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# The risk of female genital cutting in Europe: Comparing immigrant attitudes toward uncut girls with attitudes in a practicing country

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ABSTRACT

Worldwide, an estimated 200 million girls and women have been subjected to female genital cutting. Female genital cutting is defined as an intentional injury to the female genitalia without medical justification. The practice occurs in at least 29 countries in Africa, the Middle East, and Asia. In addition, globalization and migration have brought immigrants from countries where cutting is commonly practiced to countries where cutting is not traditionally practiced and may even be illegal. In countries receiving immigrants, governments and development agencies would like to know if girls with parents who immigrated from practicing countries are at risk of being cut. Risk assessments, for example, could help governments identify the need for programs promoting the abandonment of cutting among immigrants. Extrapolating from the prevalence and incidence rates in practicing countries, however, is generally not sufficient to guarantee a valid estimate of risk in immigrant populations. In particular, immigrants might differ from their counterparts in the country of origin in terms of attitudes toward female genital cutting. Attitudes can differ because migrants represent a special sample of people from the country of origin or because immigrants acculturate after arriving in a new country. To examine these possibilities, we used a fully anonymous, computerized task to elicit implicit attitudes toward female genital cutting among Sudanese immigrants living in Switzerland and Sudanese people in Sudan. Results show that Sudanese immigrants in Switzerland were significantly more positive about uncut girls than Sudanese in Sudan, and that selective migration out of Sudan likely contributed substantially to this difference. We conclude by suggesting how our method could potentially be coupled with recent efforts to refine extrapolation methods for estimating cutting risk among immigrant populations. More broadly, our results highlight the need to better understand how heterogeneous attitudes can affect the risk of cutting among immigrant communities and in countries of origin.

## 1. Introduction

Apart from the estimated 200 million girls and women living with the consequences of female genital cutting, an additional three million girls are at risk of being cut every year (World Health Organization, 2014). Cutting is historically practiced in several countries in Africa, Asia, and the Middle East. As globalization proceeds apace, however, governments and international organizations are increasingly concerned about the prevalence and risk of cutting among immigrant populations in Europe and North America. Cutting among immigrants is important for a number of reasons. Immigrants who have been cut, for example, may have special needs in terms of health care. They may find it difficult or impossible to get the care they need if they live where doctors have little or no experience with patients who have been cut and possibly infibulated. Moreover, policy makers also need to understand the risk of being cut for girls with parents who have moved from countries with a history of cutting to other countries where cutting is

uncommon and even illegal. This risk will likely determine the extent to which governments invest in efforts to promote the abandonment of cutting among immigrants. For these reasons, the European parliament has called for better data and better methods to estimate the number of women and girls cut or at risk of being cut in Europe (European Institute for Gender Equality, 2013, 2016).

Prevalence in an immigrant population refers to the proportion of girls and women who migrated from the associated practicing country and have already been cut (European Institute for Gender Equality, 2013). Girls at risk of cutting refers to uncut girls aged 18 or younger who migrated from a practicing country or have at least one parent who migrated from a practicing country (European Institute for Gender Equality, 2016). Most estimates of prevalence and risk in immigrant populations are derived by extrapolating from prevalence data in countries of origin (European Institute for Gender Equality, 2013). These data typically come from representative surveys, including the Demographic Health Survey and the Multiple Indicator Cluster Survey,

periodically implemented in the 29 or more countries where female genital cutting is traditionally practiced (Yoder, Wang, & Johansen, 2013). The simplest approach to extrapolation is to apply an estimate of prevalence from the country of origin to an immigrant population. For example, if an estimated 80% of Sudanese women in Sudan are cut, then an estimated 80% of female Sudanese immigrants in Switzerland are cut. Recently, however, a number of researchers have developed refinements that extrapolate while accounting for differences between an immigrant population and people in the associated country of origin (Exterkate, 2013; Leye, Mergaert, Arnaut, & Green, 2014). These refined methods consider, for instance, age-specific cutting rates, regional differences in cutting within a country of origin, or differences between first-generation and second-generation immigrants (Dubourg et al., 2011; Exterkate, 2013; Leye et al., 2014; Ziyada, Norberg-Schulz, & Johansen, 2016).

These refinements have the potential to greatly improve estimates of risk and prevalence because they allow for the possibility that immigrants are not necessarily like the people who remained in the country of origin. For example, one of the challenges when estimating risk among immigrants is that the age of cutting varies greatly within and between practicing countries. Ignoring this fact can distort estimated risk considerably. To illustrate, assume that every girl in a country of origin is cut the day she turns five. For every female aged five or older, prevalence is thus 100%. Further assume that in Europe all female immigrants from this country immigrated before they turned five, and they are all now above five. If we ignore these subtleties, we might conclude that the prevalence among immigrants in Europe is 100%, when in reality it could be 0% because everyone arrived in Europe before the cutting age. Dubourg et al. (2011), Exterkate (2013), and Ziyada et al. (2016) accounted for subtleties of this sort with extrapolation methods that condition on age-specific prevalence in countries of origin.

Nonetheless, even if we disaggregate prevalence data from countries of origin based on observables like age and region, extrapolation may still not fully account for selective emigration from a cutting country, and it cannot account for acculturation after immigration into a non-cutting country (Leye et al., 2014). For this reason, researchers have developed the "migration and acculturation impact factor" (Exterkate, 2013; European Institute for Gender Equality, 2016; Ortensi et al., 2015). The general idea behind this factor is to refine estimates of risk for immigrants by jointly accounting for selective migration out of the country of origin and for cultural and behavioral changes after immigrating to a new country (European Institute for Gender Equality, 2016). For example, if everyone in a particular immigrant group comes from a non-cutting area in the country of origin, the risk is zero, regardless of aggregate risk and prevalence in the country of origin. Analogously, if everyone in a particular immigrant population completely and immediately assimilates to the norms of their new home, the risk that any uncut immigrant will be cut is zero, regardless of aggregate risk and prevalence in the country of origin. Selective migration and acculturation are two very different but potentially important channels that can lead the risk of cutting among immigrants to diverge from the country of origin.

The present study directly compares attitudes about female genital cutting among Sudanese living in Switzerland to attitudes among Sudanese living in Sudan. Whether or not Sudanese immigrants are a special subset of the Sudanese population, and regardless of whether or not they move toward the values of Switzerland after immigrating, we focus directly on identifying any attitudinal differences by using the same fully anonymous method to measure implicit attitudes in both countries. Importantly, we previously validated our implicit attitudinal measure by showing that measured attitudes in Sudan were highly correlated with incidence at the community level (Vogt, Zaid, Ahmed, Fehr, & Efferson, 2016). This correlation provides us with a relationship between attitudes and a girl's risk of being cut. We use this relationship in conjunction with our attitudinal data from Switzerland

to discuss the magnitude of the migration and acculturation impact factor on the risk of being cut for girls in the Sudanese immigrant population. Moreover, using control data collected in Switzerland, we also provide results relevant to the question of whether attitudinal differences are due to selective migration or acculturation.

Finally, the methods presented here also suggest how researchers might develop robust attitudinal measures for evaluating programs that promote the abandonment of cutting among immigrants. Because all extrapolation methods begin with data from a country of origin, extrapolation can never provide a basis for evaluating programs targeted specifically at immigrants. Evaluating a program that promotes abandonment in Europe, for example, requires validated methods that can be used among immigrants themselves.

## 2. Effects of selection and acculturation

The extrapolation method is a feasible and practical method for the difficult problem of estimating the risk of cutting among immigrant girls (European Institute for Gender Equality, 2013, 2016). It has the particular advantage that it relies on representative surveys in countries of origin. Representative samples among immigrant populations are extremely challenging. In general, we do not have country-wide sampling frames that include first-generation and second-generation immigrants, families with only one parent from a country where cutting is practiced, and asylum seekers who are not yet registered (Ziyada et al., 2016). In addition to the fact that we often do not know how to delimit the immigrant population of interest, we also have little understanding of how selective migration and acculturation affect attitudes toward female genital cutting (European Institute for Gender Equality, 2016).

First, migrants may constitute a special subset of the population of origin (Leye et al., 2014; Ortensi et al., 2015). Research has demonstrated that attitudes about cutting in many African countries vary tremendously among and even within households in a local area (Bellemare, Novak, & Steinmetz, 2015; Efferson, Vogt, Elhadi, Ahmed, & Fehr, 2015; Hernlund & Shell-Duncan, 2007). This kind of variation implies ample scope for emigration that is somehow conditional on attitudes about cutting (Ortensi, Farina, & Menonna, 2015). If this kind of selection occurs, those who emigrate will not have the same attitudes regarding cutting as those who do not. Farina and Ortensi (2014), for example, surveyed immigrants from practicing countries in Italy and concluded that ignoring selective migration can lead one to overestimate the prevalence and risk of cutting in immigrant populations. Second, in addition to selection, immigrants in Europe and North America might have attitudes about cutting that differ from countries of origin because immigrants change their attitudes after arriving in their new country (Farina & Ortensi, 2014; Johnsdotter et al., 2009). Some might become more negative about cutting as they integrate in a non-cutting society, while others might become more positive about cutting as a way to maintain and assert cultural ties to their native countries. All in all we know little about the net effect of attitudinal changes after migrating (Leye et al., 2014). Generically, however, we expect both selective migration and attitudinal changes to considerably complicate the task of estimating risk among immigrants.

Recent extrapolation studies have confronted this problem by developing a number of techniques for adjusting risk based on the joint effect of selection and acculturation. Exterkate (2013) used insights from focus groups to specify high-risk, medium-risk, and low-risk scenarios for immigrant girls in the Netherlands. Ortensi et al. (2015) addressed selection by considering variation in prevalence among regions within practicing countries. They specifically distinguished between countries where cutting is widespread and countries where the practice is regionally clustered, and they used this information to adjust risk estimates for immigrant populations. Ziyada et al. (2016) carefully distinguished between the cutting risk among first-