Challenges of Estimating Prevalence and Risk of FGC in US

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Purpose of Study

- Evaluate the studies available to date
- Correct misleading impressions related to US FGC estimates
- Clarify assumptions
- Consider lessons from European studies

Data sources of studies to date

- CDC study: Jones et al. 1997
- Data sources: 1990 census with indirect method

- PRB study African Women's Health Center 2004
  - 2000 census with indirect method

- CDC study Goldberg et al. 2016
  - American Community Survey with indirect method

Indirect estimation techniques

	Categories of Immigrant Women		Age-Specific Prevalence from COO	
US Data Source	First gen.	Second gen.	< 18 years	≥ 18 years
1990 Census	√		15-49	15-49
2000 Census	√		15-49	15-49
2012 ACS	√	√	15-19	15-49

Information not available in US databases on immigrants

- Ethnicity
- Region of residence in COO
- SES prior to migration
- ACS: specific country of origin missing for 10% of immigrants

Results of studies to date

Year	Data Source	<18 years	≥18 years	Total women
1990	1990 Census	48,000	168,000	271,000
2000	2000 Census	110,498	290,000	401,350
2012	ACS 2012	169,000	344,000	513,000

Assumptions made by studies

Assumption 1:

FGC prevalence in the US is the same as that in countries of origin

Assumptions made by studies

Assumption 2:

Migrants are typical of the wider population in their country of origin

Assumptions made by studies

Assumption 3:

Girls are cut in the US at the same rate as girls in their home country.

That is, there is no change in FGC practices following migration

Key problems with prior estimation methods

- Comparisons of estimates of the number of US girls and women at risk of or who have undergone FGC across the sequential studies creates the false impression that FGC is spreading.
- Combining figures on girls who may be at risk of FGC with estimates of the number of women who have undergone FGC distorts and exaggerates the US FGC risk estimates.
- Current estimation methods produce an upper estimate of women who have been cut and girls who may be at risk of being cut that is almost certainly an overestimate.

Importance of separating estimates of girls and women with FGC from "girls at risk" estimates

- Three categories of girls and women
  - Those cut before arrival in US (1st generation)
  - Those cut since arrival in US (1.5 /2nd generation)
  - Those not cut (2nd generation)
- Those already cut no longer at risk
- No data on those cut in US

Lessons from FGC estimation methods in the EU

- Sources of data limit the precision of FGC prevalence estimates
- Conducting research among immigrants a public relations challenge
- Estimates of number of women cut before arrival is useful for health system planning
- Cutting of girls in European countries is not common, so risk of cutting is relatively low

What we know now about FGC in US

- Only national source of data is American Community Survey
- From 8-10% of immigrants have no country of origin specified
- One-half of immigrants from FGC-practicing countries in Africa come from Egypt, Somalia or Ethiopia
- No data on cultural change following migration to the US

Considering girls at risk in the US

- Work with affected communities to improve education and awareness about the law
- Consult with affected communities about how to implement child protection measures
- Consequences of implementing legislation?
- Consequences of border surveillance to prevent "vacation cutting"?

Suggestions for further research

- Conduct an update of FGC prevalence among first generation immigrants
- Estimate the number of girls in 2nd and 3rd generation for 5-6 countries that provide the most immigrants
- Design qualitative research to be conducted Egyptian, Somali, and Ethiopian communities about what influences continuity or change in FGC
- Design studies of acculturation to be conducted among Egyptian, Somali, and Ethiopian communities