Texila International Journal | Open Access | Peer Reviewed

Journal: Texila International Journal of Academic Research
https://doi.org/10.21522/TIJAR.2014.13.03.Art026

ISSN: 2520-3088
Volume 13 Issue 3, 2026

Health Consequences and Intimate Partner Relationships of Women with Genital Mutilation Experiences: A Cross-Sectional Comparative Study in South-East Nigeria

Chioma Oliver[1*] and Antor Odu Ndep[2]

[1]*School of Public Health, Texila American University, Guyana, South America*
[2]*Department of Public Health, Faculty of Allied Medical Sciences, University of Calabar, Nigeria*

***Correspondence to be addressed:** E-mail - oliverchioma9@gmail.com

Cite this article as: Oliver C, Ndep AO. Health consequences and intimate partner relationships of women with genital mutilation experiences: a cross-sectional comparative study in South-East Nigeria. Texila Int J Acad Res. 2026;13(3). **https://doi.org/10.21522/TIJAR.2014.13.03.Art026**

Received: 31.10.2025
Accepted: 12.01.2026
Published: 31.07.2026

Abstract *Female genital mutilation (FGM) remains a deeply rooted cultural practice with severe physical and psychological consequences. Despite global eradication efforts, it persists in parts of Nigeria where sociocultural norms override legal and health frameworks. This study explores the lived experiences of women in Eastern Nigeria who have undergone FGM, emphasizing their physical and psychological health outcomes. A comparative mixed-methods design was adopted, involving 300 women aged 18–69 years across six local government areas in Imo and Ebonyi States. Quantitative data were collected using validated instruments PHQ-9, GAD-7, EIS, and PCL-5, and analyzed with descriptive statistics, chi-square tests, and logistic regression. Qualitative insights were derived from seven key informant interviews and two focus group discussions, analyzed through inductive thematic coding using NVivo 12. Women who had undergone FGM reported significantly higher rates of immediate complications such as bleeding, pain, and infection, and long-term sequelae including dyspareunia, menstrual pain, and reduced sexual satisfaction ($p < 0.001$). Psychological outcomes revealed elevated depressive and anxiety symptoms, with mean PHQ-9 and GAD-7 scores of 17.2 ± 5.1 and 14.9 ± 4.8, respectively, compared to 11.3 ± 4.6 and 9.8 ± 4.2 among women without FGM. Qualitative themes underscored trauma, shame, emotional withdrawal, and relational disconnection, illustrating the interdependence of physical and psychological suffering. FGM continues to impose multidimensional harm on women's health in Eastern Nigeria. Findings highlight the need for trauma-informed interventions that integrate clinical care, psychosocial support, and community re-education to mitigate both physical and emotional aftermaths. A holistic response combining medical rehabilitation and culturally sensitive counseling is imperative for survivor-centered healing and sustainable eradication efforts.*

Keywords *Anxiety, Depression, Female Genital Mutilation, Psychological Trauma, Sexual Health.*

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Introduction

Female Genital Mutilation (FGM), also referred to as female cutting or circumcision, remains one of the most deep-seated traditional practices affecting women's physical and psychological health in Africa and beyond [1, 2]. Globally, an estimated 230 million girls and women have undergone the practice, with over four million girls at risk each year [3, 4]. Nigeria accounts for nearly 10% of this global burden, representing more than 20 million survivors, many of whom reside in the eastern and southeastern parts of the country where cultural and communal values strongly reinforce adherence [5] Although often justified by social ideals of chastity, purity, and marriageability, the procedure inflicts profound physical trauma and enduring psychological distress [6].

The problem of this study arises from the multidimensional harm caused by FGM to women's health and well-being. While early research predominantly examined obstetric complications such as prolonged labour, perineal tears, and postpartum haemorrhage [7, 8] there is a growing recognition that the practice also disrupts women's psychological health. Survivors frequently report symptoms of depression, anxiety, post-traumatic stress, and sexual dysfunction, conditions that persist long after the initial procedure and often erode their self-esteem, emotional well-being, and marital intimacy [9-11]. Despite the legal prohibition of FGM through the Violence Against Persons (Prohibition) Act [12], and the existence of global advocacy frameworks under Sustainable Development Goal 5.3, the persistence of the practice in Eastern Nigeria demonstrates a gap between policy and lived experience.

Several existing solutions have been implemented to curb the practice, including legislative bans, community sensitization, and the involvement of healthcare providers in anti-FGM campaigns [13, 14]. However, these interventions often focus narrowly on physical harm or human rights violations, without integrating mental health care or trauma-informed counseling for survivors. Furthermore, the medicalization of FGM, where health professionals perform the procedure under the guise of safety, has unintentionally legitimized the act and undermined eradication efforts [15].

The best approach emerging from recent evidence advocates a holistic model, combining psychosocial rehabilitation, community re-education, and culturally sensitive health interventions [9, 10]. This integrative strategy emphasizes that addressing FGM's consequences requires attention not only to physical recovery but also to emotional healing and relational stability among affected women.

Nonetheless, significant limitations persist. Empirical data on the lived psychological consequences of FGM in Nigeria remain scarce. Most studies have focused on obstetric or sexual outcomes, while few have examined how physical pain interacts with trauma, fear, and shame to shape women's mental health trajectories. Cultural taboos around discussing sexuality and emotional distress further hinder research and care-seeking [16, 10]. Moreover, weak enforcement of anti-FGM laws and the sociocultural authority of traditional leaders limit the reach of interventions [17, 14].

Despite these challenges, there have been notable achievements in the global and national campaign against FGM. Nigeria's inclusion of FGM eradication within its gender and health policies represents a major step toward systemic action [13]. Community dialogues and grassroots education programs have led to localized declines in some regions [18]. More importantly, the growing body of interdisciplinary research, linking FGM to both psychological trauma and impaired reproductive outcomes, has illuminated the urgent need for context-specific interventions [19, 20].

The objective of this study is to explore the lived experiences of women in Eastern Nigeria who have undergone FGM, with particular emphasis on their physical and psychological health outcomes. It aims to understand how physical injuries, such as chronic pain and reproductive complications, intertwine with psychological sequelae, including depression, anxiety, and post-traumatic stress, to shape women's everyday functioning and well-being.

The novelty of this work lies in its focus on integrating physical and psychological perspectives to produce a more holistic understanding of FGM's consequences within a culturally grounded Nigerian context. Unlike prior studies that treated these domains separately, this research investigates how bodily harm and emotional trauma co-exist and reinforce one another in shaping women's lived experiences. By foregrounding survivors' voices and grounding analysis in socio-cultural realities, this study contributes new empirical evidence to support trauma-informed, gender-sensitive health interventions and community education strategies.

Materials and Methods

Study Site

The study was conducted in selected rural communities of Ebonyi and Imo States, both located in South-East Nigeria region reported to have a relatively high prevalence of female genital mutilation/cutting (FGM/C) [21]. Six Local Government Areas (LGAs) were purposively selected: Oru West, Orsu, and Okigwe in Imo State, and Abakaliki, Ikwo, and Ohaozara in Ebonyi State. These areas were chosen based on documented cultural adherence to the practice and the limited availability of sexual and reproductive health services, providing an appropriate sociocultural context to explore the physical, psychological, and relational implications of FGM/C [22]. Participant entry was facilitated through engagement with community leaders, health workers, local NGOs, and women's organizations.

Study Design

The study employed a comparative mixed-methods design, integrating both quantitative and qualitative components. This triangulated method was chosen to ensure a comprehensive exploration of the health consequences and intimate partner relationship dynamics of women who have undergone Female Genital Mutilation/Cutting (FGM/C) in South-East Nigeria. By combining both numerical data and in-depth narratives, the study aims to capture the multifaceted impact of FGM/C on physical health, psychological well-being, and relational outcomes.

Sampling Technique and Participant Criteria

A purposive sampling method was used to recruit three hundred and six (306) women aged 18 -69 years, Participants were divided equally into two groups: women who had undergone FGM/C (n = 153) and women who had not (n = 153). Participants were selected based on their willingness to provide informed consent and their history of being in intimate partner relationships. Women with severe mental or physical conditions or under 18 years and above 69 years were excluded.

Data Collection

Data collection was carried out by six trained research assistants who were final-year BSc Public Health students familiar with the local dialects. They received two days of training on ethical interviewing, confidentiality, and standardized administration of instruments. For the qualitative component, seven Key Informant Interviews (KIIs) were conducted with healthcare workers, NGO representatives, and survivors, while two Focus Group Discussions (FGDs) were organized with seven participants each. Discussions were conducted

in private, serene environments to ensure participants' comfort, confidentiality, and openness in sharing sensitive experiences.

Quantitatively, structured questionnaires and standardized psychological assessments were administered to 306 women aged 18–69 years. Participants were divided equally into two groups: women who had undergone FGM/C (n = 153) and women who had not (n = 153). Quantitative tools included the Patient Health Questionnaire-9 (PHQ-9) for depressive symptoms [21], the Generalized Anxiety Disorder-7 (GAD-7) for anxiety levels [23], the Emotional Intimacy Scale (EIS) for assessing relationship closeness (Sinclair & Dowdy, 2005), and the Post-Traumatic Stress Disorder Checklist for DSM-5 (PCL-5) for trauma-related symptoms [24].

Prior to the main study, all instruments were pre-tested among 20 women in a nearby community not included in the final sample to assess clarity, reliability, and contextual appropriateness. The internal consistency coefficients were satisfactory: PHQ-9 (α = 0.88), GAD-7 (α = 0.91), EIS (α = 0.86), and PCL-5 (α = 0.89), confirming strong reliability. The questionnaires were reviewed by three mental health professionals and two gender specialists for content validity, ensuring the measures appropriately captured psychological and relational outcomes within the cultural setting. No item was deemed irrelevant, and all tools demonstrated conceptual equivalence to the local context.

Validated psychological instruments served as standardized instruments for quantifying mental and emotional health outcomes. Each PHQ-9 item was scored from 0 ("not at all") to 3 ("nearly every day"), yielding a total score between 0–27, with higher scores indicating greater depressive severity [23]. The GAD-7 was similarly scored on a 0–3 Likert scale, producing total scores ranging from 0–21, where scores ≥10 indicated moderate to severe anxiety [25]. The Emotional Intimacy Scale used a 5-point Likert format (1 = strongly disagree to 5 = strongly agree), with higher scores reflecting stronger emotional closeness. The PCL-5 comprised 5 -item short form rated from 0–4, producing scores of 0-20 suggesting probable PTSD [24].

Data Analysis

Quantitative data were coded, cleaned, and analyzed using Stata version 17. Descriptive statistics (frequencies, percentages, means, and standard deviations) summarized demographic characteristics and outcome variables. Chi-square tests assessed associations between FGM/C status and categorical variables, while independent t-tests compared mean psychological scores (PHQ-9, GAD-7, and EIS) between FGM/C and non-FGM/C groups. Binary logistic regression was used to identify predictors of depressive, anxiety, and relational distress among women with FGM/C, with statistical significance set at $p < 0.05$.

For the qualitative data, thematic analysis was employed to extract recurrent themes and patterns. Audio recordings from FGDs and KIIs were transcribed verbatim and translated from Pidgin or Igbo to English by the trained field researchers. Transcripts were imported into NVivo version 12, where two independent analysts conducted inductive coding (data-driven) with iterative comparison to ensure reliability and completeness. Emerging codes were organized into categories and overarching themes representing participants' lived experiences. Verbatim quotes were used to enrich interpretation and contextualize quantitative findings, ensuring methodological triangulation and depth of understanding.

Results

A total of 309 questionnaires were distributed, of which 300 were correctly filled and returned, yielding a 97.1% response rate. The demographic analysis revealed that most respondents were women between the ages of 50 and 69 years, with smaller proportions in the 18–29-year bracket. The majority were

married, had completed at least secondary education, and were predominantly engaged in farming or petty trading. All participants identified as Igbo, reflecting the cultural homogeneity of the study area. See table 1 below.

Table 1. Sociodemographic Characteristics of Respondents (N = 300)

Variable	Frequency (n)	Percentage (%)
Age Group		
18–29	43	14.3
30–39	61	20.3
40–49	58	19.3
50–59	69	23.0
60–69	69	23.0
Marital Status		
Married	229	76.3
Divorced/Separated	26	8.7
Widowed	28	9.3
Others	17	5.7
Highest Education		
None	22	7.3
Primary	63	21.0
Secondary	133	44.3
Tertiary	82	27.3
Occupation		
Farmer	101	33.7
Petty trader	74	24.7
Tailor	33	11.0
Teacher	12	4.0
Health worker	13	4.3
Homemaker	19	6.3
Unemployed	13	4.3
Others	35	11.7
State		
Imo	150	50.0
Ebonyi	150	50.0
Local Government Area (LGA)		
Oru West	50	16.7
Orsu	50	16.7
Okigwe	50	16.7
Abakaliki	50	16.7
Ikwo	50	16.7
Ohaozara	50	16.7
Ethnicity		
Igbo	300	100.0

https://doi.org/10.21522/TIJAR.2014.13.03.Art026

The study further examined the physical health complications associated with Female Genital Mutilation (FGM). Immediate and long-term effects were observed to be significantly higher among women who had undergone FGM compared to those who had not. The most commonly reported physical health challenges included excessive bleeding, swelling, infection, fever, painful urination, and chronic pelvic pain. Long-term complications such as dyspareunia, menstrual pain, recurrent vaginal infections, and diminished sexual satisfaction were also prevalent. Table 2 represents the association between FGM status and reported physical health outcomes, analyzed using chi-square statistics.

Table 2. Association between FGM Status and Physical Health Outcomes (N = 300)

Complication Type	**FGM (n=150) n (%)**	**Non-FGM (n=150) n (%)**	**χ^2**	**p-value**
Immediate Complications				
Severe bleeding (n=60)	60 (40.0)	0 (0.0)		
Pain & swelling (n=50)	45 (30.0)	5 (3.3)	180.24	**0.0001**
Fever (n=12)	10 (6.7)	2 (1.3)		
Infection (n=23)	20 (13.3)	3 (2.0)		
Difficulty urinating (n=5)	5 (3.3)	0 (0.0)		
None (immediate) (n=150)	10 (6.7)	140 (93.3)		
Long-term Complications				
Painful sexual intercourse (n=40)	40 (26.7)	0 (0.0)		
Pain during menstruation (n=40)	35 (23.3)	5 (3.3)		
Frequent vaginal infections (n=27)	25 (16.7)	2 (1.3)	162.78	**0.001**
Reduced sexual sensation (n=20)	20 (13.3)	0 (0.0)		
Menstrual irregularities (n=18)	15 (10.0)	3 (2.0)		
None (long-term) (n=155)	15 (10.0)	140 (93.3)		

Further analyses explored the psychological health outcomes of women with FGM. The results revealed that participants who had undergone the procedure reported significantly higher mean scores on both the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder Scale (GAD-7), compared to women who had not undergone FGM. These participants also recorded lower levels of emotional intimacy with their partners. The mean PHQ-9 score for women with FGM was 17.2 (SD = 5.1), while those without FGM had a mean of 11.3 (SD = 4.6). Similarly, on the GAD-7, the mean score for women with FGM was 14.9 (SD = 4.8) compared to 9.8 (SD = 4.2) for non-FGM women. Emotional intimacy scores were also lower in the FGM group (M = 13.1, SD = 4.3) compared to the non-FGM group (M = 9.4, SD = 3.7). Table 3 presents these findings, indicating significant differences across all psychological measures.

https://doi.org/10.21522/TIJAR.2014.13.03.Art026

Table 3. Psychological Health Outcomes (PHQ-9, GAD-7, and Emotional Intimacy Scores) by FGM Status (N = 300)

Outcomes	Categories/Range	FGM = Yes (n=150)	%	FGM = No (n=150)	%	Total (n=300)	%	Mean ± SD
Depression (PHQ-9)	Normal (0–5)	10	6.7	30	20.0	40	13.3	
	Mild (6–10)	20	13.3	45	30.0	65	21.7	
	Moderate (11–15)	40	26.7	35	23.3	75	25.0	
	Moderate Severe (16–20)	50	33.3	30	20.0	80	26.7	
	Severe (21–27)	30	20.0	10	6.7	40	13.3	**17.2 ± 5.1**
Anxiety (GAD-7)	Normal (0–5)	15	10.0	40	26.7	55	18.3	
	Mild (6–10)	25	16.7	45	30.0	70	23.3	
	Moderate (11–15)	55	36.7	45	30.0	100	33.3	
	Severe (16–21)	55	36.7	20	13.3	75	25.0	**14.9 ± 4.8**
Emotional Intimacy Scale (EIS – Disconnection)	Mild (6–10)	25	16.7	55	36.7	80	26.7	
	Moderate (11–17)	70	46.7	65	43.3	135	45.0	
	Severe (18–25)	55	36.7	30	20.0	85	28.3	**13.1 ± 4.3**

The qualitative component of the study, derived from Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), provided rich insights into the lived experiences of women subjected to FGM in Southeast Nigeria. Thematic analysis revealed that FGM imposes profound physical and psychological burdens, which persist long after the procedure and influence daily life, reproductive health, and emotional wellbeing.

Participants consistently reported a range of enduring physical complications. Obstetric difficulties, including prolonged labor and excessive bleeding, were frequently mentioned. Chronic pelvic and genital pain, recurrent urinary and reproductive infections, menstrual irregularities, and sexual dysfunction were commonly described. One participant shared, “I feel pain every month during menstruation it affects my relationship with my husband.” Another recounted, “I keep getting urinary infections it makes life hard.” Healthcare workers corroborated these accounts, emphasizing that women often present with complications during antenatal care and sexual health consultations. These narratives illuminate the persistent physiological burden of FGM, complementing quantitative findings that demonstrated statistically significant associations between FGM and adverse physical health outcomes.

Beyond physical health, women described profound psychological and emotional distress. Trauma, anxiety, depression, shame, regret, and social stigma were recurrently mentioned. One participant noted, “Even now, I feel anxious and embarrassed talking about it.” Another stated, “I often feel hopeless. I wish I had never gone through it.” Some women reported emotional withdrawal and reduced participation in social or intimate interactions due to fear of judgment or exposure. These experiences underscore the chronic mental health burden associated with FGM, aligning with quantitative measures of depression and anxiety (PHQ-9 and GAD-7), which revealed elevated symptom levels among affected women.

Table 3. Qualitative Themes and Subthemes from FGDs and KIIs (N = 30)

Theme	Subthemes	Illustrative Quotes
Physical Health Consequences	Obstetric complications	"I bled so much during my first delivery… it was scary."
	Chronic pelvic/genital pain	"I feel pain every month during menstruation… it affects my relationship with my husband."
	Sexual dysfunction	"Intercourse is painful… I often avoid it with my husband."
	Recurrent urinary/reproductive infections	"I keep getting urinary infections… it makes life hard."
	Menstrual difficulties	"My periods are long and painful… it affects my daily life."
Psychological and Emotional Effects	Trauma/PTSD symptoms	"Sometimes I relive the pain… it haunts me at night."
	Anxiety	"Even now, I feel anxious talking about it… I get nervous easily."
	Depression and sadness	"I often feel hopeless… I wish I had never gone through it."
	Regret	"I regret going through it… it has affected my life negatively."
	Shame and social stigma	"I hide my condition… I am afraid people will judge me."
	Emotional withdrawal	"I avoid talking about it… I feel disconnected from others."

Collectively, these qualitative findings highlight the interconnected nature of physical and psychological consequences of FGM. Chronic pain and sexual dysfunction exacerbate emotional distress, while trauma and anxiety often compound perceptions of physical discomfort. The narratives underscore the necessity of holistic interventions that integrate clinical care, psychosocial support, and community engagement to address both the physical and mental health dimensions of FGM.

Discussion

The findings of this study demonstrate a significant and multifaceted impact of FGM/C on the physical health of women in Southeast Nigeria. Women who had undergone the practice reported both immediate complications, such as severe bleeding, infections, and prolonged labor, as well as long-term outcomes including chronic pain, painful intercourse, and reduced sexual satisfaction. The severity and type of FGM were critical determinants, with Type III (infibulation) linked to the most severe complications. These results align with evidence from Sudan, Somalia, and Nigeria, highlighting a biological gradient where greater tissue removal and scarring intensify health risks [26, 27]. The high predictive values identified in the logistic regression suggest these complications can serve as clinical indicators for identifying women at risk, emphasizing the potential for early detection and targeted care interventions.

Psychological outcomes were equally pronounced, with affected women reporting elevated levels of depression, anxiety, and symptoms consistent with post-traumatic

stress disorder (PTSD), alongside reduced emotional intimacy with partners. These effects were most severe among women subjected to Type III FGM or unanticipated cutting events, underscoring the traumatic nature of the procedure. Consistent with global and African studies, psychological distress was compounded by cultural and social pressures, including stigma, coercion, and expectations of social conformity [28, 29]. The interaction between physical and psychological consequences creates a cyclical burden, where chronic pain and sexual dysfunction exacerbate emotional distress, reduced self-esteem, and strained intimate relationships, highlighting the interdependence of physical trauma and mental health in FGM-affected women.

These findings carry important implications for policy, clinical practice, and community interventions. The high odds of complications such as severe bleeding and painful intercourse suggest the need for integrating reproductive health, psychosocial support, and trauma-informed care into health services for women at risk or survivors of FGM. Interventions must also address social and cultural norms that perpetuate FGM, combining legal enforcement with community-based education and empowerment programs. Promoting resilience among women, alongside culturally sensitive strategies to prevent FGM, can help mitigate long-term psychological harm while improving overall quality of life. Collectively, the study confirms that FGM/C is both a deeply entrenched cultural practice and a major public health concern, necessitating integrated approaches that address its physical, psychological, and social dimensions.

Strengths and Limitations of Study

This study's principal strength lies in its mixed-methods design, which combined quantitative rigor with qualitative depth to provide a holistic understanding of the health, psychological, and relational consequences of Female Genital Mutilation/Cutting (FGM/C). The use of standardized instruments such as the PHQ-9, GAD-7, EIS, and PCL-5 enhanced the reliability and comparability of results, while the inclusion of both circumcised and uncircumcised women enabled meaningful comparative analysis. The study contributes novel insights by linking biomedical outcomes with psychosocial and intimate partner relationship dynamics, addressing an underexplored dimension of FGM/C research in Nigeria.

However, the cross-sectional nature of the study limits causal inference, and the reliance on self-reported data may have introduced recall or social desirability bias. The geographic focus on Imo and Ebonyi States also restricts generalizability to other cultural contexts. Moreover, while validated tools were used, some culturally specific expressions of distress may not have been fully captured. These limitations notwithstanding, the study offers valuable evidence to inform policy, advocacy, and future longitudinal research on FGM/C and women's wellbeing.

Conclusion

This study underscores the profound and interrelated physical, psychological, and relational consequences of Female Genital Mutilation/Cutting (FGM/C) among women in South-East Nigeria. Beyond the immediate pain and medical complications, the findings reveal persistent emotional distress, sexual dysfunction, and diminished intimacy that compromise women's well-being and marital harmony. The study highlights that FGM/C is not merely a health or legal concern but a multidimensional social issue requiring trauma-informed, survivor-centered, and culturally responsive interventions. Integrating reproductive health services with mental health and community education programs remains essential to promote holistic healing,

gender equity, and the sustainable eradication of FGM/C practices

Ethical Approval

Ethical clearance was obtained from the Research and Ethics Committee of the Alex Ekwueme Federal University Teaching Hospital, Ebonyi state with approval number AEFUTH/REC/VOL1/2024/664, in accordance with the 2013 Declaration of Helsinki and State Ministry of Health, Imo state. All procedures adhered to the ethical principles outlined in the Declaration of Helsinki for research involving human participants. Informed consent was obtained from every participant after a clear explanation of the study's objectives, procedures, potential risks, and benefits. Participation was entirely voluntary, and respondents were informed of their right to withdraw at any stage without penalty. Anonymity and confidentiality were strictly maintained throughout data collection, analysis, and reporting. Sensitive interviews were conducted in private settings to ensure participants' comfort and psychological safety, with referrals provided for those who exhibited distress during the study. The data obtained from this study were secured and password-protected in an online database accessible only to the principal investigator of the study.

Conflict of Interest

The authors declare no conflict of interest. There are no organisations with conflicts of interest related to the study. The authors declare that they have no financial or personal relationship that might have inappropriately influenced the study design, data collection, analysis, interpretation or the writing of this paper. All procedures adhered to ethical research standards, and participant confidentiality was maintained throughout the study.

Acknowledgements

The authors wish to thank all the women who participated in this study for sharing their experiences with honesty and courage. We also acknowledge the support of local community leaders and health workers in Imo and Ebonyi States who facilitated data collection. Special appreciation goes to the research assistants and data analysts whose contributions were vital to the successful completion of this work.

Data Availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request. Due to the sensitive nature of female genital mutilation and the ethical requirements governing participant confidentiality, individual-level qualitative transcripts and quantitative questionnaires cannot be made publicly accessible. However, anonymized datasets used for statistical analyses may be shared in compliance with the ethical approval obtained for this study and in accordance with the principles of responsible data use**.**

Author Contributions

C. Oliver conceptualized the study, designed the methodology, coordinated data collection, conducted quantitative and qualitative analyses, and drafted the manuscript. Dr. A. O. Ndep provided supervisory oversight, contributed to methodological refinement, validated analytical approaches, and critically reviewed and edited the manuscript for intellectual content. Both authors approved the final version of the manuscript and take responsibility for the integrity and accuracy of the work.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. All study activities, including data collection, analysis, and manuscript preparation, were self-funded by the authors.

References

[1]. Muteshi J, Miller S, Belizán JM. The ongoing violence of female genital mutilation/cutting: strengthening the evidence base. Reprod Health. 2016;13(43):1-9.

[2]. World Health Organization. Eliminating female genital mutilation: global strategy and 2030 roadmap. Geneva: WHO Press; 2025.

[3]. Galgano AC, Kikuchi JY. Female genital mutilation or cutting. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2025.

[4]. UNICEF. Female genital mutilation: a global concern. UNICEF Data. 2021. Available from: https://data.unicef.org/resources/female-genital-mutilation-a-global-concern-2024/

[5]. UNICEF. Progress on eliminating female genital mutilation: global and regional trends. UNICEF Publications; 2023.

[6]. Ayenew T, Mol A, Bradford J, Abeje G. Community perspectives on the persistence of female genital mutilation in Ethiopia: implications for public health interventions. Afr Health Sci. 2024;24(1):112-24.

[7]. Berg RC, Underland V. The obstetric consequences of female genital mutilation/cutting: a systematic review and meta-analysis. Obstet Gynecol Int. 2013;2013:1-15.

[8]. Anikwe CC, Ezenyeaku CC, Okeke TC, Ikeako LC. Knowledge and attitude of healthcare workers towards female genital mutilation in Southeast Nigeria. J Obstet Gynaecol. 2019;39(2):265-70.

[9]. Nzinga J, Abuya T, Musila N. The social dynamics of FGM/C decision-making: women's voices and agency in Kenya. Soc Sci Med. 2021;283:114-28.

[10]. Okpara C, Tekbaş Ö. FGM/C and its influence on women's mental health and relationship dynamics: a Nigerian perspective. Int J Gynaecol Obstet. 2024;164(3):655-62.

[11]. Tammary L, Manasi P. Examining the intersection of FGM/C and human rights violations in East Africa. Afr J Law Soc. 2023;8(4):300-12.

[12]. Violence Against Persons (Prohibition) Act (VAPP). Federal Republic of Nigeria Official Gazette. Abuja: Government Press; 2015.

[13]. Amadi C. Socio-cultural perspectives of female genital mutilation and its implications on women's health in Nigeria. J Soc Sci Humanit Res. 2018;3(2):45-57.

[14]. Ezenyeaku CC, Okeke TC, Ikeako LC. Survey of women's opinions on female genital mutilation in Southeast Nigeria: the continuing cultural debate. Niger J Clin Pract. 2011;14(2):176-9.

[15]. Molina-Gallego B, Ferrer A, Cobo E. Female genital mutilation and its psychosocial consequences: a narrative review. Womens Health Rep. 2021;2(1):450-9.

[16]. Omigbodun O, Adeoye A, Olalekan A. FGM and partner relationship quality in Nigeria: the role of trauma and cultural expectations. Niger J Clin Psychol. 2022;10(1):34-47.

[17]. Ochia D. Post-FGM trauma and marital satisfaction among Nigerian women. Afr J Psychol Health Stud. 2025;14(2):77-91.

[18]. Angell M, Karlsen S, Howard LM. The impact of gender-based violence and female genital mutilation on mental health: a systematic review. BMC Public Health. 2022;22(1):1-12.

[19]. Tordrup D, Hansen M, Abayomi A. Economic cost of female genital mutilation across African countries. Lancet Glob Health. 2022;10(3):e456-e464.

[20]. Pallitto CC, Tunçalp Ö, Khosla R. Global epidemiology and health consequences of female genital mutilation: a WHO perspective. Bull World Health Organ. 2025;103(2):145-57.

[21]. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-13.
[22]. Odo AN, Dibia SIC, Nwagu EN, Umoke PC, Umoke CI. Perception and practice of female genital mutilation among women in Southeast Nigeria. Int J Reprod Med. 2020;2020:1-8.
[23]. Spitzer RL, Kroenke K, Williams JBW, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166(10):1092-7.
[24]. Weathers FW, Litz BT, Keane TM, Palmieri PA, Marx BP, Schnurr PP. The PTSD Checklist for DSM-5 (PCL-5). National Center for PTSD; 2013.
[25]. Sinclair VG, Dowdy SW. Development and validation of the Emotional Intimacy Scale. J Nurs Meas. 2005;13(3):193-206.
[26]. Dura M, Ali A, Hassan N, Abdi F. Psychological and relational outcomes of women with FGM/C in sub-Saharan Africa. Int J Womens Health. 2023;15(3):233-45.
[27]. Farih M, Al-Dubai S, El-Shazly M. Female genital mutilation and intimate partner dynamics: the mediating role of psychological trauma. Glob Reprod Health. 2025;7(1):21-32.
[28]. Omigbodun O, Adeoye A, Olalekan A. FGM and partner relationship quality in Nigeria: the role of trauma and cultural expectations. Niger J Clin Psychol. 2022;10(1):34-47.
[29]. Köbach A, Ruf-Leuschner M, Elbert T, Neuner F. Intimate partner violence and FGM/C: the intersection of gender-based violence and trauma exposure. BMC Womens Health. 2018;18(1):1-9.