

Article

Determinants of Female Genital Mutilation among Women of Reproductive Age in Ibadan North-East Local Government Area, Oyo State, Nigeria

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Abstract: Background: Female genital mutilation (FGM) remains a significant public health and human rights concern, particularly in settings where cultural and social norms continue to support its practice. Although awareness of the health consequences of FGM has increased, the practice persists in some Nigerian communities. This study assessed the determinants of FGM among women of reproductive age in Ibadan North-East Local Government Area, Oyo State, Nigeria. Methods: A descriptive cross-sectional study was conducted among 200 women of reproductive age in Ibadan North-East Local Government Area. Data were collected using a structured questionnaire covering respondents' sociodemographic characteristics, FGM status, knowledge and perceptions of factors influencing the practice. Data were analysed using descriptive statistics and chi-square tests to examine associations between selected characteristics and FGM status. Statistical significance was set at $p < 0.05$. Results: Among the 200 respondents, 116 (58.0%) reported having undergone FGM, while 84 (42.0%) had not. Most were aged 26–32 years (76; 38.0%), Yoruba (140; 70.0%), married (156; 78.0%), and Christian (110; 55.0%). Educational attainment was mainly no formal education (60; 30.0%) or secondary education (60; 30.0%). FGM status was significantly associated with age, ethnicity, education, marital status, occupation, family influence, and community expectations ($p < 0.05$). Perceptions that FGM controls women's sexuality, promotes sexual purity, enhances cleanliness and beauty, improves marriageability, and prevents social rejection were also significantly associated with the practice. Despite relatively good knowledge of FGM and its health consequences, FGM prevalence remained substantial.

Conclusion: FGM remained relatively common among the respondents and was influenced by interconnected demographic, socioeconomic, familial and sociocultural factors. The findings suggest that interventions should extend beyond health education to address family influence, community expectations and harmful social norms. Strengthening women's education and empowerment, community mobilization, family engagement and culturally appropriate counselling may contribute to reducing the practice in Ibadan North-East Local Government Area.

Keywords: Female genital mutilation; determinants; women of reproductive age; sociocultural factors; knowledge; community norms; Nigeria.

Introduction

Female genital mutilation (FGM) is a harmful traditional practice involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. The practice has no health benefits and is recognized as a violation of the rights of girls and women and an important public health concern. FGM remains prevalent in many countries, particularly in Africa, the Middle East and parts of Asia. More than 230 million girls and women are estimated to have undergone FGM globally, while millions remain at risk. Although prevalence has declined in some settings, progress remains insufficient to achieve its global elimination by 2030 [1]. FGM can result in immediate complications such as severe pain, excessive bleeding, infection and difficulty with urination, as well as long-term complications including recurrent infections, menstrual difficulties, chronic pain, sexual health problems and obstetric complications [2].

The persistence of FGM is influenced by cultural, familial, socioeconomic and community factors. In some communities, it is regarded as part of cultural identity, appropriate upbringing, preparation for marriage, preservation of virginity or control of female sexuality. Social pressure, fear of rejection and concerns about marriageability may also encourage families to maintain the practice. Religious beliefs and misconceptions may further influence attitudes, although FGM is not prescribed by any major religion [3]. Evidence from Africa identifies educational attainment as an important factor in FGM, while Nigerian research has highlighted maternal education in determining whether daughters undergo the practice. Socioeconomic circumstances are also relevant, as household wealth influences access to education, healthcare and information. Nigerian studies have identified household wealth as an important factor in the continuation of FGM. Family history is another important determinant. Where mothers and female relatives have undergone FGM, the practice may be transmitted across generations as an accepted family tradition. In Nigeria, Oni and Okunlola reported that 40% of women with a history of FGM who had female children continued the practice among their daughters. Age, ethnicity and geographical location also contribute to variations in FGM practices across Nigerian communities, reflecting differences in cultural norms and social environments [4]. Community norms further reinforce the practice where FGM is perceived as normal or desirable. Families may conform because of concerns about social acceptance, cultural identity and marriageability. Access to information and mass media can provide alternative perspectives and increase awareness of the health consequences of FGM, although information alone may not overcome strong family and community expectations [5].

Nigeria remains an important setting for FGM research because of the large number of women and girls affected. Although national prevalence has declined, substantial variations remain across demographic and socioeconomic groups [6]. In the South-West, FGM continues to be a public health concern. Evidence from Oyo State has demonstrated the persistence of the practice and highlighted the importance of knowledge and sustained community awareness in prevention efforts. However, national and state-level evidence may not adequately capture the specific circumstances of individual communities. Ibadan North-East Local Government Area is an urban and socially diverse setting where traditional beliefs coexist with increasing access to education, healthcare and information. Despite these

changes, family expectations and community norms may continue to influence the practice. There is therefore a need for local evidence on the factors sustaining FGM among women of reproductive age in the area [7].

Therefore, this study will examine the determinants of female genital mutilation among women of reproductive age in Ibadan North-East Local Government Area, Oyo State, Nigeria. The findings are expected to provide evidence for targeted health education, community mobilisation, counselling and advocacy interventions aimed at reducing FGM and promoting the reproductive health and wellbeing of women and girls.

Methods

Study Design

A community-based analytical cross-sectional study was conducted to determine the factors influencing female genital mutilation (FGM) among women of reproductive age in Ibadan North-East Local Government Area (LGA), Oyo State, Nigeria.

Study Area

The study was conducted in Ibadan North-East LGA of Oyo State, Nigeria. The LGA was located within the Ibadan metropolis and comprised diverse communities with varying socioeconomic and cultural characteristics. The area had access to public and private healthcare facilities, educational institutions and religious organizations.

Study Population

The study population comprised women of reproductive age aged 15–49 years who had resided in Ibadan North-East LGA for at least six months prior to the study.

Women aged 15–49 years who resided in the study area and consented to participate were eligible for inclusion. Women who were seriously ill or unable to participate in the interview were excluded.

Sampling Technique and Sample Size

A multistage sampling technique was used to select participants. Selected communities within the LGA were identified, after which eligible households were systematically selected. Where more than one eligible woman was present in a household, one participant was selected by simple random sampling. Sampling continued until the required sample size of 200 participants was achieved.

Data Collection Instrument

Data were collected using a structured interviewer-administered questionnaire developed from relevant literature on FGM. The questionnaire collected information on participants' sociodemographic characteristics, FGM history, family history, cultural and social factors, religious beliefs, socioeconomic characteristics and exposure to information about FGM. The questionnaire was reviewed by experts in public health and reproductive health to ensure content validity. It was pre-tested among women of reproductive age in a community outside the study area. Necessary modifications were made before the final administration.

Data Collection and Analysis

Trained research assistants administered the questionnaires after receiving training on the study objectives, confidentiality and administration of the instrument. Interviews were conducted privately to protect participants' confidentiality, particularly because FGM was a sensitive subject. The questionnaire was administered in English or Yoruba where necessary. Data were coded, entered and analyzed using SPSS version 25.0. Descriptive statistics, including frequencies, percentages, means and standard deviations, were used to summarize the data. Appropriate tests of association were performed between FGM status and selected explanatory variables. Binary logistic regression was used to identify factors independently predicting FGM status. Results were presented as adjusted odds ratios with 95% confidence intervals. Statistical significance was set at $p < 0.05$.

Ethical Considerations

Ethical approval was obtained from the appropriate Research Ethics Committee before commencement of the study. Permission was also obtained from the relevant authorities in the study area. Participants were informed about the purpose and voluntary nature of the study, and informed

consent was obtained before participation. Confidentiality and anonymity were maintained throughout the study. Participants were informed of their right to withdraw at any time without consequences.

Results

Table 1. Socio-demographic Characteristics of Respondents (n = 200).

Variable	Frequency (n)	Percentage (%)
Age (years)		
10–18	10	5.0
19–25	64	32.0
26–32	76	38.0
33–39	40	20.0
40–46	8	4.0
≥47	2	1.0
Ethnic group		
Hausa	22	11.0
Igbo	34	17.0
Yoruba	140	70.0
Other	4	2.0
Educational level		
No formal education	60	30.0
Primary	40	20.0
Secondary	60	30.0
Tertiary	40	20.0
Religion		
Islam	86	43.0
Christianity	110	55.0
Traditionalist	4	2.0
Marital status		
Single	44	22.0
Married	156	78.0

Variable	Frequency (n)	Percentage (%)
Divorced	0	0.0
Separated	0	0.0
Widowed	0	0.0
Occupation		
Trader	30	15.0
Public servant	32	16.0
Civil servant	64	32.0
Unemployed	74	37.0

The socio-demographic characteristics of the respondents revealed a predominantly young adult study population. The highest proportion, 38.0% (76), was aged 26–32 years, followed by 32.0% (64) aged 19–25 years and 20.0% (40) aged 33–39 years. Respondents aged 10–18 years constituted 5.0% (10), while 4.0% (8) were aged 40–46 years and 1.0% (2) were aged 47 years or older. In terms of ethnicity, the majority of the respondents were Yoruba, accounting for 70.0% (140), followed by Igbo at 17.0% (34) and Hausa at 11.0% (22), while 2.0% (4) belonged to other ethnic groups [8]. Regarding educational attainment, 30.0% (60) had no formal education, 30.0% (60) had secondary education, while 20.0% (40) each had primary and tertiary education. The religious distribution showed that 55.0% (110) of the respondents were Christians, 43.0% (86) were Muslims and 2.0% (4) were traditionalists. Most respondents were married, constituting 78.0% (156), while 22.0% (44) were single. None of the respondents were divorced, separated or widowed. With respect to occupation, 37.0% (74) were unemployed, 32.0% (64) were civil servants, 16.0% (32) were public servants and 15.0% (30) were traders [9].

Table 2. Prevalence and Characteristics of Female Genital Mutilation among Respondents (n = 200).

Variable	Response	Frequency (n)	Percentage (%)
FGM status	Yes	116	58.0
	No	34	42.0
Age at FGM	<5 years	38	32.8
	5–9 years	44	37.9
	10–14 years	24	20.7
	≥15 years	10	8.6
Person who performed FGM	Traditional practitioner	76	65.5
	Healthcare worker	24	20.7
	Family member	10	8.6
	Other	5	5.2
Place where FGM was performed	Home	72	62.1
	Health facility	32	27.6
	Other	12	10.3
Type of FGM	Type I	34	29.3

Variable	Response	Frequency (n)	Percentage (%)
	Type II	42	36.2
	Type III	16	13.8
	Type IV/Unknown	24	20.7
Mother had undergone FGM	Yes	94	81.0
	No	22	19.0
FGM was practised in respondent's family	Yes	38	75.9
	No	28	24.1
FGM is widely practised among uneducated individuals	Agree	130	65.0
	Disagree	40	20.0
	I don't know	30	15.0
FGM is practised at a higher rate in rural areas	Agree	100	50.0
	Disagree	30	40.0
	I don't know	20	10.0
FGM is more practised among people in southern Nigeria than in other zones	Agree	100	50.0
	Disagree	50	30.0
	I don't know	40	20.0

The findings showed that 58.0% (116) of the respondents reported having undergone FGM, while 42.0% (84) had not. Among those who had undergone the practice, the largest proportion, 37.9% (44), reported that it occurred between 5 and 9 years of age, followed by 32.8% (38) who underwent FGM before the age of 5 years. A further 20.7% (24) underwent the procedure between 10 and 14 years, while 8.6% (10) were aged 15 years or older at the time of the procedure. Traditional practitioners were reported as the main persons performing FGM, accounting for 65.5% (76) of cases, while healthcare workers performed 20.7% (24). Family members accounted for 8.6% (10), while 5.2% (6) reported other persons. Regarding the location of the procedure, 62.1% (72) reported that FGM was performed at home, while 27.6% (32) underwent the procedure in a health facility and 10.3% (12) reported other locations [10].

Type II FGM was the most frequently reported type, accounting for 36.2% (42), followed by Type I at 29.3% (34). Type III accounted for 13.8% (16), while 20.7% (24) were unable to specify the type or reported Type IV. A substantial majority of respondents who had undergone FGM, 81.0% (94), reported that their mothers had also undergone the practice, while 19.0% (22) reported otherwise. Similarly, 75.9% (88) indicated that FGM was practiced within their families. Regarding perceptions of the distribution of FGM, 65.0% (130) agreed that the practice was widely prevalent among uneducated individuals, while 20.0% (40) disagreed and 15.0% (30) were uncertain [11]. Half of the respondents, 50.0% (100), agreed that FGM was more prevalent in rural areas, while 40.0% (80) disagreed and 10.0% (20) were uncertain. Similarly, 50.0% (100) perceived FGM to be more prevalent in southern Nigeria than in other geopolitical zones, whereas 30.0% (60) disagreed and 20.0% (40) did not know.

Table 3. Perceptions of Respondents Regarding the Determinants and Consequences of Female Genital Mutilation (n = 200).

Statement	Strongly Agree n (%)	Agree n (%)	Undecided n (%)	Disagree n (%)	Strongly Disagree n (%)
Maternal age influences the practice of FGM	44 (22.0)	76 (38.0)	40 (20.0)	28 (14.0)	12 (6.0)
Ethnicity influences the practice of FGM	60 (30.0)	80 (40.0)	30 (15.0)	20 (10.0)	10 (5.0)
Parental educational level influences the practice of FGM	40 (20.0)	72 (36.0)	20 (10.0)	48 (24.0)	20 (10.0)
Parental occupation influences the practice of FGM	34 (17.0)	66 (33.0)	40 (20.0)	40 (20.0)	20 (10.0)
FGM can cause infection	70 (35.0)	50 (25.0)	40 (20.0)	25 (12.5)	15 (7.5)
FGM can cause pain and scar formation	100 (50.0)	60 (30.0)	20 (10.0)	12 (6.0)	8 (4.0)
FGM can cause excessive bleeding	55 (27.5)	65 (32.5)	20 (10.0)	40 (20.0)	20 (10.0)
FGM can cause complications during childbirth	95 (47.5)	65 (32.5)	20 (10.0)	12 (6.0)	8 (4.0)
FGM can increase vulnerability to sexually transmitted infections	100 (50.0)	70 (35.0)	10 (5.0)	12 (6.0)	8 (4.0)
FGM can cause pain during sexual intercourse	80 (40.0)	70 (35.0)	20 (10.0)	20 (10.0)	10 (5.0)
FGM can reduce sexual desire	55 (27.5)	65 (32.5)	40 (20.0)	25 (12.5)	15 (7.5)
FGM can cause psychological trauma	45 (22.5)	55 (27.5)	40 (20.0)	40 (20.0)	20 (10.0)
FGM has no health benefits	100 (50.0)	60 (30.0)	20 (10.0)	12 (6.0)	8 (4.0)
FGM protects against sexually transmitted infections	8 (4.0)	2 (1.0)	26 (13.0)	80 (40.0)	84 (42.0)
FGM prevents promiscuity	20 (10.0)	52 (26.0)	3 (4.0)	70 (35.0)	50 (25.0)
FGM promotes sexual abstinence	12 (6.0)	28 (14.0)	10 (5.0)	80 (40.0)	70 (35.0)
FGM can be medically managed or repaired	30 (15.0)	70 (35.0)	30 (15.0)	45 (22.5)	25 (12.5)
FGM should be abandoned	105 (52.5)	65 (32.5)	15 (7.5)	10 (5.0)	5 (2.5)
FGM can be eradicated	90 (45.0)	76 (38.0)	14 (7.0)	12 (6.0)	8 (4.0)

Note: FGM = female genital mutilation.

Table 3 showed that respondents generally perceived demographic and socioeconomic characteristics as important influences on the practice of female genital mutilation (FGM). Ethnicity was the most strongly perceived demographic determinant, with 70.0% of respondents either strongly agreeing (30.0%) or agreeing (40.0%) that ethnicity influenced the practice. Similarly, 60.0% strongly agreed or agreed that maternal age influenced FGM, while 56.0% expressed the same view regarding parental educational level. Half of the respondents (50.0%) agreed that parental occupation could influence the practice. Respondents demonstrated substantial awareness of the health consequences associated with FGM. A large majority (80.0%) strongly agreed or agreed that FGM could cause pain and scar formation, while 80.0% similarly recognized its potential to cause complications during childbirth. Furthermore, 85.0% strongly agreed or agreed that FGM could increase vulnerability to sexually transmitted infections, and 75.0% acknowledged that the practice could cause pain during

sexual intercourse. Sixty percent recognized that FGM could cause infection, while 60.0% also agreed that it could reduce sexual desire. Psychological trauma was recognized by 50.0% of respondents, although 20.0% were undecided and 30.0% disagreed.

The findings also revealed the persistence of some misconceptions about FGM. Although 80.0% of respondents strongly agreed or agreed that FGM had no health benefits, 36.0% nevertheless agreed that it could prevent promiscuity [12]. Similarly, only 5.0% agreed that FGM protected against sexually transmitted infections, whereas 82.0% disagreed or strongly disagreed with this assertion. Most respondents (75.0%) disagreed or strongly disagreed that FGM promoted sexual abstinence, while 20.0% agreed. Regarding the possibility of eliminating the practice, 83.0% of respondents strongly agreed or agreed that FGM could be eradicated. Likewise, 85.0% strongly agreed or agreed that FGM should be abandoned. However, opinions regarding whether FGM could be medically managed or repaired were less consistent, with 50.0% agreeing, 15.0% remaining undecided and 35.0% disagreeing or strongly disagreeing.

Table 4. Family, Cultural and Social Factors Associated with Female Genital Mutilation among Respondents (n = 200).

Variable	SA n (%)	A n (%)	U n (%)	D n (%)	SD n (%)
FGM is believed to prevent promiscuity	20 (10.0)	40 (20.0)	20 (10.0)	70 (35.0)	50 (25.0)
FGM is believed to teach girls societal morals and values	30 (15.0)	50 (25.0)	40 (20.0)	50 (25.0)	30 (15.0)
FGM is practised to improve girls' chances of marriage	25 (12.5)	47 (23.5)	48 (24.0)	50 (25.0)	30 (15.0)
FGM is practised to control women's sexuality	35 (17.5)	67 (33.5)	38 (19.0)	40 (20.0)	20 (10.0)
Uncircumcised women are perceived as dishonourable or promiscuous	15 (7.5)	45 (22.5)	20 (10.0)	70 (35.0)	50 (25.0)
Cultural beliefs about female genitalia influence the practice of FGM	30 (15.0)	70 (35.0)	40 (20.0)	40 (20.0)	20 (10.0)
FGM is perceived as a means of promoting cleanliness and beauty	35 (17.5)	85 (42.5)	20 (10.0)	40 (20.0)	20 (10.0)
FGM is perceived as promoting sexual purity	30 (15.0)	68 (34.0)	20 (10.0)	52 (26.0)	30 (15.0)
Family members influence the decision to subject girls to FGM	40 (20.0)	75 (37.5)	25 (12.5)	40 (20.0)	20 (10.0)
Community expectations encourage the continuation of FGM	30 (15.0)	65 (32.5)	35 (17.5)	45 (22.5)	25 (12.5)
Religious beliefs influence decisions concerning FGM	20 (10.0)	55 (27.5)	35 (17.5)	55 (27.5)	35 (17.5)
Fear of social rejection can encourage families to continue FGM	35 (17.5)	70 (35.0)	30 (15.0)	40 (20.0)	25 (12.5)
FGM is regarded as an important cultural tradition in some families	40 (20.0)	75 (37.5)	25 (12.5)	40 (20.0)	20 (10.0)
Parents or relatives may pressure girls to undergo FGM	35 (17.5)	70 (35.0)	30 (15.0)	40 (20.0)	25 (12.5)

Note: SA = Strongly Agree; A = Agree; U = Undecided; D = Disagree; SD = Strongly Disagree.

Family and community influences appeared to play an important role in respondents' perceptions of the continuation of female genital mutilation (FGM). A total of 57.5% (115) of respondents strongly agreed or agreed that family members influenced decisions to subject girls to FGM, while 32.5% (65) disagreed or strongly disagreed and 12.5% (25) were undecided. Similarly, 57.5% (115) strongly agreed or agreed that FGM was regarded as an important cultural tradition in

some families. Cultural beliefs were also evident, as 50.0% (100) of respondents strongly agreed or agreed that cultural beliefs about female genitalia influenced the practice. In addition, 60.0% (120) agreed that FGM was perceived as promoting cleanliness and beauty, while 49.0% (98) agreed that it was associated with sexual purity. These findings suggest that cultural interpretations of femininity, cleanliness and acceptable behavior may contribute to the persistence of the practice [13].

Community expectations and social pressure were similarly identified. More than half of the respondents, 52.5% (105), strongly agreed or agreed that community expectations encouraged the continuation of FGM, while the same proportion, 52.5% (105), agreed that fear of social rejection could encourage families to maintain the practice. Furthermore, 52.5% (105) perceived FGM as a means of controlling women's sexuality. Perceptions relating to marriage and sexual behavior were comparatively less pronounced. Only 36.0% (72) of respondents strongly agreed or agreed that FGM was practiced to improve girls' chances of marriage, while 40.0% (80) disagreed or strongly disagreed. Similarly, 30.0% (60) agreed that FGM was believed to prevent promiscuity, whereas 60.0% (120) disagreed or strongly disagreed. Regarding the belief that FGM taught girls societal morals and values, 40.0% (80) agreed, 40.0% (80) disagreed or strongly disagreed, and 20.0% (40) were undecided. Religious influence generated mixed responses [14], [15]. While 37.5% (75) of respondents strongly agreed or agreed that religious beliefs influenced decisions concerning FGM, 45.0% (90) disagreed or strongly disagreed and 17.5% (35) remained undecided

Table 5. Association between Socio-demographic Characteristics and Female Genital Mutilation Status among Respondents (n = 200).

Variable	FGM Yes n (%)	FGM No n (%)	χ^2	p-value
Age (years)			12.847	0.025
10–18	3 (30.0)	7 (70.0)		
19–25	30 (46.9)	34 (53.1)		
26–32	48 (63.2)	28 (36.8)		
33–39	27 (67.5)	13 (32.5)		
40–46	6 (75.0)	2 (25.0)		
≥47	2 (100.0)	0 (0.0)		
Ethnic group			9.426	0.024
Hausa	7 (31.8)	15 (68.2)		
Igbo	14 (41.2)	20 (58.8)		
Yoruba	92 (65.7)	48 (34.3)		
Other	3 (75.0)	1 (25.0)		
Educational level			18.562	0.001
No formal education	48 (80.0)	12 (20.0)		
Primary	29 (72.5)	11 (27.5)		

Variable	FGM Yes n (%)	FGM No n (%)	χ^2	p-value
Secondary	31 (51.7)	29 (48.3)	4.893	0.087
Tertiary	8 (20.0)	32 (80.0)		
Religion				
Islam	56 (65.1)	30 (34.9)	5.247	0.022
Christianity	57 (51.8)	53 (48.2)		
Traditionalist	3 (75.0)	1 (25.0)		
Marital status			5.247	0.022
Single	19 (43.2)	25 (56.8)		
Married	97 (62.2)	59 (37.8)		
Occupation			11.638	0.009
Trader	23 (76.7)	7 (23.3)		
Public servant	12 (37.5)	20 (62.5)		
Civil servant	34 (53.1)	30 (46.9)		
Unemployed	47 (63.5)	27 (36.5)		

The findings in Table 5 showed that age was significantly associated with FGM status ($\chi^2 = 12.847$, $p = 0.025$). The proportion of respondents who reported having undergone FGM increased across the age groups, from 30.0% among those aged 10–18 years to 75.0% among those aged 40–46 years. Ethnicity was also significantly associated with FGM status ($\chi^2 = 9.426$, $p = 0.024$), with a higher proportion of Yoruba respondents reporting FGM compared with respondents from the Hausa and Igbo ethnic groups. Educational attainment showed a statistically significant association with FGM status ($\chi^2 = 18.562$, $p < 0.001$). Respondents with no formal education had the highest proportion of FGM (80.0%), followed by those with primary education (72.5%). In contrast, only 20.0% of respondents with tertiary education reported having undergone FGM. Religion was not significantly associated with FGM status ($\chi^2 = 4.893$, $p = 0.087$), although the proportion reporting FGM was highest among traditionalists (75.0%), followed by Muslims (65.1%) and Christians (51.8%).

Marital status showed a statistically significant association with FGM status ($\chi^2 = 5.247$, $p = 0.022$), with FGM reported by 62.2% of married respondents compared with 43.2% of single respondents. Occupation was also significantly associated with FGM status ($\chi^2 = 11.638$, $p = 0.009$), with the highest proportion among traders (76.7%), followed by unemployed respondents (63.5%).

Table 6. Association between Family, Cultural and Social Factors and Female Genital Mutilation Status among Respondents (n = 200).

Variable	FGM Yes n (%)	FGM No n (%)	χ^2	p-value
FGM believed to prevent promiscuity			8.624	0.013
Strongly agree/Agree	42 (70.0)	18 (30.0)		
Undecided	8 (40.0)	12 (60.0)		
Disagree/Strongly disagree	66 (55.0)	54 (45.0)		
FGM believed to teach societal morals and values			6.915	0.032
Strongly agree/Agree	54 (67.5)	26 (32.5)		
Undecided	18 (45.0)	22 (55.0)		
Disagree/Strongly disagree	44 (55.0)	36 (45.0)		
FGM practised to improve girls' chances of marriage			10.487	0.005
Strongly agree/Agree	52 (72.2)	20 (27.8)		
Undecided	22 (45.8)	26 (54.2)		
Disagree/Strongly disagree	42 (52.5)	38 (47.5)		
FGM practised to control women's sexuality			13.762	0.001
Strongly agree/Agree	72 (70.6)	30 (29.4)		
Undecided	20 (34.5)	38 (65.5)		
Disagree/Strongly disagree	24 (60.0)	16 (40.0)		
Cultural beliefs about female genitalia influence FGM			12.316	0.002
Strongly agree/Agree	70 (70.0)	30 (30.0)		
Undecided	16 (40.0)	24 (60.0)		
Disagree/Strongly disagree	30 (50.0)	30 (50.0)		
FGM promotes cleanliness and beauty			11.284	0.004
Strongly agree/Agree	78 (65.0)	42 (35.0)		
Undecided	10 (50.0)	10 (50.0)		
Disagree/Strongly disagree	28 (46.7)	32 (53.3)		
FGM promotes sexual purity			9.673	0.008
Strongly agree/Agree	68 (69.4)	30 (30.6)		
Undecided	10 (50.0)	10 (50.0)		
Disagree/Strongly disagree	38 (46.3)	44 (53.7)		
Family members influence decisions concerning FGM			15.842	0.001
Strongly agree/Agree	76 (66.1)	39 (33.9)		
Undecided	10 (40.0)	15 (60.0)		
Disagree/Strongly disagree	30 (50.0)	30 (50.0)		
Community expectations encourage continuation of FGM			14.216	0.001
Strongly agree/Agree	70 (66.7)	35 (33.3)		

Variable	FGM Yes n (%)	FGM No n (%)	χ^2	p-value
Undecided	14 (40.0)	21 (60.0)	4.726	0.094
Disagree/Strongly disagree	32 (53.3)	28 (46.7)		
Religious beliefs influence decisions concerning FGM				
Strongly agree/Agree	46 (61.3)	29 (38.7)	12.764	0.002
Undecided	18 (51.4)	17 (48.6)		
Disagree/Strongly disagree	52 (57.8)	38 (42.2)		
Fear of social rejection encourages continuation of FGM			13.548	0.001
Strongly agree/Agree	70 (66.7)	35 (33.3)		
Undecided	12 (40.0)	18 (60.0)		
Disagree/Strongly disagree	34 (52.3)	31 (47.7)	16.427	0.001
FGM is regarded as an important cultural tradition				
Strongly agree/Agree	75 (65.2)	40 (34.8)		
Undecided	12 (48.0)	13 (52.0)	16.427	0.001
Disagree/Strongly disagree	29 (48.3)	31 (51.7)		
Parents/relatives pressure girls to undergo FGM				
Strongly agree/Agree	74 (70.5)	31 (29.5)	16.427	0.001
Undecided	12 (40.0)	18 (60.0)		
Disagree/Strongly disagree	30 (50.0)	30 (50.0)		

The findings in Table 6 demonstrated significant associations between most family, cultural and social factors and FGM status. Respondents who agreed that FGM was practiced to control women's sexuality were more likely to report having undergone FGM (70.6%) compared with those who were undecided (34.5%) or disagreed (60.0%) ($\chi^2 = 13.762$, $p = 0.001$). Family influence showed a strong association with FGM status. Among respondents who strongly agreed or agreed that family members influenced decisions concerning FGM, 66.1% reported having undergone the practice, compared with 40.0% among those who were undecided and 50.0% among those who disagreed or strongly disagreed ($\chi^2 = 15.842$, $p < 0.001$). Community expectations were similarly associated with FGM status ($\chi^2 = 14.216$, $p = 0.001$).

Cultural beliefs also showed significant associations. Respondents who agreed that cultural beliefs about female genitalia influenced FGM had a higher proportion of FGM experience (70.0%) compared with those who were undecided (40.0%) or disagreed (50.0%) ($\chi^2 = 12.316$, $p = 0.002$). Perceptions of FGM as promoting cleanliness and beauty were also significantly associated with FGM status ($\chi^2 = 11.284$, $p = 0.004$), as were beliefs concerning sexual purity ($\chi^2 = 9.673$, $p = 0.008$). Marriage-related perceptions were significantly associated with FGM status. Among respondents who agreed that FGM improved girls' chances of marriage, 72.2% reported having undergone FGM, compared with 45.8% of those who were undecided and 52.5% of those who disagreed or strongly disagreed ($\chi^2 = 10.487$, $p = 0.005$). Fear of social rejection was also significantly associated with FGM status ($\chi^2 = 12.764$, $p = 0.002$). Similarly, regarding FGM as an important cultural tradition was significantly associated with having undergone the practice ($\chi^2 = 13.548$, $p = 0.001$). Pressure from parents or relatives showed one of the strongest associations, with 70.5% of respondents who agreed reporting FGM compared with 40.0% among those who were undecided and 50.0% among those who disagreed or strongly disagreed ($\chi^2 = 16.427$, $p < 0.001$). In contrast, religious beliefs did not show a statistically significant association with FGM status ($\chi^2 = 4.726$, $p = 0.094$).

Discussion of Findings

The study found that 58.0% of respondents had undergone female genital mutilation (FGM), indicating that the practice remained an important public health concern among the study population. This finding is consistent with evidence that FGM continues to vary substantially across Nigeria according to geographical, socioeconomic and demographic characteristics. Sanni et al. reported considerable regional variation in FGM prevalence among Nigerian women and identified education and socioeconomic characteristics as important factors associated with the practice. Age was significantly associated with FGM, with older respondents reporting the practice more frequently than younger respondents. This may reflect generational differences in exposure to education, health information and changing social norms. Similarly, Oni and Okunlola found that younger Nigerian women were less likely to continue FGM among their daughters, suggesting a gradual decline in intergenerational transmission.

Educational attainment was significantly associated with FGM. Respondents with no formal education had a higher proportion of FGM than those with tertiary education. This finding agrees with Sanni et al. and Nzelu et al. who identified higher educational attainment as an important factor associated with lower FGM-related outcomes in Nigeria. Education may improve access to health information, strengthen decision-making and increase exposure to beliefs that challenge harmful traditional practices. Ethnicity was also significantly associated with FGM. This finding is consistent with the considerable ethnic and geographical differences in FGM prevalence reported in Nigeria. The result highlights the need for culturally appropriate interventions that recognize differences in community beliefs and social expectations.

Marital status and occupation were significantly associated with FGM. The higher proportion observed among married respondents may reflect traditional expectations surrounding marriageability and female sexuality. Differences by occupation may similarly reflect variations in education, socioeconomic resources and access to information. Oni and Okunlola reported that household socioeconomic characteristics influenced the continuation of FGM among Nigerian women. Religion was not significantly associated with FGM in this study. This finding suggests that FGM should not be understood solely as a religious practice. Rather, its continuation may involve interacting cultural, familial and social factors. This interpretation is consistent with Nigerian evidence demonstrating that geographical, educational and socioeconomic characteristics are also important determinants of FGM.

The respondents demonstrated relatively good knowledge of FGM and its harmful consequences. Most had heard of FGM and rejected beliefs that it was beneficial to health, prevented promiscuity or protected against sexually transmitted infections. However, the coexistence of good knowledge with a relatively high prevalence indicates that knowledge alone may not be sufficient to change behaviour. FGM may persist because of family and community expectations even when individuals understand its health consequences.

Family influence was significantly associated with FGM. This finding supports the evidence of intergenerational transmission reported by Oni and Okunlola. Family members may encourage continuation because FGM is regarded as a traditional or socially acceptable practice. Community expectations were similarly associated with FGM, suggesting that social pressure may influence families to conform even when they recognise the harmful nature of the practice.

Perceptions concerning sexuality, cleanliness and marriageability were also important. Some respondents perceived FGM as a means of controlling women's sexuality, promoting sexual purity, ensuring marriageability or improving cleanliness and beauty. These beliefs demonstrate the influence of sociocultural norms on the practice. Such perceptions have previously been identified as important motivations for FGM, particularly through expectations surrounding female sexuality and social acceptance. Fear of social rejection was another important factor associated with FGM. Families may continue the practice because abandoning it could result in criticism or reduced acceptance within their communities. This finding supports the social-norm perspective of FGM and indicates that interventions should address community expectations rather than focusing exclusively on individual women.

The health implications of FGM further justify the need for effective prevention. Recent systematic reviews have associated FGM with adverse sexual, reproductive and psychological outcomes. Nzinga et al. (2021) reported poorer sexual-health outcomes among women who had undergone FGM, while Sylla et al. (2020) identified adverse maternal and perinatal outcomes associated with the practice.

Conclusion

Female genital mutilation remained a relatively common practice among the women studied in Ibadan North-East Local Government Area, with 58.0% reporting that they had undergone the practice. The findings showed that FGM was influenced by a combination of demographic, socioeconomic, familial and sociocultural factors. Age, ethnicity, educational attainment, marital status and occupation were significantly associated with FGM, while religion was not. Family influence, community expectations and perceptions relating to female sexuality, sexual purity, cleanliness, beauty and marriageability were also important factors associated with the practice. Although respondents demonstrated considerable knowledge of FGM and its harmful health consequences, the persistence of the practice suggests that awareness alone may not be sufficient to achieve its abandonment. The study therefore concludes that reducing FGM requires a comprehensive approach that addresses the social and cultural factors sustaining the practice. Strengthening women's education and empowerment, engaging families and community leaders, promoting accurate reproductive-health information, and challenging harmful social norms are essential strategies for reducing FGM and protecting the health, dignity and wellbeing of women and girls in the study area.

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