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Female Genital Mutilation/Cutting In Nigeria: Implications, Challenges and Panacea

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ABSTRCT

The use of mass media to mobilise support against certain crude and inhuman cultural practices has remained an essential focus on the social responsibility function of the press. Hence, this study focuses on the influence media campaigns in the eradication of Female Genital Mutilation (FGM/C) practice in Nigeria. The study is anchored on Agenda Setting Theory of the media. The survey research design was used to study a representative sample size of the target population. FGM/C is a cultural practice in many parts of the world and is entrenched in such cultures without concern for its health implications on the girl child. This appraisal attempts to draw from available literature the role the Nigerian mass media play in the campaign against the practice of FGM/C.
Keywords: Mutilation, FGM, Mobilisation, Sensitization, cultural practices, Infibulation.

INTRODUCTION

Media contents are aimed at influencing the attitude and behaviour of its target audience. To achieve this, therefore, media practitioners must understand the psychographic and demographic realities of the target audience [1], and they must appreciate the prevailing culture of the people and the most useful and persuasive approach to use in order to influence attitude. In line with its informative, educative and socialisation functions among others, the media socialise the people into accepted norms and values as well as necessitate a change in cultural pattern where necessary, since human behaviour as well as culture is dynamic [2]. One aspect of culture that the media have attempted to bring about attitude change is Female Genital Mutilation/Cutting (FGM/C).

Female genital mutilation (FGM) refers to all procedures that involve partial or total removal of the external female genitalia, or that cause other injury to the female genital organs for non-medical reasons i.e. cultural, religious or other reasons [3]. Whatever the purpose, FGM is a dangerous and potentially life threatening procedure that causes pain and suffering to the victim. According to [4], it is declining in many western worlds but it is still being practiced in many African countries. It continues to be one of the most persistent, pervasive and silently endured human rights violations in the developing world [5].

Female genital mutilation is an old age operation practiced in various parts of the world at times for different reasons. The reasons and justifications reflect the ideological and historically situation on the societies in which it has developed [6]. The origin of Female Genital Mutilations stretches far back in time and it has been practiced in many places. The term came into being in the early 1980s Until then, the term 'female circumcision' had been used [7].

Today, FGM survives primarily in large areas of Africa among Islamic and non-Islamic population groups. Excision is common from the east coast of Africa to the west; from Ethiopia to Senegal; from Egypt down to Tanzania. Infibulation is widespread in Sudan, in Ethiopia skirting the Red Sea; in Eritrea and the Ogaden; in Djibouti, Somalia, and the adjacent part of Kenya [8]. In southern Egypt, infibulation continues as well. Cases have also been reported from Mali and Nigeria. Excision is found, too, towards the southern end of the Arabian Peninsula and along the Persian Gulf. Muslims in Malaysia and Indonesia practice a mild form of

circumcision as well. Immigrants from African and Middle Eastern countries to Europe and the United States and elsewhere continue to circumcise their daughters in their adopted homelands, according to traditional custom [9]. Examples have been known in France, Sweden and Spain in recent years [10].

Also, in line with the responsibility of the mass media, various campaigns are mounted to educate, inform, enlighten, warn, persuade and even dissuade the heterogeneous, critical and sophisticated audience [11]. In this light, the mass media have been vocal and visible in recent times, as in time past, in the campaign against societal ills and harmful traditional practices [12]. The author noted that one of such harmful traditional practices, the mass media have repeatedly campaigned against is the issue of Female Genital Mutilation (FGM). To this end, the mass media, arguably, have repeatedly given coverage to all efforts aimed at fighting against FGM.

Female Genital Mutilation (FGM) is a cultural practice that started in Africa approximately 2000 years ago [13]. It is primarily a cultural practice not a religious practice. In order to eliminate the practice, one must eliminate the belief that a girl will not become a woman without this procedure. According to Nigeria Demographic and Health survey 2008, 30% of females have suffered from one form or the other of FGM in almost all states of the federation. Interestingly, this practice has continued to attract local and global attention and criticism. Hence, the media has within the dictate of its social responsibilities, continued to air and publish contents critical to the obnoxious cultural practice [14]. However, there seems to be a dearth of empirical research evidence on whether these media campaigns have actually succeeded in yielding desired dividends that is influencing the attitude of women against FGM. This situation, obviously account for this study which seeks to measure the degree of influence of these anti FGM media campaign in the elimination of the practice. There have been divergent opinions on whether the mass media campaign against FGM, is succeeding in influencing the attitude of Nigerians. On their part, [15], argue that "despite the wide spread information against FGM, it is still waxing strong in some parts of the country". This, therefore, brings to the fore, such issues as whether the language use of such media campaign is understandable to the target audience, or whether indeed the target audience do have genuine access to such media campaign.

A lot of campaigns by government and non-governmental organizations highlighting the risks associated with FGM have been mounted, yet the practice is still prevalent in some rural settings in Nigeria [16]. In this several campaigns, the mass media have been involved in one way or the other. Journalists' consistent reporting on FGM/C and campaigns to eradicate it likely indicates results of the media trainings in different parts of the country. This is anecdotal and random evidence about these efforts, however, unable to say whether they have had verifiable positive impacts on the FGM/C challenge in Nigeria. Except for VAPP's passage, which needs no further verification, most FGM/C successes cited from across the country were not borne from systematic evaluations of those campaigns or other interventions [17]. Daily newspapers have continued to crusade against the practice of FGM through their news reportage, well researched features stories and thought provoking editorials. For instance, the Punch newspaper on March 14, 2013 carried a story titled "Niger constitutes panel on Female Genital Mutilation". A similar story was carried in the news page of Daily Times of March 13, 2013 with the headline "Gov. Aliyu Sets up Committee on Gay marriage and Female Genital Mutilation." In the same vein, Thisday of May 23, 2012 and Guardian of October 18, 2010, carried stories headlined "Experts Decry female Genital mutilation" and "Stakeholders Raise Alarm over FGM" respectively [18]. Radio Nigeria Network programme titled "Health Watch" also discusses the dangers of FGM//C. This programme comes on air every Monday

by 5:30pm. For instance, on September 20, 2010 and October 18, 2010, FGM was the topic of discussion in the said programme.
The Nation Newspaper was not left out as it carried a story titled "NGO Sensitizes against Female Genital Mutilation" on its November 13, 2010 edition. Perhaps, to show how globalized the issue of FGM is, the Thisday newspaper again published a story in its February 11, 2013 edition titled "Health: UNFPA, UNICEF; Call for End to Female Genital Mutilation." The issue of FGM has obviously gone beyond the geographical frontiers of regions to gain the interest and alter concern of global development partners. In this regard, the sixth of February every year, has been designated as the International Day for Zero Tolerance of Female Genital Mutilation. In the same vein, United State Agency for International DEVELOPMENT (USAID) officially incorporated the elimination of FGM into its development agenda. It, therefore, suffices that the media have succeeded at galvanizing support and mobilizing development partners for the elimination of FGM practice. However, if the practice has continued or remained on the increase in the face of these media campaigns, it, therefore, underscores the fact that cultural attitudes are not easily changed. People usually hold on tenaciously to their cultural ideologies (no matter how irrelevant). This obviously stands as a barrier to their believability of media campaigns against such practices like FGM. This stance perhaps lay credence to the Selective Influence Theories which permit the media audience to select what media content to expose himself/herself to and whether to perceive it as true or not and consequently retain it or do away with it.
The practice of FGM is deep-rooted in gender disparity, cultural uniqueness, and ideas about purity, modesty, esthetics, status and honor (WHO 2002). Moreover, it acts as a trial to manage women's sexual life by reducing their sexual desire, thus promoting chastity and fidelity [19]. A global review of the practice shows that most of the women who have undergone mutilation live in Africa where it is practiced in at least 28 out of the 53 countries in the continent.
Painful menstruation and intercourse as well as sexual problems related to trauma from the procedure are common complications. Prolonged labour and increased maternal mortality have also been document. The immediate medical consequences according to [20] include difficulty in passing urine, chronic pain, urine retention, hemorrhage, infection, fever, stress, shock and damage to the genital organs. It also has its psychological impact and abnormalities in the female sexual function.
Most complications are reported in relation to the most severe form of FGM, infibulation. Infibulated women need to become de-infibulated in order to vaginally deliver a child [21]. De-fibulation is the procedure when the tight infibulation covering the urethral and vaginal orifices is cut open. A secondary form of FGM is re-infibulation, performed on infibulated women who have given birth, are widowed or divorced, to recreate the narrow vulva of a virgin [22]. The scar over the urethra is cut upwards and after delivery and the raw edges needs to be sutured. In Sweden, re-infubulation after delivery is forbidden [23].

Statement of the Problem

Over the century, thousands of mass media campaigns have disseminated messages about dozens of different health topics to the Nigerian public. Government and health associations in Nigeria have sought to educate and persuade the public to adopt healthy practice and to avoid behavior that pose a risk to health such as FGM through frequent and prominent placement of paid health messages in the mass media.
A study of a community in Ekwusigo LGA of Anambra State showed that the incidence of this practice increased from 150 in 1990 to 350 in 2006 despite the numerous teachings about the medical complications of FGM, as well as other health campaigns against this unacceptable practice [24]. These medical complications according to [25] include:

bleeding, infection, prolonged labour, lacerations and sometimes death. The procedure negatively affects the psychological and social health and well being of women. Despite the boundary between Enugu and Ebonyi State which is not far from each other, some communities are still neck deep in the practice [26]. Also, in spite of all the efforts in sensitizing the people through other government and non-governmental agencies highlighting the medical complications of FGM, the practice is still flourishing in some rural communities and one wonders what could be the problems and the factors that seem to preserve such practice that has many negative effects on the health of the women [27].

In the rural communities of Ebonyi State, despite the efforts of national and international organisations advocating and campaigning for the abolition of the practice of FGM not much success seems to have been recorded (United Nations Population Fund (UNFPA, 2015). However, in 2017, Izzi clan which represents made up of Abakaliki, Ebonyi and Izzi local government areas out of 13 Local Government Areas (LGA) in Ebonyi State abolished FGM/C amongst their people. In Nigeria, Ebonyi State has a prevalent rate of 74% ranks, 2nd highest most prevalent state in the practice of FGM/C in Nigeria, coming behind Osun state-77% [28].

LITERATURE REVIEW

Concept of Female Genital Mutilation

Female genital mutilation (FGM), or female genital mutilation/cutting (FGM/C) consists of procedures, performed for non-medical reasons (i.e. cultural, religious or other reasons), where the external female genitalia are partially or completely removed or injured [29]. In Nigeria, subjection of girls and women to obscure traditional practices is legendary [30]. [31] state that FGM is an unhealthy traditional practice inflicted on girls and women worldwide. The practice takes from culture to culture.

[32] FGM/C into four types: major clitoridectomy, excision, infibulations and others. Clitoridectomy, involves removal of the tip of the prepuce, with or without excision of part or all of the clitoris. Excision involves removal of the clitoris along with some part or all of the labia minora. In nifibulation, most of all the external genitalia is removed, and the vaginal opening is then stitched leaving only a small opening for the flow of urine and menstruation while others includes pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (called angurya cuts) or cutting of the vagina (gashiri cuts) [33].

Type 1: This entails the removal of the tip of the prepuce, with or without excision of part or the entire clitoris. This is called clitoridectomy. It may be ritualistic circumcision, or circumcision proper. In Muslim countries, it is known as “sunna” Circumcision meaning “traditional” [34] [35]. It is a widest practiced form.

Type 2: This type is called excision; the clitoris is removed along with part or all of the labia minora but not with the removal of the prepuce.

Type 3: Referred to as infibulations, the removal of most of all the external genitalia, the vaginal opening is then stitched closed; only a small opening is left for the flow of urine and menstrual blood. Other terms used to describe this procedure are pharaonic circumcision and Somalian circumcision. Women’s infibulation scars may have to be cut open at childbirth or if problems in sexual intercourse are encountered [36] [37].

Type 4: This is unclassified form of female circumcision. It includes pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (intrucision) or cutting of the vagina (gashiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; “zur-zur” cuts and other procedures that fall under the definition of FGM given by WHO.

The procedure can be carried out during infancy, about the eight day of delivery, childhood, at time of marriage or even during first pregnancy depending on the cultural dictates of the area. The operation is often performed by practitioners with little or no formal knowledge of human anatomy and physiology and in most cases under unhygienic conditions without the use of anesthetic or sterile instruments [38]; [39]; [40]; [41]; [42].
[43] have opined that female genital mutilation is recognised worldwide as a fundamental violation of the human rights of girls and women. The authors argue that it reflects deep rooted inequality between the sexes and constitutes an extreme form of discrimination against women. Legally, it involves a violation of the right of the children and the violation of a person's right 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 [44].

Rationale for the FGM/C in Nigeria

More than 125 million girls and women alive today have been cut in 29 countries in Africa and the Middle East where FGM/C is concentrated [45]. As many as 30 million girls are at risk of being cut before their 15th birthday if current trends continue [46]. FGM/C is a violation of girls' and women's human rights and is condemned by many international treaties and conventions, as well as by national legislation in many countries [6]. It is widely recognised as a violation of human rights, which is deeply rooted in cultural beliefs and perceptions over decades and generations with no easy task for change [3]. Yet, where it is practiced FGM/C is performed in line with tradition and social norms to ensure that girls are socially accepted and marriageable, and to uphold their status and honour and that of the entire family [7]. Though FGM is practiced in more than 28 countries in Africa and a few scattered communities worldwide, its burden is seen in Nigeria, Egypt, Mali, Eritrea, Sudan, Central African Republic, and northern part of Ghana where it has been an old traditional and cultural practice of various ethnic groups [11]. The highest prevalence rates are found in Somalia and Djibouti [5]; [6]. FGM is widespread in Nigeria. Some socio-cultural determinants have been identified as supporting this avoidable practice. FGM is still deeply entrenched in the Nigerian society where critical decision makers are grandmothers, mothers, women, opinion leaders, men and age groups. FGM is an extreme example of discrimination based on sex [23]. Often used as a way to control women's sexuality, the practice is closely associated with girls' marriage ability. Mothers chose to subject their daughters to the practice to protect them from being ostracised, beaten, shunned, or disgraced [7]. FGM was traditionally the specialisation of traditional leaders' traditional birth attendants or members of the community known for the trade [35]. There is, however, the phenomenon of "medicalization" which has introduced modern health practitioners and community health workers into the trade [13]. The WHO is strongly against this medicalization and has advised that neither FGM must be institutionalised nor should any form of FGM be performed by any health professional in any setting, including hospitals or in the home setting [27].
Several reasons ranging from socio-cultural to economic are usually given for engaging in the practice of female genital mutilation in Nigeria and in many parts of the world, especially in the developing countries. Some of these reasons might appear weird but are nonetheless held sacred by the people [5]. Among the reasons mostly offered for the continuation of FGM in Africa and other third world countries include:
The fear that the girl child will not be able to marry if not circumcised make family members to ensure that every girl child born the family undergoes FGM. [27] noted that an important part of this goes back to the belief that women who are not circumcised are indecent and wayward.
Also, women tend to lend their support to the practice inspite of the pain and agony

and consider it so vital for their daughters' future especially for their marriage. [34] has further noted that some Africans strongly hold the view that circumcised girls might control their sexual desires accordingly after maturity and thus protect them from sins and faults. While a great number of Africans also erroneously believe that, women who have not gone through circumcision in their childhood face multiple, physical problems at birth.

Among the Bambaras in Mali, it is believed that if the clitoris touches the head of the baby being born, the child will die, because the clitoris is seen as the male characteristic of the female; so in order to enhance her fertility, this male part of her has to be removed [23]. For women in Djibout, Ethiopia, Somalia and Sudan, circumcision is performed to reduce sexual desire and also to maintain virginity until marriage. For them a circumcised woman is clean [43].

Establishing identity and belongingness is another reason advanced for the perpetration of this practice. For example, in Liberia and Sierra-Leon, groups of girls of 12 years and 13 years of the indigenous population undergo an initiation rite conducted by an older women "Sowie". This involves education on how to be a good wife or a co-wife, the use of herbal medicine and secrets of female society and female genital mutilation being inclusive [7].

A woman must fit into the society or die. If she is not circumcised, she will neither marry or not have children without which she will have fewer hands to help with the daily tasks or who to take care of her at old age. FGM for them gives a woman the status of adulthood to enable her get on with her life gracefully [8]. The societies according to the author view good marriage as the pinnacle of a woman's achievement and so would like to mutilate their girls in order to make them to be worthy in the adult life [12].

Other reasons as identified by [13] in another study are: control of female sexuality; ensuring virginity until marriage; guaranteeing an economic future for the female child; reducing women to their proper role; protecting against rape; enhancing appearance and hygiene because the female genital were thought to be ugly; and practicing a religious ritual. Another reason is related to dowries. The dowry price of a woman is measured against her virginity. It is very high if her virginity is preserved before marriage notably through circumcision [4].

[16] has pointed out that many people believe that uncircumcised women have lower fertility powers compared to circumcised women and in addition are not able to control their sexual desires.

[21] has observed that many indigenous people strongly believe that female circumcision represents their purity and innocence and so do not want to hear anything about female circumcision. [27] study reveals that female circumcision has an association with maturity ceremonies and celebrations which familiarize the girl child with her responsibilities as a future woman of the society. Interestingly, this rite of passage or ceremonies are cherished as they are usually accompanied with celebration, coupled with dancing, singing and cooking special dishes as a part of their oral culture. Amnesty International Document (2013) shows that virginity in many African communities is valued as a prerequisite for marriage and equated to female honour thus, female genital mutilation is roundly defended in this context as it is assumed to reduce a woman's sexual desire and lessen temptations to have extra marital sex and thereby preserving a girl's virginity.

In the Nubian tribe, it is seen as an initiation to life or "rite of passage" into womanhood [41]. And also identified by the same author that it is for the affirmation of sexuality of the female as seen in the Bambara people of West Africa and that has the power of blunting and attenuating sexual desire.

The female external genitalia, if uncircumcised, harbour an immoral organ which induces a feeling of guilt on her [16]. This organ must then be removed from her for her to be accepted as morally clean and safe for marriage. Continuing

he said that uncircumcised girls are believed to be dirty and impure because of their offensive discharge and smell that is said to emanate from their clitoris. This is perhaps why the Arabic female circumcision is called 'tahur' meaning purity and cleanliness. Concluding, he added that in some backward areas of Sudan, it is even said that uncircumcised girls are not allowed to pray and they also believe that the female external genitalia is ugly especially the clitoris and so circumcision is advocated as a means of beautification [28]. An intact female genitalia is a threat of death for the first born baby. So if the woman is not circumcised, and the head touches the clitoris, the baby will die during birth [17].

The Law and Female Genital Mutilation (FGM)

There are no statute-based discriminatory practices against the Girl Child and Women rather what the opposite is the case. In fact, flurries of laws exist that seeks to take care of the personal rights and freedom of Girl Child and Women. The 1999 constitution of Nigeria guarantees her fundamental human rights and freedom from all sorts of abuse, the Criminal Code, 2004 makes it an offence to subject the Girl Child and Women to ordeals and proffer punishment when breached. Without mincing words, the Girl Child and Women are adequately provided for on paper that is, in the statutes and are therefore free from being subjected to any dehumanizing and degrading practices. As earlier noted, the 1999 Constitution of the Federal Republic of Nigeria guarantees the right to be free from torture and human indignity to all citizens but this is far from being the case for the Girl Child and Women. Not only are they abused; they also suffer extremes of emotional and psychological abuses from the indignity meted out to them. The general assumption in most Ebonyi cultures is that the Girl Child and Women who is not circumcised will be promiscuous; No doubt, some of these customs and process of proving non-promiscuity are repugnant to natural justice, equity and good conscience.

Consequences of Female Genital Mutilation

FGM has health and social consequences that are of various dimensions. An estimated 100–140 million girls and women worldwide are currently living with the consequences of FGM [35]. In Africa, about 3 million girls are at risk for FGM annually [8] Despite the increased international and little national attention, the prevalence of FGM overall has declined very little [31]. The procedure has no health benefits for girls and women. Adverse consequences of FGM are shock from pain and hemorrhage, infection, acute urinary retention following such trauma, damage to the urethra or anus in the struggle of the victim during the procedure making the extent of the operation dictated in many cases by chance, chronic pelvic infection, acquired gynatresia resulting in hematocolpos, vulval adhesions, dysmenorrhea, retention cysts, and sexual difficulties with anorgasmia [7]. Other complications are implantation dermoidm cysts and keloids, and sexual dysfunction [16].

Obstetric complications include perineal lacerations and inevitable need for episiotomy in infibulated paturients. Others are defibulation with bleeding, injury to urethra and bladder, injury to rectum, and purperial sepsis. Prolonged labor, delayed 2nd stage and obstructed labor leading to fistulae formation, and increased prenatal morbidity and mortality have been associated with FGM [27].

Moreover, some speculate that the practice also has psychological consequences such as decreased trust in caregivers and relationship problems stemming from painful intercourse due to infibulation [36]. Psychosocial consequences also include anxiety, fear, submission, inhibition and suppression of feeling and thinking [40]. Others surmise that the psychological damage inflicted by FGM is deeply embedded in the consciousness of those who have undergone the practice and that in the longer term, women may suffer anxiety, depression, chronic irritability, frigidity,

and marital conflicts [6]. Others assert that, regardless of health or psychological damage, FGM is a violation of human rights, and that "suppression and control over women's sexuality are demeaning to women and deny an aspect of their humanity" [11], it has been identified as a very vital public health problem [33]. The mental and psychological agony attached with FGM is deemed the most serious complication because the problem does not manifest outwardly for help to be offered [23]. The young girl is in constant fear of the procedure and after the ritual she dreads sex because of anticipated pain and dreads childbirth because of complications caused by FGM. Such girls may not complain but end up becoming frigid and withdrawn resulting in marital disharmony [7].
The most commonly reported health consequences by more than half of the midwives who were recently confronted with FGM, include psychological problems, chronic pain, sexual problems and recurrent urinary tract infections or incontinence. This is in line with the KAP-survey among Flemish gynaecologists [4], who equally reported recurrent urinary tract infections/ incontinence and chronic pain, in addition to sexual problems as the most common health problems in women with FGM [37].
From the perspective of public health, female circumcision is much more damaging than male circumcision. The mildest form, clitoridectomy, is anatomically equivalent to amputation of the penis [11]. Under the conditions in which most procedures take place, female circumcision constitutes a health hazard with short- and long-term physical complications and psychological effects [27]. The author stated that because the specialized sensory tissue of the clitoris is concentrated in a rich neurovascular area of a few centimeters, the removal of a small amount of tissue is dangerous and has serious and irreversible effects. Common early complications of all types of circumcision are hemorrhage and severe pain, which can lead to shock and death [14]. Prolonged lesser bleeding may lead to severe anemia and can affect the growth of a poorly nourished child. Local and systemic infections are also common. Infection of the wound, abscesses, ulcers, delayed healing, septicemia, tetanus, and gangrene have all been reported [12].
Long-term complications are associated more often with infibulation than with clitoridectomy alone, because of interference with the drainage of urine and menstrual blood [24]. Chronic pelvic infection causes pelvic and back pain, dysmenorrhea, and possibly infertility. Chronic urinary tract infections can lead to urinary stones and kidney damage [27]. Childbirth adds other risks for infibulated women, particularly where health services are limited. If deinfibulation is not performed, exit of the fetal head may be obstructed and strong contractions can lead to perineal tears [35]. If contractions are weak and delivery of the head is delayed, fetal death can occur and necrosis of the septum between the vagina and bladder can cause vesicovaginal fistula, a distressing condition of urinary incontinence for which women are often ostracized by their communities [11]. It is noteworthy that the bulk of the problems are psycho-sexual in nature, midwives indicating consequences of FGM, mentioned that these were either psychological. Women's fear also increases when they feel that the midwife is uncertain or does not feel competent to care [31]. A systematic review on psychological, sexual and social consequences of FGM, showed that sexual problems in women with FGM include pain during intercourse, a reduced sexual satisfaction and a reduced sexual desire [24]. A study in Sweden among women from countries where FGM is common practice, demonstrated that the most frequently mentioned experienced late complication was sexual problems [37]. A recent systematic mapping of FGM in all EU Member States, showed a lack of services providing psychological care, psycho-sexual supports and counselling by professionals skilled in post-traumatic stress disorder, sexual trauma and sexual violence [38]. This illustrates the need for competent midwives to support women with FGM during their birth process, as

well as a need for multidisciplinary teams that can also provide psycho-sexual counselling. It is an opportunity to explore whether this counselling role can be provided by midwives, including counselling on psycho-sexual consequences. Moreover, as both KAP studies showed that sexual problems are among the most commonly met problems by gynaecologists and midwives, there is an urgent need for specialised psycho-sexual counselling as part of the care for women with FGM. Our study showed a keen interest by midwives to take up this counselling role, especially among the younger generations.
[45] stated female genital mutilation (FGM) as a deliberate procedure known as benefits rather grave and serious health implications on its "victims" Some of these are briefly considered below Immediate Complication
Hemorrhage: The excision of the clitoris usually involves the cutting of the clitoral artery which has a strong flow and high pressure. This often leads to severe bleeding and serious collapse or sudden death may occur in the case of massive hemorrhage. From medical statistics, major blood loss can result in long-term anaemia.
Shock: studies have revealed that immediately after the procedure, shock due not only to the bleeding but also to the severe pain and anguish may result. And this sometimes can be fatal [1].
Infection: this is another side effect of female genital mutilation (FGM). This does occur because of the unhygienic conditions, use of unsterilized instrument or crude tools. Infection can also be contracted due to the traditional medicines used for healing the wound. It is believed that the practice of binding the patient's legs after an infibulation may aggravate an infection by preventing drainage of the wound. Emmanuel Imuetinyan Obarisiagbon & Amenze Ifeyinwa Obarisiagbon, the infection may spread internally to the uterus, fallopian tubes and ovaries, causing chronic pelvic infection and infertility.
Urine retention: is a common immediate complication of female genital mutilation (FGM), due to pain, fear of passing urine on the raw wound, tissue, swelling, inflammation, or injury to the urethra urine may be retained for hours or even for days after female genital mutilation (FGM) procedure has occurred. This condition often leads to urinary tract infection.
Evidence exists to allude to the fact that injury often occurs to the adjacent tissue of the urethra, vagina perineum and rectum. This is usually due to the use of crude instruments, poor light, and poor eyesight of the practitioner or careless procedure. This more likely if the "victim" is screaming or struggling because of pain or fear. [21].
Fractures or dislocation of the hip joint: This may occur if heavy pressure is applied to the struggling "victim" in the course of the procedure, as we suspect when several adults hold her down during the mutilation. Long –Term Complications. [32] listed the under mentioned variables as the long term complication of female genital mutilation (FGM): Bleeding, Recurrent urinary infection, Incontinence, Chronic pelvic infections, Infertility, Vulval abscesses, Keliod formations (viscious scars), Dermoid cysts, Nuerinoma, Calculus formation, Fistulae, Sexual dysfunction, Difficulties in menstruation, Problems in pregnancy and child birth, Risk of H.I.V. transmission. These are indeed grave consequences of female genital mutilation (FGM) Mental and Social Consequences Genital mutilation is commonly performed when the girls are relatively quite young and uninformed and is often preceded by acts of deception, intimidation, coercion, and violence by trusted parents, relatives and friends.

Approaches to FGM/C Management

Since interventions against FGM first started more than 40 years ago, providing information about the health risks associated with FGM has been the most popular approach. It builds on the idea that if people are informed about the negative health effects of FGM, they will abandon the practice [12]. Medicalization Approach: One important dimension of FGM/C in Nigeria is its medicalization,

utilizing health care providers to conduct the practice, for minimizing physical risks including pain, infection, and other negative health implications [12] [13]. Although medicalization is assumed to reduce the risk of FGM/C complications, it does not eliminate them nor does not change the fact FGM/C is a violation of women's and girls' rights to life, health, and bodily integrity. This has led to significant opposition by professional medical fraternities in Nigeria. [34] reports that the National Association of Nigerian Nurses and Midwives, the Nigerian Medical Women's Association, and the Nigerian Medical Association, who were against the legitimization of FGM/C as a medical necessity for females, actively campaigned against the practice and worked to inform all Nigerians and health practitioners about its harmful effects. FGM/C and its effects have now been introduced as part of the curricula for nurses and doctors by the Nursing Council of Nigeria (NCN) and the Medical and Dental Council of Nigeria (MDCN), including the aspects of the 2015 VAPP Act covering violence and practices against women and children. It has become a punishable offence for any medical practitioner, a nurse or doctor, to be involved in the practice (*ibid*). These efforts have curbed the push for partial or milder medicalization.

High levels of medical personnel: Some forms of FGM/C are good practice, not harmful, and their encouragement of the practice [4], [5], and it is unclear whether this new opposition signals weakening support for medicalization and whether it translates to actual abandonment of the practice by medical practitioners in Nigeria. It is also not known whether the reported prevalence of medicalization is evidence of entrenched support of FGM/C by medical personnel. This will require further study. It may also be helpful for study investments in whether medicalization leads to a lessening in severity of cutting, and the extent to which medicalization countermands abandonment. There is also little knowledge of options available to health workers for deciding whether to perform FGM/C, as well as the legal enforcement mechanisms for implementing the VAPP Act 2015 in relation to them.

Socio-economic and demographic Approach: Though FGM/C is mainly practiced in African countries; it is linked more with ethnic identity than nationality [13] [14]. It is an ethnic and culturally specific phenomenon, and healthcare professionals and policymakers need to be aware of the diverse meanings behind the practice in order to be able to deal with its occurrence effectively. Some broad socio-cultural and religious reasons have been identified that contribute to the continuation of the practice.

FGM/C practices took place as far back as 5,000 years ago; Egyptian mummies have been identified as having undergone the procedure [24]; [25]. Historically, women have inaccurately been perceived to be predisposed to promiscuous behaviour, and this belief persists in many cultures where FGM/C is common [30]. This is a particularly unwelcome trait in cultures where a woman's virginity and fidelity are closely associated with parental and familial 'honour' [5].

Inadequate Quality of the Information: Several researchers have pointed to the difficulties posed by employing a "laundry list" of health risks that is not adapted to the local setting [17]. Available evidence concludes that lack of total knowledge of both the magnitude and health implications of FGM/C, contributes to girls' continued circumcision. Five studies [9] [10], [11], [12], [13] list proportions of respondents voicing various reasons against FGM/C.

Interventions on the Abandonment of FGM/C

Different approaches have been used to curb the menace of female genital mutilation in Nigeria and many other countries where FGM is practiced. [6] discussed seven of the most common approaches that have undergone some form of evaluation: health risk approaches, conversion of excisers, training of health professionals as change agents, alternative rituals, community-led approaches, public statements, and legal measures.

First, information about health risks of engaging in female genital mutilation has been used and still in use as a method of curtailing FGM. Since interventions against FGM first started more than 40 years ago, providing information about the health risks associated with FGM has been the most popular approach [18]. The authors stated that health risk approach builds on the idea that if people are informed about the negative health effects of FGM, they will abandon the practice. Health risk interventions have been targeted at various population groups both as a stand-alone activity and as part of other interventions [23]; [24]. In its crudest form, it can include delivering factual and didactic messages around the physical complications of FGM by local health providers, community facilitators, or NGO staff [20]. In its broadest form, it includes local knowledge and personal sharing and reflection coupled with the provision of health care services for complications of FGM [31].

Health information has influenced policy makers to promote laws and regulations such as the care for complications in Mali and recently adopted legislation in Kenya and Guinea Bissau [35]. Media attention given to health complications can also have positive effects [38]. In 2007, the death of two girls after FGM was carried out by health care providers in Egypt was instrumental in strengthening legislation against the practice. The realization, publication, and spreading of the results of clinical studies on the negative health effects of FGM can lead to positive changes in terms of engagement of national authorities [27]. A clinical study in 2009 and requested by the Gambian Vice-President and Minister of Women's Affairs demonstrated for the first time the magnitude of immediate and long-term health consequences of FGM in the country [41].

However, this approach is faced with many challenges such as converted excisers may continue to Practice or Hand over their Knife to apprentices. A major review found that many excisers did not keep their promise to stop performing FGM [35]. In Mali, an evaluation found that 29 of the 41 excisers interviewed after completing the conversion programme declared that they still performed FGM and were not convinced that what they were doing was wrong [10]. Furthermore, if there is no change in the request for FGM, other persons will step in to fill the demand, including other excisers, health care providers, or newcomers. For example, in Kenya, excisers stopped because their services had been taken over by health providers [23]. In some cases, excisers handed over their post to their apprentices, who are often family members.

Also, health risk information has led to situations where healthcare practitioners take over FGM from the traditional practitioner through medicalization or change of type to reduce health risk. According to [31], experience suggests that health information can lead to changes other than abandonment, most commonly an increase in the extent to which health providers are performing a trend associated with a risk of institutionalisation and continuation of FGM rather than its abandonment.

Again, people may not believe the information given to explain the health risk implications of FGM. One study in the Gambia and Senegal showed that only those who were already critical to FGM believed in the information of health risks [23]; [24]. One reason for this is that the immediate complications of FGM are often attributed to other factors such as witchcraft or evil spirits [17].

Another aspect is a gap between the information given and people's personal experiences, because not all women experience health complications and those who do tend to keep silent about it [21]. Finally, both women and health professionals have generally been found not to attribute long-term health consequences to FGM [26].

Other challenges of health risk approach include inadequate quality of information, defence reactions from FGM practitioners; consideration of health risk is a lesser danger than the danger associated with abandoning the practice of FGM, and so on.

Second, the vast majority of FGM in Africa, around 80%, is carried out by traditional practitioners, that is, excisers [41]. A popular approach has been to target excisers to convince them to stop performing FGM [35]. Such interventions usually include education on the physiology of female genitalia, the harmful health consequences of FGM, their role in perpetuating it, and encouragement to stop performing FGM [11].
In some cases, training and financial support is provided for excisers to help them find sources of income other than performing FGM [43]. The expected outcome is a reduction in the numbers of excisers performing FGM subsequently leading to a reduction in the number of FGM performed [41]. One advantage of this type of intervention is their clear and limited scope and consequently clear and simple indicators to measure success, that is, number of excisers "dropping their knife" [38].
However, it could still be difficult to convert execers to turn away from the practice of FGM because according to [23] "ex-excisers may not be considered reliable when turning against FGM". [7] opined that a key motivation for converting excisers is to take advantage of, and uphold, the respected position they are alleged to have in the community.
Furthermore, being an exciser is rarely a full-time engagement and is usually combined with other tasks, such as support in childbirth. Little is known about the extent to which community members are listening to or are convinced by the arguments of converted excisers [13].
Another intervention approach is training of health professionals as change agents. Several interventions have targeted health professionals, with the aim of preventing them from performing FGM, building their capacities to identify and treat complications and recruiting them as change agents [2] Evaluations performed at the end of trainings for health professionals report an increased knowledge about FGM, health complications of FGM, and how to manage the complications, as well as an increased negative attitude to FGM [26]. In an intervention study in the Gambia, health providers expressed shock, surprise, and anger when realizing that the gynaecological complications they had been treating were consequences of FGM [16]. This realisation contributed to a change in attitude and a willingness to engage in community outreach to prevent the practice [43].
However, interventions of engaging health providers as change agents have been met with a number of challenges. According to [10] health care providers may resist working against FGM, content of the training may be inadequate, systematic difficulties in putting knowledge into practice may be encountered, and the structural support in the form of resources and time need to make health professional translate the knowledge gained in training into action may be lacking [13].
Similarly, alternative rite programmes have been adopted as control measure of FGM. In many communities, FGM is part of a larger rite of passage, often around puberty, that facilitates and marks the integration of a girl as a more mature member of the community [37]. In some of these communities, interventions have been developed to replace the rite of passage with FGM, by an alternative rite without FGM. Such alternative rites programmes are expected to fulfill the cultural tradition of a coming of age ritual, so that girls can be socially accepted without having to go through FGM. These interventions are believed to show positive attitude and respect for cultural traditions and thereby prevent defensive reactions against efforts to abandon FGM and to facilitate abandonment of FGM by maintaining the ritual framework [18].
Also, community-led approaches have been used in some communities Community-led programmes have been identified as a necessary factor to tackle the social convention of FGM [1]. Evaluations of FGM abandonment interventions suggest that community

involvement is key to creating sustainable change [27]. Community-led interventions to abandon FGM aim at promoting the empowerment of women and girls and the community at large to enable them to critically examine their own tradition and to gain the power to abandon FGM for their own benefit [17]. Empowerment refers to the process by which the girls, women, and their communities gain control over the factors and decisions that shape their lives [12]. Intervention in the form of empowerment exercise usually integrate the issue into a wider learning package, including aspects such as gender and development as well as the social, political and legal. Health. The current most widespread and systematically implemented community-led programmes show promising results [18].

Public Statements is another approach that has been used to checkmate the female genital cutting. An important element in the process of mobilizing communities is a public statement (often referred to as public declarations) of a decision to abandon FGM by a larger group, usually a significant part of a community. Such public statements both express and facilitate change in the social conventions of the community [8]. Public statements can take different forms, including signing a statement, alternative rites of passage celebrations, and multi village gatherings. A public statement can create a sense of collective change, which can help to empower families to abandon FGM and encourage others to follow. When public statements are made, this suggests that a sufficient number of individuals have decided to abandon FGM, which can further promote broad-scale abandonment [7]. It is important to note however, that when a public statement has been made, this does not necessarily indicate that the whole community supports the abandonment of FGM and some may continue to do so. Depending on the stage of readiness for change and processes running prior to the public statements, they can mark a final decision already made to abandon FGM in some communities, whereas in others they are a milestone that signifies readiness for change, and further support is needed to sustain and accelerate the process (Population Reference Bureau, 2006). Though public statements seem vital to facilitate large scale change in high prevalence communities, there are certain risks [23].

Legal measures are approaches that have been employed to end FGM. Studies indicate that legislation and its implementation can have a preventive effect [25]; [26]. Most African countries with documented FGM have now passed laws against the practice. This provides an official legal plat form for action and offers legal protection for women and can discourage excisers and families for fear of prosecution. It can also offer health professionals a legal framework to oppose requests for performing FGM.

Laws against FGM are an important policy commitment and create an enabling environment. When preceded and complemented by education campaigns and advocacy. The sensitization of leaders, as well as adequate implementation, their effect is expected to be higher. For example, it was found that the beginning of the abandonment of FGM in Burkina Faso mostly coincides with the time of the adoption and application of the law banning the practice [26]. In Ebonyi State of Nigeria, a zero FGM/C campaign was launched in Abuja on February 2016. The campaign made a new disciple of a traditional chief from southwest Nigeria, who, after the launch, stated that the programme made him view FGM/C in a different light, even though he was actively involved in the practice in his community [37]. The traditional ruler pledged to create awareness of the danger and harmful effects of the practice among his contemporaries when he returned home [13]. The summit that launched the zero tolerance for FGM/C in southwest Nigeria included the Circumcisers Descendants Association of Nigeria (CDAN). [23] reported that the campaign succeeded in convincing about 70 percent of those circumcisers to stop the practice. The remaining 30 percent were reluctant to

abandon the practice, due to FGM/C being the only source of livelihood for some of them [19]. After the summit, the association issued a statement directing all its members to implement the resolution of zero tolerance in the region.
After 13 years in the National Assembly, the Violence Against Persons (Prohibition) Act (VAPP) was signed into law on 23rd May, 2015. The then Deputy President of the Senate who presided over the session that passed the Act, acknowledged stakeholders' roles in ensuring the bill was passed, adding that it was a good step in the fight against violence in Nigeria (Premium Times 2015). The law itself was favourably reviewed, especially with the hope it will deliver on its mandate. The law was heralded as fantastic news and a landmark moment, taking advocates and stakeholder's one step closer to ending FGM/C [27].
One challenge to the effectiveness of legal measures is that the practice may go underground. FGM rituals appear to have diminished but instead the cutting has continued in some countries outside the law as a way to avoid legal implications [45]. In several contexts, laws and debates about passing or enforcing legal measures led to resistance and protest, as for example, in Senegal, Mali, and Egypt (UNFPA, 2011; UNFPA-UNICEF, 2012). A final concern has been that the existence of a law may also scare people with immediate health complications after FGM from seeking health care [29].
Many of the interventions combine two or more approaches and methods, and there is limited knowledge on the interplay and relative efficacy of the different components of an intervention [23]. Also, in some cases, most interventions do not have the total abandonment of all forms of FGM as the objective, though this is mostly an ultimate goal. Considering what is feasible within the available timeframe and budget, most interventions aim at secondary outcomes [34]. This can be to "break the silence and to initiate critical reflection upon FGM. Others aim at increasing knowledge and awareness of its association with health complications and its violation of human rights". [34]. Others again aim to change attitudes and intentions with regards to FGM [3] or at modifying the practice, either through reducing the extent of cutting [12], promoting its medicalization (e.g., in Egypt and Indonesia) [31] or changing the age at which FGM is carried out (e.g., in Sierra Leone) [25].
However, while these secondary targets are considered as a first step towards total abandonment, and many see it as a stage of change; evidence shows that the translation of these secondary goals into actual abandonment of FGMis far from automatic [24]. There are, for example, many surveys that find women who express a negative attitude to the continuation of FGM, while they still intend to let their daughters undergo the practice [31]. A major reason for this apparent contradiction between attitude and behaviour is a social and cultural pressure to uphold the tradition. Therefore, the importance of a community-wide change to enable individual families to abandon FGM is now widely recognized [34]. Experience shows that large-scale abandonment can only be expected when FGM is no longer an all-dominant social norm and families can abandon the practice without the risk of stigmatization and exclusion [31].

The Mass Media and Campaign on FGM

The mass media are diversified media technologies that are intended to reach a large audience by mass communication. The technology through which this communication takes place varies. They include the two broad areas of electronic and print media, such as radio, television, newspapers, magazines, books, pamphlets etc and the recent social media. According to [38] stated that media campaigns are varied, multifaceted, highly planned, and strategically assembled media symphonies designed to increase awareness, inform, or change behaviour in target audiences.
When a decision has been made to use a media campaign to advance a health, environmental or development cause, it may seem natural for those closest to the situation to define the main message of

the campaign. Studies have advocated that audience and needs assessment are processes which must not be overlooked [45]. It is crucial to know the audience—to know what they already know about the issue, what they associate it with, how they feel about it—in order to design an effective message. According to Sandman (2000), it is important to understand the difference between those who already perform the desired behaviour ("doers") and those who do not ("non-doers"). After the campaign is launched, it can be evaluated in several ways: by recording the exposure (for instance number of adverts in number of magazines with a circulation of so many people); by surveying people asking them to recall the message; and by observing changes in behavior or the environment that could be attributed, in part, to the campaign [40].

The power of the media in shaping perception and influencing public opinion is well known. The media have transcended time and age, going through various tools and forms, and stayed to its influencing power [34]. According to [10], mass media play an important role in explaining the issue of female genital cutting and can influence discourse among the general public as well as policy makers.

Various mass media channels serve as instrument for campaign against female genital mutilation. [35] stated that radio is suitable for contexts where literacy rates are low, distances from urban to rural areas are significant, and access to more sophisticated technology is still for the privileged few. Radio programmes such as short bulletins on the need to eradicate FGM and early marriage can reach many audience who do not have access to television and cannot afford to buy newspapers [45]. It is also good for educating school children and other people in their local language on the consequences of FGM. Brief radio broadcasts, several times a day, aimed to inform the school population about the types of FGM and the health complications caused by it; raise the awareness of students, teachers, and school headmasters about harmful traditional practices related to FGM; and convey prevailing social attitudes towards FGM [3] Can help reduce the practice of FGM.

Also, a set of supporting information leaflets in English and local language could as well be sent to all school teachers. Poster campaign with the help of a graphic artist, posters on FGM could be adapted to reflect the situation in the practicing States [3]. [11] observed that mass media campaigns are widely used to expose high proportions of large populations to messages through routine uses of existing media, such as television, radio, and newspapers. Exposure to such messages is, therefore, generally passive. Such campaigns are frequently competing with factors, such as pervasive product marketing, powerful social norms, and behaviours driven by addiction or habit. In this review, they discuss the outcomes of mass media campaigns in the context of various health-risk behaviours (eg, use of tobacco, alcohol, and other drugs, heart disease risk factors, sex-related behaviours, road safety, cancer screening and prevention, child survival, and organ or blood donation). The authors assessed what contributes to these outcomes, such as concurrent availability of required services and products, availability of community-based programmes, and policies that support behaviour change. Their study concluded that mass media campaigns can produce positive changes or prevent negative changes in health-related behaviours across large populations.

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EMPIRICAL REVIEW

[23] conducted a study on Female Genital Mutilation in Kenya: are young men allies in social change programmes? The objective of the study was to know whether young men support the practice of FGM, The study used the participatory ethnographic evaluation research approach, which is derived from anthropological methods and holds that trusting relationships and rapport with the community are pre-requisites for researching social life. Twelve PEER researchers were recruited, who conducted two interviews with their friends, generating a total of 72 narrative interviews. The majority of young men who viewed themselves as having a "modern" outlook and with aspirations to marry "educated" women were more likely not to support FGM.

Aspirations to marry educated women were one of the justifications for questioning the practice of FGM. Some young men asserted that young girls would be married once they had undergone FGM and would end their education. Support for ending FGM was highest among those who viewed themselves as embracing "modern" values, such as being educated, and who aspired to having a wife who would economically contribute to the household [6].

The researchers found that young men viewed themselves as valuable allies in ending FGM, but that voicing their opposition to the practice was often difficult. More efforts are needed by multi-stakeholders – campaigners, government and local leaders – to create an enabling environment to voice that found that even though decisions around marriage were tightly socially controlled by parents, male peers and others, young men wanted to be able to marry women without FGM, should they decide to, and in some cases were successful in negotiating this. The study however, did not focus on the issue of how to reduce the practice of FGM/C but rather it investigated men's support for FGM/C. Thus, leaving a gap that necessitated this present study.

[23] discussed the importance of health mass media campaigns and raised questions on whether they are capable of effectively impacting public health. The author concluded that, the literature was beginning to amass evidence that targeted, well-executed health mass media campaigns can have small-to-moderate effects not only on health knowledge, beliefs, and attitudes, but on behaviours as well, which can translate into major public health impact given the wide reach of mass media. Such impact can only be achieved, however, if principles of effective campaign design are carefully followed [34].

According to [41], the challenges of attributing causality to mass media campaigns' impact on public health outcomes are well established, arising from the inherent lack of a comparable control group as well as the difficulty of disaggregating the role of mass media campaigns from the other public health interventions they are typically designed to complement. [3] suggest that post-intervention, cross-sectional population surveys can provide reliable estimates of impact that are generalizable to the population, so long as threats to internal validity are addressed during the analysis stage. As the authors point out, however, to be persuasive the analysis must also be grounded in a plausible theory of causality. In a female genital mutilation communication intervention, mass media campaigns are designed based on a hypothesis of both direct and indirect impacts on behaviour. Female genital

mutilation media campaigns are grounded in theories of behaviour change and social mobilization that describe how communication feeds into a process of individuals and communities, recognizing the importance of a public health threat, learning about methods of prevention and/or treatment, taking action, and thereby improving health outcomes [35]. The core conceptual model for health campaigns hypothesizes that communication contributes to FGM behaviour change, such as prohibiting the practice, in two ways: supporting individual action (by imparting knowledge, influencing attitudes, and providing consistent and motivational reminders and shaping social norms [31],
Key evidence-based mass media campaigns strategies include using credible and popular local celebrities as messengers, distributing consistent messages across multiple mass media outlets, and reinforcing messages over time [5]. Every year, new public health mass media campaigns are launched attempting to change health behavior and improve health outcomes [21]. These campaigns enter a crowded media environment filled with messages from competing sources. Public health practitioners have to capture not only the attention of the public amid such competition, but also motivate them to change health behaviours that are often entrenched or to initiate habits that may be new or difficult [23].
[33] conducted a study on Perceptions and experiences of female genital mutilation after immigration to Sweden: An explorative study. The authors used inductive, qualitative design and are based on recorded interviews with eight women coming from Ethiopia, Somalia, Djibouti and Eritrea. The interviews comprised semi structured and open-ended questions. The inclusion criteria for the participants were an age above 18 years, origins in a part of the world where FGM is a normative practice.
The study found that women's feelings were ambivalent: though they opposed FGM, on the one hand, because of its negative effects on health, they acknowledged the practice's positive cultural aspects on the other hand.
The themes that emerged from the interviews are the role of FGM in ensuring virginity and protecting a family's honor, its role in avoiding shame and enhancing purity, social pressure experienced after immigration, an understanding of FGM as a symbol of the country of origin, and support for changing the tradition. These findings indicate that women originating from communities where FGM is normative live in a context in which the practice is viewed as an important aspect of life even after immigration. More research concerning this complex and deeply rooted cultural issue is recommended [17]. The authors recommended the empowerment of girls and their parents was mentioned by almost all the informants as one way to change the tradition of FGM. It is also important to involve religious leaders in public health work in order to abandon the practice since they play an important role among elderly and others who wish to maintain the tradition for religious reasons [37]. Exhaustive as this study was, it main focus was on perception of FGM/C. It thus did not investigate the important issue of impact of campaigns against the practice of FGM/C which this present study will undertake.
In another study conducted by [42] on Effect of female genital mutilation on female sexual function, Alexandria, Egypt, the author used adopted case–control study approach conducted on a convenient sample of 272 circumcised women with their 272 control from 4 randomly selected primary health care centers. Specially designed format (including data about socio-demographic characters, gynecological obstetric histories, and FGM act) and female sexual function index (a 19-item self-reported questionnaire for assessing the key dimensions of female sexual function) were used. The data was gathered through survey research method
Bivariate analysis was conducted to test significant differences between cases and control [33]. The study concluded that FGM was a risk factor for dysmenorrhea,

obstructed labor and postpartum hemorrhage. Cases had lower mean sexual function; moreover, half of them convinced with FGM practice and with its continuation. The study recommended further researches are needed to study the full range of FGM effects on physical, mental and psychosocial life of women. In addition, planned health education campaigns are mandatoryto elude the drawbacks of FGM and hazards of continuation control of this practice [4]. This study focused on how FGM/C impact on the sexual function of women and left an important aspect which is the investigation of how to reduce the practice of FGM. This is the gap this study is intended to fill.

Also, [41] investigated Female Genital Mutilation: a tragedy for women's reproductive health. The author used descriptive research method and found that the practice has serious health consequences, both physical and psychological. Attempts to eradicate the practice have not been successful over the past few decades. Medicalisation of the practice has added to its propagation, and this is not valid from ethical and professional standpoints [15]. Some of the health implications of FGM as found by [36] include bleeding, shock, infection, urine retention, problems at pregnancy and delivery, infertility, decircumcision and recircumcision complications such as additional loss of blood, injury to surrounding parts, fistulae, uterine pro-lapse, and infection, sexual problems, psychological disturbances and negative social consequences. The study concluded that FGM constitutes a major public health problem affecting the health of women and girls in the countries where it is practiced, subjecting them to serious health consequences. The author recommended that concerted efforts need to be exerted by the community, policy-makers, healthcare professionals and others to eliminate this tragic practice. This study focused on consequences of FGM/C on the reproductive function of women. It failed to investigate how this practice that cause women reproductive harm could be minimised, thus the need for this present study.

The study by [28] of 2003 Nigeria Demographic and Health Survey (NDHS) data to determine the spatial distribution of the prevalence of FGM and associated risk factors in Nigeria. Data for the study were collected from 7,620 women between the ages of 15 – 49 years in the 2003 NDHS. The minimum number of women sampled in each state was 915 while the maximum was 1,786. For samples of daughters, the minimum sample in a state was 265 and the maximum sample was 429 [36]. The study found that the rate of FGM was lower among unmarried women; that modernisation (education and high socio-economic status) did not have much effect on reducing FGM but education plays vital role in mother's decision to circumcise or not to circumcise the daughter. By implication, these findings show that community factors have large effect on FGM. This study was focused on the spatial distribution of the practice of FGM/C but did not investigate how this practice could be reduced. This created a knowledge gap for this study.

[27] carried out a study on *Strategies for eradicating female genital mutilation practice: implication for counseling* using a descriptive survey research design. The study investigated the various strategies used by counsellors to eradicate female genital mutilation in South East Nigeria. The sample constitute of 132 counsellors from the nine universities in South-East Nigeria. The instrument used for data collection was a structured questionnaire. The researchers found that female genital mutilation causes sexual pain, urine retention poor health, contacting HIV/AIDS, sexual frustration, contacting sexual transmitted diseases, damage to urethra, damage relationship, bladder fistulae, lowers women's self esteem, and leads to divorce. The authors further found the various strategies used by councilors to campaign against FGM include the creation of interpersonal communication between members of the community, encouraging women to be part of the advocacy that speak against

female genital mutilation, creation of awareness through enlightenment campaign, promotion of women participation in decision making process in the community, presenting meaningful education value to people, campaigning against female genital mutilation, rendering information service through the media, publishing best practices, organising seminars and workshops where women will be encouraged to be fully integrated into society, helping the community as much as possible to maintain the positive cherished traditional and culture values that are not against women, organising visits to parents guidance and significant others, counseling jingles and witty messages against female genital mutilation, and advocating for education of the women. The study however did not focus on the use of mass media channels in creating the awareness, advocacy and encouraging women to reject the practice of FGM. It rather found that interpersonal as the principal means of communication in this regard. This leaves a gap for the study of the place of broadcast media in the fight against female genital mutilation in Nigeria.

THEORETICAL FRAMEWORK

This study was anchored on the Agenda Setting Theory of the Press. The agenda setting theory describes the "ability [of the news media] to influence the salience of topics on the public agenda." [4]. This means that the more a news item is covered frequently and prominently and coverage, the mo the will regard the issue as important [33] [34].

Therefore, we assume that, if media campaigns frequently carry messages on the negative consequences of female genital mutilation, it will be seen as important and may subsequently influence public discourse on the necessity for its eradication. The eradication of female genital mutilation will only be seen as an important predictor of girl right and maternal health issue to the extent that media raise the issue through health communication campaigns that seek to influence behaviour change. Thus, Agenda setting theory refers to the idea that there is a strong correlation between the emphasis that mass media place on certain issues (e.g., based on relative placement or amount of coverage) and the importance attributed to these issues by mass audiences [38].

The agenda setting theory of mass communication was formally developed by Max McCombs and Donald Shaw in a study on the election communication and was first put forth by Maxwell McCombs and Donald Shaw in 1972 in Public Opinion Quarterly. The authors originally suggested that the media sets the public agenda, in the sense that they may not exactly tell you what to think, but they may tell you what to think about.

Agenda-setting theory rests on two basic assumptions. The first one states that the media filters and shapes reality instead of simply reflecting it. For example, news stories are not presented chronologically or according to the number of people affected by them, but rather in an order that a producer or editor determines to be the most “sensational,” or most appealing to audiences. The second assumption states that the more attention the media gives to certain issues, the more likely the public will be to label those issues as vital ones. In other words, agenda setting doesn’t necessarily tell people how they should think or feel about certain issues, but rather what issues they should think about.

The theory as stated by [21] in "Candidate Image in Election Campaigns: Attribute Agenda Setting, Affective Priming, and Voting Intentions", says that agenda setting happens in two levels. The first level agenda setting can be understood by the following line “The media may not only tell us what to think about...” While the second level of agenda setting can be understood with the help of the following continuation of the above statement.“... but also how to think about it” [24]. However, it is our view that the media do not tell people how to think about any issue but place before us what to think

about, guide the thinking by providing clue to the issue and leave the audience to think about the issue.

The agenda setting theory says that because of newspapers, television and other news media, people are aware or not aware, pay attention to or neglect, play up or down grade specific features of the public scene [37]. People tend to include or exclude from their cognitions what the media include or exclude from their content. People also tend to assign importance to what they include that closely resembles the emphasis given to events, issues, and persons by the mass media [31].

Agenda setting theory assumes direct, though not necessarily an immediate impact of the media on their audiences [12]. It also specifies that the impact is not on people's attitudes but on their cognitions, and it attributes these cognitive changes to be the result of the media performing a gatekeeper or channel role in western democracies [44]. The author stated that "The agenda setting theory does not say the media are trying to persuade – it does not charge the audience with adopting a prescriptive or advocacy or role in American society. Instead, media effects on people are seen as the principal result of the day-today work of the press in informing its audiences of the opportunities and warning the audiences of the dangers, real or imagined, in their environment and in the rest of the world" [31]. The media, by describing and detailing what is out there, present people with a list of what to think about and talk about.

The Agenda Setting Theory is considered suitable for this study because of its direct relationship with creation of awareness about the health and social implications of the practice of female genital mutilation (FGM). By making the people to understand the implications of FGM on the female child or adult, the mass media create an atmosphere of understanding that could make those that practice FGM to change their attitudes. While the Agenda Setting Theory does not directly focus on attitudinal change, the discussions and exchange of ideas the media create on critical and important issues like the practice of FGM could make it easier for those in the campaign against FGM like the Family Succour and Upliftment Foundation in Ebonyi State.

CONCLUSION

The mass media campaigns against FGM/C seem to be making many people who practice it as part of their culture to have begun abandoning the practice. However, many factor still make some families in Nigeria to engage in the practice of FGM. Some of these factors are socio-cultural: the fear that the girl child will not be able to marry if not circumcised makes family members to ensure that every girl child born the family undergoes FGM, establishing identity and belongingness is another reason advanced for the perpetration of this practice, many people believe that uncircumcised women have lower fertility powers compared to circumcised women and in addition are not able to control their sexual desires, etc. Different approaches are used to curb the practice of FGM. Media campaign, interpersonal communication, mainstreaming of the implications of FGM, training of health professionals as change agents, alternative rituals, community-led approaches, public statements, and legal measures, etc.

In all, the mass media carry the information by other agents of change towards the eradication of FGM and spread to the target audience. The mass media are diversified media technologies that are intended to reach a large audience by mass communication. The technology through which this communication takes place varies. They include the two broad areas of electronic and print media, such as radio, television, newspapers, magazines, books, pamphlets etc and the recent social media.

The power of the media in shaping perception and influencing public opinion is well known. The media have transcended time and age, going through various tools and forms, and stayed to its

influencing power. Radio programmes such as short bulletins on the need to eradicate FGM and early marriage can reach many audience who do not have access to television and cannot afford to buy newspapers [32]. It is also good for educating school children and other people in their local language on the consequences of FGM.

However, because some people or tribes in Nigeria still hold tenaciously to the practice of FGM, there is the need to go beyond the use of traditional mass media of communication like radio, television and newspaper and even to move beyond the use of social media to involve the *Ora Media* such as town crier in this effort at attitude change. Also, the village square or town hall as the case may be, would serve as a veritable platform through which rural women can be educated on the dangers involved in FGM and the need to embrace healthy cultural practices. FGM is a cultural practice that humiliates the girl child and is at the same time an infringement on the fundamental human right of women. It is a cultural practice that should the eliminated. The practice of FGM could lead to the death of the girl child, hemorrhage, shock, urine retention, etc.

REFERENCES

1. Anyamene, A. Nwokolo, C. and Anyachebelu, F.E. (2012)., Strategies for eradicating female genital mutilation practice; implications for counseling. *International Review of Social Sciences and Humanities,* 2(2), 62-67.
2. Berg, R. and Denison, E. (2012)., Effectiveness of interventions designed to prevent female genital mutilation/cutting (FGM/C): a systematic review of the best available evidence, *Studies inFamilyin Family Planning*, 43(2), 135–146.
3. Brown, E. Mwangi-Powell,F, Jerotich, M. and le May, V. (2016),. Female Genital Mutilation in Kenya: are young men allies in socialchangesocial change programmes? *Reproductive Health Matters,* Vol. 24, 118–125.
4. Brown, E. Mwangi-Powell,F, Jerotich,M. and le May, V. (2016)., Female Genital Mutilation in Kenya: are young men allies in socialchange programmes? *Reproductive Health Matters,* Vol. 24, 118–125.
5. Diop, N. Askew, I & Kabore, I., (2003)., Female *genital cutting practices in Burkina Faso and Mali and their negative he alth outcomes,* [online] Available at : https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1728-4465.1999.00219. [Accessed 12 January, 2019].
6. Elise, R. B, . Diop, N.J, Laverack, G and Leye, E. (2013)., What works and what does not: a discussion of popular approaches for the abandonment of female genital mutilation, *Obstetrics and Gynecology International*, [online] Available at: https://www.hindawi.com/journals/ogi/2013/348248/abs/ [Accessed 10 March, 2019].
7. Gaikwad, K.R. (2010)., *Agenda Setting Theory* (online). Available at: https://scholar.google.com/scholar?hl=en&as_sdt=0%2C5&q=agenda+setting+theory&oq=Age nda [Accessed 26 January, 2018).
8. Gosselin, C. (2000)., Handing over the knife: Numu women and the campaign against women in Mali," in *Transcultural Bodies:FemaleBodies: Female Genital Cutting in Global Context*, 193–214, Rutgers University Press, New Brunswick, Canada.
9. Hadi, A.A (2006)., A community of women empowered: the story of Deir Al Barsha," in *Female Circumcision*, R. M. (2006) Abusharaf, Ed., 104–124
10. Hernlund, Y. (2009)., *External review of the training and information campaign on the eradication of FGM in the Gambia,*

Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP), FOKUS/NKTF.
11. Isman, E, Ekeu, C and Berggen, V (2013)., Perceptions and experiences of female genital mutilation after immigration to Sweden: An explorative study, *Sexual & Reproductive Healthcare,* Vol. 4, 93–98.
12. Johansen, R.E.B. {2011)., Health professionals should never perform female genital mutilation, *Harmful Practices and Human Rights*, Institute International desDroits de l'Enfant, Sion, Switzerland.
13. Kandala, N.K, Nwakeze, N, Ngianga, S., and Kandala, I. (2009). Spatial Distribution of Female Genital Mutilation in Nigeria, American Journal of Tropical Medicine and *Hygiene*, 81(5), 784–792.
14. Kaplan, A. Forbes, M. and Bonhoure, I. (2011) Female genital mutilation/cutting (FGM/C) in The Gambia: long-term health consequences and complications during delivery and for the new born, *International Journal of Women Health,* 5, 323-331.
15. Kincaid, D.L. & Do M.P. (2006). Multivariate causal attribution and cost-effectiveness of a national mass media campaign in the Philippines. *Journal of Health* Communication, 11(2), 69
16. Latour`es, A. (2008)., Saisir *l'Etat en action en Afrique subsaharienne: action publique et appropriation de la cause des MGF au Mali et au Kenya [Ph.D. thesis]*, Universit´e Bordeaux IV, InstitutEd'Etudes Politiques de Bordeaux/Centre d'Etudes d'AfriqueNoiren, Bordeaux.
17. Loken, & Hornik (2010)., Use of mass media campaigns to change health behavior [online] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4248563/pdf/nihms643749.pdf [Accessed 6 April, 2019].
18. Mahmoud, M.I.H. (2016)., Effect of female genital mutilation on female sexual function, Alexandria, Egypt, *Alexandria Journal of Medicine,* 52, 55–59.
19. Mefalopolous, P. (2008). *Development communication source book*: *Broadening the boundaries of communication*. Washington D.C: The World Bank.
20. Mohamud, M. Radeny, S. Ringheim, K. (2006)., Community based efforts to end female genital mutilation in Kenya: raising awareness and organising alternative rites of passage," In: R. M. Abusharaf, Ed. *Female Circumcision*, The Free Press, Philadelphia, Pa, USA, 75–103.
21. Muteshi, J. and Sass, J. (2005)., *Female Genital Mutilation in Africa: An Analysis of Current abandonment Approaches*, PATH, Nairobi, Kenya.
22. Noar, S. (2007)., A 10-Year Retrospective of Research in Health Mass Media Campaigns: Where Do We Go From Here? *Journal of Health Communication*: *International Perspectives*. 11, 1.
23. Odoi A.T. (2005)., Female genital mutilation: In Kwawukume EY, Emuveyan EE (eds) *Comprehensive GynaecologyGynecology in the Tropics*. 1st ed. Accra: Graphic Packaging Ltd.
24. Okeke, T.C, Anyaehie, U.S.B, and Ezeenyaku, C.C.K (2012)., An overview of Female genital mutilation in Nigeria, *Annals of Medical and Health Sciences Research*,1(2), 70-73.
25. Okofo, L.K. (20175)., *The influence of media campaign in the eradication of female genital mutilation practices in selected communities of South-South Nigeria***,** [online]. Available at: http://www.unn.edu.ng/publications/files/Lawrence%20Okofo.pdf [Accessed 6 April, 2019].

26. Ola, M. and Adaramoye, D. (2017)., *Impact of youth and social media on ending female genital mutilation*, [online]. Available at: https://endcuttinggirls.org/2017/10/01/impact-of-youth-and-social-media-on-ending-female-genital-mutilation-ola-moses-and-dare-adaramoye/ [Accessed 6 April, 2019].
27. Oloo, H. Wanjiru, M., and Newell-Jones, K. (2011). Female genital mutilation practices in Kenya: the role of alternative rites of passage. A case study of Kisii and Kuria districts," in *Feed theMinds*, Kenya. *Opinion Quarterly,* 36(2), 176–187.
28. Omenugha, K. and Ekwugha U. (2008). Culture, Media and Sexuality: An Exploration of Nigerian Newspapers Reports of Women Reproductive Health and Rights. In Nwosu Ikechukwu, Oludayo Soola and Levi Nwodu (Eds) *Communication for Health and Sustainable Development in Nigeria* .Enugu; Rhyce Kerex Publisher. *Opinion Quarterly,* 36(2), 176–187.
29. Refaat, A. (2009). Medicalization of female genital cutting in Egypt," *Eastern Mediterranean Health Journal*, 15(6), 1379– 1388.
30. Rushwan, H. (2013). Female genital mutilation: A tragedy for women's reproductive health. *African Journal of Urology,* 19, 130–133.
31. Saraçoglu M and H Öztürk (2014)., Female Circumcision Andrology & Gynecology: Current Research 2: 2. http://dx.doi.org/10.4172/2327
32. Shaw, E.F. (1979). Agenda-setting and mass communication theory, *International Communication Gazette* [online] Available at: https//journals.sage.pub.com/dio/abs [Accessed 28 March, 2019].
33. Shell-Duncan, B. Hernlund, Y. Wander, K. and Moreau, A. (2010). *Contingency and change in the practice of female genital cutting: dynamics of decision making in Senegambia*, Tech. Rep.
34. Sweetman. C. (2004)., Gender, Education and Training, [online]. Available at: https://oxfamilibrary.openrepository.com/bitstream/handle/10546/121122/bk-gender-education-training-010104-en.pdf?sequence=1#page=46 [Accessed 5 April, 3019].
35. Toubia, N., (1994). Female circumcision as a public health issue, *New England Journal of Medicine*[online], Available at: https://www.popline.org/node/294036
36. Toubia, N.F and E.H. Sharief, E.H. (2003). Female genital mutilation: have we made progress?" *International Journal of Gynecology andObstetricsand Obstetrics*, 82(3), 251–261
37. UNICEF (2003)., *Overview of FMG/Cutting country profile.* UNICEF Nigeria DHS.
38. UNICEF, (2010). *The Dynamics of Social Change: Towards the Abandonment of FGM in Five African Countries*, [online] Available at: http://findgofind.co/search?q=The%20Dynamics%20of%20Social%20Change:%20Towards%20the%20Abandonment%20of%20FGM%20in%20Five%20African%20Countries
39. UNICEF, (2013a). Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change UN Children's Fund Report. *Reproductive Health Matters*, 21(42), 184-190.
40. Wakefield, M; Loken, B. & Hornik, R. (2010)., Use of mass media campaigns to change health behaviour. The Lancet, Volume 376(9748), 1261-1271.
41. WHO (2013)., *Female Genital Mutilation*: *Factsheet* No. 241. WHO, Geneva
42. WHO, (2007)., *Elimination of FGM in Nigeria Plot 617/618 Diplomatic drive*, Central District Abuja. Family Health Department, Federal Ministry of Health Phase II Federal Secretariat Abuja Dec 2007.

43. World Health Organisation (2008)., *Eliminating Female genital mutilation. An interagency statement, OHCRH, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO* [online] Available at: http://findgofind.co/search?q=Eliminating%20Female%20genital%20mutilation.%20An%20interagency%20statement,
44. World Health Organisation. (2010)., *Global strategy to stop health-care providers from performing female genital mutilation* UNAIDS, UNDP, UNFPA, UNICEF, UNHCR, UNIFEM, WHO, FIGO, ICN, IOM, WCPT, WMA, MWIA. Geneva: World Health OrganisatioWorld Health Organisation, (1999). *Female Genital Mutilation. Programmes to Date: WhatWorks and What Doesn't?* World Health Organisation, Geneva, Switzerland.
45. Yoder, P. S and Khan, S (2008)., *Numbers of women circumcised in Africa: The production of a total*. Calverton: Macro International Inc.