Awareness, Knowledge and Perception of Female Genital Mutilation and Cutting (FGM/C) Radio Campaign and practice among Women in Imo State

Abstract

The media play a crucial role in society. They educate, entertain, and inform their audience. On this note, the mass media have been a platform to inform and educate women on diseases and negatives activities like female genital mutilation and cutting. Female genital mutilation and cutting (FGM/C) is carried out for various cultural, religious and social reasons within families and communities in the mistaken belief that it will benefit the girl child. However, there are no acceptable reasons that justify female genital mutilation and cutting (FGM/C). It is a harmful practice that has no health benefits but rather exposes the girl child to dangerous health hazards. It is against this backdrop that this study sought to assess influence of radio in the campaign against female genital mutilation and cutting. Using the survey research design, the study sampled the perceptions of 394 respondents using the questionnaire as the instrument of data collection. Anchoring the study on The Health Belief Model, it was revealed that there is moderate awareness and knowledge level amongst women in Imo State about FGM/C. The study concluded that the awareness and knowledge level is responsible for the kind of perception found in the study. It was recommended that sensitization programmes like seminars should be organized for traditional rulers, religious leaders and other opinion leaders to enable them use traditional media communication channels to further sensitize and mobilize the rural women so as to consolidate the gains of the campaign and ensure total eradication of the FGM/C practice and that every media outlet in the State should take up the responsibility of championing this course.

Keywords: Female Genital Mutilation, Cutting, Radio, Women

Introduction

Female Genital Mutilation and Cutting (FGM/C) involves the partial or total removal of genitalia which the United Nations (UN) and the World Health Organization (WHO), say is a flagrant violation of the girls' and women's rights. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women (World Health Organization WHO, 2010). Not minding the health implication of FGM/C as pointed out by WHO, in Nigeria,

FGM/C is still a prevalent practice. Female Genital Mutilation and Cutting (FGM/C) is carried out for various cultural, religious and social reasons within families and communities in the mistaken belief that it will benefit the girl child. However, there are no acceptable reasons that justify female genital mutilation and cutting (FGM/C).

UNICEF (2017) states that it is estimated that more than 200 million girls and women alive today have undergone Female Genital Mutilation and Cutting in the countries where the practice is concentrated. Furthermore, there are an estimated 3 million girls at risk of undergoing female genital mutilation every year. The majority of girls are cut before they turn 15 years old. However the prevalence varies among regions within countries, with ethnicity being the most African Countries.

In Nigeria, according to Okeke (2012) Female Genital Mutilation and Cutting is a practice whose origin and significance is shrouded in secrecy, uncertainty, and confusion. Ekeocha (2015) also stated that there are about six States in Nigeria that still practice female genital mutilation and cutting including Imo State.
In May 2015, the Nigerian government led by President Goodluck Jonathan banned the practice of FGM/C in the country although for Okeke, Anyaehie & Ezenyeaku, 2017), there is still no federal law banning FGM/C in Nigeria, hence the existence of this practice. Be that as it may, for many, the ban in collaboration with the media and other stakeholders in the country will and ought to herald the needed change

According to the United Nations Secretary of State, change can happen through sustained media attention on the damaging public health consequences of FGM/C, as well as on the abuse of the rights of hundreds of thousands of women and girls around the world. In 2014, UNFPA launched a global campaign with the Guardian newspaper to improve media coverage on Female Genital Mutilation and Cutting (FGM/C) in Africa. As part of the campaign, the Pan African Award for Reportage on FGM/C will be granted annually to an African reporter who has shown innovation and commitment in covering the practice.

Media contents are aimed at improving knowledge and influencing the attitude, and behavior of their target audience. This crucial role is performed by educating, entertaining and informing their audience. Thus, the mass media have been a platform to inform and educate women on diseases and negatives activities like female genital mutilation and cutting. Sobel (2015) observed that the media play a potent role in the fight against Female Genital Mutilation and Cutting by reporting the problematic issues and themes surrounding the practice. They highlight the side effect of FGM/C with the aim of persuading people to dissuade from the practice.

Reproductive Health Professionals (2017) observe that in some places where programmes are aired by radio, the impact of such educational programmes are limited and the providers of such programmes face socio-cultural challenges with respect to the prevention of the practice. Other Challenges are associated with lack of health professionals or technical knowledge, clinical skills and limited competency observed in the design and packaging of such radio programmes. It is against this backdrop that this study intends to examine the awareness, knowledge and perception of radio in the fight against Female Genital Mutilation and Cutting in Imo State.

Presently, there seems to be a dearth of empirical research evidence on whether media campaigns have actually succeeded in yielding desired dividends that are influencing the attitude of the people against FGM/C. There have been divergent opinions on whether the mass media campaign against FGM/C, is succeeding in influencing the attitude of Nigerians (Okofo, 2015). According to Omenugha and Ekwugha (2008), despite the wide spread information against FGM/C, it is still waxing strong in some parts of the country. This is a worrisome situation. Could it be that the progammes are not well designed or that there was no professional behind the programme design? Is there any problem associated with the placement of the programme or that the target audience are overwhelmed by cultural influence? This is because most communities in Imo State are still practicing FGM/C despite the identified and perceived dangers inherent in the act. Hence there is the need for evaluation of the role of radio campaigns in discussing such practice among Imo State citizens.

Thus, this paper aimed at ascertaining the overall perception of radio programs on the fight for Female Genital Mutilation and Cutting in Imo State. The following questions guided the study: What is the level of awareness, knowledge and perception of Imo State women on Female Genital Mutilation and Cutting as created by radio campaigns; and what are the factors militating against the use of radio campaign in the prevention of female genital mutilation Cutting?

Review of Related Literature

Female Genital Mutilation and Cutting

According to World Health Organization (2017) Female Genital Mutilation and Cutting (FGM/C) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM/C due to the erroneous belief that the procedure is safer when ‘medicalized’. World Health Organization (WHO) strongly urges health professionals not to perform such procedures. World Health Organization (2017) stated that Female Genital Mutilation Cutting (FGM/C) is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Classification of Female Genital Mutilation and Cutting

Female Genital Mutilation and Cutting is classified into 4 major types (World Health Organization, 2017).

- **Type 1:** Often referred to as **clitoridectomy**, is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Type 2:** Often referred to as **excision**, is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).

- **Type 3:** Often referred to as **infibulation**, is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- **Type 4:** This includes all other harmful procedures to the female genitalia mutilation for non-medical purposes, including pricking, piercing, incising, scraping and cauterizing the genital area.

Unclassified female Genital Mutilation Cutting (FGM/C) according to Unicef (2017) include:

1. Pricking, piercing or excision of the clitoris and/or labia.
2. Stretching of the clitoris and/or labia.
3. Cauterization by burning of the clitoris and surrounding tissues.
4. Scraping of the vaginal orifice or cutting of the vagina.
5. Introduction of corrosive substances into the vagina to cause bleeding of the vagina with the aim of tightening or narrowing the vagina.
6. Any other procedure that falls under the definition of Female Genital Mutilation and Cutting given above.

History of Female Genital Mutilation and Cutting

According to Resource Library (2015), the history of FGM/C is not well known but the practice dated back at least 2000 years. It is not known when or where the tradition of Female Genital Mutilation and Cutting originated from. It was believed that it was practiced in ancient Egypt as a sign of distinction amongst the aristocracy. Some believe it started during the slave trade when black slave women entered ancient Arab societies. Some believe FGM/C began with the arrival of Islam in some parts of sub-Saharan Africa. Some believe the practice developed independently among certain ethnic groups in sub-Saharan Africa as part of puberty rites. Overall, in the history, it was believed that FGM/C would ensure women's virginity and reduction in the female desire. Many commentators believe that the practice evolved from earliest times in primitive communities that wished to establish control over the sexual behaviour of women. The Romans performed a technique involving slipping of rings through the labia majora of female slaves to prevent them from becoming pregnant and the Scoptsi sect in Russia performed FGM/C to ensure virginity. The practice is supported by traditional beliefs, values and attitudes. In some communities it is valued as a rite of passage to womanhood (for example in Kenya and Sierra Leone) while others value it as a means of preserving a girl's virginity until marriage, (for example in Sudan, Egypt, and Somalia). In most of these countries, FGM is a pre-requisite to marriage and marriage is vital to a woman's social and economic survival. It is believed by some African women that if their daughters are not circumcised, they would not get husband. This (FGM/C) harmful tradition has been guided by taboos from generation by generation. FGM/C is rooted in culture and some believe it is done for religious reasons, but it has not been confined to a particular culture or religion. FGM/C has neither been mentioned in the Quran nor Sunnah. It has been highlighted that FGM/C was practiced in the United Kingdom and United States by the gynecologists to cure women of so-called "female weakness".

The practice of FGM/C continues within some communities in various forms and even in the 20th century, girls and women are still subjected to this harmful tradition. Lorenzi (2012) stated that in the 19th century, gynecologists in England and the United States would perform clitoridectomies to treat various psychological symptom as well as "masturbation and

nymphomania. The surgeries in Victorian England and America were generally based on a now discarded theory called 'reflex neurosis,' which held that many disorders like depression and neurasthenia originated in genital inflammation. In the United States, it became illegal in 1997, and in the same year the WHO issued a joint statement with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) against the practice. FGM/C is a crime in many countries now.

As a follow up, the Organization of Islamic Cooperation (2012) called for abolishing ofFemale Genital Mutilation Cutting . This practice is a ritual that has survived over centuries and must be stopped as Islam does not support it. According to Ihsanoglu (2012), an estimated 140 million girls and women now alive have undergone the mutilating procedure in 28 African countries, as well as in Yemen, Iraq, Malaysia, Indonesia and among certain ethnic groups in South America and some immigrant communities in the West. About three million girls in Africa are said to be forced to undergo the procedure each year. The cutting is often done without anesthetic, in conditions that risk potentially fatal infection often using scissors, razor blades, broken glass and tin can lids.

In Nigeria, according to Okeke (2012) Female Genital Mutilation and Cutting is a practice whose origin and significance is shrouded in secrecy, uncertainty, and confusion. The origin of FGM/C is fraught with controversy either as an initiation ceremony of young girls into womanhood or to ensure virginity and curb promiscuity, or to protect female modesty and chastity. The ritual has been so widespread that it could not have risen from a single origin. Ekeocha (2015) stated that there are about six states in Nigeria that still practice Female Genital mutilation and Cutting including Imo state; stressing that UNICEF is sensitizing citizens on the dangers of Female Genital Mutilation and Cutting. He further states that the major reason for the persistence of Female genital Mutilation and Cutting in Nigerian communities are rooted in culture and tradition.

Empirical Review

A study carried out by Anyamene, Nwokolo and Anyachebelu (2012) titled, *Strategies for Eradicating Female Genital Mutilation and Cutting Practice: Implication for Counseling,* examined the strategies for eradicating female genital mutilation cutting. One hundred and thirty two counselors from the nine universities in South East, Nigeria were used for the study. Two research questions and one null hypothesis were formulated to guide the study. Two experts in Guidance and Counseling, one from NnamdiAzikiwe University, Awka and the other from Ebonyi State University, Abakaliki validated the instrument. Result revealed that the effects of Female Genital Mutilation and Cutting are sexual pain, urine retention, poor health, contacting HIV/AIDS and sexually transmitted diseases, damaged urethra, lowers women’s self-esteem, damaged relationship, promiscuity and can lead to divorce. Also, there was no significant difference in the strategies that would eradicate Female Genital Mutilation and Cutting based on types of university. Based on the findings, it was recommended that government should establish guidance and counseling units in various communities and recruit counselors to help check forms of maladaptive behaviours and traditional practices that affect the health conditions of people in these communities.

In related study by Okeke, Anyaehie, and Ezenyeaku, (2017) in their work on *"An Overview of Female Genital Mutilation in Nigeria*" sought to ascertain the current status of FGM/C in Nigeria. Pertinent literature on FGM/C retrieved from internet services and African Journal Online (AJOL) (FGM/C) and textbooks, journals, and selected references for proper understanding of the topic was included in this review. Through content analysis the researchers found out there is no federal law banning FGM/C in Nigeria. They confirmed the need for abolition of this unhealthy practice. A multidisciplinary approach involving legislation, healthcare professional organizations, empowerment of the women in the society, and education of the general public at all levels with emphasis on dangers and undesirability of FGM/C was recommended by the researchers as paramount.

Also, Sobel (2015) carried out a study titled *Female genital cutting in the news media: A content analysis*. The study which was a quantitative content analysis, analyzed how 15 years of newspaper coverage surrounding the launch of the Millennium Development Goals framed female genital cutting in four countries with varying prevalence levels of female genital cutting: the United States, Ghana, The Gambia, and Kenya. The study found female genital cutting is consistently portrayed as a problematic and thematic topic, largely tied to cultural rituals. However, coverage is minimal and inconsistent over time, and does not appear to be impacted by the increase in international initiatives aimed at combating the practice.

Reproductive Health Professionals, Geneva (2017) carried out a study titled *Female Genital Mutilation/Cutting: Sharing data and experiences to accelerate eradication and improve care:* (part 2 Geneva, Switzerland) discovered that the impact of educational programs are limited and providers in FGM/C prevalent countries face socio-cultural challenges with respect to the prevention of the practice. They did peer review of primary research literature retrieved through searches of electronic bibliographic databases between 2004 and 2014, and were guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework. They reported a lack of health professional or technical knowledge, clinical skills, and limited cultural competency. They concluded that there is a need for improved medical and midwifery education and training to build knowledge and skills, and to change attitudes concerning the medicalization of FGM/C and infibulations. Supportive working environments sustained by guidelines and responsive policy and community education, according to them, are necessary to enable doctors and midwives to improve the care of women with FGM and advocate against the practice.

Another study by Kunnskapssenteret (2009) titled *"Effectiveness of Interventions Designed to Reduce the Prevalence of Female Genital Mutilation"* sought to find out the effectiveness of interventions designed to reduce the prevalence of female genital mutilation compared to no or any other intervention. Using literature review, the researchers concluded that there is a paucity of high quality evidence regarding the effectiveness of interventions to prevent FGM/C and the evidence base is insufficient to draw solid conclusions. While first generation anti-FGM/C intervention studies are informative, there is an urgent need for additional studies. They therefore recommended that second generation studies should be randomized or at a minimum secure similar distribution of prognostic factors in the intervention and comparison groups. Long term to ensure viability and reliable assessment of changes in prevalence; take into account regional, ethnic and socio demographic variation in the practice of FGM/C; focus on prevalence assessed

by physical examinations behaviours, and intentions; and they should be cross disciplinary, if possible through international collaborative initiatives.

In his own study, Okofo (2015) sought to find out the use of mass media to crusade and mobilize support against certain crude and inhuman cultural practices. According to him, this has remained an essential focus on the social responsibility function of the media. Hence, his study beyond opinionated conjectures, empirically studied the influence of media campaigns in the eradication of Female Genital Mutilation and cutting (FGM/C) practice in selected communities of South-South Nigeria. The survey research design was used to study a representative sample size of the target population. A sample size of 383 was selected and administered a twenty-one item questionnaire. Research findings revealed that the media mix approach for the said campaigns, meaningfully helped at influencing the attitude of the South rural women against the FGM/C practice. The study concluded that media campaigns against FGM/C have paid off and recommended that sensitization programmes like seminars should be organized for traditional rulers, religious leaders and other opinion leaders to enable them use other rural media communication channels to further sensitize and mobilize the rural women so as to consolidate the gains of the campaign and ensure total eradication of the FGM/C practice.

Relatively, Wondimu, Nega, Mengistu, and Arja (2012) carried out a study titled *Female Genital Mutilation and Cutting: Prevalence, Perceptions and Effect on Women's Health in Kersa District of Ethiopia.* The researchers sought to identify the prevalence, perceptions, perpetuators, reasons for conducting FGM/C, and factors associated with this practice with regard to women's health. Using the interview method, the researchers found out that FGM/C was reported to be known by 327 (38.5%) of the interviewees. The majority (n = 249, 76.1%) reported that local healers were the main performers of FGM/C, and 258 (78.9%) respondents stated that the clitoris was the part removed during circumcision. The main reason for the practice of FGM/C was reduction of female sexual hyperactivity (reported by 198 women [60.3%]). Circumcision of daughters was reported by 288 (88.1%) respondents, and this showed a statistically significant association with the Christian religion ($P = 0.003$), illiteracy ($P = 0.01$), and Amhara ethnicity ($P = 0.012$). The majority of the respondents (792, 92.3%) were themselves circumcised and 68.8% did not know of any health-related problems associated with FGM/C. They further concluded that in spite of FGM/C being a common practice in the study area, only one third of the respondents stated that they knew about it. Local healers were the main performers of FGM/C. Some of the women knew about the negative reproductive health effects of FGM/C and some had also experienced these themselves. However, only a few had tried to stop the practice and the majority had taken no steps to do so. This may be attributable to the fear of becoming alienated from the cultural system and fear of isolation.

Summary of the literature review revealed that the studies were mostly reviews and overview of Female Genital Mutilation and Cutting, its effects, implications and prevalence. However, none of these studies studied the influence of radio in the campaign against Female Genital Mutilation and Cutting specifically in Imo State.

Theoretical underpinning

This study is anchored on the Health Belief Model. The HBM was originally developed in the 1950s by social psychologists working at the U.S. Public Health Service to explain why many people did not participate in public health programs such as TB or cervical cancer screening. Subsequently, it was extended by Leventhal, Rosenstock, Becker and others to explain differing reactions to symptoms and to explain variations in adherence to treatment. It has subsequently been used to guide the design of interventions to enhance compliance with preventive procedures. (Hochbaum, 1958).

The key components of the health belief model include; perceived susceptibility, perceived benefits, perceived barriers, self-efficacy, and expectations, which are the product/sum of perceived benefits, barriers and self-efficacy, cues to action (Jones, 2016).

Perceived susceptibility: Personal risk or susceptibility is one of the more powerful perceptions in prompting people to adopt healthier behaviors. The greater the perceived risk, the greater the likelihood of engaging in behaviors to decrease the risk. It is only logical that when people believe they are at risk for a disease, they will be more likely to do something to prevent it. Unfortunately, the opposite also occurs. When people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviors tend to result. This is exactly what has been found with older adults and HIV prevention behavior. Because older adults generally do not perceive themselves to be at risk for HIV infection, many do not practice safer sex (Rose, 1995; Maes& Louis, 2003).

Perceived benefits: The construct of perceived benefits is a person's opinion of the value or usefulness of a new behavior in decreasing the risk of developing a disease. People tend to adopt healthier behaviors when they believe the new behavior will decrease their chances of developing a disease. Would people strive to eat five servings of fruits and vegetables a day if they didn't believe it was beneficial? Would people quit smoking if they didn't believe it was better for their health? Would people use sunscreen if they didn't believe its efficacy? Probably not. Perceived benefits play an important role in the adoption of secondary prevention behaviors, such as screenings.

Perceived Barrier: Since change is not something that comes easily to most people, the last construct of the Health Belief Model,HBM, addresses the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behavior. Of all the constructs, perceived barriers are the most significant in determining behavior change (Janz& Becker, 1984). In order for a new behavior to be adopted, a person needs to believe the benefits of the new behavior outweigh the consequences of continuing the old behavior (Centers for Disease Control and Prevention, 2004). This enables barriers to be overcome and the new behavior to be adopted.

Self-Efficacy: Self-efficacy is the belief in one's own ability to do something (Bandura, 1977). People generally do not try to do something new unless they think they can do it. If someone believes a new behavior is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried. A significant factor in not performing HBM is fear of being unable to perform HBM correctly (Umeh& Rogan-Gibson,

2001). Unless a woman believes she is capable of performing HBM (that is, has HBM self-efficacy), this barrier will not be overcome and HBM will not be practiced.

Action Cues: The HBM suggests that behavior is also influenced by cues to action. Cues to action are events, people, or things that move people to change their behavior.
Hochbaum (1958) simplifies the Health Belief Theory using a constructs chart.
Perceived Susceptibility: An individual's assessment of his or her chances of getting the disease
Perceived benefits: An individual's conclusion as to whether the new behavior is better than what he or she is already doing
Perceived barriers: An individual's opinion as to what will stop him or her from adopting the new behavior
Perceived seriousness: An individual's judgment as to the severity of the disease
Modifying variables: An individual's personal factors that affect whether the new behavior is adopted

Cues to action: Those factors that will start a person on the way to changing behavior
Self-efficacy: Personal belief is one's own ability to do something

Relating Health Belief Model to this study implies that the way in which women perceive radio programs on Female Genital Mutilation will determine their behaviour towards it. This simply means that they are likely going to adjust their attitude and practices to the messages of Female Genital Mutilation and Cutting when they discover that they might fall victim to the negative side effect that goes with FGM/C. Radio programs on FGM/C will propel the women to avoid or at least resist FGM/C.

RESEARCH DESIGN AND METHODOLOGY

Research Design: For the purpose of this study, the researchers employed the survey research method. Survey research method has those right attributes that will allow for guided systematic and objective collection of the needed data and statistics. One advantage of the survey research method is that it offers researchers the opportunity to communicate with the respondents. This communication leads to uncovering of data needed for quick interpretation, synthesis and integration of the quantum of data accumulated in the process. Survey allows researchers to measure characteristics, opinions or behavior of a population by studying a small sample from the groups, then generalizing back to the population which is the group under scrutiny. As suitable as it is for this study, the result from such proportional representative size would be generalized on the entire population for the purpose of this study.

Population of Study: The population of this study includes all women in Imo State. The choice of women in Imo State is due to the fact that they are gender affected by FGM/C. The population of women in Imo State according to the projection of the National Population Commission for 2016 is 1, 9896,330 (NPC, 2016).

Sample Size: A sample size of 394 was drawn from the population using the Wimmer and Dominick online calculator (Wimmer and Dominick, 2018). The sample population was gotten from the population supplied by the National Population Commission. For the **Sampling**

Techniques, ordinarily, it would be a different task to realistically observe all the elements in a given population. Hence, sampling becomes necessary. The study adopted the cluster sampling technique. This afforded the researchers the opportunity to study the population of study in their own different geographical location. This means that Imo State was divided into three geopolitical Zones namely: Owerri Zone, Orlu Zone and Okigwe Zone. From these Zones, two local government areas were selected each totaling six. The select (6) Local Government Areas studied are:

Geopolitical Zones	Local Government	Wards
Owerri Zone	Owerri West and Owerri Municipal	Ihiagwa, Obinze and Aladinma, New Owerri
Orlu Zone	Orlu and Oguta	Obibi, Amaifeke and Uwaorie, Oru
Okigwe Zone	Onuimo and Okigwe	Eziama, Umunna and Ihube, Ezinachi

Instrument for Data Collection: The research instrument used was questionnaire. Ogili (2006) described it as a carefully designed instrument for collection of data in accordance with the specifications on the research question. It is a list of questions designed to elicit information from respondents by filling the information in spaces provide for the purpose. The questionnaire comprised of mostly closed ended questions. They were highly structured to the point that respondents were constrained to choose their options listed by the researchers. The instrument employed face content validity while the data collected was analyzed using simple tables, frequencies and percentages.

Discussion of Findings

In response to the awareness level of Female Genital Mutilation and Cutting among women in Imo State, data analysis showed that 98.7% respondents are aware of anti-FGM/C messages on radio in Imo State, 0.5% respondents are not aware, while 0.8% respondents can't say about the anti-FGM/C campaigns on radio. To measure the level of awareness, it was revealed that 9.9% of the respondents had very high awareness level of anti-FGM/C, 9.9% of the respondents also had high awareness level. While 49.6% had moderate awareness level, 30.5% were on the very low awareness scale.

The implication of these findings is that majority of the respondents at 98.7% are aware of anti-FGM/C among women in Imo State through radio. However, respondents' level of awareness of Female Genital Mutilation Cutting is moderate at 49.6% through the radio. These findings corroborate with the findings of Sobel (2015) in which it was revealed that mass media coverage of FGM/C is minimal and inconsistent over time. This explains the moderate level of awareness of FGM/C amongst women in Imo state. The implication is that, since 2015 when Sobel conducted his study, nothing has significantly changed in the aspect of raising awareness of Female Genital Mutilation and Cutting amongst women.

Furthermore and to test the knowledge level of **Female Genital Mutilation and Cutting among** women in Imo State, it was revealed that on a mean score of 3.9, respondents know that the

cutting of female important genitals can cause diseases. From data, it was ascertained that on a mean score of 2.3, respondents do not know that mutilation of female important genital parts can make women promiscuous. More so, on a mean score of 2.7, respondents do not know that cutting of female genital parts reduce women sexual pleasure while on a mean score of 4.2, respondents know that the lack of sexual pleasure for women due to FGM/C can cause psychological problems.

This implies that amongst women in Imo State, the dangers of FGM/C which informed the awareness campaign against its practice are not entirely understood. In essence, some group of women who perhaps do not know that the reduction in sexual pleasure of women who have had their genitals cut are prone to harm, would go ahead to cut their girl child. It further implies that the scantier what women in Imo State know about FGM/C, the tendency that the practice will continue. This is in sharp contrast with the aim of the campaigns against FGM/C.

These findings are in consonance with the findings of Wondimu, Nega, Mengistu and Arja (2012) when they carried out a study titled Female Genital Mutilation and Cutting: Prevalence, Perceptions and Effect on Women's Health in Kersa District of Ethiopia. According to this study, it was revealed that that FGM/C was reported to be known by 327 (38.5%) of the interviewees. The majority (n = 249, 76.1%) reported that local healers were the main performers of FGM/C, and 258 (78.9%) respondents stated that the clitoris was the part removed during circumcision. The main reason for the practice of FGM/C was reduction of female sexual hyperactivity (reported by 198 women [60.3%]). Circumcision of daughters was reported by 288 (88.1%) respondents, and this showed a statistically significant association with the Christian religion ($P = 0.003$), illiteracy ($P = 0.01$), and Amhara ethnicity ($P = 0.012$). The majority of the respondents (792, 92.3%) were themselves circumcised but the fact that 68.8% did not know of any health-related problems associated with FGM/C, contrast the findings of this study.

With regards to the Perception of Imo State women on Female Genital Mutilation and Cutting, it was revealed that on a mean score of 4.7, respondents perceive FGM/C to be dangerous to the health of women while on a mean score of 4.1, which is well above the mean rating used in this study, respondents think FGM reduces women's sexual pleasure.

According to data, respondents perceive that FGM/C has negative psychological effects on women especially in relating with other women. This is as the mean score arrived at is on 3.7. Furthermore, findings from analysis showed that respondents think that FGM/C and cutting of female important genital parts should be abolished. This is as the mean score of their responses is on 4.6. Finally, respondents on a mean score of 2.3 perceive that cutting important female genital parts is not capable of making a woman promiscuous.

By association, the practice of FGM/C is far from being eradicated. This is because the study of Wondimu, et al. (2012) revealed that the main reason for FGM/C practice is the reduction of hypersexual activity by women. Therefore, since women in Imo State failed to perceive female genital mutilation as being capable of making a woman promiscuous, it is suggestive that FGM/C is still in practice. Lending credence to this, Kunnskapssenteret (2009) in his study found out that there is a paucity of high quality evidence regarding the effectiveness of interventions to prevent FGM/C and the evidence base is insufficient to draw solid conclusions. But the findings of Okofo (2015) presents evidence that the media mix approach for the said campaigns,

meaningfully helped at influencing the attitude of the South rural women against the FGM/C practice. The study concluded that media campaigns against FGM/C have paid off. Apparently, the finding of Okofo is not in corroboration with the findings of this study. This is because, attitudes are a product of perceptions and a situation where perceptions in this study was not influenced by radio campaigns of FGM/C, it disagrees with the study of Okofo that found out that the attitudes of respondents were influenced by the campaigns.

Armed with the awareness, knowledge and perception level of FGMC among women in Imo State, what then are the perceived factors **militating against the prevention of Female Genital Mutilation and Cutting?**

It was revealed that on a mean score of 4.7, respondents indicated that respect and strong adherence to traditions and norms of the land is one of the factors that militate against prevention of FGM/C. Respondents also identified inadequate knowledge of current practices in the society as a factor hindering the abolishing of FGM/C. This is so as their responses are on a mean score of 4.1

In addition, respondents identified peer influence and pressure from family members which was on a mean score of 4.4 to be the factor militating against the prevention of FGM/C. The implication is that most women are still practicing FGM/C not out of their own volition but out of the influence their peers and family members exert on them. Finally, it was revealed that the 'I don't care attitude' or nonchalant attitude to positive change exhibited by women is one of the factors that prevents the practice of FGM/C. On a mean score of 4.5 which is above the mean rating for this study, this implies that the problem in preventing FGM/C is more attitudinal

The implications of these findings is that aside the perceived ineptitude of the media of communications as one aspect of challenge, the prevention of Female Genital Mutilation and Cutting comes in the shape of problems like peer influence and family members, attitudinal problem, losing touch with current practices in the society and so on. The study of Reproductive Health Professionals, Geneva (2017), opined that in countries where FGM/C is prevalent face socio cultural challenges. Similarly, they reported a lack of health professional or technical knowledge, clinical skills, and limited cultural competency was identified. They concluded that there is a need for improved medical intervention.

Recommendations

Based on the findings, the following recommendations were made:

1. Given that awareness level is moderate, there is the need to increase awareness level if the campaign is to be successful. Therefore, every media outlet in the State should take up the responsibility of championing this course. A multidisciplinary approach involving legislation, healthcare professional organizations, empowerment of the women in the society, and education of the general public at all levels with emphasis on dangers and undesirability of FGM/C was recommended by the researchers as paramount.
2. The knowledge level of Female Genital Mutilation and Cutting shows that women in Imo State do not understand totally what constitutes FGM/C and what FGM/C results into. This study therefore recommends that sensitization programmes like seminars should be organized for traditional rulers, religious leaders and other opinion leaders to enable them

use media communication channels to further sensitize and mobilize the rural women so as to consolidate the gains of the campaign and ensure total eradication of the FGM/C practice.

3. The perception of women about FGM/C towed similar pattern with the knowledge and at such, the study recommends that efforts should be geared towards consistently airing programmes that prevent FGM/C. Also, government should establish guidance and counseling units in various communities and recruit counselors to help influence the perception of individuals.
4. Factors that militate against the fight to prevent FGM/C show that the fight is far from over. Thus, it is recommended that all players in this fight should check forms of maladaptive behaviours and traditional practices that affect the health conditions of people such as FGM/C, to see to it that FGM/C is stopped.

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