM has been so rarely prosecuted in America.

That—coupled with a lack of concern for women of color—may also account for this.

Also, no one wants to turn family members or neighbors over to prosecutors.

What conclusions may we draw? First, that guesstimates of FGM are all that we have and that they vary widely both globally and in the West.

DOI: 10.23860/dignity.2019.04.02.09

Given the rise in immigration from African, Middle Eastern, and South East Asian countries; the rise in Islamic/anti- Islamic/pre-Islamic fundamentalism; and the enduring poverty and illiteracy in the developing world, not only is the suffering of women worldwide beyond belief, the problem we face in the West is huge, possibly magnitudes more than these guesstimates.

But in the West, especially in the United States, if we have the political will, we may be able to a) prevent this child abuse atrocity from happening within our borders; b) educate immigrants about the lifelong harm such a practice causes; c) have the ability to rescue children before they have been genitally mutilated; and d) retain the legal means to prosecute their parents, relatives, and doctors for refusing to obey the law.

We may be able to spare numerous girls such untold suffering. Perhaps we may even be able to abolish the practice within our borders.

We must at least try.

ACKNOWLEDGMENTS

The author would like to acknowledge the assistance of Emily G. Feldman. *Dignity* thanks Eleanor Gaetan for her review and comments on this article.

AUTHOR BIOGRAPHY

Phyllis Chesler, Ph.D., is an Emerita Professor of Psychology and Women's Studies at City University of New York. She is a best-selling author, a feminist leader, a retired psychotherapist and an expert courtroom witness. Her work has been translated into many European languages, including Polish and Spanish, and into Chinese, Hebrew, Japanese, and Korean. Dr. Chesler is a co-founder of the Association for Women in Psychology (1969), The National Women's Health Network (1974), and The International Committee for the (Original) Women of the Wall (1989). She is a Ginsburg/Ingerman Fellow at The Middle East Forum, and a Fellow at the Institute for the Study of Global Anti-Semitism and Policy (ISGAP).

Dr. Chesler was an early 1970s abolitionist theorist and activist: She wrote about and delivered speeches which opposed rape, incest. pornography, sex and reproductive prostitution, and sex trafficking. She delivered a keynote address at the first-ever Conference on Rape in 1971 in New York City. Dr. Chesler organized and/or participated in demonstrations outside the movie *Snuff*; organized the first-ever Speak-Out on Mothers and Custody of children; marched outside Dorian's Red Hand to protest the murder of Jennifer Levin by Robert Chambers after a night of drinking there; organized repeated demonstrations outside the Hackensack, New Jersey courthouse where the Baby M hearings were underway and outside the surrogacy pimp Noel Keane's NYC clinic; outside the courthouse when Joel Steinberg was sentenced for the murder of Lisa Steinberg; and in numerous ways that concerned the trial of Aileen Carol Wuornos for which she assembled a team of expert witnesses which were never called upon.

She is the author of eighteen books, including the feminist classic *Women and Madness,* as well as many other notable books including *With Child: A Diary of Motherhood; Mothers on Trial: The Battle for Children and Custody; Sacred Bond: The Legacy of Baby M; Woman's Inhumanity to Woman; and Women of the Wall: Claiming Sacred Ground at Judaism's Holy Site*. After publishing *The New Anti-Semitism* (2003), she published *The Death of Feminism: What's Next in the Struggle For Women's Freedom (2005)* and *An American Bride in Kabul (2013)*, which won a National Jewish Book Award. In 2016, she

published *Living History: On the Front Lines for Israel and the Jews 2003-2015,* in 2017 she published *Islamic Gender Apartheid: Exposing A Veiled War Against Women,* and in 2018, she published *A Family Conspiracy: Honor Killings,* and a Memoir: *A Politically Incorrect Feminist*.

Dr. Chesler has published four studies about honor-based violence, focusing on honor killing, and penned a position paper on why the West should ban the burqa; these studies have all appeared in *Middle East Quarterly*. Based on her studies, she has submitted affidavits for Muslim and ex-Muslim women who are seeking asylum or citizenship based on their credible belief that their families will honor kill them. She has archived most of her articles at her website: www.phyllis-chesler.com

The author is not a front line activist in the battle against FGM but has, over the years, written many articles (Chesler, 2014a; Chesler, 2014b; Chesler, 2014c; Chesler, 2015a; Chesler, 2015b; Chesler, 2018b) and read many reports and Memoirs on the subject (Ali, 2007; Brannon, 2019; Hosken, 1979; Mire, 2011; Russell & N. Van De Ven, 1976; Walker, 1993); interviewed survivors and their advocates, and documented the activism of others, beginning in the mid-1970s. Were there funding and time enough, the author was planning on organizing a radical feminist and conservative coalition to lobby for criminalizing FGM in the United States and for funding the political will required in order to rescue, educate, and prosecute.

RECOMMENDED CITATION

Chesler, Phyllis. (2019). Female genital mutilation in the United States: Estimating the number of girls at risk. *Dignity: A Journal of Sexual Exploitation and Violence*. Vol. 4, Issue 2, Article 9. *2019*. *https://doi.org/10.23860/dignity.2019.04.02.09*. Available at http://digitalcommons.uri.edu/dignity/vol4/iss2/9.

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DOI: 10.23860/dignity.2019.04.02.09

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