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Understanding the Health Challenges among East African Women in the U.S. with a History of Female Genital Mutilation

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Women's reproductive health, long recognized as a fundamental priority, continues to face increasing and evolving risks. Female genital mutilation (FGM) is a harmful cultural practice and a sensitive topic of significant public health importance. According to the World Health Organization, FGM affects an estimated 230 million women and girls worldwide. Published studies on lived experiences and health complications of East African women and girls in Southern California are lacking. This pilot study was conducted to understand the lived experiences and associated health challenges or complications, and barriers to healthcare for women and girls with a history of FGM. We recruited six participants and conducted semi-structured interviews with them who met the inclusion criteria. Our data analysis resulted in the development of four themes: Attitudes, Cultural Beliefs, Practices, and Myths; Health Consequences; Barriers to Healthcare Access; and Education. The participants described their lived experiences that included physical and psychological health complications, sexual dissatisfaction, excessive bleeding, painful intercourse, difficult menstruation, and reduced sexual dysfunction, including desire or libido, arousal, excitement, and orgasm. Other self-reported lived-experiences were mental health complications, including depression, anxiety, and post-traumatic stress disorder. Our results support previously published studies on self-reported health challenges and complications experienced by women with FGM. Education is key to understanding FGM, prevention, and improving healthcare access and outcomes among ethnically diverse and at-risk girls and women. This calls for essential healthcare services, with sustained evaluation of the underlying factors, cultural beliefs and practices, and their policy implications. The role of the healthcare professionals as agents of social change and servant leaders in providing high-quality care to women and girls affected by these cultural practices cannot be overemphasized. Health is considered a fundamental human right. Concerted efforts are needed to protect, support, and be culturally responsive in advocating for the eradication of FGM and related procedures to become an international priority. We recommend targeted education for at-risk populations, actionable data for localized public health intervention, as well as the enforcement of existing laws to combat or eradicate FGM and other inhumane and traumatic cultural practices.

Keywords: *female genital mutilation, FGM, genital cutting, East African women, reproductive health, culturally responsive healthcare education*

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Background

Female genital mutilation (FGM) or genital cutting, or circumcision, involves partial or total removal of external female genitalia for non-medical and non-therapeutic reasons, and often for the purpose of limiting sexual pleasure or controlling sexuality, and without the individual's consent (Agboli et al. 2020, Johnsdotter et al. 2025, UNICEF 2024). The procedure is part of global social norms and cultural practices estimated to affect over 230 million women and girls in 30 countries, primarily in the Horn of Africa (e.g., Djibouti, Eritrea, Ethiopia, and Somalia), the Middle East (e.g., Iraq and Yemen), and Asian e.g., Indonesia) have undergone the procedure (UNICEF 2024). Of the total 230 million FGM women and girls, Africa accounts for 144 million, Asia has 80 million, the Middle East has 6 million, while migrants from countries where the practice occurs, living in other countries, including Australia, Europe, Canada, and the United States of America, account for 1-2 million. It is estimated that 4 million girls remain at risk of FGM yearly. According to UNICEF (2024), the FGM prevalence rate is estimated at 90 percent or higher in some African countries, including Djibouti, Somalia, and Guinea. In the United States, over 513,000 women and girls have experienced or are at risk of FGM (Goldberg et al. 2016).

There are four major types of FGM, classified based on the degree of genital tissue removed during the circumcision (UNICEF 2024, Pallitto et al. 2025). Type I or clitoridectomy, the most common procedure, consists of partial or total removal of the clitoris and/or the prepuce; Type II or excision, involves partial or total removal of the clitoris and labia minora with or without excision of the labia majora; Type III or infibulation, involves tightening or narrowing the vaginal opening by cutting or sewing the labia together to create a seal with or without clitoral glans excision; and Type IV includes all other harmful procedures inflicted on female genitalia for non-medical reasons (i.e., piercing, pricking, incising, scraping, and cauterization or burning).

Historically, FGM is an ancient cultural practice that is shrouded in secrecy, with reported estimates considered to be gross underestimations of the actual number of affected women and girls (Agboli et al. 2020). The practice has continued due to the belief that female circumcision will prevent masturbation, decrease libido, and ultimately preserve a woman's sexuality and virginity until marriage (WHO 2025). Although FGM is prevalent in both Muslim and Christian communities throughout Africa, it has not been directly associated with religious beliefs and appears nowhere in the Bible or the Quran. In countries where FGM is practiced, women and girls must be circumcised to gain acceptance in their communities and be married, and dissenters are often stigmatized (Utz-Billing & Kentenich 2008). Older women would routinely perform the procedure using unsterilized and barbaric instruments without anesthetics or antibiotics (Odukogbe et al. 2017). In addition, several migrants from affected countries who live in North America, Australia, and Western Europe continue to practice FGM by sending daughters back to their family homeland for the procedure.

Female circumcision has no known health benefits, is considered a cultural norm, and a rite of passage for women and girls (Johnson-Agbakwu & Abdulcadir 2020). Several sexual, gynecological, obstetric, urological, and mental health complications have been reported (Goldberg et al. 2016, Pallitto et al., 2025).

The practice has been associated with various health effects and complications, including physical and psychological harms, lifelong health complications (Kaplan et al. 2011, WHO 2025). The short-term complications include severe pain, infections, bleeding, shock, urine retention, and death, whereas long-term complications include hemorrhages, scarification, genital infections, increased risks of childbirth complications, and newborn deaths (Kaplan et al. 2011, Reisel & Creighton 2015, Odukogbe et al. 2017). It is estimated that 90% of affected women expressed feelings of intense fear, helplessness, horror, and severe pain during the cutting stage (Mulongo et al. 2014, Behrendt & Moritz 2005). Although comprehensive data on mortality rates is lacking due to the stigma associated with the cultural practices, excessive bleeding due to improper wound closure has been reported as a major cause of death (Kaplan et al. 2011). However, the World Health Organization (WHO 2025) has reported that the practice significantly affects women's mental health, including increases in depression, anxiety, and post-traumatic stress disorder. Also, the affected women often faced post-traumatic stress disorder and other mental health problems as they were routinely reminded of their trauma when seeking medical treatments (Smith & Stein 2017).

A growing population of women from diverse cultures and traditions, particularly migrants from the Horn of Africa, who have experienced widespread genital cutting and have not received medical treatment, and were generally unsatisfied with their healthcare provider's level of knowledge (Utz-Billing & Kentenich 2008). Although some healthcare providers are knowledgeable of the health complications of FGM and applicable regulations, there remains a paucity of knowledge regarding the long-term significance, cultural implications, and enforcement of laws to protect at-risk women and girls.

In the United States and most developed countries, FGM is considered a violation of fundamental human rights, and in 2020, the US Congress enacted the STOP FGM Act (OWH 2025, H.R.6100-116th Congress 2021). This law created a statutory definition of genital cutting and provided detailed information on its health implications for interstate commerce. Additionally, the law broadened the scope of prohibited FGM-related conduct on minors, including attempts or conspiracy to perform the procedure; facilitating or consenting as a parent, guardian, or caretaker; and transportation of a minor for the procedure. Also, Public Law No. 116-309, enacted on January 5, 2021, specifically prohibits FGM-related conduct and mandates a maximum prison term of 10 years for any offender. According to UNICEF (2024), many countries and communities worldwide have made significant progress towards abandoning or eradicating the practice.

The main objective of this study was to understand the lived experiences of East African diaspora women who have undergone FGM and currently live in a large city in southern California, with a view to improving future healthcare access and delivery. In addition, this study will contribute to the existing literature on the risks of health complications and advocate for culturally competent healthcare access and services for those affected, with the goal of the total eradication of the practice for at-risk women and girls.

Methods

Design and Recruitment of Participants

This qualitative study is based on semi-structured interviews with FGM participants at a community clinic in a city in southern California, to understand knowledge and garner information regarding their FGM experiences, health challenges, and complications. The study was conducted as part of the requirements for a capstone project by graduate public health students, and Institutional Review Board approval was granted by the university prior to the study. Considering the sensitive nature of FGM and the stigma associated with it, extensive efforts were made to recruit eligible participants by word of mouth, networking with community members, and distributing flyers in high-traffic areas within community clinics, health centers, and faith-based organizations. The inclusion criteria were: East African women 18 years or older; had undergone FGM; and had FGM-lived experiences. The study protocol and consent form were provided to each participant before the interviews. consents. Those who agreed to participate voluntarily completed and signed the written informed consent form. No incentives were provided to the participants.

Six FGM participants who met all the eligibility requirements completed the in-depth structured interviews at a community clinic or health center. The interview questions on FGM-lived experiences were adapted from Creswell & Poth's (2018) previously published qualitative research methods and are summarized in Figure 1. This qualitative study included open-ended questions that solicited participants to describe their FGM-lived experiences, health complications, access to healthcare services, and recommendations for social changes to reduce future complications and improve healthcare services. In addition, the questions were specifically structured to assess participants' FGM norms, cultural and religious beliefs, and experiences. Each interview was audio-taped to document the discussions confidentially. Follow-up questions were developed to prompt participants to reveal further details about their experiences.

All interviews were conducted in private rooms at a community clinic for approximately 30 minutes each. To maintain confidentiality, a unique identifier was assigned to each participant’s responses, which were audiotaped, saved in a password-protected file, and subsequently transcribed verbatim using ATLAS.ti™ software for coding and data analysis.

Figure 1. *Interview Questions for FGM Participants*

Instructions: Please answer the following survey questions to the best of your knowledge.
Note: All responses to the questions will be treated anonymously and confidentially.

1. Have you undergone FGM? Yes ☐ No ☐ Don't know
2. Why was the FGM procedure performed on you?
3. How common is FGM in your community?
4. Does circumcision or FGM affect your willingness to see a doctor for health issues?
5. Are you comfortable talking to your healthcare provider about FGM?
6. What do you want healthcare providers to know and discuss with you about FGM?
7. What can healthcare providers do to make it easier for you to receive medical care?
8. Do you think FGM can cause health problems (please choose all that apply)?

☐ Menstrual problems ☐ Sexual intercourse problems ☐ Fertility problems

☐ Problems with labor during pregnancy ☐ None of the above

9. Do you think FGM will ____ your chances of marriage (please choose one):

☐ Increase ☐ Reduce ☐ Don't know

10. What other concerns about FGM would you like your healthcare provider to address?
11. Do you think the practice of FGM should continue? ☐ Yes ☐ No ☐ Don't know

Why? Please explain:

12. Would you have FGM performed on your daughter? Yes ☐ No ☐ Don't know

Why? Please explain:

Data Analysis

The transcripts were reviewed line by line for significant statements and words, then categorized into common themes or subthemes. To find common themes, qualitative methods were employed to identify health barriers for FGM participants' experiences and their knowledge of healthcare professionals regarding complications of FGM. Before coding, the interview notes were integrated into the transcripts to clarify each participant's responses and provide additional information about verbal and nonverbal responses. We extracted codes from the interview transcripts using an inductive reasoning approach. Additionally, we developed four themes with evidence from statements made by participants that included (1) Attitudes, Cultural Beliefs, and Myths about FGM; (2) Health Consequences of FGM; (3) Barriers to Healthcare Access; and (4) Education about FGM.

Results

The six participants included in the study had their FGM performed in their respective East African countries before immigrating to the United States. The results of the FGM participants' interviews, including the categories and descriptions of the themes and select quotes, are summarized in Tables 1 and 2. Four themes emerged from the analysis of the interview questions: Attitudes, Cultural Beliefs, Practices and Myths; Health Consequences; Barriers to Healthcare Access; and Education.

The FGM participants described their lived experiences, strong opposition to the practice, and advocacy for demystification, education, and total eradication. These results, along with the exemplification of each theme, are described below.

Table 1. *Qualitative Interview Coding Themes Used for the Research Study*

S/N	Category of Theme
1	Attitudes & Beliefs
2	Cultural Beliefs
3	Religious Beliefs
4	Health Consequences
5	Psychological Consequences
6	Barriers to Healthcare
7	Laws Regarding FGM
8	Education

Table 2. *Categories of Common Themes from the Interviews with FGM Participants*

Theme	Explanation	Participants' Quotes (Selected)
Attitudes, Cultural Beliefs, and Myths about FGM	Provides a description of the attitude, cultural, religious, and other beliefs regarding FGM.	• "FGM procedure is rooted in misogyny, and it's rooted in pleasing (a) man and not pleasing women. It doesn't benefit women in any way." (FGM Participant #3) • "Some people try to promote this as a religious thing, which is not true." (FGM Participant #1) • "Actually, they didn't have an explanation, it's a cultural issue and they feel like if they circumcise their daughters, they will stay out of reach of men and they will be pure women and they will be applied and not need a man until she gets married." (FGM Participant #1)
Health Consequences of FGM	Describes the psychological effects of FGM, including mental or emotional trauma, post-traumatic stress disorder (PTSD), anxiety, depression, etc.	• "There's no anesthesia, so you feel every single little thing that's happening to you." (FGM Participant #5) • "So, it's very, very traumatic, it's a very visual memory that you have in your memory that you feel and experience everything, … some kind of PTSD." (FGM Participant #6) • "Yes, yes, more cramping, more blood flows, and kidney problems, and I feel pain in my kidney like I cannot walk that much, so it affects my walking ability, and then you get a lot of headaches." (FGM Participant #3) • *"It's a very traumatic experience. I remember it like yesterday, like I will never forget it. I remember the lady's face, and I remember what happened to me, the room, the place, my recovery, everything." (FGM Participant #5)*
Barriers to Healthcare Access	Describes the barriers to accessing available healthcare and receiving needed support from their healthcare providers.	• "I would like to know ahead of time, what's going to happen to me and how they're going to deal with my situation." (FGM Participant #4) • "It was not comfortable to explain what they (doctors) can do for you." (FGM Participant

		#2)
Education about FGM	Describes the knowledge and experiences of the participants regarding FGM.	• "Educate the people, this is not any religion or anything, this is the culture, and that's not a good thing to do for women." (FGM Participant #4)

Categories of Themes

1. Attitudes, Cultural Beliefs, and Myths

All six participants independently reported that they underwent the procedure due to cultural beliefs that framed the procedure as a way to preserve purity, maintain virginity, make women and girls remain virgins until marriage, and discourage promiscuity. Participants also stated that this was not questioned in their countries of origin because the prevailing social norms required the procedure. Questioning parental decisions was viewed as challenging the culture itself because the practice remains deeply rooted in social norms, primarily driven by historical and cultural beliefs on gender identity in their societies. The participants further explained that women and girls were often unable to voice individual opinions about the practice while still living in their countries of birth.

> "Actually, they didn't have an explanation, it is a cultural issue, and they feel that if they circumcise their daughters, they will stay out of reach of men, and they will be pure women, and they will be applied and not need a man until she gets married." (FGM Participant #1)

Participants' attitudes and beliefs about FGM were examined and analyzed to understand their current views, concerns, and feelings about allowing their daughters to undergo the procedure. Overall, the participants were generally opposed to having their daughters undergo FGM. One participant described her struggles and deep anger for years to forgive her parents for subjecting her to the procedure, explaining that the experience not only caused deep anger, but it also affected her emotional and mental well-being. Although she eventually forgave them because they are her parents but has continued to suffer both emotional and mental health complications. She also emphasized the importance of maintaining a healthy lifestyle for herself and her daughter. Participants' concerns and opposition to their daughters undergoing the procedure are reflected in the following statements:

> "Because I do not want them to have what I had. The problems I came here with, there is no benefit as I said."

One participant stated that FGM should be eliminated from her culture. The other participants' responses agreed with this suggestion.

> "FGM procedure is rooted in misogyny, and it is rooted in pleasing (a) man and not pleasing women. It does not benefit women in any way." (FGM Participant #3)

Religious belief emerged as another subtheme. Participants were asked whether religion played a role in the acceptance of FGM in their countries of origin. All participants agreed that FGM was not rooted in religion but was a cultural belief and practice.

> "FGM has nothing to do with religion; it was simply a cultural thing." (FGM Participant #2)

2. Health Consequences

Participants were asked if they believed that undergoing FGM caused any health problems. Follow-up questions encouraged them to elaborate on whatever FGM-related health problems they may have experienced. Self-reported physical and psychological health consequences were sexual dissatisfaction, excessive bleeding, painful intercourse, and menstruation, reduced sexual excitement, desire, arousal, orgasm, and post-traumatic stress disorders. Four of the six participants believed that their abnormally severe menstrual cycles and excessive bleeding were due to mutilation of their vaginas. They explained that their menstrual periods caused more severe cramps, back pains, bleeding, and headaches. In addition, one of the participants noted that she experienced infections due to the blood (during menstruation) not having a large enough passageway. Three participants stated that they experienced increased difficulties during labor due to the smaller sizes of their vaginal openings when compared to the sizes of their babies. Another physical consequence that the participants reported was pain or numbness that they felt during sexual intercourse with their partners. One participant compared sexual intercourse with her husband to being raped, while another stated that she felt no pleasure during sexual intercourse.

Although no physical examinations were conducted on any of the participants, their sentiments and beliefs on the physical consequences attributed to the FGM procedure were clearly self-reported. All participants expressed feelings and experienced various physical health conditions associated with FGM. For example, one participant exclaimed as follows:

> "Yes, yes, more cramping, more blood flows, and kidney problems, and I feel pain in my kidney like I cannot walk that much, so it affects my walking ability, and then you get a lot of headaches." (FGM Participant #3)

Reported psychological consequences included various types of mental or emotional trauma that participants attributed to FGM. Some participants said they could remember the face, room, and people who were there when the FGM took place. Other participants noted that they felt shame and embarrassment when going to see the doctor because of their mutilated vaginal area, and they did not know what to say to the doctor. Another participant stated that she did not want to consult with the doctor because she was afraid of reliving the entire experience and facing the embarrassment associated with FGM. One of the participants compared relieving her FGM experience to post-traumatic stress disorder (PTSD) because she had

flashbacks and remembered each second of undergoing the FGM procedure vividly. This was corroborated by four other participants who mentioned "some kind of PTSD" that they felt from the memory of having FGM performed at a young age.

> "There is no anesthesia, so you feel every single little thing that's happening to you. So, it's very, very traumatic; it's a very visual memory that you have in your memory that you feel and experience everything." (FGM Participant #6).

Also, two of the participants expressed the excruciating pain, trauma, and post-traumatic stress disorders that they experienced during the procedure, as detailed below.

> "It's a very traumatic experience. I remember it like yesterday, like I will never forget it. I remember the lady's face, and I remember what happened to me, the room, the place, my recovery, everything." (FGM Participant #5)
> "So, it's very, very traumatic, it's a very visual memory that you have in your memory that you feel and experience everything, … some kind of PTSD." (FGM Participant #6)

3. Barriers to Healthcare Access

Barriers to accessing healthcare were another important theme that all the participants identified and related to. All the participants stated that they were uncomfortable with discussing FGM with their healthcare providers in any clinical setting. This barrier arose multiple times during the interviews in the private room. When participants reflected deeply on their struggles and experiences during their initial visits or prenatal care with health professionals, they stated that the fear of personal judgment and shame was a major barrier to accessing healthcare. Some participants shared stories that involved health professionals being completely insensitive and directly asking them what had happened to their genitals. In contrast, others merely stared in disbelief without regard to the patient's feelings. In one instance, a participant shared that after seeing the doctor's reaction to her vaginal circumcision, she wanted to run away because she was so ashamed and embarrassed. Additionally, participants reported the importance of having access to health professionals who can provide solutions to their health challenges and educate them about available options.

Several participants mentioned language barriers to accessing healthcare. For example, when asked, "What do you want healthcare providers to know and discuss with you about FGM?" The participants generally agreed that it would be best to have an interpreter to help them understand medical terms, processes, and explanations of treatment plans, rather than a simple check-up with no guidance. One of the participants summed it up as follows:

> "It was not comfortable to explain what they can do for you, and I would like to know ahead of time what is going to happen to me, and how they are going to deal with my situation." (FGM Participant #2)

4. Education

Participants were asked what they knew about FGM based on their personal life experiences, and not necessarily the education obtained at school. The issue that

stood out the most and was most important to participants was the consensus that FGM is a long-standing tradition and a deeply ingrained cultural belief, not a religious issue.

> "Some people try to promote this as a religious thing, which it is not." (FGM Participant #1)

Participants felt that the FGM procedure was unnecessary and did not benefit women in any way, so they were adamant about increasing awareness about the subject to aid in the reduction of the number of girls who undergo this practice. Participants were aware of the health consequences they faced from undergoing FGM, including excessive cramps, headaches, infections, problems with labor and delivery, reduced sensitivity, emotional trauma, and PTSD.

Additionally, they reported that other women they were close to, such as relatives, experienced various difficulties in their marriages, including reduced sexual pleasure due to FGM. Although participants' medical histories or current health conditions were not evaluated, it was important to draw on their firsthand experiences and knowledge of this subject to create an informative booklet and guide that will help address their individual concerns and those of women in their community. Most participants expressed the need for education and awareness about the practice.

> "Educate the people, this is not any religion or anything, this is the culture, and that is not a good thing to do for women." (FGM Participant #4)

Lastly, the participants generally suggested that health professionals should educate the community about FGM practices and health consequences, with the hope of preventing future generations of girls from having to undergo the procedure.

> "Because they do not understand, like they do not know what is going on. Like, in America, they do not practice that (FGM), so I do not think they have anything to offer me." (FGM Participant #3)

Discussion

There has been an increasing public health interest in issues related to FGM during the past few decades due mainly to the continuous influx of immigrants to the United States from countries where FGM is practiced. However, data on FGM experiences among diaspora communities in the United States is scanty. FGM involves the cutting, piercing, sewing, or removing parts of or all external genitals in women and girls, usually for no medical reason or health benefits, and is in violation of human rights (Hussein 2010). According to the WHO (2025), "FGM comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons." In addition, 140 million women and girls and over 513,000 females in the U.S. have experienced FGM, and an estimated 3 million girls worldwide are at risk of undergoing genital cutting every year (OWH 2025).

FGM remains a common traditional practice in 30 African countries, primarily in the southern Sahara, including parts of northern, eastern, and central Africa, as

well as some Asian and Middle Eastern countries (Hussein 2010, UNICEF 2024, Odukogbe et al. 2017). The procedure is often performed with unsterilized instruments or cutting tools, without anesthesia or antibiotics, by elderly women who are non-medical practitioners (Odukogbe et al. 2017, OWH 2025). This observation agreed with our finding that the women reported a lack of anesthesia, as stated in the following quote: "There is no anesthesia, so you feel every single little thing that's happening to you." It has been reported that in African communities, FGM is considered an important part of their culture and gender identity and that the practice virtually cuts across all religions in the continent, including Muslims, Christians, Ethiopians, Jews, and other traditional African religions (Hussein 2010). All the participants reported the issue of gender identity and religious belief or connection.

> "Some people try to promote this as a religious thing, which is not true."

Several other studies have documented physical, psychological, and long-term health consequences among FGM women and girls, including infections, problems with urinating, painful menstrual periods and bleeding, problems during and after childbirth, anxiety and depression, and post-traumatic stress disorder. These health consequences were reported by all the women interviewed during this study, as documented in the following quote from one of the participants:

> "So, it is very, very traumatic, it is a very visual memory that you have in your memory that you feel and experience everything, … some kind of PTSD."

FGM participants stated that they were less likely to talk openly about their FGM experiences because in most African cultures where FGM is performed, sex before marriage is taboo. This cultural taboo made it harder for the FGM participants to be comfortable in having conversations with healthcare professionals who have limited knowledge and experience about FGM practice. Finally, our findings revealed a communication disconnect between the FGM participants and their healthcare providers. Subsequently, healthcare professionals may not know how to lead discussions in providing care to FGM patients; hence, we advocate for culturally competent healthcare delivery.

Our results have significant implications and call on healthcare professionals to recognize that FGM patients may be unfamiliar with existing laws, including Public Law No. 116-309 in the United States. To this end, there is a need for healthcare professionals to receive culturally competent training that will position them to work with affected communities and to educate them to end FGM. At the national level, many countries, including the United States, have outlawed the practice by promulgating various legislations against the cultural practice of FGM among women and girls. The United Nations (UN) recognizes FGM as a violation of fundamental human rights, and the General Assembly has adopted a milestone resolution to intensify international communities' efforts to eradicate FGM practices by 2030 (UNICEF 2024). Additionally, both the UN resolution and the SDG framework called on the international community and national partners to work cooperatively on accelerated action to ensure the total elimination of FGM across all continents. As stated in the (UNICEF 2024), several

international and regional treaties apply either directly or indirectly to FGM: The Convention on the Elimination of all forms of Discrimination against Women; the Convention on the Rights of the Child (CRC); and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Existing laws at regional and national levels include: The European Convention for the Protection of Human Rights and Fundamental Freedoms; The Covenant on Civil and Political Rights; The African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women (The Maputo Protocol); and The African Charter on the Rights and Welfare of the Child.

A previous study among Somali women noted that women were ashamed to discuss their experiences due to FGM stigmatization and the acceptance that the practice is normal and cannot be questioned (Hussein 2010). This agrees with our findings with the East African migrants, in which the participants reported that FGM is rooted in misogyny, does not benefit women, and that social norms and health beliefs often play a key role in perpetuating the procedure. In Egypt, where circumcision of daughters has declined due to improved socioeconomic status, education, and the empowerment of women, as well as targeted social media messages (Modrek & Liu 2013, Ministry of Health and Population [Egypt] 2014). Additionally, a demographic and health survey conducted in Egypt showed a reduction of circumcision rate from 90% in 2005 to 28% and 18% in 2014 amongst girls aged 0-13 years and 0–17 years, respectively. This finding agrees with our participants' consensus never to have their daughters circumcised.

A study by Achia (2014) reported that approximately 10% of women interviewed in Kenya advocated for the continuation of FGM. This contrasts with the findings of our study, in which all six participants advocated total eradication of FGM and the need to enforce existing laws. However, the Kenyan study is a driving force for FGM. It is supported by a UNICEF (2024) report that documented a decline in FGM prevalence over the last three decades. However, the pace of decline was uneven, especially in African countries, where little progress was made amid increased population growth. UNICEF noted that if current trends persist, the number of girls and women undergoing FGM will rise significantly over the next 15 years (UNICEF 2024). In a recent study on female genital mutilation in the UK, 146 FGM cases, including 103 confirmed cases of FGM, were reported. Fewer children under 16 years presented with FGM, and there was only one prosecution in two years (Hodes et al. 2021). The authors reported consistency in attitude changes in communities where FGM is still practiced and recommended culturally competent national policies to protect and support at-risk children.

Our results showed that health communication between FGM participants and their healthcare providers was in-effective and sometimes detrimental to their FGM experiences. To assist healthcare professionals in providing better care to FGM patients, the WHO (2025) has developed comprehensive FGM guidelines and fact sheets. It is anticipated that the WHO guidelines would improve care for millions of women and girls who have experienced FGM and serve to bridge the gap between them and their healthcare providers. To prevent FGM practice among future generations, there is an urgent need for effective education and targeted communications to adequately address cultural norms, beliefs, and attitudes towards FGM in existing communities. It is important and strongly recommended that the healthcare provider educate and

communicate in a culturally appropriate manner with the women and girls who have undergone the procedure, as well as encourage them to talk to other members of their community or religious leaders for help or support about FGM. In addition, women and girls in many countries who have undergone the procedure, as well as men and boys who live in the same households, have expressed strong opposition to the practice, an indication that communities favor the eradication of FGM (UNICEF 2024).

Conclusion

Women's reproductive health remains a sensitive topic of significant public health importance, and several studies have documented severe physical, psychological, and mental health effects of FGM, an entirely preventable practice. However, studies on the FGM-lived experiences of East African women and girls in Southern California diaspora communities are lacking.

Our study adds to the literature on how understanding FGM and improving healthcare outcomes require increased knowledge of the underlying factors and cultural beliefs surrounding the practices. The role of healthcare professionals as agents of social change in FGM eradication and legislation enforcement cannot be overemphasized. It is recommended that future efforts should focus on eradicating FGM practices worldwide through culturally-tailored education of women and girls, and for healthcare providers to be adequately trained to respond to existing health complications of FGM. In consideration of the unique socio-cultural context of FGM practices and to develop evidence-based guidelines, validated measures of sexual function and health are warranted to ensure culturally-appropriate education of healthcare providers and community outreach programs for the FGM at-risk populations.

FGM involves non-medical procedures that require the removal of external female genitals for non-therapeutic reasons, often without the individual's consent. In this study, we developed four categories of themes, including Attitudes, Cultural Beliefs, and Myths about FGM; Health Consequences of FGM; Barriers to Healthcare Access; and Education about FGM. The results of this pilot study indicated that cultural competency and knowledge regarding FGM are lacking and are needed to better serve the ever-increasing population of immigrants currently living in San Diego, a large city in southern California. The culturally competent guide for FGM developed from this study includes summary information on background, cultural myths, health consequences, legislation, and policy implications. It is anticipated that the guide will benefit women and girls who have undergone FGM and assist healthcare professionals in improving their cultural competency while providing better care to FGM patients, especially in neighborhoods with high refugee and immigrant populations. The benefits of the guide include understanding FGM practice, physical and psychological health effects, and how healthcare professionals can provide needed support to affected women and girls in a more culturally competent and less uncomfortable manner. This is with a view to reducing stigmatization and health disparities surrounding FGM and improving the overall health and well-being of the affected populations.

The importance of increasing trust and sensitivity for FGM patients cannot be overemphasized, as this is vital to preventing future generations of girls from having

the disastrous health consequences and complications of FGM. It is recommended that health professionals who work in communities with refugee and immigrant populations must understand the severity of FGM, the cultural beliefs, and the differences that exist. By doing so, healthcare professionals would increase their knowledge of FGM, thus allowing them to communicate effectively and provide better and improved quality of care to those who have undergone FGM.

A deeper understanding of FGM and the impact migration plays in the practice of genital mutilation of girls and young women will require concerted local, national, and global policies and lasting measures to support research in countries known for widespread FGM practices and a lack of enforcement of international laws.

Study Limitations

The results of this pilot study should be interpreted with caution due to several limitations. The participants constituted a small sample size of migrant women of East African descent. The results cannot be generalized because the sample size was small, and because the results were self-reported based on participants' lived experiences and perceptions of FGM. In addition, the study was limited to English-proficient participants who had mutual trust with the researchers, who were of the same race/ethnicity, and lived in the same neighborhoods. In addition, the results of the study could be skewed since the researchers neither had medical confirmations that the women interviewed had truly undergone FGM nor did participants provide any clarification regarding the types of FGM they had undergone. Therefore, the findings of this pilot study may differ from the diverse experiences of the general FGM population of women and girls in the United States.

Implications for Policy and Practice

In the United States, FGM practice is illegal and is treated as a federal crime with prescribed and severe penalties, a type of child abuse and gender-based violence, including the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA). Among others, the Act requires that at or before entry into the United States, visa recipients from 28 high-risk countries must be informed of the legal and health repercussions of FGM. In addition, the US Department of Health and Human Services, as mandated by Congress, must provide medical students with information on FGM treatment and prevention. Also, the US Department of State defines FGM and cutting (FGM/C) "as all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons." Any violation of the FGM law is punishable by up to 10 years in prison, fines, or both. There is no exception for performing FGM/C because of religion, custom, ritual, tradition, or standard practice. As of August 2023, 41 states have outlawed FGM through the passage of strict laws that specifically criminalize the practice. As stated by Dr. Pascale Allotey, Director of Sexual and Reproductive Health and Research at WHO, "there is a critical need to ensure

timely, high-quality health care for survivors, to engage communities for prevention and ensure families are aware of FGM's harmful effects, alongside serious political commitment to stop the practice and educate and empower women and girls." Achia (2014) recommended using advanced statistical and spatial mapping tools to identify at-risk individuals or communities in geographic hot spots where FGM practices prevailed across different regions in Kenya. The study's implications are relevant to epidemiological research that supports policymakers and non-governmental organizations in providing actionable data for targeted and localized interventions to combat FGM.

Our study highlights several implications for public health policy and practice, as well as social change for communities affected by FGM. The study adds to existing literature by providing a deeper understanding of FGM practices based on participants' self-reported and lived experiences, including physical, emotional, and psychological health consequences. Additionally, the study provides information on the importance of culturally competent training for healthcare professionals who provide targeted care to women and girls affected by FGM in communities with high refugee and immigrant populations. Finally, this study recommends that healthcare professionals should support patients who often lack familiarity with existing FGM laws. To eradicate FGM, UNICEF calls for "leaders and communities to redouble their efforts to end gender discrimination and inequality; urgently invest in services for girls; promote girls' agency and assets; prioritize girls' rights in laws and policies; and better track the prevalence of the practice through quality data."

Recommendations for Future Research

Future research and prevention efforts are recommended to provide better insight and understanding of the prevalence of FGM with a view to addressing a larger at-risk population, its varying degrees of severity, health consequences, barriers to accessing quality healthcare, and the need for culturally competent care for FGM patients. Global efforts and research in countries with widespread FGM practice and non-enforcement of laws would provide a better understanding of its public health significance. To present a more reliable and complete picture of the prevalence and practices of FGM among refugees and immigrants in the United States, qualitative and quantitative research is urgently needed. In addition, nationally representative surveys would provide updated prevalence, experiences, perceptions, and statistical data in the United States and beyond, with a view to measuring progress towards achieving the UN General Assembly's milestone.

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