

# Understanding Female Genital Mutilation Experiences to Address the Health Challenges of the at-risk Population of East African Women in San Diego, California

*Women's reproductive health remains a sensitive topic of significant public health importance. According to the World Health Organization, female genital mutilation (FGM) affects 230 million women and girls worldwide. Published studies on FGM-lived experiences of East African women and girls in San Diego, California, are lacking. This study was conducted to understand the FGM-lived experiences, associated health complications, and healthcare access among East African diaspora communities in San Diego. We recruited and conducted semi-structured interviews with six FGM participants who met the inclusion criteria at their community clinics. Data analysis resulted in the development of four themes: Attitudes, Cultural Beliefs, Practices, and Myths; Health Consequences; Barriers to Healthcare Access; and Education. FGM 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 experiences were mental health complications, including depression or anxiety, and post-traumatic stress disorder. Our results support published self-reported FGM-related health complications experienced by women in diaspora. Education is key to understanding FGM, improving healthcare access and outcomes among ethnically diverse girls and women at-risk of FGM. This calls for essential health services, with sustained evaluation of the underlying factors, cultural beliefs, and their policy implications. The role of the healthcare professionals as agents of social change and servant leaders in the community by providing high-quality care to women affected by FGM cannot be overemphasized. Health is a human right, and we must protect and be culturally responsive in advocating that FGM eradication becomes a national priority. We recommend targeted education for at-risk populations and healthcare providers, as well as enforcing existing laws to eradicate FGM practices.*

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

## 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 or controlling sexuality, and without the individual's consent (Agboli et al., 2020; Johnsdotter et al., 2025; UNICEF, 2024). FGM also includes piercing, or sewing closed, all or part of the external genitals, often as part of the culture where it is practiced. It is estimated that over 230 million women and girls in 30 African, Middle Eastern, and Asian countries have undergone FGM (UNICEF, 2024).

1 Furthermore, the UNICEF’s report noted that each year, approximately four  
2 million girls remain at risk of FGM, with a 15 percent global increase in the  
3 number of FGM survivors when compared to 2016 data, with an estimated  
4 annual healthcare cost of US\$1.4 billion (UNICEF, 2024). More than 513,000  
5 women and girls in the United States have experienced or are at risk of FGM  
6 (Goldberg et al., 2016). Historically, FGM remains an ancient cultural practice  
7 predominantly in sub-Saharan Africa, the Middle East, and Asia (Agboli et al.,  
8 2020). FGM continues to be shrouded in secrecy, with reported estimates  
9 considered to be gross underestimations of the actual number of affected women.  
10 FGM is based on the belief that female circumcision will prevent masturbation  
11 and libido and ultimately preserve a woman’s sexuality with a view to ensuring  
12 that the woman remains a virgin until marriage (WHO, 2025). In countries where  
13 FGM is still practiced as a cultural norm, the procedure is considered a rite of  
14 passage for girls (Johnson-Agbakwu & Abdulcadir, 2020). There are no health  
15 benefits associated with FGM; however, several sexual, gynecological, obstetric,  
16 urological, and mental health complications have been reported (Goldberg et al.,  
17 2016; Pallitto et al., 2025).

18 The four major types of FGM include Type I or Clitoridectomy is the most  
19 common procedure that consists of partial or total removal of the clitoris; Type  
20 II involves excision (partial or total removal) of the clitoris and the labia; Type  
21 III is known as infibulation and involves tightening or narrowing the vaginal  
22 opening by sewing the labia together; and Type IV includes all other harmful  
23 procedures inflicted on female genitalia for non-medical reasons such as  
24 piercing, pricking, cutting, scraping, and cauterization or burning (Pallitto et al.,  
25 2025).

26 According to available data, the FGM prevalence rate is estimated at 98  
27 percent in some parts of Africa (UNICEF, 2024). Additionally, FGM has not  
28 been specifically advocated for by religious beliefs and does not appear  
29 anywhere in religious books, including the Bible or the Quran. However, FGM  
30 has remained prevalent in both Muslim and Christian communities, particularly  
31 in Africa. To gain acceptance and be married, young girls must undergo FGM,  
32 and those who do not are often stigmatized by their communities (Utz-Billing &  
33 Kentenich, 2008). Older women routinely perform FGM without anesthetics or  
34 antibiotics, often using unsterilized and barbaric instruments (Odukogbe et al.,  
35 2017). Unfortunately, several immigrants in the United States and Western  
36 Europe from the affected countries often practice FGM and/or send daughters  
37 back to their family homeland for FGM.

38 FGM has no health benefits and has been associated with both physical and  
39 psychological harms to women, with the potential for lifelong health  
40 consequences (Kaplan et al., 2011; WHO, 2025). The short-term complications  
41 of FGM include severe pain, infections, bleeding, shock, urine retention, and  
42 even death (Reisel & Creighton, 2015). Long-term FGM complications include  
43 hemorrhages, scarification, genital infections, increased risk of childbirth  
44 complications, and newborn deaths (Kaplan et al., 2011; Odukogbe et al., 2017).  
45 reported that 90% of FGM women expressed feelings of intense fear,  
46 helplessness, horror, and severe pain” during the cutting stage (Mulongo,

1 McAndrew, & Martin, 2014; Behrendt & Moritz, 2005). Although  
2 comprehensive data on FGM mortality rate is lacking, excessive bleeding due to  
3 improper wound closure is a major cause of death (Kaplan et al., 2011).

4 FGM significantly affects mental health, including increases in depression,  
5 anxiety, and post-traumatic stress disorder (WHO, 2025). FGM women were  
6 often reminded of the trauma caused and may suffer mental health problems  
7 when seeking medical support to correct their complications (Smith & Stein,  
8 2017). In the United States and other developed countries, the practice of FGM  
9 is against the law and is a violation of human rights (OWH, 2025). The United  
10 States Congress signed into law the STOP FGM Act of 2020, which created a  
11 statutory definition of FGM and provided detailed findings on the effects of  
12 FGM on interstate commerce (H.R.6100-116<sup>th</sup> Congress, 2019-2020).  
13 Additionally, the bill broadened the scope of prohibited FGM-related conduct  
14 on minors, including “attempting or conspiring to perform FGM; facilitating or  
15 consenting to FGM, as a parent, guardian, or caretaker; and transporting a minor  
16 for FGM. The federal authorities have the power to prosecute those who carry  
17 out or conspire to carry out FGM with maximum prison sentences of five to ten  
18 years. It also requires governmental agencies to report to Congress about the  
19 estimated number of females who are considered at risk of or have had FGM,  
20 and on preventive efforts (H.R.6100-116<sup>th</sup> Congress, 2021).

21 A growing population of women from diverse cultures and traditions has  
22 experienced FGM. Available literature showed that some FGM patients never  
23 received appropriate medical treatment for their conditions and were unsatisfied  
24 with the healthcare provider’s level of knowledge about FGM (Utz-Billing &  
25 Kentenich, 2008). Although some healthcare providers are knowledgeable of the  
26 health complications and regulations of FGM, there remains a paucity of  
27 information on their knowledge of the long-term significance and cultural  
28 implications of FGM, particularly among healthcare providers and FGM at-risk  
29 women. There is an urgent need to develop a culturally tailored guide to support  
30 healthcare providers in understanding and providing adequate services to FGM  
31 women.

32 The main objective of this study was to understand the lived experiences of  
33 East African diaspora women who have undergone FGM and currently live in  
34 San Diego, California, with a view to improving healthcare access and delivery.  
35 In addition, this study will add to existing literature by advocating for a  
36 culturally competent healthcare delivery to those affected and ultimately the  
37 eradication of FGM practices for at-risk women and girls.

## 38 39 40 **Methods**

### 41 42 *Design and Recruitment of Participants*

43  
44 This qualitative study is based on semi-structured interviews with FGM  
45 participants at community clinics in San Diego, California, to understand  
46 knowledge and garner information regarding their FGM experiences and health

1 complications. The study was conducted as part of the requirements of a  
2 capstone project by graduate public health students, and Institutional Review  
3 Board approval was granted prior to conducting the interviews. Participants were  
4 recruited by word of mouth and through flyers distributed in high-traffic areas  
5 within community clinics and health centers, as well as at faith-based  
6 organizations. The targeted participants were East African migrant women who  
7 lived in San Diego County and had experienced FGM. The inclusion criteria for  
8 participation included women 18 years or older; migrants from East Africa who  
9 live in San Diego and had undergone FGM; and those with lived experiences of  
10 health complications or issues related to FGM. A detailed explanation of the  
11 study protocol was provided to each participant prior to the interviews, and those  
12 who agreed to participate completed and signed the written informed consents.

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

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

30

### 31 *Data Analysis*

32

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

45

46

1 **Results**

2

3 The six participants included in the study had their FGM performed in their  
 4 respective East African countries prior to immigrating to the United States. The  
 5 results of the FGM participants' interviews, including the categories and  
 6 descriptions of the themes and select quotes, are summarized in Tables 2 and 3.  
 7 Four themes emerged from the analysis of the interview questions: Attitudes,  
 8 Cultural Beliefs, Practices and Myths; Health Consequences; Barriers to  
 9 Healthcare Access; and Education. The FGM participants described their lived  
 10 experiences, strong opposition to the practice, and advocacy for demystification,  
 11 education, and total eradication. These results, along with the exemplification of  
 12 each theme, are described below.

13

14 **Categories of Themes:**

15 *1. Attitudes, Cultural Beliefs, and Myths*

16 All 6 participants believed that the reason they were subjected to FGM was  
 17 because of their culture and the belief that having girls and women undergo FGM  
 18 would lead them to be pure, it would keep the vagina intact until marriage, and  
 19 deter them from becoming promiscuous. Additionally, all participants explained  
 20 that the practice of FGM was never questioned in their native country of origin  
 21 since cultural norms required girls and women to undergo FGM, and that to  
 22 question their parents' decision was akin to questioning their culture. FGM  
 23 participants elaborated and embodied their sentiments regarding cultural beliefs  
 24 about FGM, noting that women could not vocalize the statement while living in  
 25 their original countries of birth.

26

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

31

32 Attitudes & other beliefs about FGM were used to analyze the current  
 33 viewpoints of the participants about FGM and the participants' concerns or  
 34 sentiments towards having FGM performed on their daughters. All participants  
 35 were opposed to having their daughters undergo FGM procedures. One of the  
 36 participants explained her struggles over the years in having difficulties  
 37 forgiving her parents for subjecting her to FGM, adding that it caused her to be  
 38 very angry with her parents and made it very difficult to forgive them. However,  
 39 since they are her parents, she has learned to forgive them. Additionally, the  
 40 participants noted that FGM has affected her emotional and mental stability and  
 41 that maintaining a healthy lifestyle was important to her and her daughter.  
 42 Participants' concerns and oppositions to the FGM procedures for their  
 43 daughters are vividly captured as follows:

44

45 *“Because I do not want them to have what I had. The problems I came here with,*  
 46 *there is no benefit as I said.”*

47

1 One participant stated that the practice needs to be eliminated from her  
2 culture, and the other women supported her.

3  
4 *“FGM procedure is rooted in misogyny, and it is rooted in pleasing (a) man and*  
5 *not pleasing women. It does not benefit women in any way.”* (FGM Participant #3)  
6

7 Religious belief was another sub-theme that was included to determine  
8 whether participants felt that their religion played any role or was a reason why  
9 the FGM was so widely accepted in their country of origin. It must be noted that  
10 all participants expressed their views on religious beliefs and agreed that it was  
11 not a religious issue.

12  
13 *“FGM has nothing to do with religion; it was simply a cultural thing.”* (FGM  
14 Participant #2)  
15

## 16 2. Health Consequences

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

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

40  
41 *“Yes, yes, more cramping, more blood flows, and kidney problems, and I feel pain*  
42 *in my kidney like I cannot walk that much, so it affects my walking ability, and then*  
43 *you get a lot of headaches.”* (FGM Participant #3)  
44

45 Reported psychological consequences included various types of mental or  
46 emotional trauma that participants attributed to FGM. Some participants said  
47 they could remember the face, room, and people who were there when the FGM

1 took place. Other participants noted that they felt shame and embarrassment  
 2 when going to see the doctor because of their mutilated vaginal area, and they  
 3 did not know what to say to the doctor. Another participant stated that she did not  
 4 want to consult with the doctor because she was afraid of reliving the entire  
 5 experience and facing the embarrassment associated with FGM. One of the  
 6 participants compared reliving her FGM experience to post-traumatic stress  
 7 disorder (PTSD) because she had flashbacks and remembered each second of  
 8 undergoing the FGM procedure vividly. This was corroborated by four other  
 9 participants who mentioned “some kind of PTSD” that they felt from the  
 10 memory of having FGM performed at a young age.

11

12 *“There is no anesthesia, so you feel every single little thing that’s happening to*  
 13 *you. So, it’s very, very traumatic; it’s a very visual memory that you have in your*  
 14 *memory that you feel and experience everything.” (FGM Participant #6)*

15

### 16 3. *Barriers to Healthcare Access*

17 Barriers to accessing healthcare were another important theme that all the  
 18 participants identified and related to. All the participants stated that they were  
 19 uncomfortable with discussing FGM with their healthcare providers in any  
 20 clinical setting. This barrier arose multiple times during the interviews in the  
 21 private room. When participants reflected deeply on their struggles and  
 22 experiences during their initial visits or prenatal care with health professionals,  
 23 they stated that the fear of personal judgment and shame was a major barrier to  
 24 accessing healthcare. Some participants shared stories that involved health  
 25 professionals being completely insensitive and directly asking them what had  
 26 happened to their genitals, whereas others merely stared in disbelief without  
 27 regard to the patient’s feelings. In one instance, a participant shared that after  
 28 seeing the doctor’s reaction to her vaginal circumcision, she wanted to run away  
 29 because she was so ashamed and embarrassed. Additionally, participants  
 30 reported the importance of having a health professional offer solutions to address  
 31 their health issues and help educate them on available options.

32 Several participants mentioned language barrier to accessing healthcare. For  
 33 example, when asked the question “What do you want healthcare providers to  
 34 know and discuss with you about FGM?” The participants stated that it would  
 35 be best to have an interpreter to help patients understand medical terms,  
 36 treatment plans, and explanations, rather than a simple check-up with no  
 37 explanation. One participant summed it up as follows:

38

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

42

### 43 4. *Education*

44 Participants were asked what they knew about FGM based on their personal  
 45 life experiences, and not necessarily the education obtained at school. The issue  
 46 that stood out the most and was most important to participants was the consensus

1 that FGM is a long-standing tradition and a deeply ingrained cultural belief, not  
2 a religious issue.

3  
4 *“Some people try to promote this as a religious thing, which it is not.”* (FGM  
5 Participant #1)  
6

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

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

21  
22 *“Educate the people, this is not any religion or anything, this is the culture, and  
23 that is not a good thing to do for women.”* (FGM Participant #4)  
24

25 Lastly, all participants suggested that health professionals should educate  
26 the community about FGM practices with the hope of preventing future  
27 generations of girls from having to undergo the procedure.

28  
29 *“Because they do not understand, like they do not know what is going on. Like, in  
30 America, they do not practice that (FGM), so I do not think they have anything to  
31 offer me.”* (FGM Participant #3)  
32  
33

## 34 **Discussion and Conclusion**

### 35 *Discussion*

36  
37  
38 There has been an increasing public health interest in issues related to FGM  
39 during the past few decades due mainly to the continuous influx of immigrants  
40 to the United States from countries where FGM is practiced. However, data on  
41 FGM experiences among diaspora communities in the United States is scanty.  
42 FGM involves the cutting, piercing, sewing, or removing parts of or all external  
43 genitals in women and girls, usually for no medical reason or health benefits,  
44 and is in violation of human rights (Hussein, 2010). According to the WHO  
45 (2025), “FGM comprises all procedures that involve partial or total removal of  
46 the female external genitalia and/or injury to the female genital organs for  
47 cultural or any other non-therapeutic reasons.” In addition, 140 million women

1 and girls and over 513,000 females in the U.S. have experienced FGM, and an  
2 estimated 3 million girls worldwide are at risk of undergoing genital cutting  
3 every year (OWH, 2025).

4 FGM remains a common traditional practice in 30 African countries,  
5 primarily in the southern Sahara, including parts of northern, eastern, and central  
6 Africa, as well as some Asian and Middle Eastern countries (Hussein, 2010;  
7 UNICEF, 2024; Odukogbe et al., 2017). The procedure is often performed with  
8 unsterilized instruments or cutting tools, without anesthesia or antibiotics, by  
9 elderly women who are non-medical practitioners (Odukogbe et al., 2017;  
10 OWH, 2025). This observation agreed with our finding that the women reported  
11 a lack of anesthesia, as stated in the following quote: “There is no anesthesia, so  
12 you feel every single little thing that’s happening to you.” It has been reported  
13 that in African communities, FGM is considered an important part of their  
14 culture and gender identity and that the practice virtually cuts across all religions  
15 in the continent, including Muslims, Christians, Ethiopians, Jews, and other  
16 traditional African religions (Hussein, 2010). All the participants reported the  
17 issue of gender identity and religious belief or connection.

18  
19 *“Some people try to promote this as a religious thing, which is not true.”*  
20

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

28  
29 *“So, it is very, very traumatic, it is a very visual memory that you have in your*  
30 *memory that you feel and experience everything, ... some kind of PTSD.”*  
31

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

41 Our results have significant implications and call for healthcare  
42 professionals to understand that FGM patients may not be familiar with existing  
43 laws, including Public Law No. 116-309 in the United States. To this end, there  
44 is a need for healthcare professionals to receive culturally competent training  
45 that will position them to work with affected communities and to educate them  
46 to end FGM. At the national level, many countries, including the United States,  
47 have outlawed the practice by promulgating various legislations against the

1 cultural practice of FGM among women and girls. In the United States, Public  
2 Law No. 116-309, enacted on January 5, 2021, specifically prohibits FGM-  
3 related conduct and mandates a maximum prison term of 10 years for offenders.

4 The United Nations (UN) recognizes FGM as a violation of fundamental  
5 human rights, and the General Assembly has adopted a milestone resolution to  
6 intensify international communities' efforts to eradicate FGM practices by 2030  
7 (UNICEF, 2024). Additionally, both the UN resolution and the SDG framework  
8 called on the international community and national partners to work cooperatively  
9 on accelerated action to ensure the total elimination of FGM across all  
10 continents.

11 As stated in the (UNICEF, 2024), several international and regional treaties  
12 apply either directly or indirectly to FGM: The Convention on the Elimination  
13 of all forms of Discrimination against Women; the Convention on the Rights of  
14 the Child (CRC); and the Convention against Torture and Other Cruel, Inhuman  
15 or Degrading Treatment or Punishment. Existing laws at regional and national  
16 levels include: The European Convention for the Protection of Human Rights  
17 and Fundamental Freedoms; The Covenant on Civil and Political Rights; The  
18 African Charter on Human and Peoples' Rights (the Banjul Charter) and its  
19 Protocol on the Rights of Women (The Maputo Protocol); and The African  
20 Charter on the Rights and Welfare of the Child.

21 A previous study among Somali women noted that women were ashamed to  
22 discuss their experiences due to FGM stigmatization and the acceptance that the  
23 practice is normal and cannot be questioned (Hussein, 2010). This agrees with  
24 our findings with the East African migrants, in which the participants reported  
25 that FGM is rooted in misogyny, does not benefit women, and that social norms  
26 and health beliefs often play a key role in perpetuating the procedure. In Egypt,  
27 where circumcision of daughters has declined due to improved socioeconomic  
28 status, education, and the empowerment of women, as well as targeted social  
29 media messages (Modrek & Liu, 2013; Ministry of Health and Population  
30 [Egypt], 2014). Additionally, a demographic and health survey conducted in  
31 Egypt showed a reduction of circumcision rate from 90% in 2005 to 28% and  
32 18% in 2014 amongst girls aged 0-13 years and 0–17 years, respectively. This  
33 finding agrees with our participants' consensus never to have their daughters  
34 circumcised.

35 A study by Achia (2014) reported that approximately 10% of women  
36 interviewed in Kenya advocated for the continuation of FGM. This contrasts  
37 with the findings of our study, in which all six participants advocated total  
38 eradication of FGM and the need to enforce existing laws. However, the Kenyan  
39 study is a driving force for FGM. It is supported by a UNICEF (2024) report that  
40 documented a decline in FGM prevalence over the last three decades. However,  
41 the pace of decline was uneven, especially in African countries, where little  
42 progress was made amid increased population growth. UNICEF noted that if  
43 current trends persist, the number of girls and women undergoing FGM will rise  
44 significantly over the next 15 years (UNICEF, 2024). In a recent study on female  
45 genital mutilation in the UK, 146 FGM cases, including 103 confirmed cases of  
46 FGM, were reported. Fewer children under 16 years presented with FGM, and

1 there was only one prosecution in 2 years (Hodes et al., 2021). The authors  
2 reported consistency in attitude changes in communities where FGM is still  
3 practiced and recommended culturally competent national policies to protect and  
4 support at-risk children.

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

### 15 16 *Conclusion*

17  
18 Women's reproductive health remains a sensitive topic of significant public  
19 health importance, and several studies have documented severe physical,  
20 psychological, and mental health effects of FGM, an entirely preventable  
21 practice. However, studies on the FGM-lived experiences of East African  
22 women and girls in Southern California diaspora communities are lacking.

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

35 FGM involves non-medical procedures that require the removal of external  
36 female genitals for non-therapeutic reasons, often without the individual's  
37 consent. In this study, we developed four categories of themes, including  
38 Attitudes, Cultural Beliefs, and Myths about FGM; Health Consequences of  
39 FGM; Barriers to Healthcare Access; and Education about FGM. The results of  
40 this pilot study indicated that cultural competency and knowledge regarding  
41 FGM are lacking and are needed to serve better the ever-increasing population  
42 of immigrants currently living in San Diego. The culturally competent guide for  
43 FGM developed from this study includes summary information on background,  
44 cultural myths, health consequences, legislation, and policy implications. It is  
45 anticipated that the guide will benefit women and girls who have undergone  
46 FGM and assist healthcare professionals in improving their cultural competency

1 while providing better care to FGM patients, especially in neighborhoods with  
2 high refugee and immigrant populations. The benefits of the guide include  
3 understanding FGM practice, physical and psychological health effects, and how  
4 healthcare professionals can provide needed support to affected women and girls  
5 in a more culturally competent and less uncomfortable manner. This is with a  
6 view to reducing stigmatization and health disparities surrounding FGM and  
7 improving the overall health and well-being of the affected populations.

8 The importance of increasing trust and sensitivity for FGM patients cannot  
9 be overemphasized, as this is vital to preventing future generations of girls from  
10 having the disastrous health consequences and complications of FGM. It is  
11 recommended that health professionals who work in communities with refugee  
12 and immigrant populations must understand the severity of FGM, the cultural  
13 beliefs, and the differences that exist. By doing so, healthcare professionals  
14 would increase their knowledge of FGM, thus allowing them to communicate  
15 effectively and provide better and improved quality of care to those who have  
16 undergone FGM.

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

### 22 23 *Study Limitations*

24  
25 The results of this pilot study should be interpreted with caution due to  
26 several limitations. All FGM participants included were immigrant women of  
27 African descent who currently live in San Diego, California. The sample size of  
28 FGM participants was small, and the results were self-reported based on their  
29 lived experiences and perceptions of FGM. In addition, the study was limited to  
30 English-proficient participants who had mutual trust with the researchers, who  
31 were of the same race/ethnicity, and lived in the same neighborhoods. In  
32 addition, the results of the study could be skewed since the researchers neither  
33 had medical confirmations that the women interviewed had truly undergone  
34 FGM nor did participants provide any clarification regarding the types of FGM  
35 they had undergone. Therefore, the findings of this pilot study may differ from  
36 the diverse experiences of the general FGM population of women and girls in  
37 the United States.

### 38 39 *Implications for Policy and Practice*

40  
41 In the United States, FGM practice is illegal and is treated as a federal crime  
42 with prescribed and severe penalties, a type of child abuse and gender-based  
43 violence, including the 1996 Illegal Immigration Reform and Immigrant  
44 Responsibility Act (IIRAIRA). Among others, the Act requires that at or before  
45 entry into the United States, visa recipients from 28 high-risk countries must be  
46 informed of the legal and health repercussions of FGM. In addition, the US

1 Department of Health and Human Services, as mandated by Congress, must  
2 provide medical students with information regarding FGM treatment and  
3 prevention recommendations. Also, the US Department of State defines FGM  
4 and cutting (FGM/C) “as all procedures involving partial or total removal of the  
5 external female genitalia, or other injury to the female genital organs for non-  
6 medical reasons.” Any violation of the FGM law is punishable by up to 10 years  
7 in prison, fines, or both. There is no exception for performing FGM/C because  
8 of religion, custom, ritual, tradition, or standard practice. As of August 2023, 41  
9 states have outlawed FGM through the passage of strict laws that specifically  
10 criminalize the practice. As stated by Dr. Pascale Allotey, Director of Sexual and  
11 Reproductive Health and Research at WHO, “there is a critical need to ensure  
12 timely, high-quality health care for survivors, to engage communities for  
13 prevention and ensure families are aware of FGM’s harmful effects, alongside  
14 serious political commitment to stop the practice and educate and empower  
15 women and girls.”

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

30

### 31 *Recommendations for Future Research*

32

33 Future research and prevention efforts are recommended to provide better  
34 insight and understanding of the prevalence of FGM with a view to addressing a  
35 larger at-risk population, its varying degrees of severity, health consequences,  
36 barriers to accessing quality healthcare, and the need for culturally competent care  
37 for FGM patients. There is an urgent need for qualitative and quantitative research  
38 studies (i.e., prevalence, lived experiences, adequacy of existing legislation in  
39 controlling the practice, inherent difficulties in enforcement, etc.) A comprehensive  
40 and inclusive representation from all regions where FGM is practiced will  
41 accurately capture the experiences and perceptions regarding FGM. Global efforts  
42 and research in countries with widespread FGM practice and non-enforcement of  
43 laws would provide a better understanding of its public health significance. To  
44 present a more reliable and complete picture of the prevalence and practices of FGM  
45 among refugees and immigrants in the United States, qualitative and quantitative  
46 research is urgently needed. In addition, nationally representative surveys would

1 provide updated prevalence, experiences, perceptions, and statistical data in the  
 2 United States and beyond, with a view to measuring progress towards achieving the  
 3 UN General Assembly’s milestone.

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1 **Table 1: Interview Questions for FGM Participants**

2 **Instructions:** Please answer the following survey questions to the best of your  
3 knowledge.

4 **Note:** All responses to the questions will be treated anonymously and  
5 confidentially.

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6 1. Have you undergone FGM? Yes  No  Don't know

7

8 2. Why was the FGM procedure performed on you?

9

10 3. How common is FGM in your community?

11

12 4. Does circumcision or FGM affect your willingness to see a doctor for  
13 health issues?

14 5. Are you comfortable talking to your healthcare provider about FGM?

15 6. What do you want healthcare providers to know and discuss with you  
16 about FGM?

17 7. What can healthcare providers do to make it easier for you to receive  
18 medical care?

19 8. Do you think FGM can cause health problems (please choose all that  
20 apply)?

21  Menstrual problems  Sexual intercourse problems  Fertility problems

22

23  Problems with labor during pregnancy  None of the above

24

25 9. Do you think FGM will \_\_\_\_\_ your chances of marriage (please choose  
26 one):

27

28  Increase  Reduce  Don't know

29

30 10. What other concerns about FGM would you like your healthcare  
31 provider to address?

32 11. Do you think the practice of FGM should continue?  Yes  No

33

34 Don't know  
Why? Please explain:

35 12. Would you have FGM performed on your daughter? Yes  No

36

37 Don't know

38

39 Why? Please explain:

---

40

1 **Table 2: Qualitative Interview Coding Themes Used for the Research**  
 2 **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

3  
 4 **Table 3: Categories of Common Themes from the Interviews with FGM**  
 5 **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.	<ul style="list-style-type: none"> <li>• “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)</li> <li>• “Some people try to promote this as a religious thing, which is not true.” (FGM Participant #1)</li> <li>• “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)</li> </ul>
Health Consequences of FGM	Describes the psychological effects of FGM, including mental or emotional trauma, post-traumatic stress disorder (PTSD), anxiety, depression, etc.	<ul style="list-style-type: none"> <li>• “There’s no anesthesia, so you feel every single little thing that’s happening to you.” (FGM Participant #5)</li> <li>• “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)</li> </ul>

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		<ul style="list-style-type: none"> <li>• “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)</li> </ul>
Barriers to Healthcare Access	Describes the barriers to accessing available healthcare and receiving needed support from their healthcare providers.	<ul style="list-style-type: none"> <li>• “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)</li> <li>• “It was not comfortable to explain what they (doctors) can do for you.” (FGM Participant #2)</li> </ul>
Education about FGM	Describes the knowledge and experiences of the participants regarding FGM.	<ul style="list-style-type: none"> <li>• “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)</li> </ul>

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