Perspectives of Somali refugees regarding Female Genital Mutulation/Cutting (FGM/C) after migration.

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Abstract

Purpose*:* To explore perspectives of Somali refugees on FGM/C and potential changes in these after migration.

Methods: Qualitative semi-structured interviews were conducted in Denver, Colorado, US, with 13 Somali refugees. Thematic content analysis was used to analyze the data.

Findings*:* Change of perspectives regarding the support of FGM/C were noted among all participants, with most opposing infibulations, FGM/C type III, after migration but supporting Sunna, the cutting of the clitoris, FGM/C type I. Changes were prompted by education on FGM/C and resettling resulting in an awareness that infibulation, is not a religious requirement nor undergone by all women. Cultural beliefs regarding the importance of virginity, purity and honor to the family underpinning the rationale of FGM/C, were prevalent and some confusion in dealing with these cultural values was found. Women reported health care providers (HCP) not being culturally prepared for women with FGM/C.

Research Implications: Despite limitations to the study, findings indicate the complex process of migration and acculturation, leaving communities with cultural values in a context where these are not accepted. More research and discussion with the Somali immigrant community is required to better understand the practice of FGM/C after immigration, and how to deal with these cultural values.

Originality/value: Findings suggest some girls may still be at risk of some types of FGM/C after migration. Public health professionals, social and immigration workers should be aware of a potential risk. HCPs should prepare for caring for women with FGM/C.

Keywords: female genital mutilation, Somalia, perspective, qualitative, refugee, migrant health, acculturation

1. Introduction

As migrants and refugees cross borders, they carry deeply rooted traditions and cultural practices such as female genital mutilation. Female genital mutilation/cutting (FGM/C) comprises '*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons'* (WHO, 2014).

FGM/C is a major public health concern. This practice has been performed on approximately 125 million girls, sometime between infancy and age 15 years, mostly concentrated in western, eastern and north-eastern regions in Africa, some countries in Asia and the Middle East, as well as in some immigrant communities in North America and Europe (WHO, 2014). An estimated three million female children continue to be mutilated each year in Africa with approximately 30 million girls worldwide who are at risk (UNICEF, 2013c; WHO, 2014). FGM/C can be classified into four categories, according to the WHO, depending upon the severity of the procedure. These types are described in Table 1.

Table 1: Types of FGM/C

Types of FGM/C according to the WHO (2008)	
Type I **"Sunna"**	Partial or total removal of the clitoris (clitorectomy).
Type II **"Excision"**	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III **"Infibulation/ Pharaonic"**	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or majora (infibulation), with or without excision of the clitoris. Thorns are frequently used to close the wound.
Type IV	All other harmful procedure to the female genitalia for nonmedical purposes (e.g., piercing, incising, pricking, scraping, and cauterizing).

Source: WHO (2008)

FGM/C causes both physical and psychological devastation, even death, for women around the world and yet continues to be performed (Andro *et al*., 2014; Bacquet-Walsh *et al,*, 2012; Berg *et al*., 2010; Brown *et al*., 2013; Goldenstein, 2014; Hill *et al*, 2012; Jensen, 2010; Macready, 1996; UNFPA, 2013a). Numerous physical complications both immediate and long lasting due to unhygienic conditions and inadequate health care have been reported for all types of FGM/C including gynecological and urinary infections, intense pain, increased rates of HIV, tetanus, obstructed labor, tearing due to scar tissue, vaginal-rectal fistulas, caesarean sections, postpartum bleeding, stillborn deliveries and infant death among those who had FGM/C (Andro *et al*., 2014; Brown *et al*., 2013; Hill *et al*., 2012; Straus *et al*., 2009; WHO, 2008; WHO, 2011). Although there are additional reasons for maternal and infant mortality, such rates are highest in the world in countries where FGM/C is practiced (Berg & Underland, 2013; UNICEF, 2014).

Psychological wounds such as shame, embarrassment and isolation following this procedure can plague women their entire lives. Many women suffer from sleep disorders, difficulties in daily life, symptoms of anxiety and/or depression, low self-esteem and/or post-traumatic stress disorder as a result (Andro *et al*., 2014; Behrendt & Moritz, 2005; Beine *et al*., 1995; Berggren, 2005; Brown *et al*., 2013; Hill *et al*., 2012; Straus *et al*., 2009; Toubia, 1994; Vloeberghs *et al*., 2013; WHO, 2011). Reports of women contemplating suicide due to FGM/C have been stated throughout Africa as the pain is reported to be constant, sexual intercourse is painful and fear of infertility looms. In Sudan 20-25% of infertility cases among women can be attributed to infibulation (Althaus, 1997; Van Der Kwaak, 1992).

Limited research has been found regarding understanding perspectives towards FGM/C after migration, especially in the context of North America. Migration and acculturation to the host country can impact beliefs of migrant populations. Acculturation can be described as '*the process that may occur when two cultures interact'* resulting in migrants' attitudes, beliefs and practices to adapt to cultural practices common in the host country (Suinn *et al*., 1992). Whether acculturation impacts beliefs regarding FGM/C amongst populations migrating to

host countries where FGM/C is not a common or accepted practice, remains unclear for now and more research is required regarding perspectives of FGM/C after migration. In addition, only few of the studies have focused on sub-groups separately. Aggregation of African groups assumes cultural factors are similar for each sub group, denying the richness of each culture by itself. More research is required to understand the perspectives of each migrant population towards FGM/C, which is still prevalent. Somalia has the highest prevalence of FGM/C in the world with over 97.9% of women undergoing this procedure (Abdulcadir *et al*., 2011). Due to unrest in Somalia, 25% of the population has now fled to or been placed in other countries as refugees (Gele *et al*., 2012b). Since 1983 over 50,000 Somali refugees have resettled in the US, with just over 3,000 in the Denver metropolitan area (CDHS, 2012). The aim of this study is to explore perspectives of Somali refugees on FGM/C and potential changes in these after migration to the USA.

Methods

This descriptive, socio-cultural study was of an exploratory nature and produced qualitative data with a sample of thirteen Somali refugees, twelve female and one male. The audio-recorded interviews comprised semi-structured and open-ended questions. Interviews were conducted in the Somali language and two translators from the local community were used. Translators were trained and briefed on the importance of confidentiality. Inclusion criteria were Somali men and women over the age of 18 and living in the Denver metropolitan area. The convenience sample was recruited through snowball sampling with two gatekeepers who are active members of the Somali community. Migrant populations can be hard to reach and as the field researcher was an outsider, as a single American nurse without children, recruitment can be challenging (Chawla-Duggan, 2007). Therefore recruiting through gatekeepers and snowball sampling seemed an acceptable method (Atkinson & Flint, 2004). Two pilot interviews were conducted, which are critical to the success of any qualitative study

(Turner, 2010). These pilots revealed some weaknesses in the interview guide and in the interaction between the translator and field researcher. Revisions were made to the interview guide and more discussion with the translator resulted in a smoother collaboration. The interviews were conducted in participants' homes. The interview topics included knowledge of FGM/C, awareness of rationale, attitudes and consequences of FGM/C before and after migration. The questions, follow-up questions and probes were developed by the researcher with the research question, aim and objectives in mind. Participants were open to share their experiences.

All thirteen participants originated from Somalia, all women had undergone FGM/C, eleven participants infibulation, type III, and one participant Sunna, type I. Ages ranged from 20-70. The time spent in the USA ranged from 4 months to 12 years. All participants were Muslim, one participant was not married, one was divorced, and all other participants were married. Two participants were pregnant with their first child, and remaining participants had on average close to six children. Only one participant had received basic education and was literate and three participants were employed.

Data were collected in November and December 2013. The transcribed data were analyzed using thematic content analysis (Bryman, 2012). As the transcripts were compared and contrasted, emerging themes involving perspectives of women were identified. In addition, analysis compared and contrasted perceptions among women who have lived in Denver for varying amounts of time.

Full ethical approval was obtained from the International Online Research Ethics Committee at University of Liverpool, UK. Participants could not be identified from the data. Participants were informed that although confidentiality was of the highest importance, the researcher was required to break confidentiality if illegal practices among minors in the USA were mentioned. This is because of the illegality of FGM/C in the State of Colorado and the USA (AAP, 1998; AAP, 2010; MacReady, 1996). For that reason participants were not asked regarding their practice or intention to conduct FGM/C on daughters, if applicable.

Results

The main themes and subthemes that emerged from the interviews are presented in Table 2.

Table 2: Coding scheme

Theme	Subthemes	Sub-subthemes
1. Complications due to FGM/C	Physical	Culturally competent healthcare required in the USA
	Psychological	
2. Understanding of rationale for FGM/C	Lack of awareness of origin and purpose of FGM/C	Ensuring virginity, purity and protecting family honor
	Lack of understanding of religious requirements regarding FGM/C	
3. Attitude towards FGM/C in Somali Community	Procedure is required by community	Women driving FGM/C
		Good versus bad girls
		Bringing glory to the family
		Shame and abuse if not cut
4. Change of perspectives on FGM/C	From Infibulation (Type III) to Sunna (Type I)	Through education
		Through resettling in the USA
		Cultural changes
		Religious changes
		Confusion regarding symbolic value of procedure

Complications due to FGM/C

All female participants were cut between the ages of four and fifteen years of age and most were closed with thorns. All women spoke of immense pain when the procedure was performed, including the only participant with Sunna, type I, although she did not experience

severe physical complications afterwards. Most women still complained of pain with urinating and with menstruation. All married women experienced excruciating pain when they were opened for the first time by their husbands or by the woman who cut them. Consistent pain with intimacy, was reported by all married women and the male participant noted that his wife experienced pain with intercourse. All mothers verbalized intense pain with deliveries. Women described their bodies as consumed with 'constant cutting down there'. Most participants reported hearing of deaths related to FGM/C.

Eleven of the twelve female participants reported symptoms of anxiety and depression still lingering as a result of the procedure. Many of them reported experiencing sadness due to constantly thinking about the pain and remembering the trauma of the procedure.

Participant aged 49 years: When you have a small finger problem what are you thinking? You are thinking aaahhhhh problem, so in the very important area has problem you are always thinking of it and having mental problem. (…) the whole life has problem (…) like 99 problems.

The majority of the participants reported a yearning to please their husbands sexually but a lack of desire for intimacy due to pain and trauma. Health care not being culturally appropriate and US health care providers (HCPs) not being sufficiently prepared for women with FGM/C was discussed as a difficulty for women. One participant who had not experienced intercourse seemed embarrassed as she discussed her first examination by a doctor in the USA.

Participant aged 32 years: So when she went to the doctor it was to do (…) a pap smear, but she couldn't use any of the equipment because she is sewn up. (…) the doctor kind of ran out of the room but then went to get other equipments but that didn't work either so at the end

she found this little stick thing that she tried to do to her but she says they had no knowledge in this area (…)

Attitude towards FGM/C in Somali community

All participants reported that every Somali woman they knew had undergone some form of FGM/C. All participants agreed that there was substantial expectation and pressure from the community to have their daughters cut. A female's status within the community was dependent upon the procedure. Therefore half of the participants expressed that when they were young they demanded to be cut to be 'good' girls and they felt happy to comply with the cultural expectation.

All participants mentioned that girls who did not undergo this procedure would be 'abused' by the community, considered 'useless' and would not be married. A few female participants reported a tradition in their village where if the new bride's closure were not to her husband's satisfaction he would dig a hole in front of his tent so in the morning villagers would walk by and fall in it. This represented the openness of the bride and allowed the man to divorce her. When the girls are closed properly, it would bring 'glory' to the family and on the contrary, when she is slightly open it brings 'shame' to the family. The mothers interviewed stated that they would be 'abused' or called 'bad' mothers if they did not have their daughters cut at a young age. They also mentioned being shamed previously in Africa and now in the USA if their daughter was older and 'still walking around with that' (meaning the clitoris), not cut or not virgins when married.

Participant aged 43 years: So the communities (…) they say oh this one is so nasty because if you don't have circumcise (…) so the parents they don't like that everyone is talking so they do it.

The majority of the women expressed that they believed FGM/C was driven by women; not by men. However, two women stated that they suffer because men are always 'in control' of them, in religion and culture. The man decides if the woman is closed enough, preferably as tight as the palm of a hand, and if not then he can divorce her. In addition men are held to different standards and do not have to suffer with pain as women do.

Understanding of rationale for FGM/C

No participants were able to verbalize FGM/C's origin or purpose, rather all stated it was done to comply with family traditions. Some of the participants told stories about the possible origin of infibulation including protecting shepherd girls from rape, ancient Pharaohs desiring to stop procreation, husbands going off to war and securing the faithfulness of their wives and mothers ensuring their daughters remained virgins and 'undamaged' until marriage.

Participant aged 43 years: I am not believing in anything, not religion or cultural, I just see my community doing it, my parents doing it, so I do it to my children when they are 4 years or 5 years old because I am so happy.

Participant aged 31 years: Ultimately it comes down to that, yeah, they might say other things but I think it is just to make sure that this girl is a virgin and that when she gets married having a virgin girl brings glory to the family, having a girl that is not a virgin brings shame to the family.

The only educated participant, who had spent time in Kenya and underwent Sunna, type I, reported that she always knew infibulation was not a religious requirement. All remaining participants did not know if the Qur'an or Islamic scriptures mentioned FGM/C. Yet all participants stated that they previously believed it was fundamental to their faith.

Male participant: (…) when I marry (…) I believe the circumcision is a very important thing and a part of religion (…) it is not the religion so I asking the parents and the community where it come from. (…) So when I looking everywhere and I asking the religion bosses, the mosque bosses they tell me (…) it is Haram! [meaning: forbidden to]

Change of perspectives on FGM/C after migration

Eleven of the thirteen participants spent extended periods of time as refugees in Ethiopia before coming to the USA. All eleven of those participants stated that NGOs were educating people about FGM/C in that area. The education addressed the complications associated with infibulation, benefits of intercourse without infibulation and encouraged abolition of the practice. Two of the participants stated that the NGOs had music and dancing at the training sessions and gave money to attendees. Participants shared that this experience resulted in a change in their view of FGM and signified for many a questioning and rejection of infibulation.

Participant aged 37 years: Mind is changing when I saw a lot of NGOs talking about and they showing the problem and also I see my daughters and myself and I analyze the issues as so bad.

The remaining two participants spent time in Egypt and Kenya and did not report learning about FGM/C in those countries.

In recent years Islamic leaders worldwide have begun to condemn infibulation and support Sunna. All participants mentioned that Sunna is now seen as the preferred procedure because they believed Prophet Mohammed had this procedure done to one of his daughters.

The male participant was adamant that the religion has not changed regarding this topic, rather people are simply learning more about religion. His perspective on FGM/C changed when he spoke to religious leaders in Ethiopia. One female participant questioned why in the USA only males are circumcised and why that is not illegal as, she argued, boys undergo circumcision in Somalia for religious reasons. All participants were aware that FGM/C is illegal in the USA. Many participants verbalized that when they reached America they gained awareness that not all women in the world have FGM/C and described American women as 'free' or 'healthy'. Many stated that young daughters are 'lucky' to be living in the USA so they do not have to experience this procedure.

Three participants expressed some confusion as to their desires for FGM/C with young daughters. One unmarried participant stated that she would like to have her potential future daughter circumcised with the Sunna procedure (type I) as she still believes that is the way to ensure her daughter will be a 'good' girl. This information came up in the conversation but was not specifically asked during the interview. In addition, this woman wanted her daughter to experience the same pain as her so that she will be 'good'. Another participant stated that she had not heard of any Somali girls undergoing the procedure after migration yet she did not rule out the desire for continuation of the procedure amongst some Somali communities. It was felt that the more recent arrivals in the USA may be shocked when learning of the discontinuation of the practice and may want to continue the practice even though it is illegal. In contrast, some women stated that for those who spent more time in the USA, FGM/C, and certainly infibulation, was no longer a reality.

Participant aged 31 years: So there is two groups…to be honest, so the group that now comes to the US, they think that we are crazy, you know, …so the newer people that are coming to the US and people that are still in Somalia I think they will continue that and they want it but people here, I have never heard of a woman saying that she is going to get her daughter circumcised. It has never been something that I have heard of; it's NEVER

something that me and my family have spoken of like my mom saying 'Are you going to circumcise your daughter?' No that doesn't happen, even the Sunna.

Sunna, as the cutting or pricking of the clitoris, does not ensure virginity like infibulation. All participants who had undergone infibulation seemed to be wrestling with the concept of a 'virtuous character' as an external versus internal quality. A few participants stated that the field researcher could not possibly be a 'good' woman, as she had not undergone FGM/C. Since all but one of the participants had undergone infibulation as a physical way to display virginity, all parents seemed to struggle with the idea of being certain of virginity without FGM/C. However the male participant mentioned anatomical ways of knowing.

Male participant: The bakara is inside the body, inside the vagina (…) Allah keeps the blood somewhere and the first person to use this lady (…) they open the vagina and blood comes so we don't need to close.

The majority of participants stated that they did not ask their husbands' perspective on FGM/C in relation to their daughters. Furthermore, many women reported that their husbands cried or abused them when they heard that their daughters had undergone FGM/C. In addition, participants believed that there has been a reduction in men requiring infibulation for marriage. Both male and female participants reported that they believed men now want a woman who is not closed so that she will not experience pain with intercourse and therefore desire intimacy.

Male participant: But now I believe without circumcision the man needs because the man is feeling very good sex (…) I don't have a good life also my wife she don't have. I know when I do it what they feeling. (…) So nobody need it so women they do it for men but men not interested. So now men they don't want it. So who is the lady doing it for?

Discussion

This study explored perspectives of Somali refugees who had migrated to the USA regarding the practice of FGM/C. Understanding the cultural significance of the practice of FGM/C that is still prevalent, is vital however scarcity in studies have been found. This study adds to the understanding of the practice of FGM/C drawing significantly from cultural practices and family history. The history of FGM/C within Somali culture has been passed down orally throughout generations. It is unwritten and illustrated by only one participant in this study being educated and literate. Maintaining this family tradition was very significant to the women interviewed. All participants in this study stated they had never heard of or known a Somali woman, now over 18 years, who had not experienced FGM/C, which was confirmed in the existing literature (Berggren *et al*., 2006; Khaja *et al*., 2009). In many countries such as Somalia, the practice of FGM/C is viewed as critical to raising a responsible, 'decent' woman (Hayford, 2005; Van Der Kwaak, 1992; WHO, 2008; WHO, 2011). Sudanese, Somali and Chadian women, interviewed in their home countries, expressed desire for this procedure, stating that they are not clean, beautiful or decent women who can please a man until they are cut (Leonard, 2000; Lightfoot-Klein, 1994; Kandala *et al*., 2009; WHO, 2008) and it has been found that Somali women believe Somali culture requires FGM/C; their gender identity seemingly depending on infibulation (type III) (Van der Kwaak, 1992; Khaja et al, 2009). FGM/C is a critical aspect of Somali culture and in some regard, to be Somali is to be cut (Althaus, 1997; Harkness, 2011). Many who practise FGM believe that a woman's sexuality is uncontrollable and if not reined in can destroy the family and culture (Harkness, 2011). In our study virginity bringing 'glory and honor' to the family were thought to be important underlying reasons for the practice of FGM/C, as well as the 'cleansing' or purity aspect even of Sunna, type I, confirmed in the existing literature (Isman, Ekeus & Berggren, 2013). All female participants stated that they desired to be 'good' women and therefore had

to be cut. This concept of ‘good’ versus ‘bad’ is deeply ingrained in the Somali society and it was evident that the participants had not let this sentiment go after migration. In studies by Gele et al. (2012a) and Harkness (2011) among women from Somalia, all participants reported feeling pressured by their friends and their communities to be cut when they were young. The desire to be included was incredibly significant (Leonard, 2000). In our study participants expressed memories as young girls of excitement to undergo the procedure and reported not feeling forced to undergo FGM/C although many reported being caught and held down after seeing the cutting instruments and becoming afraid. Another study described women from Somalia, Eritrea, Sudan as feeling forced to have the procedure (Berggren *et al.,* 2006). Feelings of grief and betrayal, especially towards their mothers, after the excruciatingly painful procedure have been described (Isman *et al.,* 2013).

The debilitating physical and psychological complications experienced by the women did not seem to play a role in their perspectives of this practice, as this was not a motive for its discontinuation. Somali women in Sweden stated that although this practice is ‘physically destructive’ it is ‘culturally meaningful’ (Isman *et al.,* 2013). In contrast, complications were the primary reason Somalis gave for change of perspective in Norway (Gele *et al.,* 2012a).

From a young age, all participants believed that FGM/C was a religious obligation. This devotion to Islamic tradition was found to be the major contributing factor in the continuation of the practice of FGM/C in the study in Norway (Gele *et al.,* 2012b). Participants in the present study, like those in Dalal *et al*. (2010), stated that it was never fully discussed and as young females they did not have a say anyway, therefore no one questioned its purpose. Many participants in our study seem to question now, for the first time, the meaning of the practice. The greatest catalyst to perspective change occurred with the revelation that FGM/C, specifically infibulation, is not a religious prerequisite as was previously thought. Participants were in favor of the Sunna (type I) tradition and believed this to be a religious requirement and not harmful to women, as reflected in the existing literature (Fried *et al.,*

2013; Gele *et al.,* 2012b; Gele *et al.,* 2013). There still remains some discord among Islamic leaders worldwide but recently certain African leaders have vocalized condemnation for infibulation (Mint Akhyarhoum *et al.,* 2013; Topping, 2015). This finding highlights the importance of inclusion of religious leaders in public health work regarding FGM/C.

Our findings showed that women believed the practice of FGM/C was driven by other women, although it became clear that this was with the idea of pleasing a future spouse. This female force was also alluded to in studies by Althaus (1997) and Lightfoot-Klein (1994). The results of our study found support from the male participant to abandon all forms of FGM/C. Female participants stated that they believed men have heard about non-mutilated women who enjoy sexual pleasure and they desire to marry such women. However, 40% of approximately 105 male Somali participants living in Norway still supported the continuation of FGM/C, primarily infibulation (Gele *et al.,* 2012b). Including more and wider male participants' views would have strengthened our study.

Unlike the study by Gele *et al.* (2012a), where changes in perspectives changed with resettlement in Norway, our study reported changes, for the most part, occurring in the second country, primarily Ethiopia. These changes in perspectives, brought about by education, resulted in behavior change once participants reached the USA where the practice is illegal. In the study by Mariam *et al.* (2009) in Ethiopia it was found that 20% of 2084 male and female adolescents desired the continuation of FGM/C in their culture. Education among Ethiopians and Somalis living in Ethiopia is crucial in influencing perspectives on this practice and the work NGOs are undertaking should be encouraged. Although FGM/C is illegal in many, including African, countries, sentiments regarding its continuation among relevant populations are inconsistent. Support amongst both men and women for continuation of the tradition has been found in Ethiopia, Egypt, and Kenya in order

to keep with traditions and to control women and their sexual desire (Fahmy *et al.,* 2010; Harkness, 2011; Mariam *et al.,* 2009).

Some studies with Somali migrants in Europe have reported limited change in perspectives towards FGM/C with some participants reporting to feel 'ambivalent' towards the practice but still feeling under enormous pressure from their community to have their daughters cut in fear of limited marriage possibilities due to FGM/C ensuring virginity and purity and protecting the family's honor, demonstrating the powerful role of the cultural practice even after immigration (Abdullahi *et al.,* 2009; Isman *et al.,* 2013; Norman *et al.,* 2009). Another study in Europe found changes after migration in perspectives of men and women from East Africa, some including Somalia, towards FGM/C (Gele *et al.,* 2012). Being in Europe for some East African women relieved the cultural pressure to continue the practice and they felt able to protect their daughters from the practice, which they believed they would not have managed in their countries of origin (Thierfelder *et al.,* 2006). Migration at an early age was found to be associated with the desire to abandon the practice (Morison *et al.,* 2004). A large study in Germany including 685 women and 1082 men from Sub-Saharan countries found 18% believed FGM/C to be a religious requirement and 70% stated social acceptance or better marriage prospects were advantages of the procedure. Approximately 80% supported abolition of the procedure with male participants having a higher desire to see it continue (Behrendt, 2011).

In our study although all participants reported some level of change in perspectives regarding FGM/C, it was obvious that there was confusion. The participants seemed not 'ambivalent' as Isman *et al.* (2013) described in their qualitative study with Somali women in Sweden, but rather quick to detach themselves from this practice. Participants seemed relieved to abandon infibulation. However, all female participants believed Sunna (type I) to be the preferred practice. Although Sunna is illegal in the USA, all women spoke highly of this procedure, stating it had no complications, and that they would most likely continue its practice if they were not living in the USA. Although most people can give no rationale for the

Sunna procedure they say the blood coming from the prick or cut in the clitoris is significant, underpinned by 'good versus bad' (Thierfelder *et al.,* 2005). In a study in Somaliland, all women interviewed chose Sunna over infibulation for their daughters (Thierfelder *et al.,* 2005). Sudanese men and women in Sweden were found to shift in preference of FGM/C from infibulation (type III) to Sunna (type I) (Berggren *et al.,* 2005). Yet because Sunna does not involve closure, virginity cannot be ensured. This was an obvious concern for all participants in our study. More research into the practice of Sunna (Type 1) and possible complications is urgently required.

Due to ethical considerations participants in this study were not directly asked about their practice or intentions for their daughters which is a limitation to the findings however participants' legal protection took priority. One participant, who had no children yet, volunteered that she would like her potential future daughters to undergo this procedure. Although another participant shared she had never heard of the procedure being conducted after immigration, it was suggested that some Somali, possibly more recent immigrants to the USA, would choose to continue the practice. Other studies indicate that girls are still at risk of FGM/C despite the practice being illegal in their current country. Although, like in this study, families have felt less pressure from their communities to perform the practice, even after immigration FGM/C has been found to be still occurring (Elgaali *et al.,* 2005; Isman *et al.,* 2013). It is not clear whether the illegality of FGM/C in host countries has helped girls at risk or has driven FGM/C under ground with potentially worse outcomes and more severe mutilation and this requires more research. Sunna, type I, has been compared to circumcision for male Jews or Muslims, a culturally driven practice daily executed on young males in the USA and other western countries, indeed one of the participants in our study questioned why male circumcision was not illegal. In 1996 a group of physicians in the USA controversially proposed to conduct a procedure called a prepotomy, a one centimeter incision in the clitoris, in order to respond to 'cultural needs' of immigrant communities and

simultaneously protect young girls from being taken either abroad or illegally for more extensive, painful or dangerous procedures, such as infibulation (Wade, 2011). In 2010, the American Academy of Pediatrics (AAP) published a statement supporting a 'ritual nick', the argument being that a ritual nick, described as no more alteration than an 'ear piercing', could protect girls from worse mutilation and potentially leading to eradication of FGM/C with the support of physicians and could therefore change this Somali cultural tradition, like a cultural evolution. After condemnation by the WHO and the UN, the AAP withdrew their proposal. Opponents of the 'ritual nick' argue that all forms of FGM/C are harmful and damaging to girls and women and that physicians supporting the practice were perpetuating the barbaric cultural tradition of FGM/C which had no place in a 'civilized society such as the USA'. These polar views indicate the complexity of the concept of 'acculturation', opposing multiculturalism and feminism, but also implying a sense of 'them and us', Somali communities not adapting sufficiently to western culture, or the physicians and the AAP being too compromising (Wade, 2011). Our study adds to this ongoing debate as participants were eager to be part of the USA, however seemed confused where to place their beliefs and traditions in this context. Much discussion needs to take place as the alleged abandonment of this cultural practice leaves a gap in the Somali culture and a question about ensuring purity and virginity among their daughters (Isman *et al.,* 2013; Jensen, 2010), highlighting the complexity of migration and acculturation. Discussion with the Somali community should be encouraged to find a symbolic method to fill this gap that involves no cutting. This feeds through to health care which women described as difficult and embarrassing and not prepared for women with FGM/C, as also found in the UK (Abdullahi *et al.,* 2009). More culturally sensitive training is required for health care providers.

Limitations

The field researcher being an outsider should be noted (Krefting, 1991; Green & Thorogood, 2010). Living in the USA, where FGM/C is illegal, the participants could have resisted

sharing their desire to continue this practice. Although they may have feared condemnation by the researcher, many participants still voiced their desire for its continuation of Sunna (Jones, 2001). Using a translator may have enhanced credibility by providing the opportunity for participants to express themselves in their mother tongue. The process of translating each response can stop the flow of the qualitative interview and this was occasionally noticed. Using a translator can also be intimidating for participants discussing a sensitive topic (Green & Thorogood, 2010), which could be enlarged by the translators being from the local community, as the translators were also the gatekeepers. This was not ideal, however using gatekeepers, and acting in this double role, can be very helpful in difficult to access populations (Atkinson & Flint, 2004) and without the gatekeepers' help recruitment would have been unlikely. Participants did not seem embarrassed or intimidated and seemed to speak freely, except for one participant who displayed actions contrary to the others and behaved in a timid manner. The participant was reminded she was free to withdraw from the interview at any time although she chose to continue.

The study was based upon a small sample but in qualitative research the focus is on recruiting information rich participants rather than a representative sample from which findings can be generalized (Bryman, 2012; Guest *et al.,* 2006). Additionally, qualitative data saturation can be reached with a sample of this size (Guest *et al.,* 2006). Pilot interviews, recording and transcribing of the interviews and two researchers working in collaboration all enhanced the rigour of the study (Krefting, 1991). A rich description was provided of the setting and participant demographics supporting transferability of findings to other Somali immigrant populations (Streubert & Carpenter, 1999).

Conclusion

Little is known about perspectives related to FGM/C among Somali refugees after migration. This study made a unique contribution to the body of knowledge. Changes in perspectives

were noted among participants. Although participants' beliefs regarding religious requirement of infibulation had changed leading them to abandon continuation of this type of FGM/C, participants did supported Sunna, type I FGM/C. In addition, cultural beliefs underpinning the practice such as virginity, purity and honor of the family were still very much prevalent leaving participants with a cultural gap, indicating the complex process of acculturation. These findings suggest some girls may still be at risk of some types of FGM/C after migration. More discussion and research regarding the topic of FGM/C after immigration, is required, and including the Somali community is essential. There is a need for better understanding of the persistence of the practice after immigration and its implications on public health, as well as a need for an increased understanding of placement of cultural values in a context that does not allow for these. In addition, there is a need for increased support for women in the USA who are suffering with the effects of FGM/C and a focus on culturally appropriate health care for these women.

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