

Broadcast Media Campaigns and the Eradication of Female Genital Mutilation/Cutting in South-East Nigeria: Assessing Awareness, Knowledge, Perception and Health Behaviour

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Abstract: This study assessed the effectiveness of broadcast media campaigns in eradicating FGM/C among women in the five southeast states of Nigeria. A mixed-methods design was adopted, combining a structured survey questionnaire (n = 380) drawn via multi-stage sampling from a projected population of 11,413,299 women, with ten Focus Group Discussion (FGD) sessions (n = 30) across selected communities in South, East Nigeria. Data were analysed using Likert-scale mean scores and Pearson Moment Correlation Coefficient (two-tailed) at $p \leq 0.05$ significance level. Three null hypotheses were upheld in the study: broadcast media campaigns on anti-FGM/C showed no significant relationship with the level of awareness ($r = -0.029$, sig. = 0.514), knowledge base ($r = -0.038$, sig. = 0.400), health behaviour ($r = -0.052$, sig. = 0.249). Qualitative data corroborated these findings, revealing that campaign messages were infrequent, shallow, elitist, non-localised, and insufficiently targeted at rural women. The study concluded that broadcast media campaigns have not advanced the eradication of FGM/C in Nigeria. The study introduces and validates a four-driver model for sustainable FGM/C eradication: enhanced awareness, expanded knowledge base, positive perception shift, and health behaviour change.

Keywords: Female Genital Mutilation/Cutting, Broadcast Media Campaigns, Health Behaviour, Health Communication, Awareness.

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I. INTRODUCTION

Female genital mutilation/cutting (FGM/C) is defined by the World Health Organization (WHO, 2018) as all procedures involving the partial or total removal of external female genitalia, or other injury to female genital organs for non-medical reasons and constitutes one of the most persistent and geographically widespread human rights violations confronting women globally. Despite gains in education, economic development, and legislative reform across much of Sub-Saharan Africa, FGM/C has proved remarkably resistant to eradication. In Nigeria the most populous country on the African continent, the problem is particularly acute: the country holds the highest absolute caseload globally, estimated to account for approximately one-quarter of the 115 - 130 million

circumcised women worldwide (Okeke, Anyaechi, & Ezenyeaka, 2012).

Female genital mutilation or cutting (FGM/C) is defined by the US Department of Health and Human Sciences (2025) as the piercing, cutting, removing or sewing closed all or part of a girls or woman's external genitals for no medical reason. According to US Department of Health and Human Services (2025) worldwide as many as 140 million girls and women alive today have been cut. The implication is that the prevalence globally have experienced a stagnation or a slight upsurge.

The practice is deeply embedded in cultural, social, and economic structures. FGM/C manifests across four WHO-classified types, ranging from partial or total clitoridectomy (Type I) to infibulation, the most severe form involving the

stitching of the vaginal orifice (Type III). The immediate medical consequences are severe: haemorrhage, neurogenic shock, urinary retention, tetanus, and death. Long-term sequelae include chronic pelvic infections, obstetric complications, sexual dysfunction, and profound psychological trauma, including symptoms analogous to post-traumatic stress disorder (WHO, 2018; Jeremiah, Kalio, & Akani, 2014; Mahmoud, 2016). Crucially, women in South-East Nigeria spanning the Igbo-speaking states of Abia, Anambra, Ebonyi, Enugu, and Imo bear a disproportionate burden of this practice, with Type I excision being most prevalent in the southern zones.

The mass media, and broadcast media in particular, have been increasingly positioned within international health communication policy as catalysts for behaviour change at scale. Radio and television carry distinctive advantages immediacy, wide geographic reach, elimination of literacy barriers, cultural resonance through oral traditions, and the capacity to model normative shifts (Nwabueze, 2014). Various international and domestic health campaigns from HIV/AIDS prevention to Ebola containment have relied heavily on broadcast media messaging. In 2012, the United Nations General Assembly passed resolutions calling for FGM/C elimination, and since 2018, the United States Agency for International Development (USAID) has formally incorporated FGM/C eradication into its development agenda. Nigeria itself ratified the Maputo Protocol in 2005, and in 2015, enacted national legislation banning the practice.

Basera, Goldberg, Okoroh, Snead, Johnson – Agbakwu and Goodwin (2023) in their study concluded that women with FGM/C have significant physical and mental health needs.

According to the United States Centre for Disease Control and Prevention (2024) although FGM/C is often viewed as part of the culture of the countries where it is practiced, it has no health benefits. Infact, it can lead to immediate and long-term health problems that can affect obstetric and gynecological, issues.

Yet, despite this legislative scaffolding and sustained media attention, FGM/C prevalence in Nigeria has remained stubbornly resistant to change. This paradox raises a fundamental empirical question: have broadcast media campaigns actually produced measurable effects on the awareness, knowledge, perception, and health behaviour of Nigerian women regarding FGM/C? The literature on this question is sparse and geographically fragmented. Most prior studies have either been limited to South-South Nigeria (Amannah Okofo, 2015), focused on related health challenges such as malaria or Ebola (Mba-Nwigoh, Iririkoh and Amannah 2017; Gidado, Oladimeji, Aguku, Nwangwu, Waziri, Shuabib, Olukayaode, Nzuki, Musa, Nasidi, Adewami, Tom-Aba, Olayinka, Odubango, and Gabriel (2014) or neglected to combine quantitative and qualitative methodologies in examining this specific population and practice.

This paper addresses that gap directly. Drawing on original doctoral research conducted across South-East Nigeria, the study assesses the effectiveness of broadcast media campaigns on FGM/C eradication through four analytically distinct but interrelated outcome domains: (1) awareness and exposure, (2) knowledge base, (3) perception, and (4) health behaviour. In doing so, it also identifies the structural barriers constraining women's access to broadcast media health campaigns, and proposes a holistic four-driver model for campaign redesign. The study is theoretically grounded in the Health Belief Model (HBM; Hochbaum, 1950s; Rosenstock, 1974) and the Theory of Planned Behaviour (TPB; Ajzen, 1985, 1991).

II. REVIEW OF RELATED LITERATURE

➤ *FGM/C: Scope, Classification, and Consequences in Nigeria*

Nigeria presents a complex epidemiological picture with respect to FGM/C. The practice cuts across all six major ethnic groups, Yoruba, Hausa/Fulani, Igbo, Ijaw, and Kanuri with only the Fulani largely exempt. Type I and Type II procedures predominate in the South, while more severe forms persist in Northern zones. The WHO (2014) global prevalence estimate ranges from 0.6% to 98% across practising countries; in Nigeria, Jeremiah, Kalio and Akani (2014) reported a 34% prevalence rate in Port Harcourt (South-South), while Madara (2003) in an earlier study similarly found 34% among a community sample of 500 women in southern Nigeria. Most importantly, while there is evidence of a modest generational decline, the absolute burden remains substantial.

In a recent study, however United Nations Children's fund (Unicef) (2026) evaluated the reasons why FGM/C is still practiced especially in developing countries. The findings show that FGM/C is practiced as:

- Expression of deep rooted gender inequality.
- Suppression of a girls sexuality or to as a pre requisite for marriage or inheritance
- Rite of passage
- Cultural demands to enable the girl be eligible for marriage.

The drivers of FGM/C are multifactorial and mutually reinforcing. Ahmadi (2013) identifies cultural identity, preservation of female chastity, marriageability, hygiene misconceptions, and gender-based social conformity as principal motivators. Social conformity emerged as the single strongest driver in the present study sample (13.42%), followed by family compulsion (7.37%) findings consistent with the broader literature. Poverty and low educational attainment function as structural enablers: Nigeria is classified among the poorest nations globally, with the poverty incidence rising from 27.2% in 1980 to an estimated 62% by 2017 (Central Bank of Nigeria, 2015) Among South-East women specifically, over 70% are economically vulnerable, living below the World

Bank-defined international poverty line (World Bank, 2016). The poverty index has worsened between 2017 and 2025. According to the National Bureau of statistics (2022), 63 percent of Nigeria's population are multidimensionally poor. The data up to 2025 show worsening indices. (World Bank: 2026).

➤ *Broadcast Media and Health Campaigns: Evidence from the Literature*

A substantial body of communication scholarship affirms the theoretical potential of broadcast media in shifting health-related knowledge, attitudes, and behaviours. Kogah (2009) and Nwabueze (2014) document radio's unique attributes as a health communication channel in developing contexts: it eliminates the literacy barrier, penetrates geographic remoteness, adopts conversational language accessible to diverse audiences, and is relatively inexpensive to produce and receive. Basically, the radio is the major communication medium that fosters interactive, participatory learning in rural Sub-Saharan African communities.

Empirical evidence on broadcast campaigns and health outcomes is, however, mixed. Bowen (2013) found a statistically significant 6.6 percentage point increase in bed-net use among Cameroonians exposed to the Night Watch media campaign. Akkomah, Adebayo, Arogundade, Ayanti, Nwokolo, Inyang, Oladipapo and Mererika (2014) reported that pregnant Nigerian women who consumed anti-malaria media messages were significantly more likely to adopt preventive behaviours. Gidado et al. (2014) demonstrated that broadcast media substantially contained Ebola transmission in Lagos through rapid knowledge diffusion. However, Bauman (1991) cautioned that television-based anti-smoking campaigns for adolescents were less effective than radio-only interventions, and Mba-Nwigoh, Ikiriko and Amannah (2017) found that while EVD broadcast campaigns created general awareness, rural dwellers were systematically under-targeted.

On FGM/C specifically, Okofo (2015) the study most closely comparable to the present research found that anti-FGM/C media campaigns in South-South Nigeria generated comprehensible and largely accepted messages, and that many rural women had disengaged from the practice. However, this finding diverges markedly from the present study's South-East data, and may partly reflect methodological differences, geographic specificity, and variations in media saturation across regions. Anyamene, Nwokolo, and Anyachebelu (2012) identified inadequate guidance, counselling, and community-specific communication as critical deficits in FGM/C eradication strategies.

➤ *Theoretical Framework*

This study is anchored on two complementary theoretical frameworks: the Health Belief Model (HBM) and the Theory of Planned Behaviour (TPB).

The HBM, developed by Hochbaum, Rosenstock, and Kegels (1950s) and subsequently refined by Becker (1974), posits that health behaviour change is determined by six cognitive constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (added 1988). The model predicts that an individual will adopt a health-promoting behaviour when she believes herself susceptible to a health threat, perceives the consequences as serious, views the benefits of action as outweighing the barriers, and receives a salient prompt to act. Applied to FGM/C, the HBM explains why women do not respond positively to health campaigns: barriers cultural normalisation, family pressure, social conformity, economic vulnerability, and illiteracy systematically outweigh perceived benefits, and cues to action remain too infrequent and inaccessible to trigger change.

The theory of planned behavior TPB (Ajzen, 1985, 1991) extends the HBM by introducing behavioural intention, the product of attitudes toward the behaviour, subjective norms, and perceived behavioural control as the immediate antecedent of behaviour. For FGM/C abandonment, women's intentions are constrained by deeply entrenched subjective norms (community expectations, parental authority) and limited perceived behavioural control (economic dependence, illiteracy, isolation). The theory predicts that broadcast media campaigns, to be effective, must simultaneously address attitudinal barriers, challenge prevailing social norms, and strengthen women's perceived capacity to resist the practice. The present study's findings illuminate exactly where these campaigns fail.

III. METHODOLOGY

➤ *Research Design and Sampling Method*

A mixed-methods concurrent triangulation design was adopted, integrating quantitative survey data with qualitative focus group discussion data. This approach was selected to enable cross-validation of findings, provide both statistical generalisability and contextual depth, and address the multidimensionality of the research problem.

The study was conducted across the five states of South-East Nigeria, Abia, Anambra, Ebonyi, Enugu, and Imo representing a distinct Igbo-dominant geopolitical zone with documented high FGM/C prevalence. The target population comprised women aged 18 - 60 years resident in selected rural communities. Using the UNDP's 3.2% per annum extrapolation index from the 2006/2007 National Population Commission census baseline, the projected 2020 female population of the zone was estimated at 11,413,299 persons. The sample size was determined using the Yamane (1967) formula: $n = N / [1 + N(e)^2]$, where $N = 11,413,299$ and $e = 0.05$, yielding $n \approx 400$

respondents. Multi-stage sampling was employed: (i) all five states were retained at Stage One; (ii) one Local Government Area (LGA) was purposively selected per state based on documented FGM/C prevalence (Isiala Ngwa North, Ekwusigo, Nsukka, Ohaji/Egbema, and Ohaozara); (iii) two communities were randomly selected per LGA via paper-draw balloting; and (iv) questionnaires were allocated proportionally to state population.

For the qualitative component, thirty participants (three per community, across ten communities) were purposively selected for ten Focus Group Discussion sessions, two groups per state comprising two women and one local government official per group, ensuring institutional and gendered perspectives.

➤ Data Collection and analysis

A structured 22-item questionnaire, divided into three sections (demographic data, FGM/C psychographic data, and research question items), was employed for the quantitative component. Section C items were anchored on a five-point Likert scale (Strongly Agree = 5 to Strongly Disagree = 1). A structured FGD schedule guided the qualitative discussions, covering the same five thematic areas as the research questions: awareness, knowledge, perception, health behaviour, and access challenges.

Instrument validity was established through face and content validity assessments. Reliability was confirmed via test-retest administration on 20 non-sample respondents,

yielding a Cronbach's Alpha of 0.824 indicating high internal consistency.

Quantitative data were analysed using descriptive statistics (frequency counts, percentages, Likert mean scores) and inferential statistics (Pearson Moment Correlation Coefficient, two-tailed, via SPSS). A mean benchmark of 2.50 was applied as the decision point for Likert items. Hypotheses were tested at the 0.05 level of significance, with the decision rule: if T-test sig. value > p-value (0.05), accept the null hypothesis. Qualitative data from FGDs were analysed thematically using constant comparative analysis.

IV. RESULTS AND DISCUSSION

➤ Respondents Profile

Of 400 questionnaires administered, 380 (95%) were returned and found usable. The majority of respondents (65.52%) fell within the 18–34 age bracket. Most had only primary education or no formal education (51.32%). Students (33.42%) and unemployed women (25.52%) constituted the largest occupational categories (combined 58.94%). Poverty was pervasive: 75.27% reported very low or low income levels.

Table 1 presents the profile of women who had undergone FGM/C and the factors influencing the practice. But of the 144, that participated in FGM/C, social conformity was given as the causes factor, family compulsion (7.37%), local tradition/norms (5.26%) cultural norms/demands (5%) community identity (4.47%) and peer group pressure (2.37%).

Table 1: Prevalence and Motivating Factors for FGM/C among Respondents

Variable	Category	Frequency	Percentage (%)
FGM/C Participation	Undergone FGM/C	144	37.89
	Not undergone FGM/C	236	62.11
Motivating Factors*	Social conformity	51	13.42
	Family compulsion	28	7.37
	Local tradition/norms	20	5.26
	Cultural demands	19	5.00
	Community identity	17	4.47
	Peer group pressure	9	2.37

*Among respondents who reported undergoing FGM/C (n = 144).

➤ Broadcast Media Access and Coverage

Access to broadcast media was severely limited: only 39.47% of respondents owned or had access to a radio/television set, and only 42.37% received clear broadcast signals in their communities. Coverage of anti-FGM/C messages was assessed as poor (mean = 2.28; decision point = 2.50): 41.58% of respondents indicated they did not receive such messages often, and 23.94% reported receiving them rarely if ever.

• Awareness: Research Question 1

The study found that broadcast media campaigns have not succeeded in creating adequate awareness of anti-FGM/C messages among South-East women (mean = 2.21, below the 2.50 decision threshold). The majority (63.42%) rated the campaigns as ineffective or highly ineffective in enhancing awareness. FGD participants consistently noted that available programmes were irregular, brief, shallow in content,

linguistically inaccessible (predominantly in English), and failed to incorporate rural women's concerns or perspectives.

- **Knowledge Base Research Question 2**

Broadcast media campaigns have not meaningfully broadened women's knowledge base on FGM/C (mean = 2.23). Over two-thirds of respondents (66.84%) disagreed that campaigns had enhanced their knowledge. Corroborating sub-items measuring awareness of FGM/C health consequences (mean = 2.24), gender inequality emphasis (mean = 2.15), and legal/regulatory information (mean = 2.29) all fell below the decision threshold. FGD participants noted that women remained largely ignorant of applicable laws and sanctions, WHO/UNICEF intervention programmes, and the specific health hazards of FGM/C.

- **Perception Research Question 3**

Women's perception of broadcast media campaigns on anti-FGM/C was predominantly negative (mean = 2.10). The majority (69.21%) disagreed that the campaigns had positively shaped their perception of FGM/C. FGD discussions surfaced a pattern of gender-biased framing in media coverage, with women's rights and dignity issues characterised as under-reported or negatively presented. Participants indicated that campaigns failed to challenge the cultural belief systems

sustaining FGM/C and did not portray women as rights-bearing agents with autonomous reproductive choices.

- **Health Behaviour Research Question 4**

The study found that broadcast media campaigns have not influenced the health behaviour of South-East women with respect to FGM/C (mean = 2.31). A clear majority of respondents (53.68%) disagreed that campaigns had produced behavioural change. FGD evidence indicated that campaigns neither highlighted the long-term health challenges of FGM/C (haemorrhage, obstetric complications, neonatal risks) in sufficient depth nor provided women with the practical, motivational tools to resist the practice.

- **Access Challenges Research Question 5**

Five major structural barriers to accessing anti-FGM/C broadcast campaigns were identified and all scored above the 2.50 decision threshold (Table 2). Poverty and low income levels emerged as the most acute barrier (mean = 3.07), followed by ignorance (mean = 2.92), poor educational attainment (mean = 2.77), lack of information/viewing centres (mean = 2.73), and limited media reach (mean = 2.69). FGD participants further identified inadequate electricity supply and religious or cultural resistance to change as additional impediments.

Table 2: Challenges Constraining Access to Anti-FGM/C Broadcast Campaigns

Challenge	Agree (%)	Disagree (%)	Mean	Decision
Poverty / Low income levels	74.63	24.47	3.07	Significant
Ignorance of women	73.94	26.06	2.92	Significant
Poor quality education / Illiteracy	68.42	31.58	2.77	Significant
Lack of information/viewing centres	66.32	33.68	2.73	Significant
Limited reach of media campaigns	65.00	35.00	2.69	Significant

Decision point = 2.50. Source: Field Survey, 2018.

➤ **Hypothesis Testing**

Three null hypotheses were formally tested using the Pearson Moment Correlation Coefficient (two-tailed). All three null hypotheses were retained (Table 3). The results indicate negligible and statistically non-significant correlations between broadcast media campaign exposure and each of the three key outcome variables confirming the substantive conclusions from descriptive analysis.

Table 3: Pearson Correlation Results: Broadcast Media Campaigns and Health Outcome Variables

Hypothesis	Outcome Variable	Pearson r	Sig. (2-tailed)	Decision
H ₀₁ : No relationship between campaigns and awareness	Level of Awareness	-0.029	0.514	Accept H ₀
H ₀₂ : No relationship between campaigns and knowledge	Knowledge Base	-0.038	0.400	Accept H ₀
H ₀₃ : No relationship between campaigns and health behavior	Health Behaviour	-0.052	0.249	Accept H ₀

Significance level: $p \leq 0.05$. All correlations non-significant. Source:

➤ **The Ineffectiveness of Current Broadcast Media Campaigns**

The convergent findings from both the survey and Focus Group Discussions present an unambiguous picture: broadcast

media campaigns on anti-FGM/C in South-East Nigeria have failed to produce measurable effects across all four outcome domains examined. This conclusion is robust across multiple methodological lenses and corroborates the concerns raised by Mba-Nwigoh et al. (2017), who found that rural dwellers were systematically under-targeted in EVD broadcast campaigns a pattern that this study demonstrates applies with equal force to FGM/C campaigns.

The divergence from Okofo's (2015) more optimistic findings in South-South Nigeria warrants careful interpretation. First, the South-East presents a distinctly homogeneous Igbo-Christian cultural context in which FGM/C is deeply intertwined with identity, marriageability, and social conformity motivations that respond poorly to general health messaging absent community-specific normative reframing. Second, the severe rural poverty profile of South-East respondents (75.27% below low-income threshold; only 39.47% owning media hardware) structurally forecloses campaign access in ways that urban or peri-urban populations in Port Harcourt may not face to the same degree.

The Health Belief Model offers an explanatory frame. Current campaigns appear to be operating principally at the level of general risk communication they occasionally flag the existence of FGM/C dangers but systematically fail to engage the perceptual architecture that actually drives behaviour: personalised susceptibility, severity valuation, barrier identification and reduction, and efficacy-building. When perceived barriers (cultural normalisation, family authority, poverty, illiteracy) so dramatically outweigh perceived benefits, and when cues to action are infrequent and inaccessible, the HBM predicts exactly the null outcomes this study documents.

The Theory of Planned Behaviour adds a complementary analysis. FGM/C decisions are not individual-rational choices; they are deeply embedded in subjective normative structures familial, communal, and religious that broadcast campaigns, in their current one-directional form, cannot meaningfully challenge. The TPB predicts that campaigns must work at the level of normative change, not merely informational provision, to shift behavioural intention. The FGD participants' consistent call for community leader, traditional ruler, and religious authority involvement directly operationalises this theoretical insight.

➤ *Poverty as a Systemic Barrier*

A particularly salient finding is the primacy of poverty and structural economic exclusion as barriers to campaign access (mean = 3.07). This finding aligns with the WHO (2018) characterisation of FGM/C as a poverty-associated phenomenon, and with broader evidence that economic vulnerability diminishes women's capacity to exercise autonomous health decisions. When a majority of women lack the hardware (radio/television sets), infrastructure (electricity), and cognitive bandwidth (freed from economic survival

imperatives) to engage with health campaigns, even excellently designed messaging will fail at the delivery stage. This suggests that media campaigns cannot succeed as standalone interventions but must be embedded within broader strategies addressing the structural determinants of women's vulnerability.

➤ *The Language and Localisation Deficit*

FGD data revealed a pervasive language accessibility gap: campaigns broadcast predominantly in English fail to reach women who, in rural South-East settings, are predominantly Igbo-speaking and often functionally illiterate in English. This finding resonates with a foundational argument that effective rural communication in Nigeria must transcend literacy barriers, reach audiences through their primary languages, and reduce intellectual demands on listeners. The Pim-Pim radio drama cited positively by several FGD participants as the sole example of localised, dialect-based FGM/C messaging illustrates that linguistically calibrated formats can achieve greater reach and resonance. Yet even this programme was described as "too irregular" and "insufficiently comprehensive" to sustain awareness.

➤ *A Four-Driver Model for FGM/C Eradication*

A significant theoretical contribution of this study is the isolation and empirical validation of four critical drivers that must simultaneously and holistically be activated to achieve sustainable FGM/C eradication through broadcast media: (1) enhanced awareness, (2) broadened knowledge base, (3) positive perception shift, and (4) health behaviour change. Prior studies on FGM/C communication have tended to examine these outcomes individually and in isolation. The present study demonstrates that they form an interconnected causal chain: awareness creates the cognitive preconditions for knowledge acquisition; knowledge acquisition enables perceptual reframing; perceptual reframing is a prerequisite for motivated behavioural change.

This four-driver model has direct implications for campaign design. Campaigns that focus exclusively on awareness creation the most common modality observed in the studied broadcasts leave the chain incomplete. Equally, campaigns that address knowledge without disrupting the normative perceptual framework sustaining FGM/C will produce informed but behaviourally unchanged audiences. Effective interventions must mobilise all four drivers through sustained, multi-modal, community-anchored communication strategies.

V. CONCLUSION AND RECOMMENDATIONS

➤ *Conclusion*

This study provides robust empirical evidence that broadcast media campaigns on anti-FGM/C have not produced significant effects on the awareness, knowledge, perception, or health behaviour of women in South-East Nigeria. All three null hypotheses were confirmed at the 0.05 significance level, and qualitative data provided consistent corroboration. The primary explanatory factors include structural barriers (poverty, illiteracy, electricity infrastructure deficits, limited media reach), campaign design failures (infrequency, shallowness, urban and English-language bias, elitism), and the entrenched normative architecture of FGM/C practice within Igbo cultural communities. The eradication of FGM/C in this zone is contingent not on incremental improvements to current campaign formats but on a fundamental redesign of communication strategy, grounded in the four-driver model identified in this study.

➤ Recommendations

Based on the findings and conclusions from the study the following recommendations are made:

- **Campaign Redesign: A Multi-Driver, Community-Centred Approach:** Campaigns must simultaneously target awareness, knowledge, perception, and health behaviour change. Programming should be explicitly community-specific, developed in close collaboration with local health workers, traditional rulers, religious leaders, and women's organisations. Phone-in programmes, community drama, and testimonial formats are particularly recommended for their participatory and normative-disruption potential.
- **Language Localisation and Cultural Accessibility:** All anti-FGM/C messaging must be produced and broadcast in local Igbo dialects. The Pim-Pim model should be scaled, regularised, and expanded to cover all four FGM/C outcome domains. Dialect-specific campaign materials should be developed collaboratively with community language experts and tested with rural audiences prior to broadcast.
- **Intensified Educational Programming:** Campaigns should incorporate explicit adult literacy and health education components, addressing FGM/C health hazards, reproductive rights, and legal frameworks in accessible language. Educational partnerships with schools, churches, and community health workers should be formalised to extend campaign reach beyond broadcast media channels alone.
- **Structural and Infrastructure Investment:** Governments at federal and state levels should invest in rural electricity infrastructure and community viewing/listening centres to ensure physical access to broadcast media. Subsidised radio set distribution programmes, modelled on successful agricultural communication initiatives, should be considered as complementary tools.
- **Stakeholder Integration and Policy Coherence:** The broadcast media should systematically involve traditional rulers, religious leaders, community women's groups, and healthcare professionals in campaign planning and content delivery. Anti-FGM/C media campaigns must be integrated

with legal enforcement strategies and allied social protection programmes targeting poverty reduction and women's economic empowerment.

- **Monitoring, Evaluation, and Feedback Mechanisms:** A standardised framework for evaluating broadcast campaign effectiveness on all four outcome drivers awareness, knowledge, perception, and health behaviour should be established. Campaigns should incorporate feedback loops (community listening groups, post-campaign surveys) enabling iterative refinement.

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