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Abstract: *Harmful traditional practice, such as female circumcision (FC) performed on children causes minimal to severe health problems. FC violates the human and medical informed consent rights of female children. African immigrants from communities that practice FC are required to comply with policies that outlaw FC. The purpose of this study is twofold: 1) to gain an understanding of African immigrant women's views on FC and policies that outlaw the practice, and 2) to provide new insights and identify effective strategies for improving compliance with anti-FC laws. A phenomenological approach was deployed to gain an understanding of African immigrant women's perceptions of FC and policies that outlaw it. The results indicate that the participants want to eradicate FC; yet some of them vacillate between eradication of FC and participation in the practice.*

Keywords: Women and children, female circumcision, vulnerable populations, alternative rites of passage, medical informed consent, human rights

Introduction

Harmful traditional practices such as female circumcision (FC) are all consequences of the "value" societies place on women and girls. These practices persist in an environment where females have unequal access to education, wealth, health, and employment (United Nations 1979). This study analyzes African immigrant women's perceptions of FC and policies that outlaw the practice in the United States by utilizing some new data and offering some insights in the long-raging—still unsettled—controversy on FC.

FC is a powerful cultural practice that, specifically in Africa, is "a mark of cultural identity [which] designates membership in one's tribe …" (Shullenberger 1995) that can also embed violence (Plan International 2006). FC is one of the world's most controversial procedures (Gollaher 2000; Darby 2003; Snively 1994; Thomas 2000). The controversy persists, reaching a high fever pitch with "the growth of the permeability of national and social boundaries" (Prazak and Coffman 2007, viii), evidenced by increased migration of Africans to the United States and other countries. The interdependence instigated by the increased pace of globalization ensured an enlargement of the controversy beyond the confines of Africa (Prazak and Coffman 2007). FC takes place in many regions of the world (Gollaher 2000), including the United States and Africa—the two regions that form the focus of this study.

The debate has revolved around two main issues: 1) laws enacted in response to the procedure, and 2) failed attempts to find a compromise between cultural and universal human rights. This study integrates the United States' experience and introduces new insights into the growing literature. An intriguing question, not different from previous studies, that this research sheds light on is: Why would women who migrated to a nation where FC is outlawed with

proper enforcement than the countries they migrated from still take the risk of engaging in the secret forbidden practice? Our intent is to search for balance, nuance, common understanding, and constructive dialogue, informed by new data. While still sensitive to culture, this study goes beyond the controversy, to analyze African immigrant women's attitudes about FC and their knowledge of laws relating to the practice in the United States. The purpose of this study is twofold: 1) to gain an understanding of African immigrant women's views on FC and policies that outlaw the practice, and 2) to provide new insights and identify effective strategies for improving compliance with anti-FC laws.

In the sections that follow, a description of the types of FC and reasons for practicing FC, and human rights and medical informed consent issues will be provided. Next, a discussion of African immigrants in the United States practicing FC and a description of the health problems associated with FC will be supplied. Then, we will provide a brief overview of the FC controversy. In the next section, we describe the impact of anti-FC policies on African immigrants who practice FC in the United States. Afterwards, a description of the methodology deployed is provided. An analysis of the results of the demographic and interview data is discussed. Lastly, in the conclusion, we attempt to find some common ground that takes into consideration culture and human and medical informed consent rights of children in the FC debate, and offer some strategies for increasing compliance with anti-female circumcision policies.

Practice of Female Circumcision in Africa

Types of Female Circumcision

The World Health Organization (WHO) identifies four types of FC based on the severity of the procedure (WHO 2000). Type 1 involves removal of the prepuce (clitoral hood) with or without removal of all or part of the clitoris. This is commonly referred to as clitoridectomy and sometimes referred to as "Sunna" procedure. Type 2 involves removal of the clitoris and a part or all the external genitalia like the labia minora (small outer lips). This is commonly called excision. Type 3 entails removal of a part or all the external genitalia (clitoris, labia minora, and labia majora) and stitching and/or narrowing of the vaginal opening, leaving only a small hole for urine and menstrual flow. This is usually referred to as infibulation or pharaonic circumcision. Type 4, a catchall or unclassified category, can involve piercing, pricking, burning, and stretching of the clitoris or labia.

Infibulation is the most severe of the four categories delineated here. Infibulation combines clitoridectomy, excision, and cutting off of the labia majora to create raw surfaces, which are then stitched or held together to cover over the vagina when they heal. Thorns or stitches may be used to hold the two sides of the labia majora together, and the legs may be bound together for up to 40 days. To facilitate healing, pastes—made up of herbs, milk, eggs, ashes, or dung—may be applied or, less often, antiseptic powder (Prazak and Coffman 2007). The girl may be taken to a specially designated place to recover. For very rich families, the procedure may be performed by a qualified doctor in a hospital under local or general anesthetic. After this procedure, cutting may be necessary for penetration to be achieved during sexual intercourse and to allow a baby to be delivered.

According to estimates by Amnesty International, the vast majority of FC performed in Africa, which about 85 percent, are clitoridectomy and excision; while infibulation accounts for the remaining 15 percent (WHO 2000). The problem with these estimates is that the three categories round up to 100 percent without integrating type 4 for which no figure is provided.

Unfortunately, there are no accurate methods for counting the number of females who have been circumcised.

Just like the cutting itself, the age at which FC is performed varies, based on a multitude of factors that include the females' ethnic group, socioeconomic standing, and location—urban or rural area. The ages range from shortly after birth, through first pregnancy, to even death (WHO 2000), and averaging 4 to 8 years old. While the average age is significantly decreasing, the Amnesty International reported that "the practice is decreasingly associated with initiation into adulthood," particularly in the urban areas (WHO 2000). Depending on local customs or the decision of the parents, FC could be conducted individually or collectively in groups. Where the latter is the case, the procedure could be conducted with ceremonies or festivities, for example, as part of an initiation rite for girls who belong to a particular age cohort.

The procedure may be carried out in a girl's home or the home of a relative or a neighbor, in a health center, or at a specially designated site such as a particular tree or river, or secret bush, especially if FC is associated with initiation (WHO 2000). The circumciser may be an older woman (known as "moruithia" in Kenya), a traditional midwife or healer, a barber, qualified midwife, or physician (Merwine 1993). Usually, the procedure is performed without anesthesia. In some cultures, girls will be told to sit beforehand in cold water, to numb the area to reduce the likelihood of bleeding. The girl is immobilized, held, usually by older women, with her legs open. The procedure may be carried out using a variety of cutting instruments that can include a broken glass, a tin lid, scissors, a razor blade, kitchen knife, or a penknife (Burstyn 1995).

Health concerns and criticisms by human rights activists forced some communities to change long-established customs. For example, in response to the danger of HIV transmission, in some communities circumcisers now use sterile instruments or cut women using different razor blades (Burstyn 1995). Moreover, problems arising from the procedure are rarely attributed to the circumcisers. Instead, these problems are blamed on numerous factors, such as the girl's alleged "promiscuity" or the fact that sacrifices or rituals were not carried out properly by the parents, or to witchcraft (WHO 2000). Generally, supporters of FC have a tendency to see major complications and problems arising from the operation as rare, while opponents of the practice tend to view those as frequent. In the majority of cases, cutting infants increases the risk of serious physical consequences. The external genitalia of infant girls are not fully developed. Consequently, there is a high risk of cutting much more of the genitalia than intended. After the procedure, the legs of the girl are tied together until the wound heals. This can result in scar formation and in the fusion of the two sides of the vaginal opening through adhesions (Plan International 2006).

Common Justifications for Practicing Female Circumcision

The cultural practice of FC often goes unquestioned among community members and anyone who deviates from the norm can suffer the consequences of being ostracized, stigmatized, condemned, or harassed (Ahmadu 2000). Various reasons have been adduced on why some communities practice FC; including: (1) cultural or ethnicity identity, (2) gender identity, (3) control of women's sexuality, (4) beliefs about physical cleanness, and (5) religion. Cultural identity is the most frequently cited reason for practicing FC because "along with other physical or behavioral characteristics," FC defines who is in the group (Shullenberger 1995). This factor is most evident in instances where FC is carried out as a part of the initiation into adulthood. The most famous expression of this position was by Jomo Kenyatta, first President of an independent

Kenya, himself a Kikuyi. Kenyatta wrote that "no proper Gikuyu [Kikuyu] would dream of marrying a girl who has not been circumcised," and he opined that FC was so inherent in the initiation necessary for life as a Kikuyi that abolishing it "will destroy the tribal system" (Kenyatta 1938).

Regarding gender identity, FC is often deemed necessary in order for a girl to be considered a complete woman, as the practice marks the divergence of the sexes in terms of their future roles in life and marriage (Integrated Regional Information Network 2005). Because some people in Africa view the clitoris and labia as the "male parts" of a woman's body, their removal is believed to enhance a girl's femininity, often synonymous with docility and obedience (Integrated Regional Information Network 2005). With respect to control of women's sexuality, in many societies, FC is believed to reduce a woman's desire for sex and the chances of committing adultery (Assaad 1980). A typical statement of this position was made by a Kenyan defender of FC who reportedly stated that "FC makes women clean, promotes virginity and chastity and guards young girls from sexual frustration by deadening their sexual appetite." This is why in communities where FC is prevalent, it is extremely difficult, if not impossible, for a man to marry a female who has not undergone the procedure (WHO 2000).

In some communities, uncircumcised women are regarded as unclean persons whose genitals produce a bad odor and they should, for example, not be allowed to handle food and water (Chege, Askew, and Liku 2001). Related to this cleanness theory is the perception that the genitals of uncircumcised women are ugly and bulky. From this perspective flows various beliefs, including the notion that: 1) a woman's genitals can grow and become unwieldy, hanging down between her legs; 2) a woman's clitoris is dangerous and that it will kill a man whose penis it touches; and 3) a baby will die if its head touches the clitoris during childbirth (Chege, Askew, and Liku 2001). Others believe that FC enhances fertility or, conversely, that women who are uncircumcised cannot conceive; and that it makes childbirth safer (Chege, Askew, and Liku 2001). Lastly, although FC predates Islam and is not practiced by the majority of Muslims, it has acquired a religious dimension connected to the faith (WHO 2000). That is, religion is frequently cited as justification for FC where it is practiced by Muslims (Integrated Regional Information Network 2005).

Human Rights and Medical Informed Consent Issues

There are two international human rights instruments that protect the right to culture and cultural identity: 1) the International Covenant on Civil and Political Rights stipulates that "… persons shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practice their own religion, or to use their own language" (Covenant on Civil and Political Rights 1966), and 2) the International Covenant on Economic, Social, and Cultural Rights guarantees the right of everyone to take part in cultural life (Covenant on Economic, Social, and Cultural Rights 1966). Although these two instruments guarantee parties a right to cultural identity, FC violates the human and medical informed consent rights of girls.

From the standpoint of human rights, FC "reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women;" it is "nearly always carried out on minors and is therefore a violation of the rights of the child." Finally, the practice "violates the rights to health, security and physical integrity of the person, the right to be free from torture and cruel, inhumane or degrading treatment, and the right to life when the procedure results in death (WHO 2008). Moreover, there is global consensus that FC violates the human rights of women and female children (Convention on the Rights of the Child 1990; WHO 2008).

The CRC (1990) states that "the basic human rights of all children, include: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life." Moreover, Article 24 (3) of the 1990 CRC states that "parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." FC is considered a violation of Article 24(3) because of the health problems and violence associated with this practice.

Further, the United Nations (UN) views FC as a violation of human rights, defined as "… rights people have by reason of the fact that they are human beings. The UN has adopted several conventions to address human rights violations associated with FC, including the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) adopted in 1979 and the Convention on the Rights of the Child (CRC) adopted in 1990. CEDAW "calls on governments to modify or abolish customs and practices that constitute discrimination against women or are based on the idea of female inferiority or stereotyped roles" (Toubia 1995, 233; CEDAW 1979). To date, 187 out of 193 countries have ratified the CEDAW Treaty (CEDAW 2013). The countries that have not yet ratified it include the United States, Somalia, Sudan, Iran, Palau, and Tonga (CEDAW 2013). The Obama administration supports CEDAW and urged the U.S. Congress to ratify it (CEDAW 2013). Currently, 67 Senate votes are needed to ratify this convention.

In addition to human rights violations, the performance of FC on female children violates medical informed consent requirements. Many practicing communities in the United States circumcise girls at young ages in order to avoid resistance from the children because as they get older and form their own opinions, they may choose not to consent to the practice. Critics argue that informed consent should be obtained from the children when they reach the age of consent, not the parents, as to whether or not they should undergo elective surgeries (Weisemann *et al.* 2010). Based on this argument, we assert that FC performed on girls does not comply with medical informed consent requirements here in the United States. Some scholars "call for a moratorium of any [elective] operation before the age of consent except for medical emergencies…because the role of the parents as legal representatives of the child is controversial" (Weisemann *et al.* 2010).

Evolution of Female Circumcision in the United States

FC came to American shores through immigration—and resulted in the "incorporation of populations with strikingly different cultural heritages." Several factors are responsible for African migration to the United States. The first is the Hart-Cellar Immigration Reform Act of 1965 which increased the number of Africans and other non-Europeans migrating to the United States (Rogers 2006). Another factor comprises programs like the diversity immigrant visa (Section 203(c) of the Immigration and Nationality Act 1990). Lastly, asylum applications expanded to include the allowance of FC as a form of "persecution," became a reason to qualify for asylum, and increased the number of African immigrants (Coffman 2007). Approximately, "7,000 women and girls immigrate to the United States each year from countries where" FC is commonly practiced, and it is estimated that "hundreds of young girls either brought here or born here," from Africa, each year face the risk of being circumcised (Burstyn 1995). Between 1992 and 2005, over 64,000 persons from Somalia, a country where FC is commonly practiced, were admitted into the United States (U.S. Census 2000).

FC, arguably, is said to bring no health benefits to women but rather hurt their health. If nothing else, as the WHO points out, "the removal of or damage to healthy, normal genital tissue

interferes with the natural functioning of the body and causes several immediate and long-term poor health outcomes [including death]." Public health workers in the U.S. and Europe "first became aware of the extent of," the FC issue when they, "found themselves giving prenatal or obstetrical care to women whose genitals appeared unlike anything they had ever seen" (Davis 2001, 491). It has been estimated that between 100 and 140 million girls and women suffer from some form of physical and psychological problems associated with FC such as, chronic pelvic infection, keloids, vulva abscesses, sterility, incontinence, tetanus, Hepatitis B, urinary tract infections, fever, hemorrhaging, urine retention, shock, damage to the genital organs, difficult labor, and severe tears of the vaginal opening during childbirth, fistula, vulvae abscesses, low fertility, sterility, lack of sensation in the genitals, reduced elasticity of the vagina caused by scar tissue as a result of FC, HIV/AIDS, and death are very common among circumcised females since most procedures are carried out in extremely unhygienic conditions with crude instruments such as knives, razor blades and sharp stones (WHO 2005; Rainbow Organization 1996; Islam and Uddin 2001; Gachiri 2000; Mazharul and Uddin 2001; Kabir et al. 2003). In addition to the physical problems, some females experience psychological problems, including: anxiety, psychosis, severe depression, and insomnia (Program for Appropriate Technology and Health 1997; Toubia 1993; Chalmers and Hashi 2000; Talle 2007). Furthermore, there are some psychosocial impacts of FC, which are evident in women with fistula. Specifically, women suffering from fistula tend to isolate themselves and refrain from attending public celebrations due to feelings of shame because the continuous leakage of urine and feces into the vagina creates an offensive odor that is difficult to ignore (Bangser 2006; Kelly 1995; Muleta and Williams 1999; Women Dignity Project and Engender Health 2006).

Female Circumcision Controversy

Cultural Relativism versus Cultural Universalism

An extensive body of work, embedded in concepts of cultural relativism and cultural universalism, from numerous disciplines have engaged in debates on FC. On the one hand, "cultural relativism is the premise that [traditional] practices specific to a culture cannot be properly judged by those outside that culture because they can only be interpreted in terms of one's own beliefs and cultural understandings" (Thomasen 2007, 54). Cultural relativists argue that "rights and rules about morality are encoded in and … depend on cultural contexts;" that these rights cannot be interpreted without regard to the cultural differences of people (Baderin 2003, 16).

Some African female scholars argue that imperialistic and ethnocentric Western feminists have become "active in either scholarship or politics around FC without knowing anything about the practice or without having had a single conversation with a circumcised woman" (Nnaemeka 2005, 91). Nnaemeka (2005) concedes that both Africans and non-Africans agree that there is an urgent need to end the harmful practice of FC. However, she asserts that Africans are resistant to the imperialistic strategies used to end FC. For example, she argues that imperialistic views about ex-colonized Africans were exhibited when anti-FC policies, adopted by France in the 1980s, placed African immigrants from practicing communities at risk of arrests, trials, fines, and imprisonment (Nnaemeka 2005).

On the other hand, Baderin (2003, 17) advised that the ideals of cultural universalism in international human rights law be "advanced in a manner that escapes charges of cultural imperialism … [by] non-Western societies." Cultural universalism is the premise that fundamental human rights apply equally to all human beings regardless of culture, race, religion,

and so on (Thomasen 2007). In countries where FC is practiced, it is not considered as a form of torture and violence, instead it is viewed as a cultural requirement. However, "Westerners consider [FC as a form of] cruel and inhumane treatment of girls" (United Nations Population Fund 1989, Art. 37a) Consequently, Westerners have enacted a plethora of anti-FC policies.

Policies Outlawing Female Circumcision

Enactment and Enforcement of Anti-Female Circumcision Policies

Legal intervention is justified for [abolishing] FC "to protect persons from what is offensive or injurious, particularly where the individual is young, weak in body or mind or in a statement of particular physical or economic dependence" (Steiner, Alston and Goodman, 557). Nonetheless, by criminalizing FC, "the law may make it easier for powerless women to resist the social pressure to conform" (Medical Council 2008). In 1996, the federal government enacted 18 U.S.C. *§* 116—*a zero tolerance policy that outlawed the performance of FC on children.* The policy provides, with limited medical exceptions, that "whoever knowingly circumcises" "another person" under the age 18 "shall be fined" "or imprisoned not more than 5 years, or both." The law states that "no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual." Additionally, this law requires the Immigration and Naturalization Service to provide immigrants from countries where FC is commonly practiced, "prior to or at the time of entry into the U.S.," information on legal consequences of engaging in FC as well as information on the physical and psychological harm caused by FC.

Nineteen states in the United States have criminalized the practice (Githiora 2010). The punishments for those caught practicing FC in the United States range from 6 months in Texas to 30 years imprisonment in Illinois (Githiora 2010). The fines for violating these statutes range from $1,000 in West Virginia to $200,000 in Oregon (Githiora 2010). Ten states that do not have FC-specific statutes use general child abuse or assault laws to punish persons who engage in the practice (Githiora 2010).

The impact of enforcement of federal and state zero tolerance anti-FC laws on eradicating FC is questionable at best. To date, only a few people have been arrested and/or prosecuted for practicing FC in the United States. In 2006, an Ethiopian man circumcised his infant daughter with a pair of scissors in Atlanta, Georgia, and was later sentenced to 10 years imprisonment (Female Genital Cutting Education and Networking Project 2010). Another case occurred more recently on March 10, 2010 where a 35-year old African woman circumcised her 10-month old daughter and was charged with second degree cruelty to a child in Lagrange, Georgia. In the cases described above, the immigrants chose to comply with their cultural practice and violate (assuming they were aware of the law) anti-FC policies in the United States (Female Genital Cutting Education and Networking Project 2010). These two cases illustrate some of the cultural and legal dilemmas immigrants who come from communities that practice FC can encounter. On the one hand, immigrants have to decide whether or not it is worth the risk to engage in FC and possibly get caught, fined, or imprisoned for violating anti-FC policies. On the other hand, if immigrants choose not to comply with their cultural practice, it is highly likely that their community will ostracize them and their daughters.

The low number of arrests and prosecutions associated with FC clearly reflect problems with enforcement. "Prosecution [of] and protection [from FC] are largely dependent on someone speaking up" (Leye and Sabbe 2009, 9). The question to be asked here is: Whose responsibility

is it to report actual or suspected cases of FC? Key (1997), for example, notes that none of the anti-FC policies clarify the reporting requirements. Further, one of the gravest consequences of enforcing and prosecuting those who are held liable for engaging in FC is the girls' parents who are incarcerated for a lengthy period of time and might end up orphaned and placed into foster care. When policies are deemed as more punitive rather than protective the responsiveness and desire to comply with these policies decreases (Rahman and Toubia 2000). Rahman and Toubia (2000) believe that different types of actions to eliminate FC are appropriate for governments that receive immigrant communities. That is, governments in the receiving countries should be sensitive to the situation of immigrant women and girls who are affected by FC (Rahman and Toubia 2000).

Successful Approaches to Eliminating FC and Increasing Compliance with Anti-FC Laws

Adopting anti-FC laws and prosecuting those who do not comply with these measures alone do not appear to deter people from practicing FC. Instead, it is equally important to raise awareness among the general population, immigrant communities, and professionals about the health problems associated with FC, policies outlawing FC, reporting procedures, and punishments for those who violate these laws (Leye and Sabbe 2009). It is also essential that the cultures of the practicing communities be taken into consideration when authorities and professionals develop interventions and strategies to eradicate FC.

Another question to be asked here is: What approaches increase compliance with anti-FC policies among members from practicing communities? Several strategies to address the elimination of FC have been successfully implemented. Some of these strategies have included: enacting formal anti-FC legislation, finding other types of employment for circumcisers, educating practicing communities about the health problems associated with FC, endorsing alternative rites of passage ceremonies, and de-medicalizing FC (Shabaan and Harbison 2005; Tostan 2010; Davis 2001).

One successful novel alternative rite of passage in Kenya, *Ntanira Na Mugambo*—circumcision through words in Swahili—involving 13 rural communities as of 1993, was unveiled. Female adolescents, family members, and others in the community participated in designing the ceremony, and there was a "family life" educational component in the schools as well as a program targeting young males, explaining to them the health risks women face as a result of the procedure. This program enlisted the males in a process that ended with them making a vow not to require that their future wives be circumcised (Davis 2001). Similarly, the Tostan project encompasses these ideas and "is designed to encourage voluntary, community-driven behavior and attitude change" (Thomasen 2007, 59). Tostan is a village-based non-profit non-governmental organization located in Senegal, "whose mission is to provide human dignity to African people through the development and implementation of participatory…education programs …" (Tostan 2010). This holistic program educates participants about "hygiene, human rights, women's health and problem solving…with a focus on FC" (Thomasen 2007, 59). Since 1997, the Tostan project has been implemented in 4,854 communities in five countries that have chosen to abandon FC, including: Senegal (4,385), Guinea (364), Gambia (48), Burkina Faso (23), and Somalia (34) (Tostan 2010).

Methodology

The phenomenological approach was deployed to help us gain an understanding of African immigrant women's perceptions on FC and the policies that outlaw the practice. Interviews were conducted with nine participants who migrated from countries in Africa that practice FC (see Appendix 1). A structured survey was administered to obtain demographic information and a semi-structured questionnaire was used to obtain information about the participants' perceptions. Frequency distributions were used to analyze the demographic data and content analysis was used to analyze the interview data.

Results and Discussion

Demographic Results

The demographic questions posed in the interview include the age ranges of the women; their levels of education, marital status, religious denominations, reasons for migrating to the United States, states where they reside, length of residence in the United States, challenges faced with assimilating, ethnicity, types of FC practiced in their communities, gender of the circumciser, location of the circumcision, knowledge of females who have been circumcised, medical assistance provided, knowledge and awareness of policies that outlaw FC in the United States, and attitudes about policies that outlaw FC. A description of the demographic results is provided in Appendix 1. The majority of the respondents were originally from Somalia and Kenya, and most of the participants had been in the United States anywhere from 1 to 10 years. Half of the participants migrated to the United States for education, work, and/or to live near their family. Many of the participants lived in Ohio. Eighty-eight percent of the participants' ages ranged from 20 to 29 years and 50 or more years old. More than half of the participants had a bachelor or graduate degree. With respect to marital status, the majority of the respondents were not married. Additionally, over 50 percent of the participants were Muslim.

With regard to why the women migrated to the United States, three of the respondents (all of them Somalis) were refugees who were allowed to move to the United States because of the war in their homeland, four came to pursue education, and two came to visit with family members and later remained in the United States. The states where the respondents resided include: Maryland, Minnesota, New York, Ohio, and North Carolina. The respondents' length of residence in the United States ranges from 3 to 24 years, with a median of 9 years.

The types of FC that the respondents stated are practiced in their communities of origin include: clitoridectomy, excision, and infibulation. Usually women, especially elderly women performed FC. Only one respondent indicated she was circumcised by a man. In the few communities where men were the circumciser, one participant explained, they are never permitted to do the cutting from the front and therefore look at a female's genitalia directly "since the only man who should look at [a woman's] genitals [is] her future husband." The exception here is in instances where the operation is medicalized or conducted in a clinic. The respondents provided a range of answers about the location where FC is performed that included the home of the girl, secret locations such as a "bush," an illegal clinic, or a hospital.

Interview Results

The attitudinal, perceptual, and experiential questions addressed the following: participants' reasons for practicing FC, whether they knew persons in their family or community who experienced the procedures; if they did, what were the experiences of those individuals regarding FC; whether those persons experienced any health problems arising from the procedure; if so,

whether they received any medical help; respondents' feelings regarding FC; respondents' knowledge about policies that outlaw FC in the United States, and their perceptions of the anti-FC laws.

Reasons for Practicing Female Circumcision

The participants provided a variety of reasons that their communities practiced FC, including: preventing girls from being sexually "loose" or promiscuous before and after marriage; honoring the ancestors and not bringing shame to a girl's parents; minimizing pregnancy outside wedlock; increasing females' attractiveness and eligibility for marriage; reducing sexual urges; improving health and making the birth process easier; passing from girlhood to womanhood, as well as making uncircumcised girls clean and keeping women submissive. One respondent recounted, "girls are taught when they are young that they possess something bad between their legs that must be removed" through circumcision to keep them pure and that uncircumcised girls "cannot control their desire for men."

Participants' Attitudes and Perceptions on FC and their Experiences

The participants provided a range of responses about their attitudes, perceptions, and experiences relating to FC. The majority of the respondents indicated that both men and women support the practice. One respondent indicated that "there are a lot of women who feel their daughters won't be desirable if they don't get circumcised. From my personal experience, men have been against it. I feel like the women maybe want their daughters to experience the same pain they have." Another respondent shared "FC is supported by the entire community," elaborating that "the *women* support it because they want their daughters to be eligible for marriage, the *men* support it since it exerts their control over women, and the *girls* want it because they want to fit in with their peers." She also indicated that organizations, such as the churches, are against FC because they are forced to "provide shelter for girls running away from the practice." A respondent noted that "some men support [FC], but mostly it is supported by women," adding, "women in my community have for generations been told by their mothers, aunts, and even peers that circumcision was a rite of passage that every young girl must go through in order to become a woman." Additionally, a participant stated,

> "Men say that no one would leave the door to their house open as this would allow everyone into their house to take what they please, likewise, they wouldn't want to leave their wives open for anyone to have sex with, having her sewn shut ensures that this does not happen."

All the respondents expressed opposition to the procedure and indicated they wanted FC eradicated. What is more, some of the opposition was vehement. For example, one respondent stated that "I am totally against [FC], it ruined my life and I don't want it ruining anyone else's life. I would definitely defend anyone being circumcised; no one deserves to be mutilated." Another stated, "I do not support FC at all, it is unnecessary and serves no purpose." A third respondent labeled the practice "oppressive to women and harmful." Similarly, a participant described it as a "terrible" practice that warrants abolition because there were "too many health risks" it posed for girls and women. However, the opposition masks a complicated picture that betrays the strong cultural hold the procedure has for these women. For example, one respondent, after disclosing that FC ruined her life, in the very same breath stated, "I think being

in a new country and the fear of not knowing what [can] happen to girls made a lot of people proponents for infibulation." Another stated that FC "was a big problem" in her time and a "pain" she had resigned herself that her own daughters will go through. Lastly, one participant who was aware of the negative health outcomes associated with FC, in the same breath commented that "girls who suffer illness or die are believed to have committed some sin and failed to confess all their sins to the community and therefore are paying for their sins."

All the participants knew someone who had been circumcised. One respondent who had undergone FC indicated that she had kidney and menstrual pains following the procedure. Another respondent noted that her "understanding" was FC brought about "diseases and great sadness. Additionally, a participant shared that her aunt "experienced difficulties with conceiving and had a difficult pregnancy." Further, one respondent indicated that she contracted infections and AIDS from an unsterilized blade that was used in circumcising her. This respondent also reported that it ruined her relationship with her mother who approved the procedure and she felt betrayed by her. However, one participant's poor health outcomes resulting from FC moved her mother to allow her to have the procedure reversed as noted below:

> "My sisters were circumcised in Somalia at a time when clitoridectomy was common, plus that was the only thing my father would agree to. The thing that changed my father's mind was when one of his daughter's (my half-sister) died giving birth because of FC…After my half-sister died, my father did not allow any of us to get circumcised...Years later, my father died and my mother eventually remarried…My step-father and aunt insisted that I be circumcised…My mother knew I would be circumcised…she was outnumbered and she really didn't have much to say. When I first found out I was going to be circumcised, I would run from our house and hide at my friend's house until it got dark. We didn't have lights so I knew it couldn't be done at night. Mine was horrible. It was an older guy who circumcised me. He was very mean to me. He said he was going to punish me for running away. He circumcised me so badly and before he was done, he told me I would never forget what he did to me. He was right. I've had kidney pain and menstrual pain… My mother said she didn't know it would be as bad as it was. Later when we moved to the U.S., my mother gave me permission and I went ahead and had a reverse surgery in the U.S. when I was 16 years old. The reversal surgery took about 10 minutes and I felt nothing. The surgeons were really nice [and] my health has been good ever since the reversal surgery. One of my aunts was angry that my mother allowed me to get the reversal surgery but my mother knew I was having health problems."

From this participant's account it is clear to see that she was not willing to consent to undergoing FC as evidenced by her running away. This participant's physical health was negatively impacted by the FC procedure. This participant also noted that her mother was aware that she would be circumcised and caved into group pressure but expressed remorse once she realized the effect that circumcision had on her daughter. This account illustrates how some women can shift their views about the cultural practice of FC when they become aware of the serious health consequences. It also highlights the pressure women feel from their communities to practice FC.

Seven of the participants knew females who received medical help after undergoing FC. The respondents indicated that the medical assistance occurred in a range of settings that included traditional healers' location, clinics, and hospitals. The first treatment option for many

is the traditional healer, who uses herbs to help with infection. This is particularly the case in instances where, for fear of governmental interference, a family chooses not to go to the hospital. Given the high cost of medical care, traditional healing is also the option in many rural communities. However, "if the infections are bad and the girl's life is in danger," families try to raise money "to have the girl checked by a" qualified medical doctor. In sum, as one respondent pointed out, "since FC is a secret practice, any discussion surrounding it will present problems and is discouraged. Therefore, seeking medical help for a problem arising from the circumcision becomes problematic."

Knowledge and Perceptions of Policies that Outlaw FC in the United States

All the respondents indicated they are generally aware of laws against the practice (but not the specific details of these laws)—in the United States. None of the respondents felt that the anti-FC policies were effective. One respondent stated, "Sometimes they work and other times they do not, cultural practices tend to override laws." Some of the respondents blamed the situation on poor enforcement. Such was the case in Kenya where, in spite of the attempt by the government under Daniel Arap Moi to outlaw FC, individuals including even public figures and officials "still sent their daughters to villages far from the main cities to have them circumcised because deep down they still believed in the cultural significance and meaning of FC."

The views of the respondents were blended with solutions that they considered feasible to improve compliance and enforcement. This included a promise as part of the anti-FC campaign in Somalia that "the men would not reject the girls if they do not get circumcised." They also felt that the anti-FC policy in the United Kingdom was effective by requiring "members of practicing communities who want to take their children on vacation must have them medically examined to ensure no [circumcision] has been done prior to their vacation." The children are checked again once they returned to ensure no circumcision took place while they were supposedly on vacation. The parents or wards are then subjected to legal consequences if, upon their return, they were found to have been circumcised. Another solution is wider publicity of anti-FC laws designed to make them less "misunderstood"—and more amenable to enforcement.

In a subjectivity statement, designed to disclose any biases the researcher may have regarding the subject matter being studied, one of the authors disclosed some of the cultural and legal dilemmas in Kenya relating to FC. This author comes "from the Gikuyu community in Kenya, where FC has *deep cultural roots*." She elaborated that her "mother, who is a children's and women's development rights advocate, was the first to inform me about this practice," adding: "I was in high school and could not understand why a mother, who suffers from the physical and psychological problems related with this practice, would then have it done to her daughter." She went on importantly:

> "Over time, I came to comprehend the cultural significance of this practice within the Gikuyu community as one that ensures the transition from girlhood to adulthood, eligibility for marriage, chastity before marriage, and fidelity after marriage. I also realized that FC had larger underlying problems that were economically based, where a girl was viewed as being a valuable asset to her family's financial welfare through honorable marriage, ensured by FC, which would then attract a higher dowry. Circumcised girls are eligible for an honorable marriage that brings a large dowry to her family. I learned that FC is a cultural practice, whereby the roles of males and females are determined by the society

> and upheld by the family. Moreover, in many instances, educational and financial opportunities are not fairly distributed among males and females within very large and/or poor families. Hence, a circumcised girl can earn a higher dowry for her underprivileged family in comparison to an uncircumcised female. I also became aware of the physical and psychological effects associated with FC and that they are far reaching including urinary tract infections, bladder infections, depression, fistula, and death, just to mention a few."

In short, this author views FC as "a rite of passage" and "a requirement for marriage" among the Kikuyu people in Kenya.

Delving into the legal dilemma associated with FC, this author mentioned, "I noticed that despite the existence of policies that outlaw FC, cultural beliefs tend to override them. Even the lawmakers themselves and chiefs within districts where this practice is rampant had difficulties with implementing the laws for fear of losing constituents' votes." International law "is the body of rules which nations consider binding in their mutual relations." In an international system characterized by anarchy or the lack of a world government, international law holds the best possibility, even means, for the world community to lead through law.

The second author is an African American female who respects everyone's right to engage in cultural practices that do not harm the person, especially children. This author supports the eradication of FC and believes that effective culturally competent strategies and interventions should be employed in the United States to end female circumcision.

Conclusion: Toward the Search for a Common Ground in the FC Controversy

Some of the African immigrant women in this study vacillate between where they stand on the practice of female circumcision. They were all aware of the health problems associated with FC and want it to be eradicated. However, some of them believed the girls who underwent FC and experienced health problems or death resulted from the girls not confessing all of their sins. Furthermore, all the women were vaguely aware of policies that outlawed the practice, but did not know any specific requirements of the laws. Clearly, there is a need for educating immigrants about the requirements and punishments of the anti-FC laws.

It is not clear whether or not the anti-FC laws enacted in the United States have reduced the practice of FC among immigrants given the weak enforcement, lack of knowledge about the reporting requirements, and few cases being prosecuted. In addition, it appears that some immigrants are not familiar with the zero tolerance provision of anti-FC policies in the United States. In order to eradicate the practice, the United States needs to design some culturally competent interventions to educate immigrants about the anti-FC policies, raise awareness of the health problems associated with FC, human rights violations, and medical informed consent violations. This study is one of the few studies that have examined the medical informed consent violations that occur when female immigrant children are circumcised. Parents should let the child decide if she wants to undergo FC when she reaches the age of consent.

Most importantly, all the interventions must secure the support of practicing communities. Although, some African female scholars agree that FC should be eradicated, they disagree with the punitive measures used. There have been some culturally competent interventions that have enabled the practicing communities to agree to end FC. Effective interventions similar to the ones in the Tostan project and in Kenya discussed earlier should be designed to get immigrants in the United States to stop circumcising their female children.

Although this study obtained information from nine African immigrant women who came from communities that practiced female circumcision, it was difficult to recruit participants because the practice is secret and is not supposed to be discussed openly. It would have been helpful to not only recruit participants from other practicing countries, but also obtain the views of immigrant men. However, the findings from this study help shed new light on the perceptions, attitudes, knowledge, and experiences of African immigrant women as it relates to FC and the policies that outlaw it. Future studies should recruit a more diverse group of immigrants that include both males and females.

References

Ahmadu, Fuambai. 2000. Rites and wrongs: An insider/outsider reflects on power and excision. In Bettina Shell-Duncan and Ylva Hernlund (eds.) *Female circumcision in Africa: Culture controversy and change*. CO: Lynne Rienner.

Assaad, Marie B. 1980. Female circumcision in Egypt: Social implications, current research and prospects for change. *Family Planning* 11:3-16.

Baderin, Mashood. 2003. *International human rights and Islamic law*. London: Oxford University Press.

Bangser, Maggie. 2006. Obstetric fistula and stigma. *Lancet* 367(9509):535-536.

Burstyn, Linda. 1995. Female circumcision comes to America. http://www.theatlantic.com/past/docs/unbound/flashbks/fgm/fgm.htm (accessed March 1, 2011)

CEDAW. 2013. CEDAW by the Numbers. http://www.cedaw.org (accessed March 10, 2013).

Chalmers Beverly and Hashi Kowser, Omer. 2000. 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth* 27:227−234.

Chege, Jane N., Ian Askew and Jennifer Liku. 2001. An assessment of the alternative rites approach for encouraging abandonment of female genital mutilation in Kenya. http//www.popcouncil.org/pdfs/frontiers/FinalReports/Kenya_FGC.pdf (accessed December 10, 2011)

Coffman, Jennifer E. 2007. Producing FGM in U.S. courts: Political asylum in the post-Kasinga era. *Africa Today* 53:59-84.

Covenant on Economic, Social, and Cultural Rights. 1966. Convention on the elimination of all forms of discrimination against women. 1981. G.A. Res. 34/180., http://www2.ohchr.org/english/law/cedaw.htm (accessed January 10, 2011).

Convention on the Rights of the Child. 1990. G.A. Res. 44/25. http://www2.ohchr.org/english/law/crc.htm (accessed January 10, 2011).

Darby, Robert. 2003. Medical history and medical practice: Persistent myths about the foreskin. *Medical Journal of Australia* 178(4):178-9.

Davis, Dena S. 2001. Male and female genital alteration: A. collision course with the law? *Health Matrix Journal of Law-Medicine* 11:487-570.

Female Genital Cutting Education and Networking Project. 2006. Dad sentenced in first female genital cutting trial in U.S. http://www.fgmnetwork.org/gonews.php?subaction=showfull&id=116265612&archive=&start_from=&ucat=1& (accessed October 16, 2010).

Female Genital Cutting Education and Networking Project. 2010. Mother in Georgia charged with female genital mutilation. http://www.fgmnetwork.org/gonews.php?subaction=showfull&id=1268935417&archive

=&start_from=&ucat=1& (accessed October 16, 2010).
Gachiri, Ephigenia, W. 2000. *Female circumcision*. Nairobi, Kenya: Pauline's Publications Africa.
Githiora, Rosa. 2010. Attitudes and perceptions of female circumcision among African immigrant women in the United States: A cultural and legal dilemma. PhD dissertation, University of Akron.
Gollaher, David L. 2000. *Circumcision: A history of the world's most controversial surgery*. NY: Basic Books. 2000.
Integrated Regional Information Network. 2005. Razor's edge: The controversy of female genital mutilation. *IRIN Web Special,* March 23, 2005. http://www.irinnews.org/pdf/in-depth/FGM-IRIN-In-Depth.pdf (accessed February 10, 2011).
Islam, Mazharul and Mosleh Uddin. 2001. Female circumcision in Sudan: Future prospects and strategies for eradication. *International Family Planning Perspectives* 27(2):71-76.
Kabir, Mohammed, Zubairu Iliyasu, Isa Abubakar S. and Umar Imran. 2003. Medico-social problems of patients with vesicovaginal fistula in Murtala Mohammed Specialist Hospital, Kano, Nigeria. *Annals of African Medicine* 2:54-57.
Kelly, John. 1995. Ethiopia: An epidemiological study of vesico-vaginal fistula in Addis Ababa. *World Health Statistics Quarterly* 48(1):15-17.
Kenyatta Jomo. 1938. *Facing mount Kenya: The tribal life of the Kikuyu*. London: Secker & Warburg.
Key, Frances L. 1997. Female circumcision/female genital mutilation in the United States: Legislation and its implications for health providers. *Journal of American Women Medical Association* 52:179-87.
Leye, Els and Alexia Sabbe. 2009. Overview of legislation in the European Union to address female genital mutilation: Challenges and recommendations for the implementation of laws. Expert group meeting on good practices in legislation to address harmful practices against women. United Nations, EGM/GPLHP/2009/EP.09. http://www.un.org/womenwatch/daw/egm/vaw_legislation_2009/Expert%20Paper%20EGMGPLHP%20_Els%20Leye_.pdf (accessed April 16, 2013).
Medical Council. 2008. Good medical practice in seeking informed consent to treatment. www.stateclaims.ie/.../2009/referenceguideconsentforexamination.pdf (accessed July 21, 2010).
Merwine, Maynard H. 1993. How Africa understands female circumcision. *New York Times* November 24, A24.
Muleta, Mulu and Gordon Williams. 1999. Postcoital injuries treated at the Addis Ababa Fistula Hospital, 1991-1997. *Lancet* 354(9195): 2051-2052.
Nnaemeka, Obioma. 2005. African women, colonial discourses, and imperialist interventions: Female circumcision as impetus. In Obioma Nnaemeka (ed.) *Female circumcision and the politics of knowledge: African women in imperialist discourses.* CT: Praeger Publishers.
Plan International. 2006. Tradition and right: Female genital cutting in West Africa. http://www.crin.org/docs/femalecutting.pdf (accessed February 10, 2011).
Prazak, Miroslava and Jennifer Coffman E. 2007. Anthropological perspectives on female genital cutting: Embodying tradition, violence, and social resilience. *Africa Today* 53(4): v-xi.

Rahman, Anika and Nahid Toubia. 2000. *Female genital mutilation: A guide to laws and policies worldwide*. London: Zed Books.

Rainbow Organization. 1996. *Female genital mutilation: A fact sheet*. Nairobi, Kenya. 1996.

Reymond, Laura, Asha Mohamud, and Nancy Ali. 1997. Program for Appropriate Technology in Health (PATH-Kenya). *Female genital mutilation: The facts, information sheet*, Nairobi, Kenya.

Rogers, Reuel R. 2006. *Afro-Carribbean immigrants and the politics of incorporation: Ethnicity, exception, or exit*. United Kingdom: Cambridge University Press.

Section 203(c) of the Immigration and Nationality Act. §131 of the Immigration Act of 1990 (Pub. L. 101-649)

Shabaan, Layla M. and Sarah Harbison. 2005. Reaching the tipping point against female genital mutilation. *The Lancet* 366(9483):347-349.

Shullenberger, Bonnie. 1995. Africans view circumcision as rite. *New York Times*, A26, June 22, 1995. http://www.nytimes.com/1995/06/22/opinion/l-africans-view-circumcision-as-rite-715895.html (accessed March 11, 2011).

Snively, Judith. 1994. Female bodies, male politics: Women and the female circumcision controversy in Kenyan colonial discourse. PhD dissertation, University of Michigan.

Steiner, Henry J., Philip Alston and Ryan Goodman. 2008. *International human rights in context*. NY: Oxford University Press.

Talle, Aud. 2007. Female circumcision in Africa and beyond: The anthropology of a difficult issue. In Ylva Hernlund and Bettina Shell-Duncan (eds.) *Transcultural bodies: Female genital cutting in global context* (9-106). NJ: Rutgers University Press.

Thomas, Lynn M. 2000. Ngaitana (I will circumcise myself): Lessons from colonial campaign to ban excision in Meru, Kenya. In Bettina Shell-Duncan and Ylva Hernlund (eds.), *Female circumcision in Africa: Culture, controversy, and change*. CO: Lynne Rienner.

Tostan. 2007. Community Led Development. Abandoning female genital cutting. http://www.tostan.org/web/page/586/sectionid/547/pagelevel/3/interior.asp (accessed November 13, 2010).

United Nations. 1979. Harmful traditional practices affecting the health of women and children Fact Sheet No. 23. www.ohchr.org (accessed December 21, 2012).

UN General Assembly. 1966. *Covenant on Civil and Political Rights*. Treaty Series 999, 171. http://www.unhcr.org/refworld/docid/3ae6b3aa0.html (accessed April 16, 2013).

United Nations Population Fund 1989. Promoting Gender Equality. Convention on the rights of the child. Article 37a. Geneva, Switzerland.

Weisemann, Claudia, Susanne Ude-Koeller, Gernot Sinnecker H. G. and Ute Thyen. 2010. Ethical principles and recommendations for the medical management of differences of sex development (DSD)/intersex in children and adolescents. *European Journal of Pediatrics* 169(6):671–679.

Women's Dignity Project and Engender Health. 2006. Living with obstetric fistula: The devastating impacts of the condition and ways of coping. *New York: Engender Health* , http://www.engenderhealth.org/files/pubs/maternal-health/Obstetric_Fistula_Brief_3_Impacts_and_Coping.pdf (accessed June 14, 2008).

World Health Organization. 2010. Female genital mutilation. Fact Sheet No. 241 http://www.who.int/mediacentre/factsheets/fs241/en/ (accessed December 29, 2010).

World Health Organization. 2005. *Female genital mutilation/cutting: A statistical exploration*. New York, NY: UNICEF.

World Health Organization. 2008. Eliminating female genital mutilation: An interagency statement. http://www.whqlibdoc.who.int/publications/2008/9789245196442_eng.pdf (accessed December 10, 2011).

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Appendix 1: Demographic Data

Topic	Frequency
Country of Origin	
Somalia	4
Kenya	4
Egypt	1
Years of Residence in U.S.	
1—10 years	7
11—20 years	1
21 or more years	1
Reasons for Migrating to the U.S.	
Education, Work, and Family	4
Refugee	3
Visiting Children	2
Challenges Faced	
Language, social, cultural barriers	9
Isolation	2
Location of Residence in the U.S.	
Ohio	4
Minnesota	2
Maryland	1
New York	1
North Carolina	1
Age of Participants	
20—29 years old	4
30—39 years old	0
40—49 years old	1
50 or more years old	4
Education	
Less than high school	2
High school diploma	2
Bachelor's degree	4
Graduate degree	1
Marital Status	
Single	4
Married	2
Widow	3
Religion	
Christian	4
Islam-Sunni	5
Ethnicity of Communities Practicing FC	
Somali	4
Gikuyu	2
Kalenjin-Tugen	2
Egypt-Arabic	1

Appendix 1: Demographic Data Continued

Topic	Frequency
Types of FC Practiced	
Clitoridectomy	5
Infibulation	4
Gender of Circumciser	
Female (Elderly)	7
Male	2
Location of FC	
Hospital or Illegal Clinic	4
Bush or Forest	3
Home compound	2
People You Know that Have Been Circumcised	
Self	4
Daughters	3
Mothers	2
Aunts	2
Sister	1
High school classmate	1
Medical Assistance Provided for Complications	
Yes	4
No	3
Not Sure	2
Knowledge and Awareness of Policies that Outlaw FC	
Yes	0
No	9
Attitudes about Policies that Outlaw FC	
Ineffective	9
Not enforced	1
Not easy to understand	1
Unclear consequences	1