Int. Migration & Integration (2018) 19:259–276
https://doi.org/10.1007/s12134-018-0544-6

West African Immigrant Perspectives on Female Genital Cutting: Experiences, Attitudes, and Implications for Mental Health Service Providers

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Published online: 12 February 2018

Abstract This small pilot study analyzed the experiences of female genital cutting (FGC) among West African immigrants in New York City from three West African countries (the Gambia, Guinea, and Mali) with FGC prevalence rates of 76, 97, and 89%, respectively, among girls and women aged 15 to 49 years. Nine women participated in two focus group sessions. In the first group, five female participants ranged in age from18–20, and in the second, four participants ranged in age from 31 to 44. Focus group data were analyzed using a grounded theory approach. Despite the small sample size, the findings of this exploratory study highlight important aspects of immigrant women's experiences regarding FGC and indicate the need for further exploration. Participants drew from personal experiences to discuss FGC and their views of the practice. Salient themes that emerged included the secretive and violent nature of the practice, the primacy of matriarchal decision-makers, the fear among immigrant mothers that their children would be subjected to FGC without their consent, and health care encounters in the USA. The findings of this study are considered in light of their implications for research, service provision, and policy.

This research was supported by a Professional Staff Congress—City University of New York (PSC-CUNY) Grant Number 66771-00 44 awarded to Adeyinka M. Akinsulure-Smith.

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Keywords Female genital cutting · Female circumcision · Female genital mutilation · African immigrants · Gender-based violence

Introduction

The practice of female genital cutting (FGC), also referred to as female genital mutilation or female circumcision, is a deeply rooted traditional practice around the world. The World Health Organization (WHO) defines female genital mutilation/cutting (FGM/C) 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 2016). Service providers and scholars have long argued that the conditions under which FGC occurs can create severe short- and long-term consequences on reproductive and mental health (Abor 2006; Ball 2008; Behrendt and Moritz 2005; Larsen and Okonofua 2002; Mulongo et al. 2014; Nour 2004; Raya 2010; Whitehorn et al. 2002; WHO 2016; Utz-Billing and Kentenich 2008). Despite their arguments, it has been estimated that at least 200 million women and girls worldwide have undergone some form of FGC, and each year some 3 million girls are at risk (United Nations Children's Fund 2016; WHO 2016).

Migration Patterns and FGC

In recent years, global migration patterns have led to the spread of FGC, from regions in sub-Saharan Africa and the Middle East where it is most prevalent, to Western countries (Baron and Denmark 2006; Utz-Billing and Kentenich 2008; Whitehorn et al. 2002). In countries like the United States (US), the sub-Saharan African immigrant population is one of the fastest growing immigrant communities. Rising steadily over the years, the sub-Saharan African immigrant population has nearly doubled every decade between 1980 and 2010, and increased by 29% between 2010 and 2015. By 2015, there were 2.1 million sub-Saharan Africans living in the US (Anderson 2017). Within this burgeoning immigrant group, approximately 44.6% originated from West Africa, 35.7% from East Africa, 7.5% from Central Africa, and 5.8% from Southern Africa (Zong and Batalova 2017). The majority of this immigrant population is from countries in sub-Saharan Africa with high FGC prevalence rates (Mather and Feldman-Jacobs 2015). The majority have settled in California, Maryland, New Jersey, New York, Texas, and Virginia (Anderson 2017).

Preliminary findings by the Population Research Bureau noted that in 2013, approximately 507,000 women and girls in the US had undergone FGC or were at risk of the procedure (Mather and Feldman-Jacobs 2015). New York State, one of the top destinations for sub-Saharan African immigrants (Anderson 2017), hosts the greatest estimated numbers of girls and women at risk for FGC (Sanctuary for Families 2013). However, these estimates, derived from prevalence rates from immigrants' home countries, do not necessarily reflect the reality that immigrant populations are often fundamentally different from those that remain (Jasso et al. 2004). As such, they as a group warrant special attention, not just in terms of establishing prevalence, but with regard to experiences regarding the procedure, both pre- and post-migration.

Even though the number and diversity of African immigrants in the US has increased, their needs and practices remain poorly understood and there is a growing need to evaluate their health care needs and practices (Venters et al. 2011; Venters and Gany 2011).

Sanctions Against FGC in the US

With the passage of Federal Prohibition of Female Genital Mutilation Act in 1996, performing FGC on anyone under the age of 18 years of age became illegal in the US (Nour 2015). While 24 of 50 states have criminalized FGC since 1994, there is variability among state laws. As noted by Akinsulure-Smith and Sicalides (2016), some states outlaw the practice on any female regardless of age, while others address the need for culturally sensitive education and outreach to affected communities. At least 12 states have made it a felony for a parent or guardian to allow a female minor to undergo FGC, irrespective of whether the parent or guardian arranges or performs the cutting. Only seven state statutes address vacation cutting by making it a felony to knowingly remove or allow a female minor to be removed from the state to undergo FGC (Akinsulure-Smith and Sicalides 2016; p. 359).

Despite these laws, anecdotal reports from service providers in New York City (NYC) suggest that the practice continues within the African immigrant community (Equality Now 2016; Sanctuary for Families 2013; Sussman 2011). Although there is no mandatory reporting of adult immigrants who have already had FGC, as in any other form of abuse and violence against minors, it is the responsibility of state mandated reporters (e.g., medical and mental health professionals, teachers) to alert child protective agencies of suspected cases of FGC.

As populations migrate to Western countries, they carry with them the cultural and traditional practices of their countries of origin (Nour 2015; Whitehorn et al. 2002). In the US, the influx of immigrants from regions that have high FGC prevalence rates has exposed service providers unfamiliar with FGC to multiple dilemmas in service provision, including legal and ethical considerations around child protection, as well as how to respond appropriately to any psychological and physical problems caused by FGC (Cook et al. 2002; Jaeger et al. 2009; Kalev 2004; Monahan 2007; Raya 2010; Webb and Hartley 1994).

Reported Consequences of FGC Among Sub-Saharan African Immigrant Populations

The widespread existence of deleterious consequences of FGC among immigrant populations is itself uncertain, as is the nature and scope of these problems that may stem from the practice. It is important to note that much of the current literature regarding FGC is based on the experiences of individuals who have undergone type III, arguably the most severe procedure (WHO 2016). While it has been argued that FGC can have negative consequences for reproductive and mental health, other research has suggested that FGC does not have deleterious effects for all women who undergo it, including those who subsequently migrate to the US (Akinsulure-Smith 2014; Berg et al. 2010; Obermeyer and Reynolds 1999; The Public Policy Advisory Network on Female Genital Surgeries in Africa 2012). One study examining

FGC among West African immigrant women in New York City found that 7 out of 23 participants (30%) reported a history of FGC (Akinsulure-Smith 2014), but that there were no significant differences on the mental health measures between women who had experienced FGC and those who had not. A more recent study with women from the Gambia, Guinea, Mali, and Sierra Leone living in NYC also found no major differences in reproductive or mental health problems among those who had undergone the procedure and those who had not (Chu and Akinsulure-Smith 2015), though women with FGC were more likely to report a history of vaginal pain and decreased sexual arousal, and both groups overwhelmingly voiced resistance to the practice.

Thus, faced with a rising number of immigrants from Africa to the US (Anderson 2017; Zong and Batalova 2017), as well as evidence that female West African immigrants may be at risk for FGC while living in the US despite laws against this practice (Sanctuary for Families 2013; Sussman 2011), and conflicting information about the prevalence and nature of problems stemming from the practice, service providers in the US often find themselves unprepared to respond to the practice of FGC among their clients, including any psychological and physical consequences that might be caused by the practice (Burstyn 1995; Sanctuary for Families 2013; Sussman 2011). It is interesting to note that although there is some literature in the medical field to inform medical providers how to appropriately provide services to women who have undergone FGC (Horowitz and Jackson 1997; Nour 2004), until recently there has been a lack of similar guidance for mental health professionals (Akinsulure-Smith and Sicalides 2016).

The Present Study

In order to provide appropriate mental health services to women and girls reporting negative sequelae of FGC and develop effective interventions, a thorough understanding of these factors is crucial. Given the limited information about immigrant women and girls regarding FGC and the increasing number of immigrant women and girls from sub-Saharan African countries with high FGC prevalence rates to the US, this study aims to document and understand the experiences of West African women immigrants who have had this procedure, using a focus group approach. Findings from this pilot study can be used to understand the attitudes and practices in the West African immigrant community regarding FGC and to inform health services and interventions aimed at addressing and responding to FGC within this community.

Method

Design and Setting

Community Advisory Board In order to ensure that all procedures were culturally informed, the authors created a Community Advisory Board (CAB) which comprised of women *and* men from the West African community. It is possible that in their roles as fathers, husbands, community, and spiritual leaders, African men may contribute to

the persistence of the practice of FGC (Amusan and Asekun-Olarinmoye 2006; Bjälkander et al. 2012; Missailidis and Gebre-Medhin 2000). As such, we determined that it would be useful to have male representation on the CAB. The purpose of the CAB was to provide cultural insight, review the recruitment and data collection procedures, consent forms, and the focus group interview guide, and provide insight on the interpretation of the findings. All materials and procedures were adjusted according to the suggestions made by the CAB.

Recruitment and Data Collection All procedures were approved by the Institutional Review Board of the City College of New York (CCNY), City University of New York (CUNY), and participants provided written consent. Recruitment of participants from three West African immigrant communities—the Gambia, Guinea, and Mali, countries with FGC prevalence rates of 76, 97, and 89%, respectively, among girls and women aged 15 to 49 (UNICEF 2014). Recruitment was purposive and conducted throughout New York City (NYC), focusing on areas with high concentrations of these immigrant populations: Harlem and the Bronx. Information about the study was disseminated widely with the support of the CAB and various African immigrant serving community-based organizations in NYC during the fall of 2013. Women who called a confidential phone number dedicated to the study and expressed an interest in participating were screened for eligibility, i.e., were over 18, whether they had experienced FGC, were from one of the three immigrant communities, and lived in the New York area. Women ages 18–25 were invited to attend a focus group on 1 day, and older women, ages 30–55, on another day.

Procedure

All focus groups were held at the first author's office at CCNY. Prior to starting the focus group discussion, food and drinks were served to uphold the African cultural expectations of hospitality. Each focus group lasted approximately 60 min, and conducted in English by two moderators and a research assistant.

At the end of each focus group, all participants received an "FGC Information Packet," containing information about FGC and related resources in NYC. Also included in the packet was a copy of the consent form and contact information for the first author. Each participant received compensation for participation and transportation.

Participants

Nine women with personal experiences of FGC from the Gambia ($n = 1$, 11%), Guinea ($n = 2$, 18%), and Mali ($n = 6$, 67%) participated in two focus groups. They ranged in age from 18 to 44 years old, with an average age of 27. Six of the participants were single and three were married. Of the nine participants, eight were high school graduates and one held a graduate degree. The women had resided in New York from two to 15 years, with an average length of stay in New York of 6.4 years. Six women had children (6 boys and 13 girls) ranging in age from 7 months to 14 years. Although all of the focus group participants reported that they had experienced FGC as young children, none of them disclosed the exact age at which they had been cut. Demographic characteristics are displayed in Table 1.

Table 1 Participant demographics

Variable	Group 1	Group 2
n	5	4
Mean age	19.2	36.5
Mean years in New York	3.4	10.25
Country of origin		
Guinea	2	0
Mali	3	3
The Gambia	0	1

Data Collection

In semi-structured, open-ended focus groups, participants were asked the following questions: (a) What is FGC is called in your country/culture/ethnic group? (b) Is FGC discussed in the community? (c) Why is FGC performed? (d) What are the benefits of FGC for girls and women? (e) How is FGC harmful to girls and women? (f) Who determines whether a girl/woman should have FGC? (g) Where do parents who want it for their girls have it done here in the US or at home? (h) Is FGC legal or illegal in NYC? (i) Where do women or girls who have had FGC go for health care in case of complications? (k) There are people who want FGC stopped and others who want to continue it, what do you think?

Each focus group was audio recorded and attended by two moderators and two note-takers. The moderators led the discussion and took brief notes to track conversation and steer discussion back to research topics as necessary. Note-takers collected three types of data: the order of speakers, notable behaviors, and quotes that illustrated the primary themes of discussion. Note-takers transcribed the first drafts of the focus groups. The moderators then reviewed each draft while listening to the audio recordings, editing where necessary. Any inconsistencies between what transcribers recorded and what moderators heard were noted. Following the moderators' review of the draft transcriptions, transcribers and the moderators met to discuss inconsistencies and finalize each transcription.

Data Analysis

Focus group data were analyzed using a grounded theory approach (Charmaz 2014). Since there is very limited prior research on this population that could lead us to generate testable hypotheses, this deductive method was chosen. Furthermore, a grounded theory approach has been suggested in situations in which researchers are interested in personal experiences of participants in their social context (McLeod 2001).

Drawing upon open coding strategy, the research team reviewed the recordings and identified potential codes. Transcriptions were entered into the ATLAS.ti Qualitative Research Software for coding and analysis. The research team members coded the transcript of the first focus group and then met to examine overlap in their open codes. Following consensus on these codes, the team applied these codes to the transcripts of

the second focus group and suggested additional open codes. This process was followed by a research meeting in which the final set of codes to be used for all transcripts was determined. The codes are presented in Table 2.

The coding procedure established for each transcript followed a step-by-step procedure to increase coding reliability. Two coders (moderator and a research assistant) independently coded their assigned transcripts. The coders merged their coded documents, using the "same Primary Documents same codes" merge procedure of separate, single-document "hermeneutic units" in ATLAS.ti. Coders then discussed each portion

Table 2 Codes

Code	Description
AGE	Age at which FGC is performed
AUTHORITIES	Influence of African or US Governments on FGC
BENEFITS	What are the advantages of FGC
BETRAYAL	Expressions of feelings of betrayal, e.g., children feeling betrayed by adults
CELEBRATION	Reference to any festivity or celebration, including before, during, or after FGC
CIRCUMCISER	Individual who performs FGC
CONSEQUENCES OF FGC	Can be medical or non-medical. May include responses from focus group question no. 4, no. 5
DECISION-MAKING	Who decides about FGC, how are decisions made. May include responses from focus group question no. 7
DISCUSSION OF FGC	Manner in which FGC is discussed (e.g., openly or privately), by whom, etc. May include responses from focus group question no. 2
DISSENT IN FAMILIES	Disagreement in families regarding FGC
EXPERIENCE OF FGC	Who was the individual with?
FEAR	Expressions of fear, including fear of FGC, fear of not getting FGC, fear of "going home," fear of health care professionals
LAUGHTER/HUMOR	In vivo code. Any laughter or use of humor
LEGALITY	Any reference to laws, including laws regarding FGC, legal sanctions, etc. May include responses from focus group question no. 9
MEDICAL TREATMENT	Any reference to medical treatment, related to FGC or not, here or in Africa. Includes interaction with health care professionals. May include responses from focus group question no. 10
NAMES/TYPES OF FGC	Names of FGC, different types of FGC. May include responses from focus group question no. 1
PAIN	Any reference to pain associated with FGC, short-term or long term, including pain management during and after procedure
REASONS FOR FGC	Reasons given for FGC. May include responses from focus group question no. 3, no. 6
REJECTION OF FGC	
SOCIAL NORMS/TEASING	Discussion of social norms and sanctions (e.g., teasing, ridicule, lowered status) in relation to FGC
SURPRISE/TRICKERY	Includes children being surprised by FGC procedure, FGC being performed with parents' consent
TOOL	Instrument used for FGC

of coded text in order to come to consensus. Consensus documents were merged with documents that had been coded along theoretically relevant demographic axes: gender, religion, and age group. All documents were merged into a single hermeneutic unit for thematic analysis. Using adjacency operators "within," "encloses," "overlapped by," "overlaps," "follows," "precedes," and "co-occurs," the intersection of the codes with other codes listed in Table 2 presented relevant data for the current study.

Results

The goal of this study was to understand the experiences of female West African immigrants regarding FGC using a focus group approach. Although some spoke of lessons learned from other women, all spoke from their personal experiences. Topics covered in the focus groups included the rationale for performing FGC, the decision-making process, the procedure, physical and emotional consequences to FGC, attitudes towards the practice, and their concerns as immigrant women with daughters. Themes that emerged within these topics included function versus tradition as the rationale for the practice, matriarchs as the primary decision-makers, social pressure to engage in the practice, the use of surprise and physical restraint during FGC and subsequent feelings of anger and betrayal, immediate and long-term physical consequences of FGC related to reproductive and sexual health, a uniform resistance to the practice and distress over the threat of their children being cut without their consent, and dealings with health care providers in the US.

Rationale for FGC: Curtailing Sexuality Versus Custom

Participants reported that the principle rationale for performing FGC is an attempt to reduce women's pleasure in sexual activity, and thus prevent a woman from engaging in premarital sexual activity. While one participant captured this reasoning, "They don't want the girls to do sex before marriage" (Malian female, 37 years); others recognized that FGC as ineffective in preventing premarital sex and early pregnancies, "I have friends that did FGC but they have child before they even married so I think that there's no benefit" (Guinean female, 18 years). A number of the participants mentioned cultural traditions as a critical reason for continuing the practice: "They still following the culture saying that "Well, it never disturb our parents so why are we stopping it? We need to continue" (Gambian female, 34 years).

Decision-making

Centrality of Matriarchs Participants reported that decisions involving FGC (e.g., whether to perform the procedure, timing of the procedure) were made primarily by the matriarchs in the family, sometimes without the consent of the child's parents.

My grandmother was the one that took me…She told my mom and my mom was like "No, not yet." But one day, early in the morning, like 5 o'clock, she just take us to that place and it was only grandmothers...It was very dark outside, before, maybe before 7, it's done, the work is done. They call my mom. We've cut your daughter (Guinean female, 20 years).

Social Pressure to Perform FGC Focus group participants reported that a family's decision about whether to perform FGC on their daughters could also be influenced by strong external forces in the community. Families who chose not to perform FGC on their children were subject to gossip in the communities, and uncut girls subjected to bullying, thus creating substantial community pressure.

They call you *blakoro* [laughs] … Like a man, you're like a man. They think that if you don't cut, that thing will stay growing... like it's gonna stay growing like…a penis. (Malian female, 20 years).

Experiences of FGC

Secrecy, Surprise, and Force For girls who were old enough to understand what occurs during FGC, the specifics of the procedure were kept secret. Participants reported that this secrecy is due to the family's concern that girls would run away if they knew about what would happen. These concerns on the part of the family were not unfounded; several participants described their own and other girls' attempts to flee in an effort to avoid being cut:

> I was surprised. I didn't even know. They told me I was going some places. I was happy, I said, "Ok. We're going out." You know we're going [keying?]. But then I went to the places… I was about to run away [chuckles]. They catch me [laughs]. (Guinean female, 20 years)

Many described being tricked by family members, sometimes being taken to the procedure under the guise of a celebration.

Emotional Aftermath A number of the women clearly recalled the sense of betrayal they felt by close family members, whose betrayal compounded their sense of trauma. An 18-year-old Guinean participant described expressing her deep sense of betrayal to her grandmother: "When they done I went to my grandma and said I do not love you no more, I will never forgive you because it was really, like, it hurts."

Physical Impact In addition to the emotional aftermath, participants described short-term and long-term physical consequences of FGC. Many of the physical effects of FGC depended on the different tools, settings, and degree of cutting for the procedure, "Yeah it's depending how they cut it. Because like I say some people take knife, some people take razor, some people go to the hospital…" (Gambian female, 34 years). Participants, particularly younger ones, described first-hand knowledge of the more immediate consequences of FGC, the most serious consequence being death from bleeding. "Even like few months ago, my aunt like, daughter died because the reason of that. So they cut her in Mali, the blood cannot stop. So she died." (Malian female, 20 years).

Some recalled the pain and difficulty of urinating after the procedure: "And sometime when you are going to get up you know? It's painful. You can't open your leg,

[laughs]. If you walking, your feet is going like that" (Guinean female, 20 years), yet others spoke of painful irregular periods:

> For me, sometimes, like when I see my period this month, I can wait for another four to five months before seeing another period. And I talk to my doctor about it and she say it might be because of that. Because she don't see any other problem that could cause that." (Malian female, 18 years)

Older participants also shared experiences with longer-term consequences from FGC, particularly difficulties around childbirth:

> I have three, three kids. They never come out. Everything is fine. Contraction very good. But at five centimeter, my cervix don't open up. And the doctor tell, "Oh, you have done too much time for labor so you can't pass, you have to sign a paper... for the C-Section." I think that's one of the consequences for the genital cuts...Everything good but why the baby don't come. (Malian female, 37 years).

Other long-term consequences reported by participants included difficulties in sexual arousal. However, one area discussed by these women that has not been mentioned in the literature is the difficulties in sexual functioning can impact marital relationships:

> So they cut it, after that you don't get well with your husband, your husband is not happy with you. You come tell them, they "oh, oh please stay, oh be quiet, don't." That's it [laughs]. (Malian female, 37 years).

Changing Attitudes

Rejection of FGC All participants strongly expressed anti-FGC sentiments, citing some of the consequences described above, particularly around young girls dying as a result of FGC. It is striking that they even mentioned family members also rejecting FGC. In one case, a grandmother, a circumciser came to reject the practice after a girl she cut nearly died.

> And then the last time was like in 2009, I think, she did that to a girl and the girl start bleeding, like a lot, and she say that was the first time that happen to her. Like somebody bleed a lot like that. Like 'cos the girl, um, be bleeding and it will be taking the whole bed, then it'll be getting out of the bed and all that, so she said that she will never do that again because she never experience something like that. And the girl almost died, but thank God, nothing happen to her and she survived. (Malian female, 18 years)

Laws in Home Countries Changing attitudes in some of the participants' home countries were reflected in anti-FGC legislation. All participants were very aware of

the laws, or lack of laws, in their countries of origin around FGC. In countries where the practice is banned, enforcement is made difficult due to secrecy and difficulties of enforcement. A 20-year-old participant from Guinea described the difficulties of eliminating FGC in her country:

> They still wanna do it so it would be very hard to stop it. If is America like, let's say, even if you are in trouble, they gonna arrest you but in Africa, if it somebody die, you know, is just a small group they go bury you. The government didn't know about anything.

An 18-year-old from Mali stated that the FGC ban in her country led her family to perform FGC in secret:

> You know, they say, in my country, they say you don't have the right to do that no more. You can't do that if not they, the police gonna arrest you, right? So you not supposed to be talking about it, like for my cousin, they, that time the police say, "Oh, you cannot do it no more." So they hide hers... and they went, they just went to go do it. But mine, it wasn't something that they asked so I think everybody know about it already. But for my cousin it was like something for only the family people will know about it and no other children could speak about it outside 'cos it wasn't good. If not the family was gonna get in trouble.

Concerns for Immigrant Families

Persistent Threat of FGC The fear that one's daughter may undergo FGC in a parent's absence is particularly salient in the context of immigration. Participants expressed concern for their daughters back home:

> I have a daughter, but she's not with me she's with my mother. When I told my mother about it, I don't want you to do that to my daughter. My mother says "You crazy! They did that to you, you say you don't want? You don't want to do it to your daughter." (Gambian female, 34 years)

In addition, their personal objections to the practice, several participants described warnings from US doctors that if daughters return from a visit back to Africa having undergone FGC, parents will face legal difficulties:

> Even sometimes when you say you wanna go to Africa when you have a little girl, the doctor keep saying you better not do to the girl 'cos if you come, we're gonna know and they gonna be in trouble... so they don't do. (Malian female, 18 years)

Another participant recalled this scenario concerning a relative:

> One of my aunts, um, she take her daughter to vacation, but [dialogue between] But before she go....Uh-huh...in Mali...she say that she's going just vacation but

she just go to cut her and after she come here she go to the hospital, they check her, so she have problem for that. (Malian female, 20 years)

Such action can create reluctance in parents to seek professional medical treatment for children who have been cut:

Like, if the girl have a little problem, or get a little bleeding, like you know sometime, if they itching, they scratch it, so sometime the mommy just take care of it and buy some medicine in the store, they do not bring them in the hospital cos they are scared of getting trouble. (Guinean female, 20 years)

Participants expressed frustrations that their relatives in their home countries have difficulties understanding the refusal of their relatives in the US to cut their daughters:

Like one day, my grandma called my mom, … she keep saying (about a younger sister), "she's a nine now, now she's growing. So you have to send her back so I can cut her." And my mom said like, "In here, you cannot cut girl." And she was like, "what kind of country is this that you don't have to." And she keep telling my mom that you have to bring her, so she have to cut, before she get married. I say, "what? I cut and I don't want my daughter to cut so. (Malian female, 20 years)

Experiences with Medical Providers Participants described varying experiences and relationships with medical providers, including avoiding the hospital for fear of getting in trouble if it is discovered that a child has been cut, as discussed above, or because they are undocumented. One participant described the experience of a friend who had undergone infibulation, a variation of FCG in which the clitoris and the inner and outer labia are excised, and the edges of the vulva are sutured together, leaving only a small opening for urination and menstrual blood. The participant's friend was unable to consummate her marriage due to these sutures, but feared seeking medical help due to her undocumented status:

So what happen is that we were so scared cos you know like when they got married like after they, she decided to you know come and meet her husband in Bronx here. So that night, the husband couldn't enter and we didn't know why. So she call me and told me that so I was so scared, we even involve my husband on that, because we were scared. So we don't know what to do. And this was like that for more than a week. And she came here she don't have papers so we were scared because her husband too he didn't have papers so they were scared to go to the hospital. (Gambian female, 34 years)

The same participant experienced embarrassment due to her the medical staff's insensitive and invasive questioning about the FGC procedure that she had undergone:

Two different nurse, I don't know, who ask me that. "Why do they do that? They did that to you? Do you know when they did that to you? Do you have children?

> Will you allow them to do that to your daughter?" And you know like when the results come, I will see they did that to me. That's the time I know they call it circumcised because they say female circumcision, what they see. So I feel embarrassed. (Gambian female, 34 years)

Discussion

This qualitative study about FGC with immigrant women from high-prevalence West African countries yielded much rich data and many of the themes that emerged, such who the decision-makers are, the immediate and long-term consequence of FGC corresponded to other studies (Bjälkander et al. 2012; Nour 2015). Because the goal of the study was to provide insight into the experiences of immigrant women with the aim of better preparing service providers to address issues related to FGC, some of the themes we felt were particularly of note included secrecy and the taboo nature of the practice, concerns about their daughters being subjected to FGC overseas without their consent and the subsequent legal fallout in the US, and interactions with health professionals in the US.

The secrecy regarding the practice of FGC came out in the focus groups primarily when participants discussed how they were surprised and often deceived on the day of their cutting, and the subsequent emotional and physical aftermath of a procedure that often entailed physical restraint and violence on an unwilling young girl. Though there are variations between ethnic/tribal traditions, FGC is a practice that is often shrouded in secrecy and considered a taboo topic. The women in these focus groups were obviously willing to discuss the practice and were forthright in sharing their experiences and beliefs. However, in recruiting for the study, we found some reluctant to share their experiences. For example, during the course of this study at least one woman from the Sierra Leonean immigrant community expressed interested in participating via a third party, but ultimately decided not to. Such individuals expressed a fear of being identified and being viewed as betraying the secret society that she belonged to due to her FGC experience. This reluctance speaks to the fact that the purpose and timing of FGC may vary depending on ethnic association. Unlike these participants from the Gambia, Guinea, and Mali where FGC is increasingly performed at an early age, in Sierra Leone (where FGC is practiced by all ethnic groups except the Christian Krios), FGC plays a central role in the initiation rites into secret societies for women (e.g., the Bondo or Sande) during which girls are taken into "the bush," and taught local customs, sexual education, feminine hygiene, housekeeping, and childrearing skills, key elements in the rites of passage into adulthood (Fanthorpe 2007; Statistics Sierra Leone and ICF Macro 2009). In such a setting, being a part of the secret society is also associated with certain political and social power for women (Ahmadu 2000), thereby raising the individual's status within her community (Finke 2006).

All of the participants in the study were aware of the legal status of FGC in their home countries. Unlike the Gambia, FGC is illegal in both Guinea and Mali; however, all of the participants spoke of FGC occurring on a regular basis without government intervention. While on the surface, passing legislature against FGC in various countries seems to reduce the incidence, based on these focus groups, it became clear that making

FGC illegal merely drove the practice underground. Furthermore, as a number of our participants reported that increasingly FGC is occurring at a younger age so there is less resistance by the young girl ("Now they do it like when you born, 7 days or before 40 days." Malian female 37 years).

Service providers also should be aware that unlike Western cultures in which a child's parents typically serve as the primary decision-makers for the children's healthcare decisions in both legal and cultural terms, social structures in West African countries often elevate the rights of older matriarchs (e.g., grandmothers) to make such decisions over the rights of the parents (Hemmings 2011; Shell-Duncan et al. 2010). In this study, a theme that emerged was primacy of non-parental decision-makers (especially older women) who wield power, and the subsequent fear voiced by the women that their daughters, who either currently lived in their home country or lived in the US but frequently visited their home country, would be subjected to FGC without their consent.

Participants expressed frustration at the manner in which their parents and older relatives dismissed their rejection of the practice as an artifact of acculturation. Because their objections were minimized by the decision-makers and, based on their experiences, the FGC process could be abrupt and forcible, they were faced with a dilemma whereupon engaging in normal family activities in their home countries (e.g., vacations, weddings) posed a threat to their daughters and, by extension, themselves. The fear that they could get into "trouble" with US authorities should their minor daughter be subjected to FGC, even if the procedure was conducted without their consent, added another layer of anxiety that participants had to navigate. Mental health service providers should be aware that these realities exist, that children whose parents are not in favor of FGC may still be at risk, and that these family dynamics, which are quite different from a Western emphasis on the centrality of parents as decision-makers, can complicate how FGC is negotiated within immigrant families.

Lastly, participants reported mixed experiences with health care professionals in the US regarding their own FGC histories. While women expressed concerns that many undocumented immigrants have regarding seeking health care and fear of being reported to immigration officials, the severity of some of the complications that can manifest as a result of FGC makes it especially important that these women seek care and that the care they receive is both appropriate and appropriately delivered. Participants described being taken aback by the reactions of their medical providers to their FGC. Though the interactions described were primarily with medical rather than mental health or social service staff, the need to approach the topic of FGC with sensitivity and not to overstep the bounds of the interaction (e.g., asking, "Will you do that to your daughter?") is important in all domains of care. It is also important for service providers to recognize that for some, FGC is seen as an expression of power and beauty, that "the focus of FGM is not primarily on surgical intervention or the manipulation of a girl's or woman's sexual organs" (Finke 2006, p. 13).

Limitations

There are a number of limitations in this pilot study that warrant mention. In the first place, a major limitation in this study is the small sample size, one much smaller than

that generally regarded as needed in qualitative studies to achieve data saturation. Because this was a pilot study, we wanted to ensure that participants would be comfortable and willing to discuss such a sensitive topic. In addition, the purposive and self-selected nature of this community-based sample limits the ability to generalize the findings of this study to the larger population of West African immigrant women and girls.

Other limitations include the self-selectivity of the sample, as well as its ethnic makeup. It is important to note that women have reported positive experiences as a result of their FGC experience (Abusharaf 2001); however, this was not the case among the participants in these focus groups. This study represents West African women who were willing to discuss a topic that is not typically deliberated in an open forum. This self-selection bias may have created a sample more heavily weighted to women who held strong opinions against FGC, whereas women who are in favor of FGC and likely know it is controversial or taboo in the US may be reluctant to discuss their perspectives. There are also variations between ethnic groups in social norms regarding the discussion of FGC. Participants in this sample came largely from the Bambara, Fulani, Mandingo, and Sonike ethnic groups where FGC is typically performed in the early years and not clearly associated with rites of passage to feminine adulthood, an association that may impact women's feelings about the practice as well as their willingness to discuss it.

Implications for Research, Service Provision, and Policy

This study points to a few directions which may be fruitful for future research endeavors. First, as described above, FGC is sometimes associated with secret societies that reinforce the practice as a significant rite of passage. Thus, in order to fully and truly understand West African immigrant female attitudes towards FGC, future studies should explore this subject along the lines of ethnicity, rather than country boundaries or geographic lines, as ethnic beliefs and customs around FGC might be more salient than regional differences. Given the primacy of matriarchs in the decision-making process, further research on those matriarchal relationships that influence the practice and how the immigration experience impacts those relationships would be useful in developing interventions.

In terms of implications for health care services, service providers who work with this population should recognize that clients who have undergone FGC may have experienced a ritual that was traumatic, in part because of its element of deception, surprise, and force, and that they may be experiencing an ongoing fear for their children's safety because they may not have the type of absolute authority over their children's welfare that would be presumed in Western cultures. The topic itself may be uncomfortable for women to discuss because of sociocultural power structures, which may be influenced by external forces such as government prohibition (both in their country of origin and the US) and that perpetuate the taboo nature of the practice.

Policy implications include the need to systematically educate health care providers on how to deliver services to their patients who have undergone FGC a way that does not perpetuate fear and opens a dialogue between patients and health care providers.

Conclusion

This small qualitative study represents an important step to directly understanding the experiences and needs of West African women and girls who underwent FGC, particularly those who are immigrants in countries where the practice of FGC is illegal. While we recognize that not all women who have experienced FGC report negative sequelae, participants in this pilot study openly spoke of the traumatic nature of their own experiences, particularly the physical and psychological impact of the procedure, as well as their sense of betrayal by trusted female figures. It is particularly striking that all participants expressed a fear of visiting their home countries with their female children, lest their children be forced to undergo FGC. Such fears are further compounded by their fear repercussions by US officials as a result of anti-FGC laws.

As the number of women and girls from countries with high FGC prevalence rates immigrate to the US, service providers must be aware of the range of FGC-related experiences and the multiple dimensions to the practice as they work to provide relevant mental, physical, and social services.

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