



June 2016

FEMALE GENITAL MUTILATION/ CUTTING

Existing Federal Efforts to Increase Awareness Should Be Improved

GAO Highlights

Highlights of [GAO-16-645](#), a report to the Honorable Harry Reid, Minority Leader, U.S. Senate

Why GAO Did This Study

FGM/C comprises all procedures that involve partial or total removal of the external female genitalia, or other harm to the female genitals for non-medical reasons. The rationale for FGM/C often includes cultural, religious, and social factors in families and communities. In the United States, women and girls believed to be most at risk of FGM/C are those from immigrant families from countries where FGM/C is practiced.

GAO was asked to review the federal response to address FGM/C in the United States. In this report, GAO examines (1) what is known about the number of women and girls at risk of or subjected to FGM/C, (2) the protections available and actions taken to protect women and girls, and (3) the extent to which actions are taken to educate and assist immigrant communities and key stakeholders. GAO analyzed documents and spoke to officials from five relevant federal agencies; spoke with officials from local law enforcement, health care, education, and social services sectors; and assessed agency actions against federal internal control standards.

What GAO Recommends

GAO recommends that State provide information to additional visa recipients and that each federal agency document its domestic FGM/C awareness efforts. The agencies generally agreed with the recommendations; however, State disagreed with documenting its awareness efforts, noting that it is not responsible for domestic outreach and education. GAO maintains that the recommendation is valid as discussed in the report.

View [GAO-16-645](#). For more information, contact Marcia Crosse at (202) 512-7114 or crossem@gao.gov, or contact Gretta L. Goodwin at (202) 512-8777 or goodwing@gao.gov.

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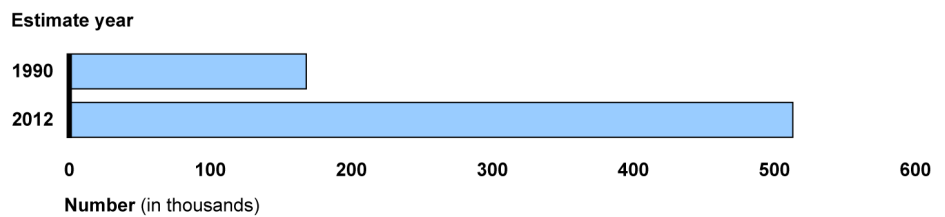
FEMALE GENITAL MUTILATION/CUTTING

Existing Federal Efforts to Increase Awareness Should Be Improved

What GAO Found

The Centers for Disease Control and Prevention (CDC) estimated that 513,000 women and girls in the United States were at risk of or had been subjected to female genital mutilation/cutting (FGM/C) in 2012, a threefold increase from its 1990 estimate. CDC attributes this change primarily to increased immigration from countries where FGM/C is practiced, rather than an increase in the occurrence of FGM/C. Agency estimates were not able to distinguish between those who have already been subjected to FGM/C and those who are at risk.

CDC Estimates of the Number of Women and Girls in the United States at Risk of or Who Have Been Subjected to Female Genital Mutilation/Cutting, 1990 and 2012



Source: GAO analysis of Centers for Disease Control and Prevention (CDC) documents. | GAO-16-645

Women and girls at risk of or who have been subjected to FGM/C in their home country may seek federal protection in the United States through different avenues of the immigration process, and GAO found that there have been few U.S. investigations and prosecutions. According to Department of Homeland Security officials, protection is most commonly provided through the asylum process, where individuals must demonstrate that they have been persecuted or fear persecution in their home country on account of protected grounds such as religion or nationality. While FGM/C is a crime under federal and many state laws, law enforcement officials identified few investigations and prosecutions related to FGM/C. Officials said that this may be due, in part, to underreporting.

Federal agencies and others provide education and assistance regarding FGM/C, but gaps exist and agencies lack documented plans for future efforts. The Department of State (State) directly provides information on FGM/C in a fact sheet only to certain types of visa recipients who apply in countries where FGM/C is practiced. State does not provide the fact sheet to nonimmigrant visa recipients as these visas are for temporary stays; however, some of these visas permit stays in the United States for multiple years. In addition, State does not directly provide the fact sheet to visa recipients who are nationals of countries where FGM/C is common, but apply at posts in other countries. Visa recipients who do not directly receive the fact sheet may be unaware of the health and U.S. legal consequences of FGM/C. Federal agencies have made efforts to increase awareness of FGM/C among stakeholder groups, including hosting roundtables and developing educational materials. However, the agencies lack documented plans for future efforts. Internal controls state that agencies should establish plans and document activities. Absent this, the federal government may be unable to ensure that its activities meet the needs of and that it communicates effectively with external parties, such as key stakeholder groups.

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Abbreviations

CDC	Centers for Disease Control and Prevention
DHS	Department of Homeland Security
DOJ	Department of Justice
Education	Department of Education
EOIR	Executive Office for Immigration Review
FBI	Federal Bureau of Investigation
FGM/C	female genital mutilation/cutting
HHS	Department of Health and Human Services
ICE	U.S. Immigration and Customs Enforcement
IV	immigrant visa
NIV	nonimmigrant visa
State	Department of State
UNICEF	United Nations Children's Fund
USCIS	U.S. Citizenship and Immigration Services

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June 30, 2016

The Honorable Harry Reid
Minority Leader
United States Senate

Dear Senator Reid:

Female genital mutilation/cutting (FGM/C) comprises all procedures that involve partial or total removal of the external female genitalia, or other harm to the female genital organs for non-medical reasons. The rationale for FGM/C often includes cultural, religious, and social factors within families and communities.¹ The United Nations Children’s Fund (UNICEF) estimated in 2016 that over 200 million women and girls have been subjected to FGM/C worldwide, although the exact number is unknown.² In the United States, women and girls believed to be most at risk of FGM/C are those born to immigrant families from countries where FGM/C is practiced, mainly in parts of Africa and the Middle East. One publication estimated that as many as 500,000 women and girls in the United States were at risk of or had been subjected to FGM/C as of 2013.³

Federal efforts to prevent FGM/C in the United States, and to provide assistance to women and girls who are at risk of or have been subjected to FGM/C, encompass a range of activities and services. These activities and services relate to law enforcement, immigration, health care,

¹The World Health Organization notes that in every society where it is practiced, FGM/C is a manifestation of gender inequality that is deeply entrenched in social, economic, and political structures. The practice is often considered in these societies a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage. FGM/C is often motivated by beliefs about what is considered proper sexual behavior, and it is linked to premarital virginity and marital fidelity. See, World Health Organization, *Eliminating Female Genital Mutilation: An Interagency Statement*, UNFPA, UNICEF, UNIFEM, OHCHR, UNHCR, UNECA, UNESCO, UNDP, UNAIDS, WHO (Geneva, Switzerland: 2008).

²See UNICEF, *Female Genital Mutilation/Cutting: A Global Concern* (New York, N.Y.: 2016).

³Feldman-Jacobs, Charlotte and Mark Mather, *Women and Girls at Risk of Female Genital Mutilation/Cutting in the United States*, a report prepared at the request of the Population Reference Bureau, February 2015.

education, and social services. At the international Girl Summit 2014, the United States committed to several areas of domestic response to FGM/C.⁴ For example, one domestic commitment was to provide information on FGM/C to educators and nongovernmental organizations that serve immigrant and refugee populations in communities throughout the United States with large populations of girls at risk.

In the United States, the federal response to FGM/C requires the efforts of multiple federal agencies. The Department of Homeland Security (DHS), the Department of Justice (DOJ), and the Department of State (State) share responsibility for the U.S. immigration system. In addition, DHS and State share responsibility for providing information on the health and legal consequences of FGM/C to certain visa recipients. DHS and DOJ share responsibility for federal FGM/C investigations and prosecutions. The Department of Health and Human Services (HHS) is responsible for public health research, guidelines, and programs, as well as for issuing grants that address public health issues. The Department of Education (Education) disseminates information and performs outreach to education professionals.

You asked us to review the federal response to address FGM/C domestically and abroad for women and girls at risk of or who have ever been subjected to the practice. The first report focused on U.S. efforts abroad.⁵ This is the second of the two reports responding to your request, and in this report we focus on the federal government's domestic efforts to combat FGM/C. In this report, we examine

1. what is known about the number of women and girls in the United States at risk of or who have been subjected to FGM/C;
2. the protections available and actions taken, if any, by federal and selected state and local agencies to protect women and girls in the United States at risk of or who have been subjected to FGM/C; and

⁴The United Kingdom government and UNICEF cohosted the Girl Summit in July 2014 to build partnerships and galvanize the global movement to end FGM/C and child, early, and forced marriage.

⁵GAO, *Female Genital Mutilation/Cutting: U.S. Assistance to Combat This Harmful Practice Abroad Is Limited*, [GAO-16-485](#) (Washington, D.C.: April 27, 2016).

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3. the extent to which federal agencies and others have taken action to educate and assist immigrant communities and key stakeholders about FGM/C.

To examine what is known about the number of women and girls in the United States at risk of or who have been subjected to FGM/C, we collected and reviewed documentation from HHS's Centers for Disease Control and Prevention (CDC), including the agency's estimates on the prevalence of FGM/C among women and girls in the United States for 1990 and 2012. We also collected and reviewed documentation related to efforts to measure FGM/C prevalence in the United Kingdom to inform our understanding of alternate methods to estimate prevalence.⁶ We reviewed journal articles and reports related to prevalence from the United States and other countries, as well as publications from nongovernmental organizations and medical associations. In addition, we interviewed officials at CDC and government officials from the United Kingdom about their efforts to measure prevalence.

To examine protections available and the actions taken to protect women and girls at risk of or who have been subjected to FGM/C, we reviewed agency documentation and interviewed officials from the agencies responsible for managing relevant immigration processes. Specifically related to the asylum process, we selected a generalizable sample of DHS case files from fiscal years 2014 and 2015 involving women from countries with known prevalence of FGM/C who filed affirmatively with DHS's U.S. Citizenship and Immigration Services (USCIS) and whose asylum applications were granted.⁷ We reviewed these case files to assess whether FGM/C was a basis for the asylum determination. In order to determine the reliability of the data we used to select the case files, we reviewed relevant documentation on the database, conferred with knowledgeable officials, and reviewed the data for any obvious errors or abnormalities. We determined that the data were sufficiently reliable for the purposes of our reporting objectives. We spoke with DHS and DOJ officials who are responsible for investigating and prosecuting FGM/C-related crimes and adjudicating immigration proceedings involving women who are at risk of or have been subjected to FGM/C. We then interviewed officials from two relevant nongovernmental organizations that provide

⁶Experts we spoke with said that the United Kingdom's efforts to measure prevalence of FGM/C are well-known and considered advanced.

⁷Affirmative asylum claims are those filed with USCIS at the initiative of the applicant.

legal support to immigrant women. To understand the actions taken on the local level to protect women and girls who are at risk of or have been subjected to FGM/C, we met with officials from law enforcement and child protective services agencies from selected local communities with large populations of immigrants from countries with known prevalence of FGM/C. To identify these communities, we used data from multiple sources, including the most recent UNICEF data on FGM/C prevalence at the time of our selection, as well as U.S. Census Bureau population data. Using these data, we identified the following communities: Los Angeles, California; Minneapolis, Minnesota; New York City, New York/Newark, New Jersey; and Washington, D.C.

To examine the extent to which cognizant federal agencies and others have taken action to educate and assist immigrant communities and key stakeholders about FGM/C, we reviewed documentation and interviewed officials from several federal, state, and local agencies, as well as key stakeholder groups. To understand the Department of State's outreach efforts pertaining to informing visa recipients about the consequences of FGM/C, we obtained data on the visa processing workload for fiscal years 2012 to 2015 from two State information systems. We analyzed data on issued visas for temporary or permanent stays in the United States to assess State's efforts to target FGM/C information to visa recipients. We assessed the reliability of the data by reviewing documentation on the information systems that contain the data, speaking with knowledgeable agency officials, and reviewing our prior work on the systems. We determined that the data obtained from these systems were sufficiently reliable for the purposes of our reporting objectives. We also examined the agencies' decisions to target information to certain visa recipients against the Office of Management and Budget's Memorandum on Updated Principles for Risk Analysis.⁸ At the federal level, we interviewed five departments and their relevant agency components responsible for outreach to key stakeholders on FGM/C. We also assessed agency actions against the relevant standards for internal control in the federal

⁸According to the guidance from the Office of Management and Budget, risk assessment should encompass all appropriate hazards (e.g., risks to human health). This guidance also states that the depth or extent of the analysis of the risks, benefits, and costs associated with a decision should be commensurate with the nature and significance of the decision.

government.⁹ At the state and local level, we interviewed officials from state and local health agencies in our selected communities, as well as officials from local law enforcement agencies and school districts. We also interviewed key stakeholder groups on their outreach efforts, including health care providers who are knowledgeable about FGM/C, and officials from three medical associations and four nongovernmental organizations serving the immigrant community.

We conducted this performance audit from June 2015 to June 2016 in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. For additional details on our scope and methodology, see appendix I.

Background

FGM/C varies by the type of practice, by country, and by age. Women or girls at risk of or who have been subjected to FGM/C may enter the United States through a variety of immigration paths. Once in the United States, certain federal and state laws exist to penalize the practice of FGM/C.

FGM/C Types and Health Consequences

According to the World Health Organization, there are four major types of FGM/C:¹⁰

- type I (clitoridectomy) partially or totally removes the clitoris or the skin around it;
- type II (excision) partially or totally removes the clitoris and the labia minora, with or without removal of the labia majora;
- type III (infibulation) narrows the vaginal opening by creating a seal through cutting and sewing together the labia minora and labia majora, with or without removal of the clitoris; and

⁹Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹⁰See World Health Organization, *Eliminating Female Genital Mutilation: An Interagency Statement*.

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- type IV (other) includes all other harmful procedures, including pricking, piercing, incising, scraping, and cauterizing the genital area for non-medical purposes.

FGM/C has no health benefits and can have numerous short- and long-term adverse health consequences.¹¹ Short-term consequences can include severe pain, excessive bleeding, shock, swelling, delayed or incomplete healing, and infections and hemorrhaging, which can lead to death. Long-term consequences may include chronic pain and infections, scar tissue, and chronic menstrual and urinary tract problems. In addition, FGM/C can lead to mental health problems, sexual problems, and obstetric complications, including increased need for Caesarean sections during childbirth.

Countries with Known Prevalence of FGM/C

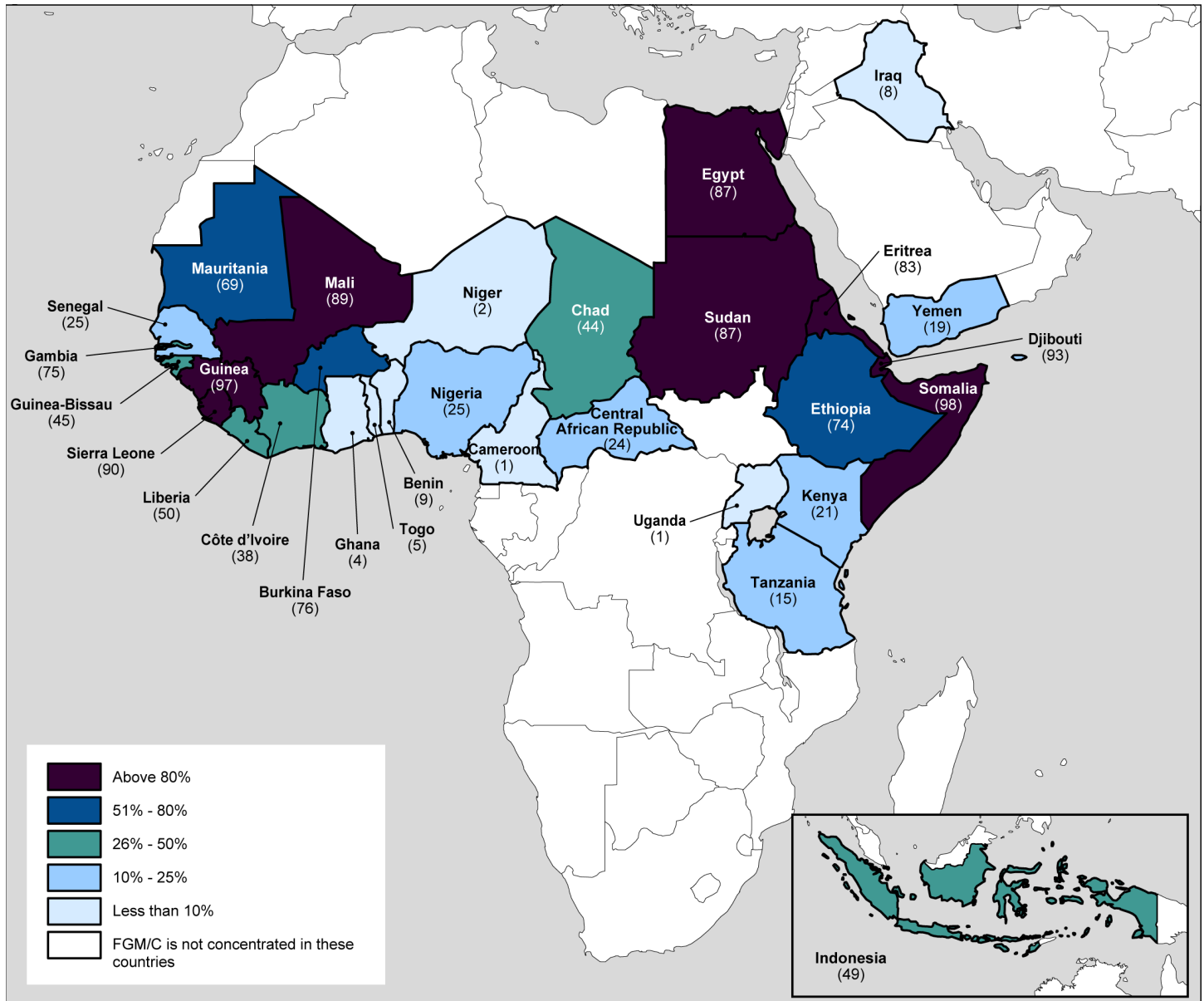
According to UNICEF, FGM/C has been reported to occur in all parts of the world, but is most prevalent in western, eastern, and northeastern regions of Africa; some countries in Asia and the Middle East; and among certain immigrant communities in North America and Europe. UNICEF's prevalence data are based on nationally representative household surveys, conducted from 2004 to 2015.¹² There are 30 countries where FGM/C is known to be prevalent based on rates estimated by UNICEF in 2016, which includes the addition of Indonesia for the first time as a country with known prevalence of FGM/C.¹³ There are additional countries, such as Colombia and India, where FGM/C is known to occur, but prevalence has not been estimated. Figure 1 shows UNICEF data on the percentages of women and girls between the ages of 15 and 49 who have undergone FGM/C in the countries with known prevalence.

¹¹World Health Organization, *Health Risks of Female Genital Mutilation*, accessed on April 4, 2016, http://www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en/.

¹²The most recent results are based on surveys conducted between 2013 and 2016.

¹³While UNICEF reported that 49 percent of girls age 11 and under in Indonesia have been subjected to FGM/C, data were not available on women and girls ages 15 to 49. See, UNICEF, *Female Genital Mutilation/Cutting: A Global Concern*. Previous reports from UNICEF focused on 29 countries with known prevalence of FGM/C.

Figure 1: Percentages of Women and Girls Ages 15 to 49 Who Have Reported Undergoing FGM/C in Countries with Known Prevalence



Source: United Nations Children's Fund (data); Map Resources (map). | GAO-16-645

Notes: A 2016 report from the United Nations Children's Fund (UNICEF) indicates that there are 30 countries where female genital mutilation/cutting (FGM/C) is known to be prevalent. UNICEF's estimate is based on nationally representative household surveys conducted from 2004 to 2015. The 2016 report includes girls age 11 and under in Indonesia who have been subjected to FGM/C. Data were not available on women and girls ages 15 to 49 in Indonesia.

According to UNICEF, in most of the countries with known prevalence, the majority of girls who are subjected to FGM/C are harmed before the age of 5. In Somalia, Egypt, Chad, and the Central African Republic, at least 80 percent of girls who are subjected to FGM/C are harmed between the ages of 5 and 14. However, data show that the practice is becoming less common in many countries found to have a high prevalence of FGM/C. For example, while the overall prevalence rate is 87 percent for women and girls ages 15 to 49 in Egypt, the prevalence of FGM/C among girls ages 15 to 19 has declined from 97 percent in 1985 to 70 percent in 2015. In addition, UNICEF reported in 2013 that 24 countries where FGM/C is prevalent have enacted legislation—varying in scope—related to FGM/C.¹⁴ According to UNICEF, some laws ban the practice only in government medical facilities and by medical practitioners; other laws ban the practice anywhere.

Immigrant Communities and Avenues to Enter or Remain in the United States

Immigrant communities across the United States include foreign nationals who have entered the United States through the immigration process. In fiscal years 2014 and 2015, nearly 30,000 women and girls from countries with known prevalence of FGM/C obtained lawful immigration status or protection in the United States through one or more avenues including the visa process, the asylum system, or refugee resettlement.¹⁵ The process for lawfully entering or remaining in the United States is based on a number of factors, including the type of immigration benefit and the applicable eligibility criteria.

Visas

U.S. immigration law provides for the admission of various categories of foreign nationals into the United States, on either a temporary or permanent basis. Those who wish to come to the United States on a temporary basis and are not citizens or nationals of countries that participate in the Visa Waiver Program must generally obtain a

¹⁴UNICEF, *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change* (New York, N.Y.: July 2013).

¹⁵Members of immigrant communities also include some U.S. citizens. For example, U.S. citizens who are the children of foreign-born parents, have strong cultural ties to foreign countries, or reside in a household that is headed by a foreign-born person or spouse are considered to be part of an immigrant community for the purposes of this review.

nonimmigrant visa (NIV).¹⁶ NIV holders include a wide range of visitors, such as tourists, foreign students, diplomats, and temporary workers who are admitted for an authorized period of time and a specific purpose. There are dozens of types of NIVs that foreign nationals can obtain by fulfilling the requirements of a specific nonimmigrant category within their authorized period of admission. For example, victims of certain crimes may be eligible to obtain a “U” visa—one type of NIV—if they are a victim of qualifying criminal activity, such as FGM/C, are helpful to law enforcement in the investigation or prosecution of the criminal activity, and meet certain other eligibility requirements.

The immigrant visa (IV) process allows foreign nationals to immigrate to the United States permanently. There are also many different types of employment- or family-based IVs that an individual can obtain.¹⁷ USCIS and State’s Bureau of Consular Affairs manage the visa application process at over 220 visa-issuing posts abroad. The process for determining who will be issued or refused a visa comprises several steps, often including in-person interviews. Personal interviews with consular officers are required by law for all immigrants seeking IVs and most nonimmigrants seeking NIVs.¹⁸ By law, DHS, in cooperation with State, is

¹⁶The various classes of nonimmigrant aliens are defined under 8 U.S.C. § 1101(a)(15); see also 8 U.S.C. § 1184 (Admission of nonimmigrants). Citizens or nationals of countries in the Visa Waiver Program—administered by DHS—are eligible to travel to the United States for tourism or business for stays of 90 days or less without first obtaining a visa. 8 U.S.C. § 1187. There are currently 38 countries designated as Visa Waiver Program countries. Citizens or nationals of countries that do not participate in the program must obtain an NIV to travel to the United States. Upon arriving at a port of entry, nonimmigrants must undergo inspection by DHS officers, who determine whether or not they may be admitted into the United States. If DHS determines a nonimmigrant is admissible, he or she is granted an authorized period of admission.

¹⁷See 8 U.S.C. §§ 1153-1154. There are also special IV categories, such as for Iraqi and Afghan citizens employed by the U.S. government and for people from countries with historically low rates of immigration to the United States. These special visas are obtained through a different process than other IVs.

Most IV applicants must be sponsored by a U.S. citizen relative, U.S. lawful permanent resident, or a prospective employer. For some categories of IVs, the applicant can self-sponsor, such as skilled workers in some specialized fields and immigrant investors.

¹⁸According to U.S. immigration law, every alien applying for an NIV who is at least 14 years old and not more than 79 years old must submit to an in-person interview with a consular officer unless the alien meets specific criteria and the interview is waived under certain circumstances by either the consular officer or the Secretary of State. 8 U.S.C. § 1202(h).

required to make information on the health and legal consequences of FGM/C available to individuals who are issued IVs or NIVs prior to or upon entry into the United States.¹⁹

Asylum System and Refugee Resettlement

In addition to the visa process, the asylum system and refugee resettlement may be available to women and girls from countries with known prevalence of FGM/C. Table 1 describes specific ways for women and girls at risk of or previously subjected to FGM/C to obtain immigration status or protection in the United States through the asylum system, withholding of removal, or refugee resettlement.

Table 1: Summary of Selected Processes to Gain U.S. Immigration Status or Protection for Women and Girls at Risk of or Subjected to Female Genital Mutilation/Cutting

Immigration process	Who is eligible?	Which agency handles their application?
Affirmative asylum	<p>Foreign nationals who are present in the United States, generally apply within one year of arrival in the country,^a</p> <ul style="list-style-type: none"> meet the definition of “refugee” under U.S. immigration law by credibly demonstrating past persecution or well-founded fear of future persecution based on one or more protected grounds: race, religion, nationality, membership in a particular social group, or political opinion; and are not statutorily ineligible for asylum due to, among other factors, being convicted of a particularly serious crime, participating in the persecution of others, or having been firmly resettled in another country prior to arrival in the United States. 	<ul style="list-style-type: none"> U.S. Citizenship and Immigration Services (USCIS) within the Department of Homeland Security (DHS) adjudicates affirmative applications for asylum.^b
Defensive asylum	<p>Foreign nationals who meet the “refugee” definition and are not otherwise statutorily ineligible for asylum, first file their asylum application while in removal proceedings in the United States, and generally apply within one year of arrival in the country.</p>	<ul style="list-style-type: none"> Immigration judges from the Executive Office for Immigration Review (EOIR) within the Department of Justice adjudicate defensive applications for asylum.^b Attorneys from U.S. Immigration and Customs Enforcement’s (ICE) Office of the Principal Legal Advisor within DHS represent the federal government in these proceedings.

¹⁹8 U.S.C. § 1374.

Immigration process	Who is eligible?	Which agency handles their application?
Withholding of removal	<p>Foreign nationals who are in removal proceedings in the United States</p> <ul style="list-style-type: none"> either applied for withholding separately, or in conjunction with an asylum application and were deemed statutorily ineligible for asylum, or were denied asylum because they did not credibly demonstrate their eligibility; and demonstrate a clear probability that, if returned to the proposed country of removal, their life or freedom would be threatened on account of race, religion, nationality, membership in a particular social group, or political opinion.^c 	<ul style="list-style-type: none"> Immigration judges from EOIR adjudicate applications for withholding of removal. Attorneys from ICE's Office of the Principal Legal Advisor represent the federal government in these proceedings.
Refugee resettlement	<p>Foreign nationals who qualify as "refugees," are not present in the United States, and are generally also outside their home country. Prospective refugees cannot be firmly resettled in any foreign country, and must be deemed of special humanitarian concern to the United States and admissible as an immigrant.</p>	<ul style="list-style-type: none"> On an annual basis, the Administration proposes the ceiling for refugee resettlement to Congress that the President approves. The majority of refugees gain access to the resettlement process through referrals from the United Nations High Commissioner for Refugees. The Department of State (State) contracts with nongovernmental and international organizations to process refugee applications, conduct medical examinations, and schedule transportation for refugees bound for the United States. USCIS officers adjudicate the refugee claim during an in-person interview to determine admissibility to the United States. State contracts with nine resettlement agencies to provide initial reception and placement services for up to 90 days. The Department of Health and Human Services' Office of Refugee Resettlement provides social services that help refugees become self-sufficient as quickly as possible after their arrival in the United States.

Source: GAO analysis of agency documents. | GAO-16-645.

^aAn applicant must file for asylum within one year of arrival in the United States, unless he or she can demonstrate that there are changed circumstances that materially affect the applicant's eligibility for asylum or that the delay in filing an application for asylum is due to extraordinary circumstances. In either case, any delay must have been reasonable under the circumstances. See 8 U.S.C. § 1158(a)(1), (2)(B), (D). In addition, under 8 U.S.C. § 1158(a)(2)(E), the one year filing deadline does not apply to an unaccompanied alien child as defined by 6 U.S.C. § 279(g)(2).

^bImmigration judges also review and adjudicate affirmative asylum applications that have been referred to the court by USCIS.

^cIn addition, unless rebutted by DHS, an applicant is presumed to be eligible for withholding of removal under INA § 241(b)(3) as a result of having suffered past persecution on one or more of the five protected grounds for asylum. See 8 C.F.R. § 208.16(b)(1).

Federal and State Laws on FGM/C

A number of federal and state laws exist to penalize the practice of FGM/C in the United States. Since 1996, there have been specific federal criminal penalties for performing FGM/C in the United States on anyone

under 18 years old, including fines, up to 5 years in prison, or both.²⁰ In 2013, Congress amended the federal statute related to FGM/C to criminalize the knowing transportation of a girl under 18 years old from the United States for the purpose of performing FGM/C abroad—often referred to as “vacation cutting.”²¹

In addition, some states have enacted laws specifically criminalizing FGM/C, while other states may pursue FGM/C offenses under other related statutes, such as child abuse laws. In some instances, states require that an occurrence of FGM/C be reported. DOJ indicates that two states, Illinois and Tennessee, have mandatory reporting for FGM/C.²² All states have mandatory reporting laws governing child abuse, which may apply to reporting FGM/C depending on the relevant circumstances and particular statutory requirements. Some state laws address other areas of FGM/C, such as provisions prohibiting “vacation cutting” or provisions for community education and outreach. According to DOJ, some states also criminalize performing FGM/C on both adults and children.

²⁰18 U.S.C. § 116. The federal FGM/C criminal provision was created by section 645 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, div. C, tit. VI, subtit. D, § 645, 110 Stat. 3009, 3009-708 to -709.

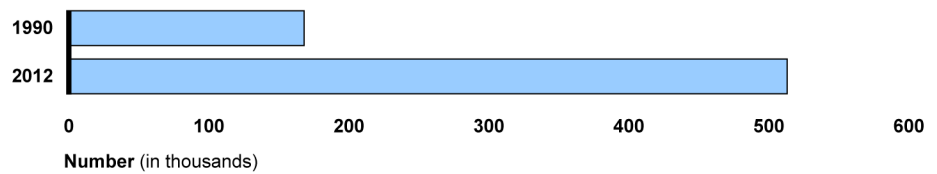
²¹National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239, div. A, tit. X, subtit. H, § 1088, 126 Stat. 1632, 1970.

²²Abused and Neglected Child Reporting Act, 325 Ill. Comp. Stat. 5/1, *et seq.*; Tenn. Code Ann. § 38-1-101.

About A Half Million Women and Girls in the United States Estimated to Be at Risk of or Have Been Subjected to FGM/C

CDC published a report in 2016 estimating that 513,000 women and girls in the United States were at risk of or may have been subjected to FGM/C in 2012.²³ While subject to certain limitations, this represents a substantial increase—about threefold—from CDC’s prior estimate of 168,000, which was based on 1990 data.²⁴ (See fig. 2.) CDC attributed this increase to a sharp rise in recent decades in the U.S. population originating from countries where FGM/C is commonly practiced, and noted that the increase occurred despite FGM/C prevalence not increasing or seemingly falling in many of these countries.

Figure 2: CDC Estimates of the Number of Women and Girls in the United States at Risk of or Who Have Been Subjected to FGM/C, 1990 and 2012
Estimate year



Source: GAO analysis of CDC documents. | GAO-16-645

Notes: Using the same methodology as it did to determine its 1990 rate, the Centers for Disease Control and Prevention (CDC) estimated that 545,000 women or girls were at risk of female genital mutilation/cutting (FGM/C) in 2012. However, CDC found that its estimate of 513,000 women or girls at risk of FGM/C was more reliable because of newer data sources that were not available when it produced its 1990 estimate. Therefore, we use CDC’s most reliable estimate for 2012 in this figure.

To develop both estimates, CDC applied country-specific prevalence rates of FGM/C to the estimated number of women and girls living in the United States who were born in that country or who lived with a parent born in that country. The 2012 estimate was based on

- U.S. Census Bureau data from its 2012 American Community Survey, and
- population-based, country-specific FGM/C prevalence estimates compiled from national surveys (most often Demographic and Health

²³Goldberg, H., et al., “Female Genital Mutilation/Cutting in the United States: Updated Estimates of Women and Girls at Risk, 2012,” *Public Health Reports*, vol. 131 (2016).

²⁴Jones, W.K., et al., “Female Genital Mutilation. Female Circumcision. Who Is at Risk in the U.S.?” *Public Health Reports*, vol. 112 (1997).

Surveys supported by the United States Agency for International Development or UNICEF's Multiple Indicator Cluster Surveys).

The most significant change in CDC's latest methodology from that used for its 1990 estimate was the application of different prevalence rates to younger women and girls, specifically those aged 15 to 19. The lower prevalence rate applied to this population reflects the reported lower risk of FGM/C in this age range in the countries from which the women and girls immigrated.

CDC acknowledged four specific limitations to its most recent estimate, which are similar to those applicable to the 1990 estimate.

1. **Estimate does not account for changes in behavior upon moving to the United States.** CDC's estimate assumes that, with regard to FGM/C practices, people behave the same in the United States as they would in the countries from which they came. However, there are several reasons why the behaviors are likely to differ from those in the countries of origin, including assimilation, differences in education and other socioeconomic characteristics, and U.S. laws banning FGM/C. The authors note that these differences would very likely result in reduced risk for FGM/C. While there are no data to test this hypothesis for a U.S.-based population, a systematic review of FGM/C studies in Europe concluded that children born to an immigrant family run relatively little risk of undergoing FGM/C.²⁵
2. **Estimate does not account for variation of prevalence within countries of origin.** CDC's estimate was based on national prevalence levels reported for the countries of origin where FGM/C is practiced. However, in many of those countries, the prevalence of FGM/C varies by geographic area (e.g., urban or rural), ethnic group, and other factors including socioeconomic status. Further, the population coming to the United States may not be representative of the entire country of origin.
3. **Estimate does not include countries where it is known that FGM/C is practiced, but for which there are no data.** CDC only had FGM/C prevalence estimates from countries for which such information had been published at the time the agency's estimates

²⁵M. Exterkate, *Female Genital Mutilation in the Netherlands: Prevalence, Incidence and Determinants*, Pharos Centre of Expertise on Health for Migrants and Refugees (Utrecht, Netherlands: January 2013).

were developed. There are several countries where FGM/C is known to be practiced, but for which no data were then available.²⁶ CDC stated that excluding such countries from their analysis could have resulted in an underestimate. Notably, an updated report from UNICEF published after CDC's most recent estimate provided data for the first time on the number of girls subjected to FGM/C in Indonesia. Specifically, in 2013, Indonesia collected data on the occurrence of FGM/C in girls ages 0 to 11; the data indicate that about 49 percent of girls in this age group have undergone FGM/C. CDC officials told us that the Indonesia data would likely increase the U.S. estimate by approximately 50,000 women and girls. Further, CDC noted that the length of time since the most recent FGM/C prevalence surveys were conducted varied by country, such that if prevalence were changing, the country of origin data could be somewhat outdated.

4. Estimate does not capture data for undocumented individuals.

CDC reported that it is difficult to determine the number of undocumented individuals who have come to the United States from countries where FGM/C is commonly practiced, or the probability that such individuals would be captured in the U.S. population estimates. They noted that the result is a possible underestimation of U.S. women and girls at risk of FGM/C.

In addition, neither of CDC's estimates distinguishes between women and girls in the United States who have already been subjected to FGM/C and those who are at risk, due to the lack of scientifically valid data available on the former. In the report for the 2012 estimate, the authors said that until scientifically valid data are collected, the approach used provides the best available information on the potential levels of FGM/C. CDC and others have acknowledged that collecting more scientifically valid data would be difficult due, in part, to the cultural and legal sensitivity of the information needed. International efforts to collect data on the actual occurrence of FGM/C have faced similar challenges. Starting in October 2015, however, the United Kingdom began requiring health care providers in England to report through a nationwide database any instance of FGM/C described to them or discovered during physical exams.

²⁶Evidence suggests that FGM/C exists in additional countries, such as Columbia, India, Malaysia, Oman, Saudi Arabia, and the United Arab Emirates; however, no nationally representative data on FGM/C were available for these countries, according to UNICEF.

CDC and others have stated that further data on the occurrence of FGM/C collected at the community and individual level would facilitate prevention efforts and the provision of services to women and girls who have been subjected to FGM/C. According to CDC officials, the agency is currently working on the development of a strategy and methodology for a potential future study that would provide scientifically valid data about the actual prevalence of FGM/C in the United States. CDC began working with a contractor at the beginning of fiscal year 2016 to design the study, examining what has been done in the past and what methodologies may be applicable. Officials told us that the contractor will examine possible methodologies and conduct expert interviews with community leaders on the best approaches for obtaining information and working with the affected communities, and is also working to explore potential difficulties and challenges. CDC officials told us there are two major challenges to such a study being conducted—the first being funding, and the second being the difficulty of encouraging the population of interest to disclose information about FGM/C, a sensitive topic that is also an illegal act in the United States. CDC officials told us they have obtained some federal funding for such a study and are pursuing a variety of additional potential funding sources, including nongovernmental options.

Protections Are Available through the U.S. Immigration System to Women and Girls at Risk of or Who Have Been Subjected to FGM/C; Investigations and Prosecutions Are Few

Women and girls at risk of or who have been subjected to FGM/C in their home country may seek federal protection on that basis through avenues in the U.S. immigration system. There have been few FGM/C-related investigations or prosecutions. Law enforcement and child protection officials we spoke with said this may be due, in part, to instances not being reported.

Women and Girls at Risk of or Who Have Been Subjected to FGM/C May Seek Protection through the U.S. Immigration System

Asylum

Women and girls at risk of or who have been subjected to FGM/C in their home country may seek federal protection on that basis through different avenues of the immigration process. Specifically, the avenues available are (1) asylum; (2) withholding of removal; (3) refugee resettlement; or (4) a “U” nonimmigrant visa.²⁷ According to DHS officials responsible for managing these immigration processes, women and girls at risk of or who have been subjected to FGM/C seeking protection on that basis have most commonly done so through the affirmative asylum process.²⁸

When applying for asylum, an individual must meet the definition of “refugee” under section 101(a)(42)(A) of the Immigration and Nationality Act by demonstrating that they have been persecuted or fear they will be

²⁷ See 8 U.S.C. §§ 1101(a)(3) (an “alien” is any person who is not a U.S. citizen or national), (15)(U) (U nonimmigrant classification); 1157 (Admission of Refugees); 1158 (Asylum); 1184(p) (Petitioning Procedures for U nonimmigrant visas); 1231(b)(3) (Withholding of Removal); *Matter of Kasinga*, 21 I&N Dec. 357 (BIA 1996) (The practice of female genital mutilation, which results in permanent disfigurement and poses a risk of serious, potentially life-threatening complications, can be the basis for a claim of persecution).

While we present some of the key avenues to obtain immigration relief for those who have undergone or fear being subjected to FGM/C, according to DHS and DOJ officials, other relief or protection from removal may also be available to women and girls at risk of or who have been subjected to FGM/C. For example, a girl could receive Special Immigrant Juvenile status or cancellation of removal for certain non-permanent residents, provided the applicable eligibility requirements are satisfied. See 8 U.S.C. §§ 1101(a)(27)(J), 1229b(b). In addition, an individual submitting a Form I-589, Application for Asylum and for Withholding of Removal, may indicate that they also want to apply for withholding of removal under the United Nations Convention Against Torture. See 8 C.F.R. §§ 1208.16(c), 1208.17. However, DHS noted that, while FGM/C may be considered torture in terms of severity, it must generally be performed by or with the acquiescence of a government official. Because this is rarely the case, it is an unlikely form of relief for FGM/C victims.

²⁸ Affirmative asylum claims are those filed with USCIS at the initiative of the applicant. Defensive asylum claims are asylum claims made during removal proceedings in immigration court as a defense against removal from the United States. An alien making a defensive claim may have been placed in removal proceedings after having been stopped at the border without proper documentation, identified as present in the United States without valid status, or identified as potentially removable on one or more grounds, such as for certain kinds of criminal convictions. In addition, when an affirmative applicant without valid immigration status is not found eligible for asylum by USCIS, he or she is referred to removal proceedings, where the asylum claim may be renewed. If an individual is statutorily ineligible for asylum based on, for example, having been convicted of a particularly serious crime, or an individual’s asylum claim is ultimately denied because he or she did not credibly demonstrate eligibility for asylum then the applicant may seek other forms of relief or protection from removal in immigration court proceedings, such as withholding of removal under INA § 241(b)(3).

persecuted on account of their race, religion, nationality, membership in a particular social group, or political opinion. Under U.S. immigration law, the practice of FGM/C is considered a form of persecution, which can support a valid asylum or refugee claim.²⁹ According to USCIS asylum officers, women and girls at risk of or who have already been subjected to FGM/C typically demonstrate their eligibility for asylum status as members of a particular social group.³⁰ For example, in the decision that established FGM/C as a valid basis for a claim of persecution, asylum was granted to a woman because she had a well-founded fear of persecution based on her membership in a particular social group, defined as “[y]oung women of the Tchamba-Kunsuntu [t]ribe [of Northern Togo] who have not had FGM[C], as practiced by that tribe, and who oppose the practice.”³¹

Based on our review of a generalizable sample of alien files for females from the countries where there is a known prevalence of FGM/C, and who were granted asylum affirmatively in fiscal years 2014 and 2015, we estimate that approximately 40 percent (1,075 of 2,756) were granted asylum at least partly on the basis of FGM/C.³² According to our file review, as well as interviews with USCIS asylum officers, the majority of the FGM/C-based asylum claims USCIS has adjudicated involved adults who had previously been subjected to FGM/C. For example, 28 of the 39 alien files we reviewed where asylum was granted at least partly on the basis of FGM/C involved adult applicants who had already been subjected to FGM/C. Asylum officers explained that, compared to other types of asylum claims, FGM/C-based claims are generally

²⁹*Matter of Kasinga*, 21 I. & N. Dec. 357 (BIA 1996).

³⁰We interviewed USCIS asylum officers at five asylum offices covering our select communities.

³¹21 I. & N. Dec. at 368.

³²This estimate has a 95 percent confidence interval that extends from 29 to 49 percent (811 to 1338 of 2,756).

Under U.S. immigration law, an alien is any person who is not a U.S. citizen or national. USCIS creates an alien file, called an A-file, to serve as the one central file for all of the applicant’s immigration-related applications and related documents. There were additional asylees in our sample who had been subjected to FGM/C, but USCIS did not grant asylum affirmatively on that basis and instead granted asylum on other grounds. In addition, one alien file we reviewed was associated with an affirmative asylum claim filed with USCIS, which was granted by DOJ’s Executive Office for Immigration Review (EOIR) after referral from USCIS.

straightforward to adjudicate, because applicants typically submit a medical affidavit from a physician indicating that the applicant has been subjected to FGM/C. This affidavit, along with other evidence, such as the applicant's credible testimony and information on the country conditions, provides support for granting asylum on the basis of FGM/C. According to asylum officers we spoke with, the main challenge in adjudicating FGM/C-based asylum claims is the nature of the act itself, which requires sensitivity on the part of the officers who work with applicants. The officers also noted that such sensitivity is not unique to FGM/C claims, and is needed to adjudicate many different types of asylum claims.

Although the majority of the affirmative asylum claims involving FGM/C that USCIS has adjudicated involved adult applicants who had previously been subjected to FGM/C, USCIS asylum officers told us they have seen cases involving applicants who sought asylum because they feared they would be subjected to FGM/C if they returned to their home country. For example, in the Board of Immigration Appeals decision that first established FGM/C as a valid basis for an asylum claim, the applicant testified that she had been subjected to a forced marriage at age 17 and fled her home country when her husband and aunt planned to force her to undergo FGM/C before the marriage was consummated.³³ In addition, according to USCIS officials, they have adjudicated cases where a parent is applying for asylum to protect his or her daughter from being subjected to FGM/C. According to officials, these cases are often more challenging to adjudicate, because the parent has to establish that they would be the target of persecution as a result of their daughter undergoing FGM/C.³⁴ Attorneys from U.S. Immigration and Customs Enforcement's (ICE) Office of the Principal Legal Advisor—the office responsible for litigating asylum cases in immigration court—who cover three of our four selected local communities said that most of the FGM/C-based claims they see in court

³³21 I. & N. Dec. at 358. The Board of Immigration Appeals is the highest administrative appellate body within EOIR for interpreting and applying immigration laws. The Board of Immigration Appeals has been given nationwide jurisdiction to hear appeals from certain decisions rendered by immigration judges and by USCIS.

³⁴An alien may not establish eligibility for asylum or withholding of removal based on the fear that his or her daughter will be harmed by being forced to undergo FGM/C upon returning to the alien's home country unless the alien establishes that his or her daughter will be harmed by being forced to undergo FGM/C as a means to persecute the alien. See *In re A-K-*, 24 I. & N. Dec. 275 (BIA 2007).

are referrals from USCIS, and many of those cases involve parents seeking asylum to protect a daughter from FGM/C.

Withholding of Removal

In addition to applying for asylum, women and girls at risk of or who have been subjected to FGM/C, and are already in immigration court proceedings on one or more charge(s) of removability, may seek withholding of removal to avoid being returned to the proposed country of removal. Individuals who are applying for withholding of removal must meet a higher legal standard than those seeking asylum.³⁵ Specifically, to be eligible for withholding, an individual must show a clear probability that, if returned to their home country, his or her life or freedom would be threatened, based on the same five grounds—race, religion, nationality, membership in a particular social group, or political opinion—as those applying for asylum.³⁶ According to officials from DOJ’s Executive Office for Immigration Review (EOIR)—the federal agency that manages the immigration courts—they are unable to determine the number of women and girls who were granted withholding of removal related to FGM/C, because the agency’s database does not track certain factors such as the gender of the applicant and the underlying grounds that support the applicant’s claim for relief.

Refugee Resettlement

Individuals applying for refugee status from outside the United States must generally meet the same legal requirements as those applying for asylum in the United States, in that they are to demonstrate they have been subjected to persecution or have a well-founded fear of future persecution on account of the same five grounds—race, religion, nationality, membership in a particular social group, or political opinion.³⁷ Although having experienced or being at risk for FGM/C is a basis for obtaining refugee status, according to State and USCIS officials, FGM/C is unlikely to be used in a refugee claim. According to the United Nations High Commissioner for Refugees, refugees are often in a very vulnerable

³⁵See *Immigration & Naturalization Serv. v. Cardoza-Fonseca*, 480 U.S. 421 (1987).

³⁶Id. See also 8 U.S.C. § 1231(b)(3); 8 C.F.R. § 208.16. In addition, an applicant has a rebuttable presumption of eligibility for withholding of removal under INA § 241(b)(3) as a result of having suffered past persecution on one or more of the five protected grounds for asylum. See 8 C.F.R. § 208.16(b)(1).

³⁷Refugees must also generally be outside their home country except in such special circumstances as specified by the President, allowing any otherwise eligible person to qualify for refugee status even though such person is within his or her country of nationality or, if stateless, habitual residence. See 8 U.S.C. § 1101(a)(42).

situation—fleeing war and oppression—and cannot rely on the protection of their own governments. Data from State’s Bureau of Population, Refugees, and Migration show that women and girls from the Central African Republic, Eritrea, Ethiopia, Iraq, Sierra Leone, Somalia, and Sudan—all countries where FGM/C is practiced—are the African nationalities that have resettled as refugees in the United States in fiscal years 2014 and 2015.³⁸ Over 27,000 women and girls from these countries resettled in the United States during this time period. According to State officials, they do not know how many of these women and girls are at risk of or have been subjected to FGM/C.³⁹

“U” Nonimmigrant Visas

“U” visas allow victims of qualifying crimes (including FGM/C), who have suffered substantial physical or mental abuse and meet certain other criteria, to remain in the United States to assist federal, state, or local authorities investigating or prosecuting the qualifying criminal activities.⁴⁰ Further, the qualifying crime that the victim is providing information to law enforcement about must have occurred in the United States or violated U.S. law, and the victim must be legally admissible to the United States. “U” visa recipients commonly are authorized to stay in the United States for a period of up to 4 years, which can be extended by DHS.⁴¹ There is also a process in place for “U” visa recipients to petition for permanent residency. Family members of such victims may also be eligible to obtain derivative “U” nonimmigrant status. The number of “U” visas that may be granted to principal petitioners each year is limited by law to 10,000.⁴² However, there is no cap for family members accompanying the victim’s petition, such as the spouse, children, or other eligible family members.

³⁸The data on refugees from Sudan includes refugees from both Sudan and South Sudan.

³⁹One reason this may be the case is because State officials would be unlikely to learn of instances of FGM/C among the refugee population. For example, the required refugee medical exam does not require a screening for FGM/C; therefore the only way such instances would be known is if the refugee applicant informed the physician during the exam.

⁴⁰See 8 U.S.C. § 1101(a)(15)(U). “U” nonimmigrant status, a form of temporary immigration relief for crime victims, was created by the Battered Immigrant Women Protection Act of 2000. See Pub. L. No. 106-386, div. B, tit. V, § 1513(b), 114 Stat. 1464, 1534. We address “U” visas specifically in this discussion because, unlike other categories of visas, they offer a specific form of protection to victims of FGM/C. A discussion of visas more broadly is presented later in this report.

⁴¹8 U.S.C. § 1184(p)(6).

⁴²See *id.* § 1184(p)(2)(A).

There Have Been Few FGM/C-Related Investigations or Prosecutions Due, in Part, to Instances Not Being Reported

Officials from federal and other law enforcement agencies in our review identified few investigations and prosecutions that were related to FGM/C.⁴³ At the federal level, DOJ's Federal Bureau of Investigation (FBI) had two investigations from fiscal year 1997 to 2015, one of which resulted in a prosecution on other charges. In fiscal year 2002, the FBI investigated two cases—one in El Paso, Texas, and one in Los Angeles, California—but no actual victims were identified in either of these cases. The FBI field office in El Paso initiated an investigation related to FGM/C, but the case did not result in any arrests or prosecutions. This investigation was pursued based on an email tip from an unidentified female. She alleged that she was subjected to FGM/C and that an unknown male was cutting other girls in El Paso. However, because she could not be identified, the investigation ended and the case was closed. The FBI field office in Los Angeles conducted an undercover investigation that resulted in the arrest of two individuals who were subsequently prosecuted and convicted. In that case, a man ran a business that offered body piercing and modifications, and during communications with an undercover FBI agent, he claimed to have performed FGM/C in the past and offered to perform FGM/C on two fictitious 8- and 12-year-old girls. He and his girlfriend pled guilty to conspiracy, child pornography, and obscenity charges, and were sentenced to 5 years and 2 years in federal prison, respectively.

Also at the federal level, ICE officials stated that the agency has not had any criminal investigations of FGM/C. However, the officials identified at least 25 individuals in immigration court proceedings who were suspected of assistance in the perpetration of FGM/C.⁴⁴ Of the 25 suspected perpetrators, officials were aware of 1 individual who was removed from the country in July 2005. The remaining 24 were granted relief or protection from removal, were still in immigration proceedings, or were

⁴³According to DOJ officials, the Executive Office for United States Attorneys, in conjunction with DOJ's Human Rights and Special Prosecutions Section, sent a memo in November 2014 to all U.S. Attorney's Offices advising the offices of the FGM/C federal criminal statute enacted in 1996 and the amendment in 2013 prohibiting the transportation of a minor overseas for the purpose of performing FGM/C. In addition, the memo attached a newsletter discussing FGM/C and efforts to uncover violations of this statute. Officials from the Executive Office for United States Attorneys provided this information to U.S. Attorney's Offices to assist prosecutors in the event that they receive an FGM/C-related referral from a law enforcement agency.

⁴⁴ICE officials said that they do not have a precise record of removal proceedings related to FGM/C.

not issued a travel document by their home country to implement the immigration court's final order of removal. The individuals in these cases were suspected of involvement with FGM/C that occurred abroad, either through vacation cutting or prior to their arrival to the United States. ICE identified most of the individuals through their own admissions of involvement in FGM/C or by reviewing travel records and medical records of the individuals' children, and identifying contradictory timeline information.

At the state and local levels, we found few investigations and prosecutions related to FGM/C in states with and without specific laws against the practice. According to DOJ officials, they were aware of two state prosecutions related to FGM/C. In 2006, an Ethiopian man in Georgia was convicted of aggravated battery and cruelty to children for cutting his daughter's genitalia, and sentenced to 10 years in prison. In 2013, a woman in Illinois was found guilty by a jury of aggravated battery and was sentenced to 10 years in prison for cutting her 13-month-old daughter. Three of the four local law enforcement agencies we spoke with from our selected metropolitan areas were each aware of at least one case related to FGM/C in their respective jurisdictions, none of which resulted in a prosecution because the FGM/C occurred overseas or the victim stopped cooperating with law enforcement.⁴⁵ For example, one local law enforcement agency investigated a case in 2012, in which a woman came forward about being subjected to FGM/C when she was a child. According to officials from that agency, the woman reported that she was sexually abused by a male relative over the course of several years, which occurred prior to and after her arrival in the United States. During one episode of abuse when she began to fight back, he cut her genitalia with the intent of making her undesirable to other men. In addition, all four of the local child protection agencies we spoke with confirmed that reports of FGM/C performed on minors would be considered a form of child abuse or neglect if a minor's parent or guardian were involved, and such reports would trigger an investigation. Officials

⁴⁵One local law enforcement agency that we spoke to was not among the counties we chose for our selected communities, but was within one of the metropolitan areas on which we focused. Unlike our other selected communities, this agency was located in a jurisdiction that did not have specific state laws against FGM/C, so we spoke with officials to obtain their additional perspective. Also, we requested an interview with officials from one other law enforcement agency, but they did not respond.

from only one of the four child protection agencies we spoke with were aware of a case related to FGM/C.

There is no designated federal tipline where individuals can report actual or suspected instances of FGM/C for investigation or potential prosecution; however, there are several existing tiplines that could be used for this purpose. Federal law enforcement agencies, as well as others, provide avenues to report instances of FGM/C for investigation and potential prosecution, but few instances have been reported. FGM/C, as well as other crimes, can be reported to federal tiplines managed by the FBI and ICE; the agencies have received a total of five reports related to FGM/C. FBI's tipline received three reports related to FGM/C from fiscal year 1997 to 2015, and FBI officials stated that no information was available to indicate that any of those reports resulted in an investigation.⁴⁶ ICE's tipline received two reports that were related to FGM/C since fiscal year 2014, and ICE officials stated that those reports were determined not to be actionable. According to officials from DOJ's Human Rights and Special Prosecutions Section, instances of FGM/C can also be reported to their tipline, which forwards the information to law enforcement, and has received two tips related to FGM/C. Officials from three of the four local child protection agencies in our selected communities and one other that we spoke with said that all instances of child abuse and neglect that happen within their jurisdiction are reported through their tiplines.⁴⁷

In addition to the federal tiplines, the National Center for Missing and Exploited Children maintains the CyberTipline, which accepts reports from the general public and electronic service providers related to the sexual exploitation of children, in general.⁴⁸ These reports are

⁴⁶The federal law that criminalized FGM/C took effect during fiscal year 1997, 180 days after the enactment of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 on September 30, 1996. See Pub. L. No. 104-208, div. C, tit. VI, subtit. D, § 645(c), 110 Stat. at 3009-709 (18 U.S.C. § 116 note).

⁴⁷We requested an interview with officials from one other local child protection agency, but they did not meet with us.

⁴⁸The National Center for Missing and Exploited Children operates the CyberTipline with funding through federal grants and in partnership with multiple federal agencies and military criminal investigative organizations. The CyberTipline receives tips from electronic service providers and the general public. The National Center for Missing and Exploited Children refers these tips to the Internet Crimes Against Children task forces, which are comprised of federal, state, and local law enforcement officials.

subsequently passed on to law enforcement. Officials said that, of the 7 million reports they received since the CyberTipline was launched in 1998, they have not identified any reports that were related to an actual instance of FGM/C.

Local law enforcement and child protection officials told us that immigrant communities may underreport due to cultural norms, victims' reluctance to betray their community or family members, and concern about potential effects on their immigration status and that of their family members. In addition, although many professionals who may be in contact with girls at risk for FGM/C are mandatory reporters (e.g., health care, school, and child care officials), they may be uncertain about whether FGM/C should be reported. For example, health care providers we spoke with stated that they may not report instances of girls being at risk of or subjected to FGM/C due to uncertainty about mandatory reporting requirements (e.g., if FGM/C occurred before arriving in the United States), or because they prefer to counsel parents on the consequences of FGM/C to change parents' position on the issue. School officials we spoke with had little or no experience encountering FGM/C among their students, in general, and school officials may not be certain of what actions are appropriate when they encounter suspicions of FGM/C, which can affect reporting. For example, an official from a nongovernmental organization that works with Somali women said teachers contacted them for guidance on dealing with suspicions of vacation cutting. In addition, a former school psychologist who now works with a national organization told us about an instance when school officials had suspicions of vacation cutting that was not reported. However, they did not confirm these suspicions with the student or her family, out of concern that she would be pulled out of school and her home environment would be disrupted. Without clear evidence that FGM/C had occurred, the officials decided to provide the student with general support for trauma. States' mandatory reporting requirements vary across jurisdictions, are dependent on the relevant facts and circumstances, and would be subject to some level of interpretation by the reporting official.⁴⁹ These factors can make it challenging to determine the appropriate course of action when encountering potential instances or risks of FGM/C on minors.

⁴⁹According to HHS's Children's Bureau, most states designate professions whose members are mandated by law to report child abuse and neglect. These individuals, or "mandatory reporters," typically have frequent contact with children, such as school personnel, health care workers, child care providers, and law enforcement officers.

Federal Agencies and Others Provide Education and Assistance Related to FGM/C, but Gaps Exist and Federal Agencies Lack Documented Plans for Future Efforts

Federal agencies and others have provided education and assistance related to FGM/C in immigrant communities, but such efforts made before immigrants' arrival in the United States are limited by the gaps in how State makes FGM/C-related information available to certain visa recipients. While federal agencies have made efforts to increase awareness of FGM/C for key stakeholder groups, they lack documented plans for future education and outreach efforts.

Federal Agencies and Nongovernmental Organizations Provide Education and Assistance to Immigrant Communities, but Gaps Exist in Notifying Certain Visa Recipients About FGM/C

Federal agencies provide education on the health and legal consequences of FGM/C and assistance to immigrants before and after arrival in the United States.

Before arrival. Before arrival in the United States, State provides education on FGM/C to both refugees and visa recipients.⁵⁰ According to an official from State's Bureau of Population, Refugees, and Migration, refugees receive a hard copy of the *U.S. Government Fact Sheet on Female Genital Mutilation or Cutting* along with the letter that informs them that their refugee status is approved. During the cultural orientation process, one fact sheet is provided per family for all African nationalities. The fact sheet was last updated in June 2014 through an interagency effort led by USCIS. (See appendix II for a copy of the fact sheet.) In addition, the official said FGM/C is often covered during the 2 to 5 day cultural orientation process, which has sessions where they discuss frequently asked questions, as well as U.S. law. The official explained that refugees are not required to participate in cultural orientation, but it is highly encouraged.

DHS, in cooperation with State, is also required by law to make information available to individuals who are issued immigrant visas or nonimmigrant visas about the health consequences of FGM/C and the

⁵⁰Prospective asylees are not included in State's educational initiatives abroad because they must be physically present in the United States or arrive in the country (whether or not at a designated port of entry), to be eligible to apply for asylum.

legal consequences of involvement in the practice in the United States.⁵¹ In addition, the law instructs the agencies to limit the provision of the information to individuals from countries where FGM/C is “commonly practiced.”⁵² State has taken the lead in implementing this requirement, and according to the agency’s Foreign Affairs Manual, the Bureau of Consular Affairs should emphasize making this information available to IV recipients compared to NIV recipients.⁵³

As such, IV recipients who applied in countries where FGM/C is commonly practiced are directly provided a hard copy of the fact sheet at the time of their in-person interview.⁵⁴ NIV recipients, however, are not provided a hard copy of the fact sheet during their interview; instead, Consular Affairs has made the fact sheet indirectly available to them by displaying it in the posts’ visa section waiting area. Figure 3 is a photograph of the fact sheet displayed at the post in Tanzania.

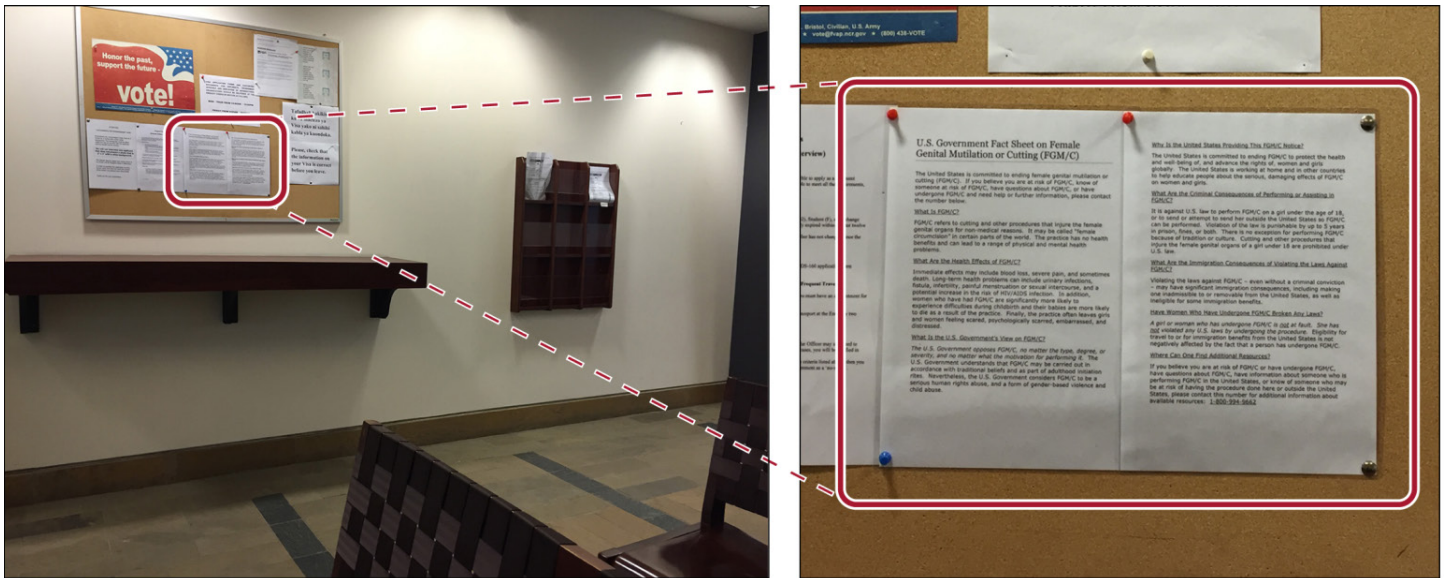
⁵¹8 U.S.C. § 1374. This section states that the legacy Immigration and Naturalization Service (now DHS), in cooperation with State, shall make available for immigrant and nonimmigrant visa holders information about the health and legal consequences of FGM/C, prior to or at the time of entry into the United States.

⁵²8 U.S.C. § 1374(b). To the extent practicable, the provision of information regarding the consequences of FGM/C is to be limited to aliens from countries where it is commonly practiced.

⁵³The manual does not specify why the information is provided to IV recipients and not NIV recipients.

⁵⁴Consular officers inform IV applicants about whether their application is approved or denied at the end of the IV interview. In instances when multiple family members’ IV applications are approved, State’s Foreign Affairs Manual requires consular officers to provide one hard copy of the fact sheet to each family who receives IVs.

Figure 3: The “U.S. Government Fact Sheet on Female Genital Mutilation or Cutting” on Display in Waiting Area at the Post in Tanzania, March 8, 2016



Source: GAO. | GAO-16-645

According to State data, from fiscal year 2012 to 2015, about 200,000 IV recipients and over 1 million NIV recipients applied through countries where FGM/C is commonly practiced.⁵⁵ Therefore, only about one in six visa recipients in these countries would have been directly provided information about FGM/C by receiving a hard copy of the fact sheet during the interview; the remaining recipients would have been informed if they independently found and reviewed the fact sheet in the post waiting area.⁵⁶ State officials could not determine why the agency initially decided not to provide a hard copy of the fact sheet to NIV recipients. However, officials stated that NIV recipients are expected to be in the United States on a short-term, temporary basis. Further, State officials said that there

⁵⁵The total number of IVs is derived from the posts where State requires consular officers to provide the fact sheet. Because State does not require that the fact sheet be directly provided to any NIV recipients (and thus does not list posts where consular officers must do so), the total number of NIVs is derived from the countries on the Foreign Affairs Manual's broader list of countries where FGM/C is commonly practiced.

⁵⁶At a post in Iraq, we observed that the fact sheet on FGM/C was not displayed in the waiting area. After we informed State about this, they contacted the post to remind them about the requirement to display the fact sheet, and according to officials, the fact sheet is now being provided as indicated in the Foreign Affairs Manual.

are a larger number of NIV applicants, who are migratory in nature, in which case providing them with the fact sheet would be an inefficient approach to addressing FGM/C. Nevertheless, several NIVs permit stays in the United States for multiple years. For example, according to federal law, recipients of “L” NIVs—individuals (and their spouse and minor children) who are transferring from their employer’s foreign office to an office in the United States to work in a management or executive role, or in a position requiring specialized knowledge—may stay for up to 7 years for managers or executives and 5 years for specialized employees.⁵⁷ Recipients of “B” NIVs—individuals travelling to the United States for business or pleasure—are initially admitted for not more than 1 year and, if authorized by DHS, may subsequently extend their stay in increments of up to 6 months each.⁵⁸ Certain NIV recipients, such as “K,” “T,” and “U” visa holders, may be eligible for lawful permanent residence, provided they satisfy the applicable statutory criteria.⁵⁹ Furthermore, NIV recipients may overstay their visas. ICE officials identified at least one instance when a woman who overstayed her “B” visa subjected her daughters to FGM/C through suspected vacation cutting. After overstaying her visitor visa, officials said that the woman gave birth to three U.S. citizen daughters and subsequently sent two daughters back to her home country where they were suspected to have been cut. ICE officials argued that the woman should be barred from relief because she did little to protect her daughters from being subjected to FGM/C.⁶⁰

⁵⁷8 U.S.C. §§ 1101(a)(15)(L), 1184(c)(2); 8 C.F.R. § 214.2(l).

⁵⁸8 U.S.C. § 1101(a)(15)(B); 8 C.F.R. § 214.2(b). With certain exceptions, B-2 visitors for pleasure who are admissible and issued a Form I-94 will be admitted for a minimum period of 6 months, even if less time is requested, provided such individuals have a valid passport. 8 C.F.R. § 214.2(b)(2).

⁵⁹8 U.S.C. §§ 1101(a)(15)(K), (T), (U), 1255(d), (l), (m). “K” visas are for fiancées of U.S. citizens and their accompanying minor children. “T” visas are specifically for people who are or were victims of human trafficking. “U” visas are specifically for people who are or were victims of certain qualifying crimes.

⁶⁰According to officials, ICE does not have a precise record of removals related to FGM/C and many individuals involved in these cases may have been granted relief or are still in immigration proceedings.

According to the Office of Management and Budget, risk assessment should encompass all appropriate hazards (e.g., risks to human health).⁶¹ This guidance also states that the depth or extent of the analysis of the risks, benefits, and costs associated with a decision should be commensurate with the nature and significance of the decision. Under State's current approach, a relatively large number of NIV recipients from countries where FGM/C is commonly practiced may not be informed of the health and legal consequences of FGM/C and may choose to participate in the practice.

In addition to not directly notifying NIV recipients in countries where FGM/C is commonly practiced, State does not directly notify IV or NIV recipients who are nationals of these countries, but received their visas outside of the relevant countries identified by State or UNICEF. Individuals are not obligated to apply for visas in their home country, so those who are from a country where FGM/C is commonly practiced or known to be prevalent may also apply for visas at posts in other countries. For example, the U.S. post in London issued at least 6,581 NIVs to nationals of countries with known prevalence of FGM/C in fiscal year 2015, which is comparable to the number of visas issued at posts in countries with known prevalence of FGM/C, such as the post in Burkina Faso that issued 5,450 NIVs.⁶² However, under State's current policy, the NIV recipients who were issued an NIV in London would not have been directly informed about the health and legal consequences of FGM/C in the United States. Instead, this information is made available through the fact sheet posted in each post's visa section waiting area. Under State's current policy and practice as outlined in the Foreign Affairs Manual, direct provision of the fact sheet is limited to IV recipients who are issued their visas at posts in the countries where FGM/C is commonly practiced. Table 2 lists other posts that issued at least 1,000 NIVs to nationals from countries with known prevalence of FGM/C.

⁶¹See Office of Management and Budget, *Memorandum for the Heads of Executive Departments and Agencies: Updated Principles for Risk Analysis*, M-07-24 (Washington, D.C.: September 19, 2007). This memorandum is addressed to the heads of executive departments and agencies. It provides guidance and advises the agencies to (1) review their current risk analysis practices and guidelines; and (2) incorporate the outlined principles as the agencies develop, update, and issue risk analyses and guidelines.

⁶²See appendix III for the total number of NIVs issued at posts located in countries with known prevalence of FGM/C.

Table 2: NIVs Issued at Posts Outside of Countries with Known Prevalence of FGM/C to Nationals from These Countries with Known Prevalence, Fiscal Year 2015

U.S. post location	Number of nationalities from countries with known prevalence served	Number of nonimmigrant visas (NIV) issued to nationals of countries with known prevalence
London, United Kingdom	27	6,581
Dubai, United Arab Emirates	29	5,490
Toronto, Canada	28	4,587
Riyadh, Saudi Arabia	28	4,309
Doha, Qatar	27	4,277
Abu Dhabi, United Arab Emirates	23	3,299
Jeddah, Saudi Arabia	26	3,250
Calgary, Canada	28	2,817
Paris, France	30	2,437
Amman, Jordan	16	2,345
Ottawa, Canada	29	2,007
Montreal, Canada	29	1,633
Singapore	17	1,597
Kuwait City, Kuwait	23	1,519
Vancouver, Canada	26	1,296
Dhahran, Saudi Arabia	21	1,287

Source: Department of State's Bureau of Consular Affairs. | GAO-16-645

Note: This table includes posts that issued more than 1,000 NIVs in fiscal year 2015 to nationals of the 30 countries identified by the United Nations Children's Fund as having known prevalence of female genital mutilation/cutting (FGM/C).

Further, certain countries with known prevalence of FGM/C have a relatively large proportion of their nationals who were issued NIVs in countries without known prevalence. For example, in fiscal year 2015, 81 percent (3,664 of 4,525) of Yemen nationals were issued NIVs in countries where the practice was not prevalent, such as in Saudi Arabia. Also in fiscal year 2015, there were 12 nationalities that had over 1,000 individuals issued NIVs through posts located in countries without known prevalence of FGM/C. For example, 13,118 of 156,147 Nigerian nationals worldwide (about 8 percent) applied for NIVs through other posts, such as in Calgary and London. (See appendix IV for more information on the nationalities with the highest numbers and percentages of visa recipients applying through other posts.) Under State's Foreign Affairs Manual, these individuals were not directly provided information on FGM/C.

The law requires that, to the extent practicable, the provision of information on the consequences of FGM/C be limited to individuals from countries where FGM/C is “commonly practiced.” State’s current policy and practices have implemented this limiting provision by providing the fact sheet only to individuals who are issued IVs at posts located in these countries. Consular Affairs officials told us there would be significant costs and training involved with changing their current approach to make the information available to IV and NIV recipients from countries where FGM/C is commonly practiced—regardless of where the individual applied—in an identical manner. For example, officials stated that in addition to the cost of making additional photocopies of the fact sheet, they would have to update the Foreign Affairs Manual and send guidance to all posts regarding which IV and NIV recipients should receive the fact sheet.⁶³ However, we believe the costs and training associated with making the information available to NIV recipients in the same manner as for IV recipients, whether or not such IV or NIV recipients applied from posts in countries where FGM/C is commonly practiced, would be minimal under State’s current approach. For example, while consular officers would have to receive updated guidance regarding which visa recipients should receive the fact sheet, they would not have to receive any additional guidance on the content of the fact sheet because, according to Consular Affairs officials, consular officers are not supposed to engage in discussion about the fact sheet. Further, a 2014 survey by Consular Affairs found that no visa recipients had asked questions about the fact sheet. There have been thousands of IV and NIV recipients who are nationals of countries with known prevalence of FGM/C who were not directly provided this information during their visa application process. As a result, they may have entered the United States without having been made aware of the health and legal consequences of FGM/C, and they may have participated in the practice.

After arrival. After arrival in the United States, HHS, State, and USCIS provide education and assistance to immigrant communities on FGM/C through both general and targeted efforts. State’s Office of Religion and Global Affairs has ongoing outreach efforts to religious groups in U.S.

⁶³According to State officials, the level of training needed to implement such a change is dependent on where the post is located. For example, posts that only process NIVs may need additional direction than is provided in State’s Foreign Affairs Manual, as consular officers in this type of post may not be aware of the requirement to inform visa applicants about FGM/C.

immigrant communities and has targeted the issue of FGM/C. For example, agency officials said they met with the Council on American-Islamic Relations to add content about FGM/C to personal booklets, which summarize individuals' rights and responsibilities while living in the United States. According to agency officials, USCIS has prioritized raising awareness about FGM/C by developing informational materials targeted toward immigrant communities. For example, USCIS developed a general brochure with information about FGM/C similar to what is included in the fact sheet, and will develop a child-friendly brochure to inform children about actions to take if they are concerned about being subjected to FGM/C. The officials also said that they plan to develop an audiovisual product for audiences who are unable to read with information about the consequences of FGM/C.

HHS's Office on Women's Health Helpline—which is open to and intended for the general public—provides callers with information and connects them to resources on health care topics including FGM/C. Also, CDC officials told us that it can facilitate providing targeted assistance to some immigrants through the agency's role in the refugee process. CDC is responsible for ensuring that immigrants and refugees entering the United States do not pose a public health threat. The immigrant visa and refugee medical examination is one method of evaluating the health of individuals applying for entry into the United States; these mandatory exams are performed overseas by physicians under the guidance of CDC's Technical Instructions.⁶⁴ The primary purpose of the overseas

⁶⁴All applicants for immigrant visas must have a physical and mental medical examination prior to visa issuance. See 8 U.S.C. § 1201(d); 22 C.F.R. § 42.66. The purpose of the medical examination is to determine eligibility to receive a visa by identifying whether certain health conditions exist that could result in inadmissibility to the United States under the provisions of the Immigration and Nationality Act. In addition, nonimmigrant visa applicants may be required to take a medical examination under certain circumstances. See 8 U.S.C. § 1201(d); 22 C.F.R. § 41.108. Each applicant for refugee resettlement is to submit to a medical examination as required by 8 U.S.C. §§ 1201(d), 1222(b). See 8 C.F.R. § 207.2(b). The medical examination is to include: a mental status examination; and a physical examination that includes, at a minimum, examination of the eyes, ears, nose and throat, extremities, heart, lungs, abdomen, lymph nodes, skin, and external genitalia. The examination does not include a specific screening for FGM/C and an official from an organization that is responsible for providing many of the overseas exams told us that certain types of FGM/C are unlikely to be diagnosed through an external genital exam.

CDC's Technical Instructions focus on the required medical screening of refugees and immigrants for diseases of public health significance, such as tuberculosis, in accordance with U.S. immigration law.

exam is to ensure the safety and protection of U.S. public health from communicable illnesses. In addition to the Technical Instructions for overseas exams, CDC has developed the Refugee Health Guidelines, which are best practices for state public health departments and health care providers to use in conducting the initial domestic health exams of refugees upon arrival in the United States, including screening for FGM/C. According to HHS officials, there are four primary purposes of the domestic medical exam: (1) follow up on health issues identified during the overseas exam; (2) identify communicable diseases not already identified; (3) identify personal health conditions that left unidentified could impact an individual's ability to successfully resettle; and (4) refer refugees to primary care and ensure continuity of care between the overseas exam and when the refugee resettles in the United States. According to HHS officials, while the domestic health exam for the refugee resettlement process is not mandated by federal regulations, officials from HHS told us it is highly encouraged for states to perform these exams.⁶⁵ When the domestic medical exam is performed, it may provide an opportunity for health care providers to provide targeted assistance to women and girls who have undergone FGM/C, such as referrals for specialized care or mental health services. One health care provider we spoke with said that during the domestic exam, FGM/C is something that providers in his practice screen for, although they may delay this screening until they have established a relationship with the patient.

In addition to their general and targeted efforts addressing FGM/C, federal agencies have several grant programs that have either been designated specifically for or may be used to provide education and assistance to immigrant communities related to FGM/C. For example, HHS's Office on Women's Health released a funding announcement in January 2016 designated for FGM/C-related activities. The announcement was for the Female Genital Cutting Community-Centered Health Care and Prevention Project, a new project that will provide funding for organizations that focus directly on addressing problems with

⁶⁵Under 8 C.F.R. § 207.2(b), refugee applicants must submit to a medical examination prior to obtaining refugee status, and upon arrival at a U.S. port of entry for purposes of admission into the United States.

FGM/C-related health care needs and prevention.⁶⁶ Other agencies also have grant programs under which FGM/C-related activities are allowable. For example, officials from HHS's Office of Refugee Resettlement said that their office funds Ethnic Community Self-Help grants, which have provided funding to four organizations that specifically described supporting FGM/C activities.⁶⁷

DOJ also has grant programs through its Office on Violence Against Women and Office of Justice Programs (through its Office for Victims of Crime, and the Office of Juvenile Justice and Delinquency Prevention), but that are not solely designated for FGM/C-related activities. According to Office on Violence Against Women officials, the agency does not have the statutory authority to target funding to assist victims of FGM/C through the Violence Against Women Act, which funds services specifically for victims of domestic violence, dating violence, sexual assault, and stalking, and their families. However, according to DOJ officials from the Office on Violence Against Women and the Office of Justice Programs, women who have been subjected to or threatened with FGM/C could access services from the grantees if they would otherwise qualify for services. For example, DOJ's Office on Violence Against Women reported that a grantee from their Legal Assistance for Victims Program provided assistance to a woman who was a victim of domestic violence whose husband had threatened to subject her three daughters to FGM/C.

Several nongovernmental organizations and health care providers also provide education and assistance on FGM/C to immigrants and their communities. We identified two nongovernmental organizations that provide legal services for immigrants, including women and girls at risk of or who have been subjected to FGM/C. These organizations also provide referrals for other services as needed and have provided girls who are at risk of FGM/C with general guidance and preventative assistance. For example, to help prevent vacation cutting, one such organization supports the concept of developing safety plans for at-risk girls who travel abroad.

⁶⁶Applications for funding were due by April 15, 2016. The total amount to be awarded is \$2 million, which will support awards of \$50,000 to \$333,000 annually for a 3-year period for each award recipient.

⁶⁷The Ethnic Community Self-Help grant program seeks to strengthen organized ethnic groups. The program provides funding to grantees that provide ongoing support during refugees' first 5 years in the United States. According to Office of Refugee Resettlement officials, there were 27 applicants in fiscal year 2014.

According to child protection officials in one of our selected communities, another nongovernmental organization has developed protection plans for at-risk girls, such as by making copies of passports and developing strategies for helping them to escape to a consular post if in danger. We also identified two specialized clinics in the United States that provide treatment to women and girls who were subjected to FGM/C, and several health care providers who conduct research and outreach to immigrant communities on FGM/C. Additionally, there are several health care providers who offer certain FGM/C-related health care services, such as defibulation (the reconstructive surgery of scar tissue used to reverse certain types of FGM/C).

Federal Agencies and Others Have Targeted Education and Outreach Activities to Key Stakeholder Groups, but Federal Agencies Lack Documented Plans for Future Efforts

Federal agencies and other entities have made efforts to increase awareness of FGM/C for key stakeholder groups. The federal government has demonstrated a commitment to increasing awareness about FGM/C among key stakeholders in the United States, including nongovernmental organizations, law enforcement officials, immigration officials, educators, and health care providers. The United States participated in the Girl Summit 2014 hosted by the United Kingdom and UNICEF—a convening of government officials, civil society groups, and those from the private sector—to discuss domestic and international strategies for combating FGM/C and other types of gender-based violence. Following the summit, the U.S. government committed to taking several actions to address FGM/C in the United States, several of which involved education and outreach to key stakeholders. Specifically, the government committed to the education and outreach goals of

- providing information on FGM/C to educators and immigrant and refugee service provider organizations in communities throughout the United States with large populations of girls at risk;
- strengthening awareness and training for health care providers serving girls and women at risk for or living with the consequences of FGM/C, and disseminate information to clinicians in community health centers; and
- establishing an information and resources depository with links to health and legal providers, to inform women and girls of their rights, and provide options for those seeking help.

Table 3 provides a summary of selected efforts agency officials told us they have made to provide education and outreach to key stakeholder groups on FGM/C, many of which are in line with the Girl Summit commitments.

Table 3: Selected Federal Agency Efforts to Educate Key Stakeholders on Female Genital Mutilation/Cutting (FGM/C)

Key stakeholder	Efforts to educate
Law enforcement officials and prosecutors	<ul style="list-style-type: none"> • In summer 2015, the Department of Justice’s (DOJ) Federal Bureau of Investigation’s International Human Rights Unit briefed field office officials about the FGM/C statute during conference calls and briefed participants at a training conference. • The Department of Homeland Security’s Federal Law Enforcement Training Center, sponsored by U.S. Immigration and Customs Enforcement’s (ICE) Human Rights Violators and War Crimes Unit, has briefed new ICE law enforcement agents on FGM/C laws as part of ongoing mandatory training. • DOJ’s Human Rights and Special Prosecutions Section and the Executive Office for United States Attorneys issued guidance to all U.S. Attorney’s Offices on the federal FGM/C law and the basis of bringing a prosecution under the statute. • DOJ’s Human Rights and Special Prosecutions Section provided training on FGM/C at the National Conference for Victims of Crime Act for administrators from Victim Assistance offices across the United States. • DOJ’s Human Rights and Special Prosecutions Section and the Executive Office for United States Attorneys provided webinar training on FGM/C for victim witness advocates at U.S. Attorney’s Offices across the country.
Immigration officials	<ul style="list-style-type: none"> • U.S. Citizenship and Immigration Services (USCIS) began providing information on FGM/C to its Community Relations Officers in February 2015 to disseminate in the communities where they work.^a • In 2015, USCIS created a webpage with information on FGM/C. Among other resources, the webpage contains the U.S. Government Fact Sheet on FGM/C in English and relevant translations, the USCIS FGM/C brochure, and links to information and resources from other federal agencies and international organizations. • In July 2015, USCIS hosted an outreach and educational event for immigration service providers in Chicago. • USCIS incorporated FGM/C into the training that asylum and refugee officers receive, as FGM/C may be related to aspects of an individual’s eligibility determination. • In spring 2016, ICE’s Office of the Principal Legal Advisor briefed its human rights field attorneys on FGM/C criminal law and persecutor issues, and provided ICE contact information for investigative leads.
Educators	<ul style="list-style-type: none"> • The Department of Education’s (Education) Office of Safe and Healthy Students has provided information on FGM/C in various outlets to increase educators’ awareness. This outreach includes using Twitter to highlight other federal agencies’ posts on FGM/C, posting the U.S. Government Fact Sheet on FGM/C on the agency’s website, and placing several pieces of information about FGM/C in an office newsletter. • In February 2016, Education’s Office of Safe and Healthy Students hosted with DOJ’s Human Rights and Special Prosecutions Section a roundtable discussion on FGM/C. The objectives of the roundtable were to raise awareness of FGM/C for educators and representatives of national educational organizations, provide information on the health and legal consequences of FGM/C, as well as inform participants on how to identify warning signs for at-risk girls, and how to address the issue including reporting potential instances of FGM/C.
Health care providers	<ul style="list-style-type: none"> • In July and November 2015, at the request of the Washington, D.C., Board of Medicine, DOJ’s Human Rights and Special Prosecutions Section briefed the Board of Medicine on laws covering FGM/C and ways it could use its oversight role to educate health care providers about the legal implications of FGM/C.

Key stakeholder	Efforts to educate
Other cross-cutting efforts	<ul style="list-style-type: none"> <li data-bbox="459 464 1523 621">• In January 2016, the Department of State’s (State) Office of Religion and Global Affairs cohosted a panel with the Organization of Islamic Cooperation with the goal of prompting discussion and raising awareness of FGM/C to commemorate Zero Tolerance Day. The Office of Religion and Global Affairs also developed a public service announcement video that included survivors, family members, and religious leaders speaking out against FGM/C, and published an editorial article for a newspaper and a blog for State’s website on FGM/C. <li data-bbox="459 632 1523 758">• In March 2015, Education’s Office of Safe and Healthy Students cohosted a webinar with DOJ’s Office of Juvenile Justice and Delinquency Prevention, titled Keeping Kids Safe: Preventing Female Genital Mutilation/Cutting in the United States. The webinar focused on raising awareness, understanding FGM/C and its effects, providing resources to identify and prevent FGM/C, and explaining the laws that keep children safe. <li data-bbox="459 768 1523 957">• The Department of Health and Human Services (HHS) held two listening sessions on FGM/C in 2014 and 2015 with the objective of identifying lessons learned and best practices, and gaps in services for women and girls subjected to or at risk of FGM/C, and to discuss collaboration between civil society and the federal government. In October 2014, HHS held a civil society listening session on the U.S. domestic response on FGM/C with advocacy groups and officials from various federal agencies. In September 2015, HHS’s Office on Women’s Health held a listening session with advocacy groups, health care providers, and staff from federal agencies. <li data-bbox="459 968 1523 1073">• DOJ’s Human Rights and Special Prosecutions Section hosted roundtables with U.S. Attorney’s Offices in Chicago in June 2015, in Newark in September 2015, and in Washington, D.C. in February 2016 that brought together various stakeholders, including health care providers and other federal partners, to discuss the legal aspects of FGM/C. <li data-bbox="459 1083 1523 1184">• DOJ’s Human Rights and Special Prosecutions Section issued and made available on its website a brochure about FGM/C federal law with translations in Amharic, Arabic, and French, and distributed the brochure to U.S. Attorney’s Offices, nongovernmental organizations, and the human rights community.

Source: GAO analysis based on interviews and review of agency documents. | GAO-16-645.

^aAccording to USCIS, Community Relations Officers are external communicators positioned within every USCIS District Office across the United States. These individuals provide support to the Public Engagement Division by raising awareness and promoting national programs and agency initiatives to local community leaders and organizations. USCIS’s Public Engagement Division is responsible for developing and maintaining relations with a variety of stakeholders, including community-based organizations, faith-based and advocacy groups, law enforcement entities, and others who regularly interact with USCIS and its customers. These officials develop local partnerships, inform stakeholders, and inform agency policy and procedures by gathering external feedback.

Nongovernmental organizations have also undertaken education and outreach efforts on their own to provide assistance to key stakeholder groups. For example, a nongovernmental organization in Washington, D.C., has hosted semiannual discussions about FGM/C with participants from federal agencies, European governments, various advocacy organizations, and health care providers. Additionally, two nongovernmental organizations provided training to local law enforcement agencies. One medical association has developed guidelines for treating patients who have experienced FGM/C. However, the existence of these guidelines may not be widely known among providers. Another medical association developed a brochure that pregnant women who had undergone FGM/C could give to their health care providers to help the

providers understand the practice and discuss FGM/C in a culturally sensitive and respectful manner. Further, several health care providers we spoke with have developed their own training materials on FGM/C, and have conducted speaking tours at medical schools and hospitals to raise awareness of FGM/C amongst providers, including how to treat women who have been subjected to the practice.

When we asked key stakeholder groups about the federal government's role related to education and outreach on FGM/C, these groups noted that they would like to see the federal government provide additional information on FGM/C, which would include increasing awareness on the issue. For example, officials from local child protection agencies suggested that the federal government's role should include providing education to immigrant communities, stakeholder coordination, and guidance to states on FGM/C laws and policy development. In general, despite having higher populations of immigrants from countries with known prevalence of FGM/C, local officials in our selected communities described having little or no experience encountering instances of FGM/C. Given this relative lack of experience with encountering FGM/C, some officials said that the federal government could play an important role in providing access to informational resources, including education on FGM/C and guidance on how to respond if they do encounter instances of FGM/C. In addition, local law enforcement and child protection officials told us that it would be helpful to receive training on FGM/C and guidance for mandatory reporters from the federal government.

As discussed previously, federal agencies have made efforts to increase stakeholders' awareness of FGM/C, and agency officials identified additional activities they have planned for the near future. For example, DOJ officials stated that, in June 2016, they will be part of a panel at a national conference for refugee health providers, which will include two health care providers and an FGM/C activist. DOJ officials also stated that, in June 2016, officials will participate in a webinar with the Department of Education for the American School Health Association, and will then host a roundtable for stakeholders in Maryland in coordination with the U.S. Attorney's Office, Education, FBI, HHS, ICE, and USCIS in the summer of 2016. Additionally, DOJ officials said they are working with officials from HHS's Office on Child Abuse and Neglect to discuss holding an FGM/C panel at the HHS-sponsored National Conference on Child Abuse and Neglect in August 2016. Officials from DHS told us that they are in the process of developing a child-friendly brochure to inform children about actions to take if they are concerned

about being subjected to FGM/C. Additionally, officials from State's Office of Religion and Global Affairs stated that they plan to continue their outreach to religious groups in order to better link the agency's domestic and international advocacy efforts on FGM/C.

However, the agencies have not documented their previous and planned education and outreach efforts. Therefore, it is unclear whether and how these agencies will continue or expand their efforts to key stakeholders in the longer term. Officials from all five agencies we spoke with told us that they do not have a written plan for how they will conduct education and outreach efforts on FGM/C moving forward, in part, because the agencies had not considered developing such a plan. Project management standards state that when an entity is planning a project—that is, a temporary endeavor to create a unique product, service, or result—it is important to define relevant activities and determine the scope, sequence, and schedule of those activities, among other things.⁶⁸ In addition, GAO's Standards for Internal Control in the Federal Government state that federal agencies should establish plans to help ensure goals and objectives—such as increasing awareness about FGM/C—can be met.⁶⁹ Furthermore, internal controls state that documentation of agency decisions and activities is important because it provides a means to retain organizational knowledge, mitigate the risk of having that knowledge limited to a few personnel, and communicate that knowledge to external parties, as appropriate.

Officials from DOJ told us that they were unsure how a written plan would improve coordination or efforts to conduct education and outreach beyond current efforts. For example, agency officials said that they coordinate with other agencies in planning education and outreach activities and share information about planned activities, as needed, through email or

⁶⁸See Project Management Institute, *A Guide to the Project Management Body of Knowledge (PMBOK guide)*, 5th ed. (Newtown Square, Pa.: 2013).

⁶⁹See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014).

meetings, which we have identified as a promising practice for agencies that have similar goals and objectives.⁷⁰

However, having a written plan can assist agencies in communicating their intended education and outreach activities on FGM/C, and benefit agencies' coordination efforts and information sharing with one another. Moreover, given that stakeholders we interviewed have expressed interest in receiving additional information and guidance on FGM/C from the federal government, it would also be beneficial for agencies to articulate and share their education and outreach plans with these stakeholders as appropriate. It is important to equip key stakeholders, particularly those at the state and local level, with information on the health and legal consequences of FGM/C, so that they will be able to take appropriate action and provide needed assistance when appropriate if they encounter someone who is at risk of or has been subjected to FGM/C. Additionally, documentation, such as a written plan, could assist agencies by establishing and communicating the who, what, where, when, and why regarding efforts to increase awareness about FGM/C. Without a documented plan for each agency's education and outreach efforts, agencies may be unable to ensure that activities on FGM/C meet the needs of external parties, such as key stakeholder groups, or effectively use federal resources to combat FGM/C. Furthermore, given the different agencies that play a role in providing education and outreach on FGM/C in the United States and the likelihood that these agencies may conduct outreach to similar stakeholders, having a written plan that is shared with other agencies could help enhance agencies' ongoing coordination and collaboration efforts.

Conclusions

Estimates suggest that at least 200 million women and girls worldwide have been subjected to FGM/C, and about half a million in the United States are at risk of or have undergone the practice. FGM/C has both immediate and long-term health and social consequences. While federal agencies have made efforts to provide assistance to women and girls in

⁷⁰See GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, [GAO-06-15](#) (Washington, D.C.: Oct. 21, 2005). Officials from several agencies told us that the National Security Council staff's sub-Interagency Policy Committee on FGM/C includes agencies throughout the federal government, such as DHS, DOJ, Education, HHS, and State. We attempted to confirm information about the sub-Interagency Policy Committee with National Security Council staff; however, they declined to provide any information on activities related to FGM/C.

the United States at risk of or who have been subjected to FGM/C, and increase awareness of the issue, certain efforts to educate immigrant communities and plan agency activities on FGM/C are lacking. Since the Department of State does not provide a fact sheet on FGM/C directly to NIV recipients or to any visa recipients from countries where FGM/C is commonly practiced but who apply elsewhere, these recipients may be unaware of the health and legal consequences of FGM/C and choose to participate in this practice. Given the significant long-term effects that FGM/C can have on women and girls, the potential benefit of providing the fact sheet to additional visa recipients—helping to prevent the further practice of FGM/C—outweighs the likely additional effort and costs of doing so. Furthermore, while multiple agencies throughout the federal government have made efforts to increase awareness of FGM/C through ad hoc education and outreach efforts, it is unclear how these agencies will identify and implement needed efforts moving forward. Absent a documented plan for each agency’s education and outreach efforts, the federal government may be unable to ensure that its activities to increase awareness of FGM/C are meeting the needs of and communicated effectively to external parties, such as key stakeholder groups, or that it is making the best use of federal resources. Identifying these opportunities through project planning and sharing the plans among federal agencies and stakeholder groups with different roles and expertise could potentially enhance collaboration to combat FGM/C in the United States, and be responsive to stakeholders’ request for additional guidance.

Recommendations for Executive Action

To increase awareness of the health and legal consequences of FGM/C among visa recipients, we recommend that the Secretary of State update the Foreign Affairs Manual to require

- posts located in countries where FGM/C is commonly practiced to directly provide information about FGM/C to nonimmigrant visa recipients in the same manner as is done for immigrant visa recipients; and
- posts located outside of the countries where FGM/C is commonly practiced to directly provide information on FGM/C to immigrant and nonimmigrant visa recipients who are nationals of countries where FGM/C is commonly practiced.

To make the best use of federal resources directed toward combating FGM/C in the United States, we recommend that the Attorney General and the Secretaries of Education, Health and Human Services, Homeland Security, and State each

-
- develop a written plan that describes the agency’s approach for conducting education and outreach to key stakeholders in the United States regarding FGM/C; and
 - communicate the plan with other relevant federal agencies and stakeholder groups, as appropriate.

Agency Comments and Our Evaluation

We provided a draft of this report to DHS, DOJ, Education, HHS, and State. The agencies provided technical comments, which we incorporated as appropriate. DHS, Education, HHS, and State also provided written comments, which are reprinted in appendixes V, VI, VII, and VIII.

State agreed with our recommendation that it expand the direct provision of information about FGM/C to immigrant and nonimmigrant visa recipients who are nationals of countries where FGM/C is commonly practiced. In its written comments, State described its plan to change the manner in which the fact sheet is distributed. As part of that change, State’s Bureau of Consular Affairs is revising its current procedure in order to provide the fact sheet to applicants electronically during the application process. Once electronic, the Bureau of Consular Affairs will directly provide the fact sheet to applicants for both immigrant and nonimmigrant visas who are nationals from countries where FGM/C is commonly practiced no matter where they apply. State will then update the Foreign Affairs Manual to reflect this new process.

State disagreed with our recommendation that it develop and share a written plan, and, in its agency comments, emphasized that its activities are to provide information about FGM/C abroad and not domestically. However, as we noted in the report, State’s Office of Religion and Global Affairs has undertaken several activities to reach out to immigrant populations as part of its efforts to link the agency’s domestic and international advocacy on FGM/C. While State’s domestic activities may be limited to this population, we believe that having a plan to describe its role and outreach efforts is still important to communicate to other agencies and key stakeholders.

DHS, DOJ, Education, and HHS generally concurred with our recommendation that each agency develop and share a written plan on their FGM/C education and outreach efforts. In agreeing with the premise of our recommendation, Education noted in its written comments the importance of coordination across the federal government to improve collaboration and be responsive to stakeholder needs. For this reason, Education suggested that our recommendation designate a lead agency

to coordinate a written plan so that agencies can agree on the roles and responsibilities for outreach and education. HHS similarly stated that a single, unified strategy would be more effective, and that leadership for coordinating and disseminating such a strategy would best be filled by the National Security Council staff's sub-Interagency Policy Committee. While we recommended that each agency develop its own plan, if the agencies, under the leadership of National Security Council staff or a designated lead agency that they select, prefer to develop a single plan, we believe that such an approach would be consistent with the intent of our recommendation.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from its date. At that time, we will send copies to appropriate congressional committees, the Attorney General and the Secretaries of Education, Health and Human Services, Homeland Security, and State. The report is also available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact us at (202) 512-7114 or crossem@gao.gov, or (202) 512-8777 or goodwing@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IX.

Sincerely yours,



Marcia Crosse
Director, Health Care



Gretta L. Goodwin
Acting Director, Homeland Security and Justice

Appendix I: Scope and Methodology

In this report, we examine

1. what is known about the number of women and girls in the United States at risk of or who have been subjected to female genital mutilation/cutting (FGM/C);
2. the protections available and actions taken, if any, by federal and selected state and local agencies to protect women and girls in the United States at risk of or who have been subjected to FGM/C; and
3. the extent to which federal agencies and others have taken action to educate and assist immigrant communities and key stakeholders about FGM/C.

To examine what is known about the number of women and girls in the United States at risk of or who have been subjected to FGM/C, we collected and reviewed agency documentation and journal articles, as well as interviewed agency officials. Specifically, we collected and reviewed documentation from the Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC), including the agency's estimates on the prevalence of FGM/C among women and girls living in the United States for 1990 and 2012. We also collected and reviewed documentation related to efforts to measure FGM/C prevalence in the United Kingdom, as well as journal articles and reports from the United States and other countries, and publications from nongovernmental organizations and medical associations.¹ In addition, we interviewed officials at CDC and government officials from the United Kingdom about their efforts to measure prevalence.

To examine the protections available and the actions taken to protect women and girls at risk of or who have been subjected to FGM/C, we reviewed documentation from and held interviews with federal agency officials who are responsible for managing the relevant immigration processes, which foreign women at risk of or who have been subjected to FGM/C could use to avoid potential harm in their home countries. Specifically related to the asylum process, we spoke with officials from the Department of Homeland Security's (DHS) U.S. Citizenship and

¹During the course of our work, experts we spoke with told us that the United Kingdom's efforts to measure prevalence of FGM/C were well-known and considered advanced. As such, we sought information on these efforts through documents and interviews with government officials to inform our understanding of alternate methods to estimate prevalence.

Immigration Services (USCIS) about trends in FGM/C-based affirmative asylum claims they adjudicate.² We also spoke with officials from the Department of Justice's (DOJ) Executive Office for Immigration Review (EOIR) and DHS's U.S. Immigration and Customs Enforcement (ICE) about trends in FGM/C-based asylum and withholding of removal cases adjudicated in immigration courts. Related to the refugee process, we spoke with officials from the Department of State's (State) Bureau of Population, Refugees, and Migration, HHS's Office of Refugee Resettlement, and USCIS about their efforts to resettle refugees in the United States who come from countries with known prevalence of FGM/C. We also interviewed officials from two relevant nongovernmental organizations—Sanctuary for Families and the Tahirih Justice Center—both of which provide legal support to immigrant women. In addition, we obtained case information from and interviewed agency officials who are responsible for investigating and prosecuting FGM/C-related crimes, including officials from DOJ's Human Rights and Special Prosecutions Section and Federal Bureau of Investigation (FBI). We also spoke with officials from ICE regarding investigations.

In order to estimate the number of women and girls who are at risk of or who have been subjected to FGM/C and were granted affirmative asylum in the United States, we obtained data and reviewed case files on granted affirmative asylum claims involving females from countries with known prevalence of FGM/C, as identified by the United Nations Children's Fund (UNICEF) in 2013.³ Specifically, we obtained data on individual asylum applicants from USCIS's Refugee, Asylum, and Parole System database for all cases adjudicated by USCIS in fiscal years 2014 and 2015. We chose this time period to understand recent efforts to seek asylum among females from countries with known prevalence of FGM/C. To determine the reliability of the data, we reviewed relevant documentation from USCIS on the database, conferred with knowledgeable officials, and reviewed the data for any obvious errors or abnormalities. We determined that the data were sufficiently reliable for the purposes of our reporting objectives. We analyzed the data to develop a list of cases involving

²Affirmative asylum claims are those filed with USCIS at the initiative of the applicant.

³See UNICEF, *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change* (New York, N.Y.: July 2013). UNICEF's 2013 report identified 29 countries with known prevalence of FGM/C, and was the most recent data published by UNICEF at the time of our analysis. Federal agencies commonly use UNICEF's statistical work to identify countries with prevalence of FGM/C.

female applicants from the countries with known prevalence of FGM/C who were granted asylum affirmatively by USCIS during this time period. We then selected a random, generalizable sample of 100 cases from a population of 2,756 cases and reviewed the alien file associated with each case to determine whether USCIS had granted asylum, at least in part, on the basis of FGM/C.⁴ We limited our review of files to affirmative asylum cases granted by USCIS rather than affirmative cases granted by EOIR after referral from USCIS, defensive asylum claims originating in removal proceedings, or claims for withholding of removal, because EOIR—the agency responsible for adjudicating these types of cases in immigration court—does not track certain factors such as the gender of the applicant and the underlying grounds that support the applicant’s claim for relief or protection from removal. Further, DHS and DOJ officials told us that the highest volume of FGM/C-based asylum claims would be affirmative asylum claims.⁵ To enhance and confirm our understanding of the data, we also conducted interviews with USCIS asylum officers in five of the eight asylum offices nationwide, as well as ICE attorneys responsible for litigating asylum cases in the four immigration courts that serve areas with large populations of immigrants from countries with known prevalence of FGM/C. Our methodology for selecting the locations for these interviews is described in more detail below.

To learn about the actions taken on the local level to protect women and girls who are at risk of or have been subjected to FGM/C, we interviewed officials from selected local law enforcement and child protective services agencies on the extent to which the agencies had conducted any FGM/C-related investigations. These agencies were located in four communities with large populations of immigrants from countries with known

⁴USCIS creates an alien file, called an A-file, to serve as the one central file for all of the applicant’s immigration-related applications and related documents. There were additional asylees in our sample who had been subjected to FGM/C, but USCIS did not grant asylum affirmatively on that basis and instead granted asylum on other grounds. In addition, one alien file we reviewed was associated with an affirmative asylum claim filed with USCIS, which was granted by EOIR after referral from USCIS.

⁵Officials from State and USCIS told us that refugees do not typically seek refugee status on the basis of FGM/C; therefore, we did not request similar data on refugees. However, we did receive data from State on the number of refugees from countries with known prevalence of FGM/C that resettled in the United States in fiscal years 2014 and 2015. To assess the reliability of these data, we asked officials questions about how the data are entered and maintained, and determined that the data were sufficiently reliable for our purposes.

prevalence of FGM/C. To select these communities, we consulted data from multiple sources. These included

- UNICEF's 2013 statistical report on FGM/C,⁶
- U.S. Census Bureau's 2008 American Community Survey data on foreign-born populations from Africa,
- Population Reference Bureau's 2015 report that identified the top 10 metropolitan statistical areas in the United States for women and girls potentially at risk of FGM/C,⁷ and
- field locations for key federal agencies we planned to interview, such as the local asylum offices that serve these metropolitan statistical areas.

We then compared the metropolitan statistical areas identified by the American Community Survey, the Population Reference Bureau, and asylum office locations to find areas of overlap. Through this analysis, we identified three metropolitan statistical areas that were present in all three sources—Washington, D.C.; Los Angeles, California; and New York City, New York/Newark, New Jersey. Given that UNICEF data reports the highest prevalence of FGM/C in Somalia, we wanted to ensure that at least one metropolitan statistical area with a large population of Somali-born immigrants was included. Therefore, we added Minneapolis, Minnesota, as an additional community for our review. To target our interviews with local law enforcement and child protection agencies, we used 2014 county-level American Community Survey data to identify the single county within each of the four metropolitan statistical areas that had the largest African-born population from countries with known prevalence of FGM/C.⁸ The counties we identified were Montgomery County, Maryland (Washington, D.C.); Los Angeles County, California

⁶See UNICEF, *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*.

⁷This part of our analysis was conducted before UNICEF's 2016 release of updated FGM/C statistics, which added Indonesia to its list of countries where FGM/C is prevalent.

⁸For the purpose of focusing on countries where FGM/C is prevalent, we defined "African-born" as individuals who were born in one of the 29 countries identified in UNICEF's 2013 statistical report identifying countries where FGM/C is prevalent. We defined an "African-born family" as any household in which (1) the head-of-household is African-born, or (2) the head-of-household's spouse is African-born. Therefore, all individuals residing in these households, including U.S. citizen children with African-born parents, were included in the counts produced for each county.

(Los Angeles); Bronx County, New York (New York City/Newark); and Hennepin County, Minnesota (Minneapolis).

To examine the extent to which the federal agencies and others have taken action to educate and assist immigrant communities and key stakeholders about FGM/C, we reviewed documentation and interviewed agency officials from the Department of Education’s Office of Safe and Healthy Students; DHS; DOJ; HHS’s CDC, Office of Refugee Resettlement, and Office on Women’s Health; and State regarding their outreach and collaborative efforts. We also interviewed health care providers who are knowledgeable about FGM/C and officials from three medical associations, as well as three nongovernmental organizations on their outreach efforts. For the medical associations, we interviewed officials from the American Congress of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American College of Nurse-Midwives. For the nongovernmental organizations, we interviewed officials from Isuroon, Safe Hands for Girls, Sanctuary for Families, and the Tahirih Justice Center. To understand FGM/C efforts at the state and local level, we contacted state refugee health coordinators, and state and local health department officials from our selected communities and corresponding states. We also spoke with officials from three school districts in the Washington, D.C., metropolitan area—Montgomery County Public Schools (Maryland), Alexandria City Public Schools (Virginia), and Fairfax County Public Schools (Virginia). Further, we spoke with the National Association of School Psychologists. We also assessed federal agency actions against the relevant standards for internal control in the federal government.⁹

To understand State’s outreach efforts pertaining to informing visa recipients on the consequences of FGM/C, we obtained data from State’s Bureau of Consular Affairs on the number of immigrant visas (IV) and nonimmigrant visas (NIV) issued during fiscal years 2012 through 2015 to individuals from and posts located in countries with a known prevalence of FGM/C. Per State’s Foreign Affairs Manual, consular officers are to (1) provide a copy of the U.S. Government Fact Sheet on FGM/C to individuals who were issued an IV at specific posts designated to provide IV services to the 30 countries where State determined FGM/C is

⁹Internal control is a process effected by an entity’s oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

commonly practiced (direct notification); and (2) display a copy of the fact sheet in the waiting area of all posts worldwide (indirect notification).¹⁰ To determine how many IV and NIV recipients from the countries where FGM/C is commonly practiced, including nationals from those countries, were directly versus indirectly provided information on FGM/C, we obtained and analyzed IV and NIV data. For the 30 countries identified by State as being where FGM/C is commonly practiced, we analyzed State data from fiscal year 2012 to 2015 on (1) the total number of IVs issued by the 20 posts that provide IV services, and (2) the total number of issued NIVs by the 27 countries with posts that provide NIV services.¹¹ For the 30 countries determined by UNICEF as being where FGM/C is considered prevalent, we analyzed State data from fiscal year 2015 on (1) the total number of NIVs issued to nationals of each of the 30 countries, and (2) the number of NIVs issued at a post located outside of the 30 countries to nationals of the 30 countries.¹² We chose the time period of fiscal years 2012 through 2015 to be able to identify any trends before and after vacation cutting was added to the statute criminalizing FGM/C in 2013.¹³ We obtained data from two systems used by State's Bureau of Consular Affairs: the Immigrant Visa Allocation Management System and the Consular Consolidated Database. We assessed the reliability of the data by reviewing documentation provided by the Bureau of Consular

¹⁰9 FAM 504.10-4 Female Genital Mutilation Notification. We used the version of the Foreign Affairs Manual in which the section covering the provision of information about FGM/C was updated on November 18, 2015. Not every country where FGM/C is commonly practiced has an IV-issuing post. In such cases, Consular Affairs designates a processing post in another post to serve individuals who would otherwise apply in their own countries. For example, Somalia does not have post, so the post in Djibouti is designated to process IV applications for individuals from Somalia. Nonetheless, individuals may apply for visas at any visa-issuing post worldwide.

¹¹State's Foreign Affairs Manual includes a list of 30 countries where FGM/C is currently practiced, which differs from the list of countries identified by UNICEF. Unlike UNICEF's list, State's list includes the Democratic Republic of the Congo and does not include Indonesia. The remaining 29 countries are the same. Among State's list of countries, the manual also lists 20 specific posts where consular officers are required to provide a hard copy of the fact sheet to IV recipients. There are 27 NIV-issuing countries among the 30 countries listed in State's Foreign Affairs Manual.

¹²Unlike State's Foreign Affairs Manual, UNICEF's 2016 release of updated FGM/C statistics lists 30 countries with known prevalence data of FGM/C, which includes Indonesia and does not include the Democratic Republic of the Congo. The remaining 29 countries are the same.

¹³For data based on visa recipients' nationality, we limited our analysis to fiscal year 2015 in order to provide the most recent information on immigration patterns.

Affairs, speaking with knowledgeable agency officials, and reviewing our prior work on the systems. We determined that the data obtained from these systems were sufficiently reliable for the purposes of our reporting objectives. We also examined the agency's decisions to target information to certain visa recipients against the Office of Management and Budget's Memorandum on Updated Principles for Risk Analysis.¹⁴

We conducted this performance audit from June 2015 to June 2016 in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁴According to the guidance from the Office of Management and Budget, risk assessment should encompass all appropriate hazards (e.g., risks to human health). This guidance also states that the depth or extent of the analysis of the risks, benefits, and costs associated with a decision should be commensurate with the nature and significance of the decision.

Appendix II: U.S. Government Fact Sheet on Female Genital Mutilation or Cutting

U.S. Government Fact Sheet on Female Genital Mutilation or Cutting (FGM/C)

The United States is committed to ending female genital mutilation or cutting (FGM/C). If you believe you are at risk of FGM/C, know of someone at risk of FGM/C, have questions about FGM/C, or have undergone FGM/C and need help or further information, please contact the number below.

What Is FGM/C?

FGM/C refers to cutting and other procedures that injure the female genital organs for non-medical reasons. It may be called “female circumcision” in certain parts of the world. The practice has no health benefits and can lead to a range of physical and mental health problems.

What Are the Health Effects of FGM/C?

Immediate effects may include blood loss, severe pain, and sometimes death. Long-term health problems can include urinary infections, fistula, infertility, painful menstruation or sexual intercourse, and a potential increase in the risk of HIV/AIDS infection. In addition, women who have had FGM/C are significantly more likely to experience difficulties during childbirth and their babies are more likely to die as a result of the practice. Finally, the practice often leaves girls and women feeling scared, psychologically scarred, embarrassed, and distressed.

What Is the U.S. Government’s View on FGM/C?

The U.S. Government opposes FGM/C, no matter the type, degree, or severity, and no matter what the motivation for performing it. The U.S. Government understands that FGM/C may be carried out in accordance with traditional beliefs and as part of adulthood initiation rites. Nevertheless, the U.S. Government considers FGM/C to be a serious human rights abuse, and a form of gender-based violence and child abuse.

Why Is the United States Providing This FGM/C Notice?

The United States is committed to ending FGM/C to protect the health and well-being of, and advance the rights of, women and girls globally. The United States is working at home and in other countries to help educate people about the serious, damaging effects of FGM/C on women and girls.

What Are the Criminal Consequences of Performing or Assisting in FGM/C?

It is against U.S. law to perform FGM/C on a girl under the age of 18, or to send or attempt to send her outside the United States so FGM/C can be performed. Violation of the law is punishable by up to 5 years in prison, fines, or both. There is no exception for performing FGM/C because of tradition or culture. Cutting and other procedures that injure the female genital organs of a girl under 18 are prohibited under U.S. law.

What Are the Immigration Consequences of Violating the Laws Against FGM/C?

Violating the laws against FGM/C – even without a criminal conviction – may have significant immigration consequences, including making one inadmissible to or removable from the United States, as well as ineligible for some immigration benefits.

Have Women Who Have Undergone FGM/C Broken Any Laws?

*A girl or woman who has undergone FGM/C is **not** at fault. She has **not** violated any U.S. laws by undergoing the procedure.* Eligibility for travel to or for immigration benefits from the United States is not negatively affected by the fact that a person has undergone FGM/C.

Where Can One Find Additional Resources?

If you believe you are at risk of FGM/C or have undergone FGM/C, have questions about FGM/C, have information about someone who is performing FGM/C in the United States, or know of someone who may be at risk of having the procedure done here or outside the United States, please contact this number for additional information about available resources: **1-800-994-9662**

Appendix III: Nonimmigrant Visas Issued in Countries with Known Prevalence of Female Genital Mutilation/Cutting

Table 4: Total Number of NIVs Issued at Posts Located in Countries with Known Prevalence of FGM/C, Fiscal Year 2015

Post location: Country (City)	Total number of NIVs issued
Nigeria (Lagos)	88,994
Nigeria (Abuja)	54,436
Indonesia (Jakarta)	52,662
Egypt (Cairo)	40,395
Kenya (Nairobi)	20,834
Indonesia (Surabaya)	12,472
Ethiopia (Addis Ababa)	12,360
Ghana (Accra)	9,481
Uganda (Kampala)	7,973
Tanzania (Dar es Salaam)	7,967
Cameroon (Yaoundé)	7,479
Burkina Faso (Ouagadougou)	5,450
Cote D'Ivoire (Abidjan)	5,204
Liberia (Monrovia)	4,533
Senegal (Dakar)	3,828
Iraq (Erbil)	3,728
Sudan (Khartoum)	2,591
Iraq (Baghdad)	1,982
Mali (Bamako)	1,951
Benin (Cotonou)	1,822
Togo (Lomé)	1,691
Eritrea (Asmara)	1,637
Mauritania (Nouakchott)	1,466
Sierra Leone (Freetown)	1,426
Niger (Niamey)	1,355
Guinea (Conakry)	1,328
Chad (N'Djamena)	1,176
Gambia (Banjul)	985
Yemen (Sanaa)	656
Djibouti (Djibouti)	655

Source: GAO analysis of data from the Department of State's Bureau of Consular Affairs. | GAO-16-645

Notes: The posts included are those located on the United Nations Children's Fund's (UNICEF) list of countries with known prevalence of female genital mutilation/cutting (FGM/C). These totals include nonimmigrant visas (NIV) issued to individuals who were nationals of the country in which they applied, in addition to individuals who were foreigners of the countries in which they applied. Not all of the countries identified by UNICEF are listed, because some countries do not have a post, such as Somalia. Also, some countries have multiple posts, such as Indonesia.

Appendix IV: Nationals of Countries with Known Prevalence of Female Genital Mutilation/Cutting Issued Nonimmigrant Visas in Countries without Known Prevalence

Table 5: Nationals of Countries with Known Prevalence of Female Genital Mutilation/Cutting (FGM/C) Who Were Issued the Most or Highest Proportions of NIVs at Posts Located in Countries Without Known Prevalence, Fiscal Year 2015

Nationality (Country)	Number of NIVs issued in countries without known prevalence	Total NIVs issued in posts worldwide	Percentage of NIVs issued in countries without known prevalence
Bissau-Guinean (Guinea-Bissau)	66	176	38%
Cameroonian (Cameroon)	2,681	10,089	27%
Central African (Central African Republic)	63	285	22%
Egyptian (Egypt)	16,028	55,317	29%
Eritrean (Eritrea)	1,019	2,810	36%
Ethiopian (Ethiopia)	2,324	14,573	16%
Ghanaian (Ghana)	2,320	11,660	20%
Indonesian (Indonesia)	6,011	70,297	9%
Iraqi (Iraq)	7,569	13,499	56%
Kenyan (Kenya)	2,862	22,090	13%
Nigerian (Nigeria)	13,118	156,147	8%
Senegalese (Senegal)	1,228	4,684	26%
Somali (Somalia)	208	331	63%
Sudanese (Sudan)	2,648	5,080	52%
Yemeni (Yemen)	3,664	4,525	81%

Source: GAO analysis of data from the Department of State's Bureau of Consular Affairs. | GAO-16-645

Note: Neither immigrant visas nor nonimmigrant visas (NIV) are processed in Guinea-Bissau, the Central African Republic, or Somalia.

Appendix V: Agency Comments from the Department of Education



UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF ELEMENTARY AND SECONDARY EDUCATION

WASHINGTON, D.C. 20202

THE ASSISTANT SECRETARY

JUN 13 2016

Ms. Marcia Crosse
Director, Health Care

Ms. Gretta Goodwin
Acting Director, Homeland Security and Justice
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Crosse and Ms. Goodwin:

I am writing in response to the recommendation made in the U.S. Government Accountability Office (GAO) draft report, "Female Genital Mutilation/Cutting: Federal Efforts to Increase Awareness Need Improvement" (GAO-16-645). I appreciate the opportunity to comment on the draft report on behalf of the U.S. Department of Education (Department).

We appreciate GAO's review of the federal response to address female genital mutilation/cutting (FGM/C) for women and girls at risk of or who have ever been subjected to the practice in the United States. The report acknowledged some of the successful Federal agency and interagency work that has been done in this area. The report has offered a recommendation, and we provide our response to the recommendation below:

Recommendation: *To make the best use of federal resources directed toward combatting FGM/C in the United States, we recommend that the Attorney General and the Secretaries of Education, Health and Human Services, Homeland Security, and State each:*

- *develop a written plan that describes the agency's approach for conducting education and outreach to key stakeholders in the United States regarding FGM/C;*
- *and*
- *communicate the plan with other relevant federal agencies and stakeholder groups, as appropriate.*

Response: We are always interested in improving coordination across all levels of government, and we share the view outlined in the report that improved Federal coordination will better enhance collaboration to combat FGM/C in the United States and be responsive to stakeholders' request for additional guidance.

www.ed.gov

400 MARYLAND AVE., SW, WASHINGTON, DC 20202

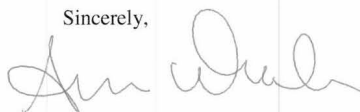
The Department of Education's mission is to promote student achievement and preparation for global competitiveness by fostering educational excellence and ensuring equal access.

**Appendix V: Agency Comments from the
Department of Education**

We note that other federal agencies address FGM/C as one of many domains within their portfolios. As noted in your draft report, the federal response to FGM/C requires the efforts of multiple federal agencies, including several of which have grant programs that have been designed specifically for or may be used to provide education and assistance to immigrant communities related to FGM/C. The U.S. Departments of Health and Human Services and Justice are two such agencies with funding allocated for this purpose. In view of this significant role for other agencies around FGM/C, we would encourage GAO to modify its report to recommend the selection of a lead agency charged with primary responsibility for coordinating the written plan identified by GAO. Such an approach would allow the agencies involved to agree on the assignment of roles and responsibilities best suited for educating and outreaching to key stakeholders.

We appreciate the opportunity to review the draft report and comment on the recommendation. I am enclosing a document with a technical comment.

Sincerely,



Ann Whalen
Delegated the authority to perform the
functions and duties of Assistant Secretary for
Elementary and Secondary Education

Appendix VI: Agency Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUN 13 2016

Marcia Crosse
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Crosse:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Female Genital Mutilation/Cutting: Federal Efforts to Increase Awareness Need Improvement*" (GAO-16-645).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: FEMALE GENITAL MUTILATION/CUTTING: FEDERAL EFFORTS TO INCREASE AWARENESS NEED IMPROVEMENT (GAO-16-645)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation

To make the best use of federal resources directed toward combating female genital mutilation/cutting (FGM/C) in the United States, we recommend that the Attorney General and the Secretaries of Education, Health and Human Services, Homeland Security, and State each:

- Develop a written plan that describes the agency's approach for conducting education and outreach to key stakeholders in the United States regarding FGM/C; and
- Communicate the plan with other relevant federal agencies and stakeholder groups, as appropriate.

HHS Response

HHS concurs with GAO's recommendations regarding the importance of interagency coordination to maximize federal efforts directed to combatting FGM/C in the United States. Such collaboration is critical to ensure that resources are leveraged appropriately and to avoid duplication of federal efforts. As GAO noted in the report, the National Security Council's sub-Interagency Policy Committee on FGC/M (sub-IPC) currently coordinates federal efforts to address FGC/M in the United States. HHS believes that the sub-IPC remains the appropriate vehicle for such coordination, and will continue to defer to the White House for direction regarding any strategy or plan under its purview.

While, HHS notes the importance of written plans to ensure accountability, we have concerns that five distinct federal plans would inevitably result in fragmentation and duplication of efforts, and that stakeholders and the public would be better served by a single, unified strategy. HHS would defer to the sub-IPC for coordination and dissemination of such a strategy.

Appendix VII: Agency Comments from the Department of Homeland Security

U.S. Department of Homeland Security
Washington, DC 20528



**Homeland
Security**

June 14, 2016

Marcia Crosse
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Gretta L. Goodwin
Director, Homeland Security and Justice
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Re: Draft Report GAO-16-645, "FEMALE GENITAL MUTILATION/CUTTING: Federal Efforts to Increase Awareness Need Improvement"

Dear Ms. Crosse and Ms. Goodwin:

Thank you for the opportunity to review and comment on this draft report. The U.S. Department of Homeland Security (DHS) appreciates the U.S. Government Accountability Office's (GAO) work in planning and conducting its review and issuing this report.

DHS fully supports the U.S. Government position on female genital mutilation/cutting (FGM/C). The U.S. Government opposes FGM/C, no matter the type, degree, or severity, and no matter what the motivation for performing it. The U.S. Government considers FGM/C to be a serious human rights abuse, gender-based violence, and, when done to children, a form of child abuse. DHS is committed to ending FGM/C and will continue its work to educate communities about the damaging effects of FGM/C.

As discussed in the draft report, efforts to address FGM/C domestically involve a variety of stakeholders at the local, state, and national levels and ongoing coordination within and among U.S. Government agencies and stakeholder groups. The Department is pleased to note GAO's positive recognition of U.S. Citizenship and Immigration Services (USCIS) and U.S. Immigration and Customs Enforcement (ICE) efforts to raise awareness of the harm caused by FGM/C, the laws prohibiting the practice, and assistance available to women and girls who have undergone FGM/C or are at risk of undergoing the procedure. For example, the draft report highlighted USCIS' creation of FGM/C educational materials available to the public, including a webpage dedicated to sharing information and resources, a brochure

that can be distributed at outreach events and via other avenues, and an interagency update of the "U.S. Government Fact Sheet on Female Genital Mutilation or Cutting (FGM/C)."

The draft report contained two recommendations for DHS, with which the Department concurs. Please see the attached for our detailed response to each recommendation.

Again, thank you for the opportunity to review and comment on this draft report. Technical comments were previously provided under separate cover. Please feel free to contact me if you have any questions. We look forward to working with you in the future.

Sincerely,



JIM H. CRUMPACKER, CIA, CFE
Director
Departmental GAO-OIG Liaison Office

**Attachment: DHS Management Response to Recommendations
Contained in GAO-16-645**

GAO recommended that the Secretary of Homeland Security:

Recommendation 1: Develop a written plan that describes the agency's approach for conducting education and outreach to key stakeholders in the United States regarding FGM/C.

Response: Concur. The USCIS Office of Policy and Strategy, working under the auspices of the DHS Council on Combatting Violence Against Women, will play a leading role in creating a plan describing the general approach and specific actions DHS plans to undertake in working toward its goal of educating and reaching key stakeholders in the United States with relevant information about FGM/C. In developing this plan, USCIS will work with other DHS components and offices having equities in this issue area, including ICE and the DHS Office of Policy, to create a coordinated and cohesive plan. Estimated Completion Date (ECD): November 30, 2016.

Recommendation 2: Communicate the plan with other relevant federal agencies and stakeholder groups, as appropriate.

Response: Concur. The USCIS Office of Policy and Strategy and other DHS components and offices, as appropriate, will consult with other relevant federal agencies and stakeholder groups throughout the creation of the plan, as needed, to improve the plan through their shared expertise, input, and feedback. Once the plan has been completed, DHS will share it with other federal agencies through existing interagency fora and lines of communication. The entire final plan or certain elements of it may also be shared with the public through outreach led by USCIS and coordinated with the DHS Council on Combatting Violence Against Women and other relevant DHS components and offices. ECD: December 31, 2016.

Appendix VIII: Agency Comments from the Department of State



United States Department of State
Comptroller

Washington, DC 20520

JUN 10 2016

Dr. Loren Yager
Managing Director
International Affairs and Trade
Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548-0001

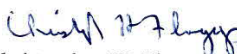
Dear Dr. Yager:

We appreciate the opportunity to review your draft report, "FEMALE GENITAL MUTILATION/CUTTING: Federal Efforts to Increase Awareness Need Improvement," GAO Job Code 100129.

The enclosed Department of State comments are provided for incorporation with this letter as an appendix to the final report.

If you have any questions concerning this response, please contact Andrea Lage, Attorney Adviser, Visa Office Legal Affairs, Bureau of Consular Affairs at (202) 485-7585.

Sincerely,


Christopher H. Flaggs

Enclosure:
As stated

cc: GAO – Marcia Crosse
CA – Michele T. Bond
State/OIG - Norman Brown

Department of State Comments on GAO Draft Report

**FEMALE GENITAL MUTILATION/CUTTING: Federal Efforts to Increase
Awareness Need Improvement**
(GAO-16-645, GAO Code 100129)

The Department of State appreciates the opportunity to comment on the draft report *Female Genital Mutilation/Cutting: Federal Efforts to Increase Awareness Need Improvement*.

Recommendation 1: To increase awareness of the health and legal consequences of FGM/C among visa recipients, we recommend that the Secretary of State update the Foreign Affairs Manual to require:

- Posts located in countries where FGM/C is commonly practiced to directly provide information about FGM/C to nonimmigrant visa recipients in the same manner as is done for immigrant visa recipients.
- Posts located outside of the countries where FGM/C is commonly practiced to directly provide information on FGM/C to immigrant and nonimmigrant visa applicants who are nationals of countries where FGM/C is commonly practiced.

Response :

The Department agrees that potentially affected populations should be provided this information. The Bureau of Consular Affairs (CA) has examined the manner in which it provides the Fact Sheet on Genital Mutilation/Cutting (Fact Sheet) as required by 8 U.S.C. 1374. The Bureau will be revising the current procedure to change the manner in which the Fact Sheet is distributed and to expand the pool of applicants who receive the Fact Sheet.

Currently, 9 FAM 504.10-4(A) requires that consular officers in posts that are the primary immigrant visa processing post for nationals from countries identified in the Foreign Affairs Manual as countries where FGM/C is commonly practiced are required to provide a copy of the Fact Sheet to principal applicants issued an immigrant visa. 9 FAM 504.10-4(A) also requires that all posts worldwide display a copy of the Fact Sheet in the immigrant and nonimmigrant visa waiting room(s).

In order to be compliant with 8 U.S.C. 1374 and ensure the Bureau continues to work towards its goal of eliminating the amount of paper that is passed back and forth between the consular officer and visa applicants, the Bureau is looking into amending its current procedure in order to provide the Fact Sheet to applicants

-2-

electronically during the application process. Once electronic, the Fact Sheet would be distributed to applicants for both immigrant and nonimmigrant visas who are nationals from countries where FGM/C is commonly practiced no matter where they apply, as follows:

- 1) All immigrant visa applicants who are or were a national of a country where FGM/C is commonly practiced would be linked directly to the Fact Sheet and would be asked to certify that he/she had read and understood the Fact Sheet before signing and submitting the DS-260, Online Application of Immigrant Visa and Alien Registration;
- 2) All nonimmigrant visa applicants who are or were a national of a country where FGM/C is commonly practiced would be linked directly to the Fact Sheet and would be required to certify that he/she had read and understood the Fact Sheet before signing and submitting the DS-160, Online Application of Nonimmigrant Visa.

The Bureau anticipates that it will take time before system adjustments can be implemented that will allow for the Fact Sheet to be provided electronically. During the intervening time period, distribution of the Fact Sheet will continue as currently proscribed, however posts worldwide will be directed to produce larger copies of the Fact Sheet for display in the visa wait room(s). The Bureau will work with the Foreign Service Institute to ensure that students in visa-related course are reminded of the requirement to provide the Fact Sheet to immigrant visa applicants. Once electronic distribution is implemented, the FAM will be updated to reflect the revised procedure. This revised procedure will ensure the widest distribution possible by providing all individuals from countries where FGM/C is commonly practiced with access to the Fact Sheet regardless of place of application or visa class while furthering the Bureau's overall goal of electronic paperless visa processing.

The Fact Sheet is currently available on travel.state.gov in English and several other languages. The Bureau will examine options to make the Fact Sheet available on the website of the primary immigrant visa processing post for countries where FGM/C is commonly practiced and all nonimmigrant visa processing post in countries where FGM/C is commonly practiced.

Recommendation 2: To make the best use of federal resources directed toward combating FGM/C in the United States, we recommend that the Attorney General

-3-

and the Secretaries of Education, Health and Human Services, Homeland Security, and State each:

- Develop a written plan that describes the agency's approach for conducting education and outreach to key stakeholders in the United States regarding FGM/C; and
- Communicate the plan with other relevant federal agencies and stakeholders group, as appropriate.

Response:

The Department rejects the recommendation and defers to the domestic agencies named in the recommendation. Although the Department is committed to providing information about FGM/C to potentially affected populations abroad, as outlined in its response to Recommendation 1, it is not responsible for conducting education and outreach to key stakeholders in the United States.

Appendix IX: GAO Contact and Staff Acknowledgments

GAO Contacts

Marcia Crosse, (202) 512-7114 or crossem@gao.gov
Gretta L. Goodwin, (202) 512-8777 or goodwing@gao.gov

Acknowledgments

In addition to the contacts named above, Robert Copeland, Assistant Director; Kristy Love, Assistant Director; Ashley Dixon; Amber Gray; Julie T. Stewart; Julia Vieweg; and E. Jane Whipple made key contributions to this report. Jill K. Center; Justin Fisher; Cynthia Grant; Eric Hauswirth; Drew Long; Amanda Miller; Jan Montgomery; Jon Najmi; and Emily Wilson also contributed to the development of this report.

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