Published in final edited form as:

J Immigr Minor Health. 2014 June ; 16(3): 559–561. doi:10.1007/s10903-012-9763-7.

Exploring Female Genital Cutting Among West African Immigrants

Adeyinka M. Akinsulure-Smith

The City College of New York, City University of New York

Abstract

Although many African women immigrate to the United States from countries with high prevalence rates for Female Genital Cutting (FGC), there has been limited research exploring the incidence and impact of FGC among this growing immigrant population. This pilot study sought to examine the experiences of FGC among West African immigrant women in the US. Of the 23 participants, 7 reported a history of FGC, with Muslim participants reporting significantly higher rates of FGC than Christians (Fisher's Exact=.045). Most of the women who had experienced FGC were from Sierra Leone (Fisher's Exact=.027). Limitations of the study are discussed along with suggestions for future research aimed at understanding the impact of FGC, reducing the prevalence and demand for FGC among African immigrant women and improving the health and quality of life of women who have undergone the procedure.

Keywords

Female Genital Cutting; Africans; immigrants

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.

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

Participants

Recruitment of participants from the Sierra Leonean and Liberian immigrant communities (countries with FGC prevalence rates of 94% and 45%, respectively (WHO, 2008)) was purposive and conducted throughout New York City, particularly in areas with high concentrations of these populations - Harlem, the Bronx, and Staten Island. Information regarding the study was disseminated with the assistance of a Community Advisory Board, organizations that serve African immigrants, local African businesses, and the local African media.

Data Collection

Participants were offered their choice of interview date/time and location: the Principal Investigator (PI)'s office, a private home set up within the community, or rooms set up in a local African Community-Based Organization.

Audio computer-assisted self-interview (ACASI) was used to facilitate data collection. The computer screen displayed the text of each question and its answer alternatives while a prerecorded female voice read them to the participant, who listened privately through headphones. Participants answered questions by touching the appropriate response option on the computer screen. ACASI standardizes survey administration across a variety of settings and maximizes responses to highly personal and sensitive questions. The use of ACASI has been demonstrated to increase participants' sense of privacy, thereby improving the accuracy of reporting of sensitive issues, and reducing the occurrence of socially desirable responses (Des Jarlais et al., 1999). Each participant received \$50 for her participation.

Measures

The following instruments were administered: a demographic data sheet designed for this study (including country of origin, age, ethnicity, marital status, education level, and FGC experience); the Life Events Checklist (LEC), a self-report measure of exposure to traumatic events in a respondent's lifetime (Blake et al., 1995); the PTSD Checklist – Civilian Version (PCL-C; Weathers, Litz, Herman, Huska & Keane, 1993), a self-report measure that lists the 17 *DSM-IV* symptoms of PTSD; and the Center for Epidemiologic Studies Depression Scale

(CES-D), a 20 item self-report measure of depression (Radloff, 1977). All instruments have been validated on a wide range of populations.

Analysis

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

IRB

This study was approved by the Institutional Review Board of the City College of New York, the City University of New York.

Results

The participants were 23 women from Sierra Leone (n=11, 48%) and Liberia (n=12, 52%). They were between the ages of 20 and 57, with an average age of 36.17 years (SD = 10.60). Respondents were predominantly Christian (n=17, 74%) with few Muslims (n=6, 26%). Education levels varied: 15 (65%) completed secondary school; 4 (17%) graduated from college; 2 (9%) completed trade school; 1 (4%) completed graduate school; and 1 (4%) never attended school. Respondents identified their ethnic groups as follows: 4 (17%) Bassa; 4 (17%) Kru; 3 (13%) Temne; 2 (9%) Mandingo; 2 (9%) Mende; 1 (4%) Krahn; 1 (4%) Krio; 1 (4%) Susu; 1 (4%) Sapro; 1 (4%) Fula; and 1 (4%) Kru/Bassa. Two (9%) did not answer.

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

Discussion

The small sample size and narrow focus on Sierra Leonean and Liberian women who had experienced significant civil war-related trauma may impact the generalizability of these findings to other African immigrant women. However, the fact that a third of the sample had experienced FGC speaks to a need for further exploration of this issue. 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 present within African immigrant communities (Kallon & Dundes, 2010). Although FGC clearly exists among both Sierra Leonean and Liberian immigrants, 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 were much topical.

A larger study examining the impact of FGC on African immigrant women to 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.

Acknowledgments

This research was supported by an NIMH Grant Number R25MH083602 and a Professional Staff Congress – City University of New York (PSC-CUNY) Grant Number 64459-0042 awarded to Adeyinka M. Akinsulure-Smith.

References

- Ball T. Female genital mutilation. *Nursing Standard*. 2008; 23(5):43–47. [PubMed: 18947082]
- Blake DD, Weathers FW, Nagy LM, Kaloupek DG, Gusman FD, Charney DS, Keane TM. The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress*. 1995; 8:75–90.10.1007/BF02105408 [PubMed: 7712061]
- Des Jarlais DC, Paone D, Milliken J, Turner CF, Miller H, Gribble J, Friedman SR. Audio-computer interviewing to measure risk behaviour for HIV among injecting drug users: A quasi-randomised trial. *Lancet*. 1999; 353(9153):1657–61. [PubMed: 10335785]
- Jones W, Smith J, Kieke B, Wilcox L. Female genital mutilation/female circumcision. Who is at risk in the US? *Public Health Report*. 1997; 112:368–377.
- Kallon I, Dundes L. The cultural context of the Sierra Leonean Mende woman as patient. *Journal of Transcultural Nursing*. 2010; 21(3):228–236.10.1177/1043659609358781 [PubMed: 20519726]
- McCabe, K. African immigrants in the United States. 2011. Retrieved from <http://www.migrationinformation.org/USfocus/display.cfm?ID=847>
- Radloff LS. The CES-D Scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement*. 1977; 1:385–401.10.1177/014662167700100306
- Sipsma HL, Chen PG, Ofori-Atta A, Ilozumba UO, Karfo K, Bradley EH. Female genital cutting: current practices and beliefs in western Africa. *Bulletin of the World Health Organization*. 2012; 90(2):120–127.10.2471/BLT.11.090886 [PubMed: 22423163]
- Sussman, N. After school in Brooklyn, West African girls share memories of a painful ritual. *The New York Times*. Apr 25. 2011 Retrieved from <http://www.nytimes.com/2011/04/26/nyregion/brooklyn-girls-from-west-africa-recall-genital-cutting.html>
- Utz-Billing I, Kantenich H. Female genital mutilation: an injury, physical and mental harm. *Journal of Psychosomatic Obstetrics & Gynecology*. 2008; 29(4):225–229.10.1080/01674820802547087 [PubMed: 19065392]
- Weathers, F.; Litz, B.; Herman, D.; Huska, J.; Keane, T. The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. Paper presented at the annual meeting of the International Society for Traumatic Stress Studies; San Antonio, TX. 1993 Oct.
- World Health Organization. Eliminating female genital mutilation: an interagency statement. 2008. Retrieved from http://whqlibdoc.who.int/publications/2008/9789241596442_eng.pdf

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

Table 1

	Women with FGC (n=7)		Women without FGC(n=16)		<i>P</i>
	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