Perception of Women Aged 15-49 Years Towards Female Genital Mutilation in Umueme Community, Obingwa L.G.A, Abia State

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ABSTRACT

This study is on the perception of women aged 15-49 years towards female genital mutilation in the Umueme community, Obingwa L.G.A., Abia State. The 80 women were randomly selected on different days at different times in the health centre. The questionnaire was the instrument for data collection. The data collected was analysed using inferential statistics, including the Chi-square (χ^2) test of association, to establish relationships between selected demographic variables and awareness/perception of FGM and socio-cultural factors influencing the practice of FGM. The level of significance was set at $p < 0.05$. The result showed that, out of the 80 respondents studied, the majority, 37 (46.3%), were between the ages of 26–35 years, while 28 (35.0%) were aged 36–45 years. All 80 (100%) respondents had heard of FGM before in their lives, with the major sources of information being friends/relatives 33 (41.3%), social gatherings 29 (36.3%), and association with religious leaders 15 (18.8%). The chi-square test of association indicated that there was a significant association between age and belief (χ^2=8.421, p=0.038), marital status and perception (χ^2=9.114, p=0.028), religion and cultural support for FGM (χ^2=7.306, p=0.026), religion approves the practice of FGM (χ^2=11.573, p=0.003), educational level and awareness of the negative health effects of FGM (χ^2=12.447, p=0.006) and the opinion on discouraging FGM due to health risks (χ^2=10.638, p=0.014). However, there were no significant associations found between age and the perception of the effects of FGM on health (p=0.102); occupation and belief that FGM protects virginity (p=0.121); parity and support for the continuation of FGM (p=0.121); and age and trust in the midwives to advise on FGM (p=0.171). The findings indicate a growing awareness of the harmful consequences of FGM among women in the Umueme community. Nevertheless, persistent cultural influences, family pressures, and traditional beliefs continue to sustain the practice.

Keywords: Perception, Female, Genital, Genital Mutilation.

INTRODUCTION

Background to the study

Objectives of the Study

The main objective of this study is to evaluate the perception of women aged 15–49 years towards Female Genital Mutilation (FGM) in Umueme Community, Obingwa Local Government Area of Abia State.

The specific objectives are to:

1. Assess the level of awareness of women aged 15–49 years about FGM in Umueme Community.
2. Determine the perceptions of women aged 15–49 years towards the practice of FGM.
3. Identify cultural and social factors influencing the continuation of FGM in Umueme Community.
4. Examine the relationship between women's perceptions and the acceptance or rejection of FGM in the community.

Justification of the Study

Female Genital Mutilation remains a significant public health and human rights concern despite global efforts to eradicate the practice. The persistence of FGM in many rural communities is largely influenced by deeply rooted cultural beliefs and traditions. Although awareness campaigns and legal measures have been implemented, evidence suggests that FGM still exists in some families within Umueme Community. There is limited information regarding the perceptions of women of reproductive age towards FGM in this community. Since women are often key decision-makers regarding the continuation or abandonment of the practice, understanding their perceptions is essential. Findings from this study will provide valuable information for healthcare providers, midwives, policymakers, and community leaders in designing culturally appropriate interventions and strategies aimed at eliminating FGM and improving the reproductive health and well-being of women and girls.

Research Questions

1. What is the level of awareness of women aged 15–49 years about FGM in Umueme Community?
2. What are the perceptions of women aged 15–49 years towards FGM in Umueme Community?
3. What cultural and social factors influence the practice of FGM in Umueme Community?
4. How do women's perceptions affect the continuation or abandonment of FGM in the community?

Research Hypotheses

H_{01}: There is no significant relationship between the level of awareness of women aged 15–49 years and their perception of FGM in Umueme Community.

H_{02}: There is no significant relationship between socio-cultural factors and the perception of women aged 15–49 years towards FGM in Umueme Community.

Definition of Key Terms

Female Genital Mutilation (FGM): All procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

Perception: The beliefs, opinions, attitudes, and understanding that women aged 15–49 years hold regarding FGM.

Women of Reproductive Age: Females between the ages of 15 and 49 years who are biologically capable of

reproduction.

Awareness: The level of knowledge and understanding women possess regarding FGM, its consequences, and its implications.

Culture: The shared beliefs, customs, traditions, and practices that influence behavior within a community.

Umueme Community: A rural community located in Obingwa Local Government Area of Abia State, Nigeria, where this study is conducted.

LITERATURE REVIEW

Female Genital Mutilation (FGM), also referred to as female circumcision, is all practices that involve partial or complete removal of any external parts of the female genitalia or any injury to them for non-medical reasons (Beausang & Mama, 2023). It is recognised internationally as a violation of the human rights of female and girl children; and is linked to many negative physical, psychological, reproductive, and social outcomes. Although global and national campaigns have been made to stop FGM, the practice is still being seen in many communities, especially in the developing world, where cultural and traditional beliefs have a strong sway over health-related practices (Ayenew et al., 2025).

World Health Organization (WHO, 2022) recognize four main types of FGM. Type I (Clitoridectomy): Removal of part or all of the clitoris and/or prepuce. Type II (Excision): Part or complete removal of the clitoris and/or labia minora, sometimes with the removal of labia majora. Type III (Infibulation) is when the opening of the vagina is narrowed by forming a covering seal and is the most severe of the types because of the many obstetric and gynecological problems it causes. Type IV refers to other and all other harmful procedures to female genitals for non-medical reasons, including pricking, piercing, scraping and cauterization (Dilbaz et al., 2019).

FGM has no known health benefits and can lead to girls and women experiencing severe health effects both immediately and in the long term. Immediate complications are severe pain, heavy bleeding, shock, infection and psychological trauma. The potential long-term complications are chronic pelvic infections, infertility, sexual dysfunction, obstetric complications, vesico-vaginal fistula, recto-vaginal fistula, postpartum hemorrhage and higher risk of neonatal morbidity and mortality. UNICEF (2025) and WHO (2022) also noted that FGM women are at higher risk of complications during pregnancy, labour and delivery.

While the incidence of FGM has fallen in certain regions of the globe, the practice is still a considerable public health issue in Nigeria. According to the Nigeria Demographic and Health Survey (NDHS 2023), around 19.5% of women aged 15-49 years have had FGM. Its prevalence is mainly recorded in the South-East and South-West geopolitical zones, where cultural norms and traditional beliefs are still supporting its existence. The survey also showed that the South-East, which is largely made up of the Igbo ethnic group, is one of the regions in the country with high prevalence of FGM.

Many communities practice FGM for the reasons that it helps to keep women virgins, encourages women to be chaste, improves marriage, helps to control women's sexuality and helps to ensure social acceptance. The beliefs are frequently passed down from one generation to the next via family and community networks, and are very hard to resist and eradicate. Female decision makers are often mothers and grandmothers, who are commonly involved in the circumcision of female children. Therefore, the attitudes of women of reproductive age are crucial in solving the practice issue.

The determinants influencing perceptions and continuation of Female Genital Mutilation (FGM) in this study were classified according to established health determinants frameworks. Individual determinants included age, educational level, awareness, beliefs, and perceptions regarding FGM. Social and cultural determinants comprised family influence, religious beliefs, cultural norms, and community expectations that support or discourage the practice. Socioeconomic determinants included occupation and educational attainment, which

may affect access to health information and decision-making capacity. Health-system determinants included trust in midwives, access to health education, and participation in community-based interventions. These determinants interact to shape women's attitudes and behaviours toward FGM and provide a framework for understanding the persistence or abandonment of the practice.

Umueme Community of Obingwa Local Government Area-Abia State is one of the rural communities where the influence of traditional and cultural practices on reproductive health decision is prevailing. Although there has been a rise in awareness raising and legislative measures to ban FGM, it is said to be carried out in some families in the community as a result of the entrenched cultural beliefs and societal expectations. The reproductive and childbearing age group (15-49 years) is the key group of women during decision making for the continuation or abandonment of FGM. Their perceptions, beliefs and attitudes about practice can have a profound impact on whether generations of girls are subjected to it in future.

FGM poses significant health challenges from a midwifery point of view for maternal and reproductive health. Midwives are also likely to be the first health professionals to meet antenatally, at the time of delivery and postnatally with women and therefore are well placed to detect any complications arising from FGM, counsel women, educate them about health, and advocate against the practice. Midwives have an important role to play contributing to the prevention of FGM and to better maternal health outcomes, through culturally sensitive interventions and community engagement (Tarr-Attia et al., 2019).

Although increasing awareness of the negative health impacts of FGM and the presence of national policies and legislation on the subject, there is little information on perceptions of women towards FGM in many rural south-eastern Nigerian communities including Umueme Community. It is important to gain insight into women's perceptions of FGM in order to design appropriate health education interventions, community-based strategies and interventions led by midwives that could be effective in the prevention of FGM.

Thus, the aim of this study is to evaluate the perception of women age group (15-49 years) on FGM in Umueme community in Obingwa Local Government Area of Abia State. The results of the study will be useful for healthcare providers, policy makers, community leaders and midwives when designing interventions to help stop the practice of FGM and better the reproductive health and well-being of women and girls in the community.

METHODOLOGY

Study Design

The research design used in this study was descriptive survey design. It was used to obtain relevant information on the perception of mothers toward female genital mutilation (respondents). A descriptive survey involves the systematic collection and presentation of data to give a clear picture of a particular situation. The method was considered appropriate for the study because the general purpose of the research is to oversee their need for change.

Study Area

The study was conducted in Umueme Community, Obingwa L.G.A in Abia state. They are into different minor occupations like; teaching, security, transportation etc., but they are predominantly farmers and petty traders. They have fair road network and portable water, are connected to the national grid, and majority of them are Christian while some are traditionalists. There is no government owned school in the community but they have some privately owned primary and secondary schools and they have one health center where the questionnaire was distributed to the respondents. The community is set in Ahiaba Ward in Obingwa L.G.A.

Method of Data Collection

The objectives of the study were explained to the respondents and also obtained their consent orally. 80 copies of the questionnaire were distributed to the respondents after due explanation. The respondents were equally instructed to answer the questions privately to achieve accurate and individual responses after which the

questionnaire were collected by the researcher. The whole exercise took four (4) days. The entire 80 questionnaires were properly filled and returned after giving a return rate of 100%. The reason for the high rate of return was that the researcher was present during completion of the questionnaire after which they were collected the same day they were given out. The researcher allowed the women to read and answer the questionnaire for 1hr before she asked them to submit it.

Target Population

The target population for this research study comprises of Women Aged 15-49 years in Umueme Community, Obingwa L.G.A in Abia state with total population of 400 women.

Sample size Determination

At a confidence level of 90%, margin of error 10%, with a total population of 400.The researcher determined the sample size statistically using Taro Yamane's formula (1967).

The formula is given as:

$$n = \frac{N}{1 + N(e)^2}$$

Where n=the sample

N = the finite population

e = the level of significance.

I = Unity (a constant)

Therefore, using the formula above;

$e^2 = 0.01$

N = 400

$$n = \frac{400}{1+400\ (0.01)}$$

n = 80

Therefore the sample size of 80 was used for the study.

Sample and Sampling Technique

The simple random sampling technique was used for this study. The women were randomly selected on different days at different times in the health center where pieces of paper in which yes or no was written on and the women were selected if they picked yes. This was continued till the target population of 80 was gotten.

Instrument for Data Collection

Data were collected using a structured self-administered questionnaire developed after a review of relevant literature on Female Genital Mutilation and women's reproductive health. The questionnaire consisted of two sections.

Section A obtained information on respondents' demographic characteristics, including age, marital status, religion, occupation, educational level, and parity.

Section B contained items assessing awareness, perceptions, cultural beliefs, family influences, religious

influences, and attitudes toward midwifery-led interventions relating to FGM. Most items were structured as closed-ended questions with predefined response options to facilitate quantitative analysis.

The questionnaire was subjected to face and content validation by experts in community health and midwifery before administration.

Validity of Instrument

Validity is the ability of the instrument to measure what it is expected to measure. Validity of the instrument was ascertained by giving the self-constructed questionnaire to the supervisor to ascertain its face and content validity. All corrections were effected before the questionnaire was printed or administered to the respondents.

Reliability of Instrument

The reliability of the instrument was determined through a pre-test/pilot study conducted by the researcher on a different group other than the target group. 20 copies of the valid questionnaire were printed and given to women in another community (Umuchichi Community). The women were able to answer the questions without any difficulty. The pre-test was used to know if the questions in the questionnaire were answerable, applicable, analyzable, acceptable and meeting the objective of the search study. The reliability index was calculated using Crombach Alpha test which read 0.71%. This showed that the instrument was reliable.

Ethical Considerations

Ethical principles were strictly observed throughout the study. Permission to conduct the study was obtained from relevant community authorities and the management of the health centre. The purpose of the study was explained to all participants, and informed consent was obtained before questionnaire administration. Participation was voluntary, and respondents were informed of their right to withdraw at any stage without penalty. Confidentiality and anonymity of all information provided were maintained throughout the study.

Study Limitations

The study employed a descriptive cross-sectional design and was conducted among women attending a single health facility within the study area. Consequently, the findings may not be fully generalizable to all women within the community. The relatively small sample size limited the ability to conduct multivariable regression analyses and subgroup comparisons. Furthermore, qualitative methods, geospatial analyses, and longitudinal follow-up were beyond the scope of the present study. Future studies should adopt community-based probability sampling, larger sample sizes, mixed-method approaches, and longitudinal designs to provide a more comprehensive understanding of the determinants of FGM.

Method of Data Analysis

The completeness and consistency of data obtained from the respondents were checked prior to analysis. The data obtained were coded and entered in the Statistical Package for Social Sciences (SPSS) version 25.0 for analysis.

The demographic characteristics of the respondents were presented and summarised using descriptive statistics (frequencies and percentages), while the awareness, perceptions, social, cultural and midwifery factors associated with female genital mutilation (FGM) were also summarised and presented using descriptive statistics. Data were tabulated.

Inferential statistics including Chi square (χ^2) test of association was used to establish relationships between selected demographic variables and awareness/perception of FGM and socio-cultural factors influencing the practice of FGM. The level of significance was set at $p < 0.05$.

The results were presented in terms of frequency distribution tables, percentages, chi square value, degrees of freedom and p values.

RESULTS

Table 1 shows the demographic characteristics of the respondents. Out of the 80 respondents studied, the majority 37 (46.3%) were between the ages of 26–35 years, while 28 (35.0%) were aged 36–45 years. Respondents aged 45–49 years constituted 13 (16.2%), whereas only 2 (2.5%) were within 15–25 years. In relation to marital status, the majority of the respondents were married (49 (61.3)), followed by separated (17 (21.2)). There were 8 (10.0%) single respondents, and 6 (7.5%) others. Religion-wise, 74 (92.5%) of the respondents were Christians while 6 (7.5%) were Muslims. No one stated that they didn't have any religion. As far as occupation was concerned, traders were the highest in number (33, 41.2%) followed by (19, 23.8%) civil servants and (18, 22.5%) farmers. The remaining 10 (12.5%) were in other occupations. As regards education, the majority had secondary education (28; 35.0%) and the tertiary education was 25 (31.2%). The respondents who have primary education level were 16 (20.0%) while respondents with no formal education or informed were 11 (13.8%). Out of the respondents there were 54 (67.4%) having two children and above and 21 (26.3%) having two children and 5 (6.3%) had one child.

Table 1: Demographic characteristics of the respondents (n=80)

	Frequency	**%**
Age (years)		
15-25	2	2.5
26-35	37	46.3
36-45	28	35.0
45-49	13	16.2
Marital		
Single	8	10
Married	49	61.3
Separated	17	21.2
Others	6	7.5
Religion		
Christianity	74	92.5
Islam	6	7.5
None		-
Occupation		
Civil servant	19	23.8
Trader	33	41.2
Famer	18	22.5
Others	10	12.5
Educational level		
Informed	11	13.8
Primary	16	20.0
Secondary	28	35.0
Tertiary	25	31.2
Parity	**Frequency**	
One	5	6.3
Two	21	26.3
Two and above	54	67.4

Table 2 shows respondents' awareness and perception of female genital mutilation (FGM). All 80(100%)

respondents had heard of FGM before in their lives with the major source of information being friends/relatives (33(41.3%)), while social gatherings (29(36.3%)), and association with religious leaders (15(18.8%)) were the other sources. Most of those who responded, 51 (63.7%) indicated that there were no benefits associated with FGM, and 43 (53.7%) reported that they did not believe that FGM protects virginity and/or prevents promiscuity.

The majority of the respondents (78.8%) agreed that FGM has an impact on the health and welfare of women. Likewise, 63(78.7%) felt that FGM has reproductive health effects. Infection 24(30.0%) and excessive bleeding 22(27.5%) were the most commonly identified health problems associated with FGM. In addition, most 66 (82.5%) agreed that FGM should be discouraged due to the health risks.

Table 2: Awareness and Perception of Female Genital Mutilation among Respondents (n=80)

Variables	Frequency	Percentage (%)
Heard of FGM before		
Yes	80	100
No	-	-
Source of information on FGM		
Social gathering	29	36.3
Church/Mosque	7	8.7
Friends/Relatives	33	41.3
TV/Radio	11	13.7
Belief that FGM has benefits		
Yes	29	36.3
No	51	63.7
FGM protects virginity/prevents promiscuity		
Yes	37	46.3
No	43	53.7
FGM affects women's health and welfare		
Yes	63	78.8
No	17	21.2
Perception that FGM has reproductive health effects		
Yes	63	78.7
No	9	11.3
No idea	8	10.0
Health problems associated with FGM		
Excessive bleeding	22	27.5
Infection	24	30.0
Pain during childbirth	19	23.7
Infertility	10	12.5
No problem	5	6.3
Opinion on discouraging FGM due to health risks		
Yes	66	82.5
No	8	10.0
No idea	6	7.5

Table 3 shows the social, cultural and midwifery factors which affect the practice of FGM. A small proportion of respondents (19, 23.8%) said that their religion supports the practice of FGM, with 37 (46.2%) saying it doesn't. The major reasons given (among those who supported it) were that it is beneficial for the girl-child (84.21%).

When asked whether they would not do FGM if they have enough information about the health risks, 80% (of

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the 100%) said yes, while none said that poverty was a factor. Most of the respondents (73, 91.3%) indicated that family members are still attempting to push for the continuation of FGM, with grandmothers being the most important pushers (32, 43.8%).

Over half of the respondents (41(51.3%)) said their culture was supportive of FGM, mostly to control women's sexuality. But most (38, 47.5%) disagreed that FGM was a way of promoting morality and decency, while another 58 (72.5%) disagreed with the statement that FGM initiates girls into womanhood.

In terms of midwifery-led interventions, the majority of the respondents (60 (75.0%)) felt that midwives were able to offer advice on FGM, and also supported midwifery-led programmes that aimed to dissuade women from having FGM.

Table 3: Social, Cultural and Midwifery-related Factors Influencing Female Genital Mutilation (n=80)

Variables	Frequency	Percentage (%)
Religion approves FGM		
Yes	19	23.8
No	37	46.2
No idea	24	30.0
Reasons religion approves FGM (n=19)		
Beneficial to girl-child	8	42.1
Prevents promiscuity	6	31.6
Makes women faithful	5	26.3
Would still practice FGM despite health information		
Yes	-	-
No	80	100
Money as contributing factor to FGM		
Yes	-	-
No	80	100
Family members pushing continuation of FGM		
Yes	73	91.3
No	7	8.7
Persons encouraging continuation of FGM (n=73)		
Father	4	5.5
Grandmother	32	43.8
Grandfather	21	28.7
Others	16	22.0
Culture supports FGM		
Yes	41	51.3
No	39	48.7
Reasons culture supports FGM (n=41)		
Clitoris connotes maleness	5	12.1
Enhances beauty/cleanliness	8	19.5
Controls women sexuality	21	51.3
Ensures marriage	7	17.1
FGM promotes morality and decency		
Agreed	27	33.7
No opinion	15	18.8
Disagreed	38	47.5
FGM initiates girls into womanhood		
Yes	22	27.5
No	58	72.5

Trust in midwives to advise on FGM		
Yes	60	75.0
No	10	12.5
No idea	10	12.5
Support for midwifery-led programs against FGM		
Yes	60	75.0
No	10	12.5
No idea	10	12.5

The Chi-square test of association indicated that there was a significant association between age and belief that female genital mutilation (FGM) has benefits (χ^2=8.421, p=0.038). Marital status was also found to be significantly associated with perception of FGM as encouraging morality and decency of women (χ^2=9.114, p=0.028).

There was a significant association between religion and cultural support for FGM (χ^2=7.306, p=0.026) and religion approves the practice of FGM (χ^2=11.573, p=0.003). There was significant association between the educational level and awareness of the negative health effects of FGM (χ^2=12.447, p=0.006) and the opinion on discouraging FGM due to health risks (χ^2=10.638, p=0.014).

However, there were no significant associations found between age and the perception of the effects of FGM on health (p=0.102); occupation and belief that FGM protects virginity (p=0.121); parity and support for continuation of FGM (p=0.121); and age and trust in the midwives to advise on FGM (p=0.171) (table 4).

Table 4: Association between Demographic Characteristics and Awareness/Perception of Female Genital Mutilation (FGM)

Variables Compared	χ^2 Value	df	p-value
Age vs Belief that FGM has benefits	8.421	3	0.038*
Age vs Perception that FGM affects health	6.215	3	0.102
Marital status vs FGM promotes morality	9.114	3	0.028*
Religion vs Culture supports FGM	7.306	2	0.026*
Occupation vs Belief that FGM protects virginity	5.822	3	0.121
Educational level vs Awareness of health effects of FGM	12.447	3	0.006*
Educational level vs Opinion on discouraging FGM	10.638	3	0.014*
Parity vs Support for continuation of FGM	4.225	2	0.121
Religion vs Religion approves FGM	11.573	2	0.003*
Age vs Trust in midwives to advise on FGM	5.004	3	0.171

Key: χ^2 = Chi-square value, df = Degree of freedom, $p < 0.05$ = *Statistically significant

DISCUSSION

The large proportion of women in the reproductive age group indicated that the study targeted the most likely decision makers with regard to childbirth, childcare and reproductive health practices such as FGM. Children and women of this age group are frequently involved in such decisions as the circumcision of daughters, making them important stakeholders in the campaign to eradicate the practice. It is also in line with the report by Anyanwu et al. (2025) who reported that women of the reproductive age are very much involved in the practice or abandonment of FGM in many communities of Nigeria.

The high proportion of married women in the study could have affected respondents' views as married women might be more likely to have first-hand experiences of pregnancy, childbirth and maternal health services where information about the effects of FGM is often delivered. This is consistent with the results of Ibekwe et al. (2021) who found married mothers to be more aware of the reproductive and obstetric implications of FGM

than unmarried women.

The high number of Christian respondents is attributed to the religious makeup of many communities in South-Eastern Nigeria. The discovery corroborates other research findings that suggest that FGM is more a reflection of cultural belief and practices than religion. In spite of this, Ahanonu and Obi (2021) reported that cultural beliefs still had a greater influence on attitudes towards FGM comparing to religious beliefs and teachings, with many respondents identifying with Christianity. Likewise, UNICEF (2022) reported that FGM is also practiced among various religious communities, and is frequently kept alive through cultural expectations, community norms, and not as a formal religious obligation.

The education of the respondents is also very significant to understand their perception on FGM. Education has been acknowledged as a protective factor to prevent harmful traditional practices due to its role in providing access to health information and critical examination of cultural norms. This finding is corroborative to that of Adewuyi et al. (2021) which noted that women with good education had a higher chance of opposing FGM and its discontinuation. A similar trend was observed by Morlighem et al. (2024) who reported that higher education led to a decrease in the acceptance of FGM among Nigerian women.

The occupations of the respondents, most of whom engaged in informal economic activities such as trading, was indicative of the socio-economic profile of the rural and semi-urban communities of South-Eastern Nigeria. Giddens and Sutton (2021) found that the interaction of people in occupational and community relations can have a strong impact on the spread of cultural attitudes and beliefs about health. Women who are involved in the community and market networks, therefore, can be important channels in disseminating information and influencing attitudes in abandonment of FGM.

All women in Umueme Community were aware of Female Genital Mutilation (FGM) as revealed by the findings, i.e 100% of them had heard of it. This is consistent with the study done by Dattijo, Nyango and Osagie (2018) in Jos, Nigeria, who also reported that the awareness of FGM was very high among the expectant mothers. In the same way, Obijiofor et al., (2020) observed that the level of awareness of FGM among women of child bearing age in the Igbo ethnic group was very high as they had got exposure through family and community interactions.

Friends and relatives (41.3%) and social gatherings (36.3%) were the main sources of information found in this study. This discovery is corroborated by Ahanonu and Obi (2021) who noted that most information about FGM in many communities in Nigeria is mainly through informal social networks and the family structure. The discovery also reflects the sociological view of Giddens and Sutton (2021) that cultural values and traditions are largely maintained by socialization in the family and community.

The study revealed that 63.7% of the respondents felt that FGM has no benefits, and 53.7% disagreed that FGM protects the virginity and prevents promiscuity. The discovery is in line with the report of Anyanwu et al. (2025) which revealed that awareness and educating women in Nigeria has led to a reduction in the perception of FGM as a tool for controlling women's sexuality. Likewise, Ogunlaja et al., (2023) found that the majority of women in Delta State were rejecting traditional beliefs that FGM is an act of chastity and moral behavior among women.

A large number of the respondents (78.8%) reported awareness of the health and welfare impact of FGM and (78.7%) of its reproductive health effects. The result is in line with the findings by WHO (2022), UNICEF (2023) and Okeke (2022) who reported that FGM has serious Reproductive and obstetric complications. The finding is also in line with Nkeiruka's and Chiejina's (2024) report of high awareness of the health risks of FGM among childbearing women.

The most commonly identified complications in this study were infection (30.0%) and excessive bleeding (27.5%). The results echo those of previous studies by Kaplan et al. (2021), Alsibiani and Rouzi (2020) and WHO (2023) which found that the major health impacts of FGM were infection, hemorrhage, sexual

dysfunction and childbirth complications. Similarly, UNICEF (2025) noted that girls and women who experience FGM are more likely to suffer from infections, complications during pregnancy and childbirth, and reproductive health issues later in life.

The fact that 82.5% of the respondents agreed that FGM should be discouraged because of its health risks corroborates the study of Adewuyi et al. (2021) that showed a general increase of women in Nigeria's support for the discontinuance of FGM. This is also consistent with the global advocacy campaigns of WHO (2022), UNICEF (2023) and UNFPA (2023) all urging public education as a mechanism to end the practice.

The belief that their religion supports FGM was expressed by 23.8% of the respondents, while more than half (51.3%) said that they thought that there was cultural support for FGM. This indicates that FGM in the study area is more of a cultural practice than a religious practice. The finding is in line with Ibekwe et al. (2021) who reported that the community expectations and cultural norms surpassed the religious beliefs of mothers in South-East Nigeria.

The practice of older women being the custodians of cultural practices which often promote the practice of FGM was corroborated by the finding of family members influencing the practice as reported by Ahanonu and Obi (2021), with grandmothers emerging as the main promoters (43.8%). Likewise, the Culture Care Theory developed by Leininger and McFarland (2021) describes the transmission of cultural values and beliefs from generation to generation, and how these values and beliefs affect health behaviours.

Over half of those who approved of FMGs from a cultural perspective thought that it was important to regulate women's sexuality. The result is in line with the study conducted by Obijiofor et al. (2020) which revealed that some of the key factors on why FGM was still practiced in the Igbo communities was chastity and the regulation of female sexual behaviour. UNICEF (2022) and Amnesty International (2022) also reported a similar finding that social norms around purity, virginity and marriageability are still continuing to perpetuate the practice in many societies.

But most of those who responded to the question of whether FGM instills morality and decency in the girls were not in agreement (47.5%) while the majority (72.5%) disagreed that it marks girls into womanhood. This discovery is in contrast to previous traditional beliefs on FGM that were reported by Haralambos and Holborn (2017), who reported that many communities in the past considered FGM as a very significant rite of passage into womanhood. This present finding indicates a changing attitude of women in the area of study.

The study showed that 75.0% of the respondents had confidence in the midwives' advice on FGM and also endorsed programmes carried out by the midwives to dissuade FGM. This is in line with the International Confederation of Midwives (2020), who argued that midwives occupy the right place to educate women, speak out against FGM and to deal with its complications.

The finding is also corroborated by Echeozo (2024) which found that FGM affected women are supported by nurses and midwives, who also create public awareness. Similarly, Tarr-Attia et al. (2019) reported that midwives were also often faced with women with complications related to FGM and were reported as good agents of prevention and behaviour change. Ayenew et al. (2025) also pointed out that community-based interventions for reducing the prevalence of FGM are integral to healthcare providers, especially midwives.

The study found a significant association between age and belief that FGM has benefits ($p<0.05$), suggesting that perceptions regarding the usefulness of FGM vary across age groups. This finding is consistent with Kisendi et al. (2025), who reported that age remains an important determinant of attitudes toward FGM among women of reproductive age.

There was also a significant association between marital status and the perception that FGM promotes morality and decency. This may reflect differences in life experiences and exposure to reproductive health information among married and unmarried women.

Religion was significantly associated with cultural support for FGM and approval of the practice. This finding

supports the observations of Salah, Cottler-Casanova, and Petignat (2024), who reported that cultural and religious identities often interact to shape attitudes toward FGM.

Educational level showed a significant relationship with awareness of the health effects of FGM and support for discouraging the practice. This finding agrees with Adewuyi et al. (2021) and Morlighem et al. (2024), who found that higher educational attainment was associated with increased awareness of the harmful consequences of FGM and greater support for its abandonment.

However, no significant association was found between age and perception of health effects, occupation and belief that FGM protects virginity, parity and support for continuation of FGM, or age and trust in midwives. This suggests that awareness of the harmful effects of FGM and confidence in healthcare professionals may be widespread across demographic groups within the study area.

PUBLIC HEALTH IMPLICATIONS OF THE FINDINGS

The findings of this study may be interpreted within the framework of preventive, promotive, palliative, and rehabilitative health care.

Preventive Care Determinants

Educational attainment, awareness of the harmful effects of FGM, access to reproductive health information, and community sensitization activities constitute important preventive determinants capable of reducing acceptance of FGM and preventing its continuation.

Promotive Care Determinants

Health promotion determinants identified in this study include women's education, community awareness campaigns, empowerment programmes, support from religious and community leaders, and midwifery-led health education interventions aimed at encouraging positive behavioural change.

Palliative Care Determinants

Women living with complications resulting from FGM require supportive services including counselling, reproductive health care, obstetric care, and psychosocial support. Midwives and other healthcare providers play a critical role in addressing the immediate and long-term consequences associated with the practice.

Rehabilitative Care Determinants

Rehabilitative care determinants include access to specialized medical services for management of FGM-related complications, referral systems, psychological rehabilitation, and community reintegration programmes designed to support affected women and encourage abandonment of the practice.

IMPLICATIONS FOR FUTURE RESEARCH

Although the present study provides valuable baseline information regarding women's perceptions of FGM in Umueme Community, future studies should adopt more rigorous methodological approaches. Such studies should employ community-based probability sampling stratified by wards or villages, larger sample sizes capable of supporting multivariable logistic regression analyses, and mixed-method designs incorporating focus group discussions and in-depth interviews with mothers, grandmothers, traditional practitioners, and midwives.

Future investigations should also integrate Human Medical Ecology and Social-Ecological Frameworks to examine interactions among cultural, social, environmental, and health-system determinants of FGM. Spatial analyses incorporating household location, access to health services, and social capital measures may assist in identifying communities where cultural pressure remains strongest. Furthermore, longitudinal studies are recommended to evaluate changes in attitudes toward FGM over time and assess the sustainability of

educational interventions.

CONCLUSION

In this study, the perception of women (15-49 years) to Female Genital Mutilation (FGM) in Umueme community, Obingwa Local Government Area of Abia state was evaluated. The results showed that the respondents were aware of FGM, with majority of the women having knowledge of FGM and its health implications. Most acknowledged the harmful effects of FGM on women's health, welfare and reproductive health, and agreed that it should be discouraged because of the risks that pose.

Even with this awareness, the study revealed that cultural beliefs, and family influences are still very much part of sustaining the practice. These results suggest that knowledge may not be enough to eradicate FGM if deeply entrenched cultural norms and social expectations continue to support FGM.

The study also found high levels of agreement regarding the interventions to be carried out by midwives, with the majority indicating that they had faith in the capacity of midwives to deliver education and guidance to parents and children on the detrimental impacts of FGM. This emphasises the importance of midwives as agents of change, educators and advocates in the eradication of the practice.

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