Exploring Female Genital Cutting Among West African Immigrants

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In memory of the victims of the Liberian and Sierra Leonean civil wars and in celebration of the resilience of the human spirit!

Purpose of Study

This pilot study sought to examine the experiences of Female Genital Cutting (FGC) among West African immigrant women in the US.

Background

Female Genital Cutting (FGC), also known as Female Genital Mutilation or Female Circumcision, is a deeply rooted cultural practice, with a long and controversial history. The World Health Organization (WHO) has defined FGC as any procedure that involves partial or total removal of the external female genitalia or any injury to the female genital organs for cultural or non-therapeutic reasons (WHO, 2008).

Existing research indicates that the practice of FGC has negative repercussions for the current and future physical, psychological, emotional, sexual and reproductive health of many women, severely and negatively impacting their quality of life (Ball, 2008; Utz-Billing & Kentenich, 2008; WHO, 2008).

It has been estimated that up to 140 million women and girls worldwide have undergone some form of FGC, and each year an additional 3 million girls are at risk (WHO, 2008).

In the United States (US) alone, approximately 168,000 women and girls were determined to be living with or at risk for FGC. A majority were African immigrants residing in US metropolitan areas (Jones, Smith, Kieke, & Wilcox, 1997).

Although 16 states have instituted criminal sanctions against the practice of FGC since 1996, the rising number of African immigrants to the US from countries with high FGC prevalence rates (McCabe, 2011; WHO, 2008), along with anecdotal reports from service providers (Sussman, 2011), suggest that the practice continues within the African immigrant community.

Specific Aims

To date there has been limited research regarding the prevalence and impact of FGC among female African immigrants in the US. This lack of research is surprising considering that many African women immigrate to the US from countries with high FGC prevalence rates (Jones et al., 1997; WHO, 2008). Given this dearth of information and the fact that these African immigrant women utilize US health care systems and resources, this study seeks to document the experiences of FGC within the female African immigrant community.

Method

Recruitment

Purposive in areas with high concentrations of West Africans—i.e., Harlem, the Bronx, and the Richmond neighborhood on Staten Island. Information regarding the study was disseminated with the help of a Community Advisory Board (CAB) and African immigrant serving organizations, as well as through local West African immigrant media outlets (e.g., a radio show)

Method

Procedures

Given the widespread reluctance of West Africans to discuss their sexual behavior, it was anticipated that the combination of structured Audio Computer-Assisted Self Interview (ACASI) and open-ended interviewing would provide an opportunity for these participants to openly share their experiences and behaviors regarding sensitive topics.

Survey

- Demographic information
- Knowledge about HIV/AIDS and modes of transmission
- Pattern of condom use/sexual behavior
- Pattern of substance use
- Knowledge of HIV/AIDS services in their past and present communities
- Sources of information about HIV/AIDS
- Experiences with FGC
- Mental health wellness measures
- Open ended questions about their experiences with HIV/AIDS resources and services in home country and immigrant country

Participants

23 African forced migrant women living in NYC

- Liberian (n=12, 52%)
- Sierra Leonean (n=11, 48%)
- Christian (n=17, 74%)
- Muslim (n=6, 26%)
- Ages 20-57

Analyses

After data collection was completed, the responses to the instruments were coded and analyzed using Statistical Package for the Social Sciences (SPSS). Frequencies and descriptive statistics were calculated for all variables.

Summary of Results

- Participants with a history of FGC did not differ from participants without FGC in regards to psychological symptoms scores and traumatic life (see Table 1).
- Seven (30%) of the participants reported a history of FGC.
- Muslim participants had significantly higher rates of FGC than Female Christian participants (Fisher's Exact=.045).
- Most Muslim participants with FGC were from Sierra Leone (Fisher's Exact=.027).

Table 1: Comparison of psychological adjustment, traumatic life events, and demographics between women with and without female genital cutting.

	Women with FGC (n=7)		Women without FGC(n=16)		P
	M	SD	M	SD	
CES-D	35.4	17.3	37.5	11.3	.734[a]
PCL-C	29.9	10.3	29.2	9.6	.882[a]
Life Events Checklist	3.9	1.8	3.8	3.7	.992[a]
Country of Origin Sierra Leone, n (%)	6	85.7	5	31.3	.027[b]
Muslim, n (%)	4	57.1	2	12.5	.045[b]
Age	36.1	10.8	36.2	10.9	.993[a]

a = independent sample t-test
b = Fisher's Exact

Conclusions

Although results of this study must be viewed in light of the limitations (e.g., small sample size, exclusive focus on Liberian and Sierra Leonean forced female migrants, and narrow geographic focus), this small pilot study reflects the findings of other studies showing that while FGC varies across sub-Saharan Africa, the prevalence remains high (Sipsma et al., 2012; WHO, 2008) and is present within African immigrant communities (Kallon & Dundes, 2010).

While FGC clearly exists among both Sierra Leonean and Liberian forced migrants, the higher reported FGC among immigrant Sierra Leonean women is reflective of the higher prevalence rate in Sierra Leone, (WHO, 2008). Although there were no significant differences in psychological functioning between women who had experienced FGC and those who had not, it is possible that, for all of the participants, their more recent experiences of extensive war trauma in their home countries overshadowed other experiences.

Future Directions

- A larger study examining the impact of FGC on African immigrant women from a wider range of countries with high prevalence rates, as well as a thorough understanding of the psychosocial factors related to FGC is fundamental to the development of effective interventions.
- Future studies could focus on developing the foundation for interventions: a) to reduce the occurrence of FGC through sensitive education within African immigrant communities; b) to educate women who have already experienced FGC on how to work with their health care providers and thereby take the best possible care of themselves; and c) to train professionals to provide culturally-sensitive therapeutic services for those who have experienced FGC or are at risk for it.
- Findings from such a study could serve as an initial step towards the development of training and practice policies for mental and medical health service providers. Such policies can help reduce the prevalence of and demand for FGC among African immigrant women, as well as improve the health and quality of life of women who have undergone the procedure.

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THANK YOU!

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