

FGM/C in Nigeria:

Country Profile Update
March 2023



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Introduction

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28 Too Many joined Orchid Project on 1 April 2022. Combining the forces of 28 Too Many and Orchid Project provides an opportunity to draw on the unique strengths and experiences of both organisations, ultimately enhancing the movement to end FGM/C.

Orchid Project is a non-governmental organisation catalysing the global movement to end FGM/C, a human-rights violation that harms the lives of girls, women and their communities. Orchid Project partners with pioneering grassroots organisations around the world and shares knowledge and best practice to accelerate change. Orchid Project also advocates among governments and global leaders to ensure work to end FGM/C is prioritised.

28 Too Many brings an established research-and-evidence function to Orchid Project, helping it provide the high-quality evidence and best practice needed to guide policy- and decision-making as well as donor investments in the anti-FGM/C sector. This evidence and research, coupled with Orchid Project's existing programming, advocacy and movement-building efforts, will strengthen the capacity of organisations and activists globally and support them to bring an end to FGM/C by 2030.

Use of this Country Profile Update

This update is intended to be used in conjunction with and as a supplement to the report **Country Profile: FGM in Nigeria** published by 28 Too Many in 2016, which may be downloaded at <https://www.28toomany.org/country/nigeria/>.

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many (part of Orchid Project). We seek updates on the data and invite comments on the content and suggestions on how our reports can be improved.

For more information, please contact us at research@orchidproject.org/.

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Please note the use of a photograph of any girl or woman in this Country Profile Update does not imply that she has, nor has not, undergone FGM/C.

List of Abbreviations

Please note that, throughout the citations and references in this report, the following abbreviations apply.

‘DHS 2013’ refers to National Population Commission – NPC/Nigeria and ICF International. (2014) *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria: NPC/Nigeria and ICF International. Available at <https://dhsprogram.com/publications/publication-FR293-DHS-Final-Reports.cfm>.

‘MICS 2016–17’ refers to National Bureau of Statistics (NBS) and United Nations Children’s Fund (UNICEF) (2017) *Multiple Indicator Cluster Survey 2016–17, Survey Findings Report*. Abuja, Nigeria: National Bureau of Statistics and United Nations Children’s Fund. Available at <https://www.unicef.org/nigeria/reports/multiple-indicator-cluster-survey-2016-17-mics>.

‘DHS 2018’ refers to National Population Commission – NPC/Nigeria and ICF (2019) *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF. Available at <https://dhsprogram.com/publications/publication-FR359-DHS-Final-Reports.cfm>.

All cited texts in this Country Profile Update were accessed in February/March 2022, unless otherwise noted.

AU	African Union
AIDS	Acquired Immunodeficiency Syndrome
CRA	Child Rights Act
DHS	Demographic and Health Surveys
ECOWAS	Economic Community of West African States
FGM/C	female genital mutilation/cutting
GDP	gross domestic product
GBV	gender-based violence
HIV	Human Immunodeficiency Virus
IDP	internally displaced person
INGO	international non-governmental organisation
IPV	intimate-partner violence
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	maternal mortality ratio
NGO	non-governmental organisation
SDGs	Sustainable Development Goals
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation
VAPP Act	Violence Against Persons (Prohibition) Act
WHO	World Health Organization

A Note on Data

Statistics on the prevalence of FGM/C are compiled regularly through large-scale household surveys in developing countries, predominantly the **Demographic and Health Survey (DHS)** and the **Multiple Indicator Cluster Survey (MICS)**. For Nigeria, the main surveys are the DHS 2013, the MICS 2016–17 and the DHS 2018.

The DHS 2003 found a higher prevalence of FGM/C than did the DHS 2008, but this is largely because of how FGM/C was defined and presented for each survey. In 2008, some of the questions included Type 4 cuts such as *angurya* and *gishiri*, which are largely unique to ethnic groups in Nigeria. For the DHS 2013, this inclusion was more specific and clear. Comparison of prevalence before and after 2013 should therefore be made with caution due to these variations.

DHS reports do not use World Health Organization FGM/C typology. The categories of FGM/C used in the DHS surveys for Nigeria are 'cut, flesh removed', 'nicked, no flesh removed', 'sewn closed' (infibulation) and 'don't know/missing'.

UNICEF highlights that self-reported data on FGM/C needs to be treated with caution since women may be unwilling to disclose having undergone FGM/C due to the sensitivity of the subject or its illegal nature in some countries. In addition, they may be unaware that they have been cut or the extent of the cutting, especially if it was carried out at a young age.

Measuring the FGM/C statuses of girls aged under 14, who have most recently undergone FGM/C or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end the practice. Alternatively, responses to questions about FGM/C of girls can indicate the effect of laws criminalising the practice or a shift in societal attitudes towards it, which may make it harder for mothers to report that FGM/C was carried out, as they may fear incriminating themselves. Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM/C after the age of 14.

As for any dataset, it is also important to note that some results of these surveys may be based on relatively small numbers of women, particularly when the data is further broken down by, for example, location or age. Therefore, in some cases, the trends observed should be interpreted with caution. It should be made clear that any limitations of the data used in this report do not mean that the data are not useful; they simply mean that one should be careful about drawing 'hard and fast' conclusions, and Orchid Project has, accordingly, taken that approach when researching and writing this Country Profile Update.

Executive Summary

This Country Profile Update provides comprehensive information on the most recent trends and data on FGM/C in Nigeria. It includes an analysis of the current political situation, legal frameworks and programmes to make recommendations on how to move towards eradicating the practice. This report serves as an update to **28 Too Many's 2006 Country Profile**. Its purpose is to equip activists, practitioners, development partners and research organisations with the most up-to-date information to inform decision-making on policy and practice in the Nigerian context.

Elections took place in Nigeria in February 2023. Presidential candidate Bola Tinabu, from the governing All Progressives Congress party, was announced as the president-elect on 1 March 2023.¹

Statistics on the prevalence of FGM/C in Nigeria were compiled through Demographic and Health Surveys (*DHS*) in 2013 and 2018 and a Multiple Indicator Cluster Survey (*MICS*) in 2016–2017.

The prevalence of FGM/C in Nigeria appears to be decreasing. In 2013, 24.8% of women aged 15–49 years had been cut, and in 2018 this figure was down to 19.5%.² In 2018, 13.7% of women in Nigeria aged 15–19 had undergone FGM/C, as opposed to 31.0% of women aged 45–49.³

However, there is some evidence from interviews conducted in Nigeria that at least part of the reported decrease is due to **social desirability bias and community self-surveillance of cutting**, as a result of which women will be more reluctant to report that they have been cut. It is likely that the introduction of the Violence Against Persons (Prohibition) Act (see below) is one cause.

Additionally, over the period 2013 to 2018, **a worrying trend emerged among girls** (aged 0–14 years), of whom 19.2% had been cut in 2018, as opposed to 16.9% in 2013.⁴ Of particular note is that, among girls whose mothers are uncut, the percentage who *have* been cut has doubled.⁵ This is slightly unusual and a matter of concern. Further research into why this is so would be useful, but in a 2013 report, UNICEF emphasises the problem of a **'culture of silence'** in Nigeria, in which there is a significant gap between people's personal views on FGM/C and their feelings of social obligation to have girls undergo the cut and a lack of agency in the decision.⁶

40.9% of the Nigerian population is under 15 years of age, which represents 87,838,000 young people (42,943,785 female).⁷ The prevalence of FGM/C among girls (19.2% in 2018) means that, given the current population, **more than 8.2 million girls have been cut**.

It is important to note that **the states where the most women are affected by or are at risk of FGM/C are not necessarily those with the highest prevalence**. States with higher population numbers but lower prevalence may have higher numbers of women and girls affected. When population numbers are used, the priority states change from those with the highest percentages (Imo, Ekiti, Ebonyi, Kaduna, Kwara and Osun) to Lagos, Kaduna, Imo, Kano and Oyo. The increasing prevalence among girls in rural areas is also of concern, given that a significant portion of the population lives in rural areas.

Historically, Nigeria has followed the opposite trend to other countries where FGM/C is practised. Cutting has primarily been practised by those in the highest wealth quintiles, those with the most education and those who identify as Christian. However, this is starting to change.

*The majority of both cut and uncut women do not believe there are any benefits to the practice.⁸ Various data indicate that **the major reason for the continuation of cutting in Nigeria is tradition.***

The most common reason women give for opposing FGM/C is medical opinions against it,⁹ although traditional cutters are the **primary agents performing FGM/C** (on 85.4% of women aged 15–49 and 92.8% of girls aged 0–14).

Ethnicity plays a major role in the social and cultural norms of Nigerians and their motivations for continuing practices such as FGM/C. The highest prevalence is among Yoruba (34.7%) and Igbo (30.7%) women and girls, and the lowest is among Tiv and Igala women and girls (less than 1% each).¹⁰

The mean **age of cutting** decreased from 3.1 years in 1999 to 1.7 years in 2018.¹¹

‘Cut, flesh removed’ is the **most common type of FGM/C performed** in Nigeria (on 40.7% of women who have undergone FGM/C), ‘cut, no flesh removed’ the second (9.6%), and ‘sewn closed’ the least (5.6%).¹² The percentage of women who don’t know what type of cut they experienced increased to 44.1% from 26.3% in 2013.¹³ The data indicate a substantial increase in *angurya*, a type of cutting that, alongside *gishiri*, is almost exclusive to Nigeria.¹⁴

Article 39 of the Nigerian Constitution grants freedom of expression and the freedom to ‘hold opinions and to receive and impart ideas and information without interference.’¹⁵ In practice, however, reports on the **freedom of the press** in Nigeria paint a worrying picture about the nature of information veracity, control and suppression.¹⁶ A surprisingly low number of both women and men use the internet on a regular basis;¹⁷ thus, anti-FGM/C messages would be better spread through the most popular media, television and radio.¹⁸ Increasing media infrastructure and distribution would allow Nigerians to be exposed to opposing ideas about FGM/C and information about the risks and consequences associated with it. Nevertheless, greater access to the media will not be of help if authorities negate trust by continuing to control information and education resources.

Nigeria’s legal system is complex. Both levels of government play roles in the enactment of laws prohibiting FGM/C in Nigeria: although the Federal Government is responsible for passing general laws, the state governments must then adopt and implement those laws in their respective areas.

The Constitution’s Article 34(1) provides that every individual is entitled to respect for the dignity of their person and, accordingly, no one ‘shall be subjected to any form of torture, inhuman or degrading treatment or punishment’.¹⁹ **The Federal Government’s action plan against FGM/C** was for the period 2013–2017.²⁰ In December 2021, a new plan was announced, but as at the time of publication it has not been released.²¹ The **Violence Against Persons (Prohibition) Act**, which came into force on 25 May 2015, criminalises violence against women and specifically

prohibits FGM/C at Clause 6.²² However, without mirroring laws in each state, the act is only effective in the Federal Capital Territory of Abuja. As of October 2022, 32 of the 37 states and territories have passed it. Of those remaining, two states have not yet assented; Lagos and the Ekiti states have, respectively, the Protection Against Domestic Violence and the Gender-Based Violence Prohibition laws, which contain some of the provisions of the act.²³ Activists urge more active implementation and enforcement.²⁴

Nigeria is moving away from its Sustainable Development Goals. At 130th out of 144 countries, Nigeria is ranked lower on the Gender Equality Index than many of its neighbouring countries.²⁵ The **indicators of women's inequality with men** in Nigeria are extremely troubling. For example, The maternal mortality ratio has increased from 813 (2015) to 917 deaths per 100,000 live births (2020).²⁶ Gender-based violence and child marriage are both prevalent. This inequality calls for gender-transformative approaches to abolishing FGM/C.

There are numerous **international and local non-governmental organisations** working to eradicate FGM/C, using a variety of strategies including national and regional advocacy, engaging with the ethnic drivers of the practice, addressing patriarchal gender norms that perpetuate FGM/C, promoting education about FGM/C through digital media and traditional outlets, and engaging with religious leaders. A comprehensive overview of these approaches, with examples from active organisations, is included in this report.

This report calls for the following actions:

- **focus** programmatic response in the states that have the highest estimated numbers of women and girls affected by FGM/C, which include Lagos, Kaduna, Imo, Kano, Oyo, Osun and Ondo;
- **shift** the focus of programming to include women in rural areas, those in the lowest wealth quintiles and those with the lowest levels of formal education, among whom the practice is increasing;
- **work with** those who serve as protectors of the practice to shift the norms that contribute to women's senses of social obligation to cut (this includes mothers, mothers-in-law and grandmothers, as well as traditional birth attendants);
- **target** adolescent girls and pregnant and breastfeeding women with interventions, to shift social norms that influence the cutting of daughters at young ages;
- **promote** assenting to the Violence Against Persons (Prohibition) Act in all states and effectively implement it, especially in Kano and other states where there are large estimated numbers of women and girls affected by FGM/C; and
- **give urgent attention** to the Sustainable Development Goals and reversing the downward trends in each area, with particular emphases on maternal health and education.



Part 1: Update on Situation and Trends

Political Conditions

Elections, a protracted crisis in the north, and increasing violence and instability throughout Nigeria have placed the rights of women and girls at risk, reducing their participation in decision-making, increasing the likelihood of them experiencing gender-based violence and reducing the likelihood of them staying in school. In areas where FGM/C is practised, this reduction of rights can have catastrophic effects and increase the chances of girls and women being cut.

Electoral Politics

Nigeria is starkly **divided along religious lines**, having a predominantly Muslim population in the north and a largely Christian population in the south. President Tinubu is a Muslim from the Southern Zone of Nigeria; he chose Kashim Shettima, from Borno state in the Northern Zone, as his vice-president.²⁷

Former President Buhari approved an **amendment to Nigeria's electoral law** to provide additional and advance funding to the Independent Electoral Commission and allow electronic card readers for voting. The card readers were opposed by some politicians, who were concerned that the country's telecommunications infrastructure would hinder voting in some areas, particularly in the north.²⁸

A **bill was proposed to increase political representation by women**, by reserving special seats for female parliamentarians in national and state assemblies. However, this bill was rejected by the Senate.²⁹ On 2 March 2022, women, together with activists who had worked for years to get the bill before the Senate, marched in Abuja in protest of the decision.³⁰

Violence and Instability

Northern Nigeria has experienced violence and instability since the early 2000s. **Boko Haram and the smaller Islamic State in West Africa Province (ISWAP)** have wreaked havoc in the northern regions. They are well known for their attacks on schools and the kidnapping of girls, but they have also been responsible for attacking churches, government agencies and security forces.³¹ The insurgency has displaced more than two million people, and it is estimated that at least 40,000 have been killed and a further 314,000 have lost their lives due to indirect consequences of the insecurity.³²

However, not all violence can be attributed to Boko Haram or ISWAP. Due to the insecurity and the economic crisis in the country, there has been an increase in gang-related activity, particularly kidnapping for ransom³³ and attacks on police stations³⁴ and on trains as they travel through the country.³⁵ Buhari's election campaign was built on reducing the violence, and he has been heavily criticised for failing to do so.³⁶

The Nigerian Government has tried to reintegrate former Boko Haram and ISWAP fighters through an initiative known as **Operation Safe Corridor**. The official statistic is that 35,000 fighters and their families have surrendered.³⁷ The Government has aimed to rehabilitate fighters and support de-radicalisation, but reintegration has been challenging, and many community members struggle to overcome the anxiety they experience from living in close proximity to former fighters and their families. However, some people believe that they deserve a second chance and have tried to forgive them and allow them to reintegrate.³⁸

In May 2021, the leader of Boko Haram, Abubakar Shekau, reportedly committed suicide in battle. The death of Boko Haram's leader and the potential destabilisation of Boko Haram as a result may serve to strengthen ISWAP, supporting its goal of establishing a caliphate by encouraging the backing of the Islamic State and persuading new recruits.³⁹

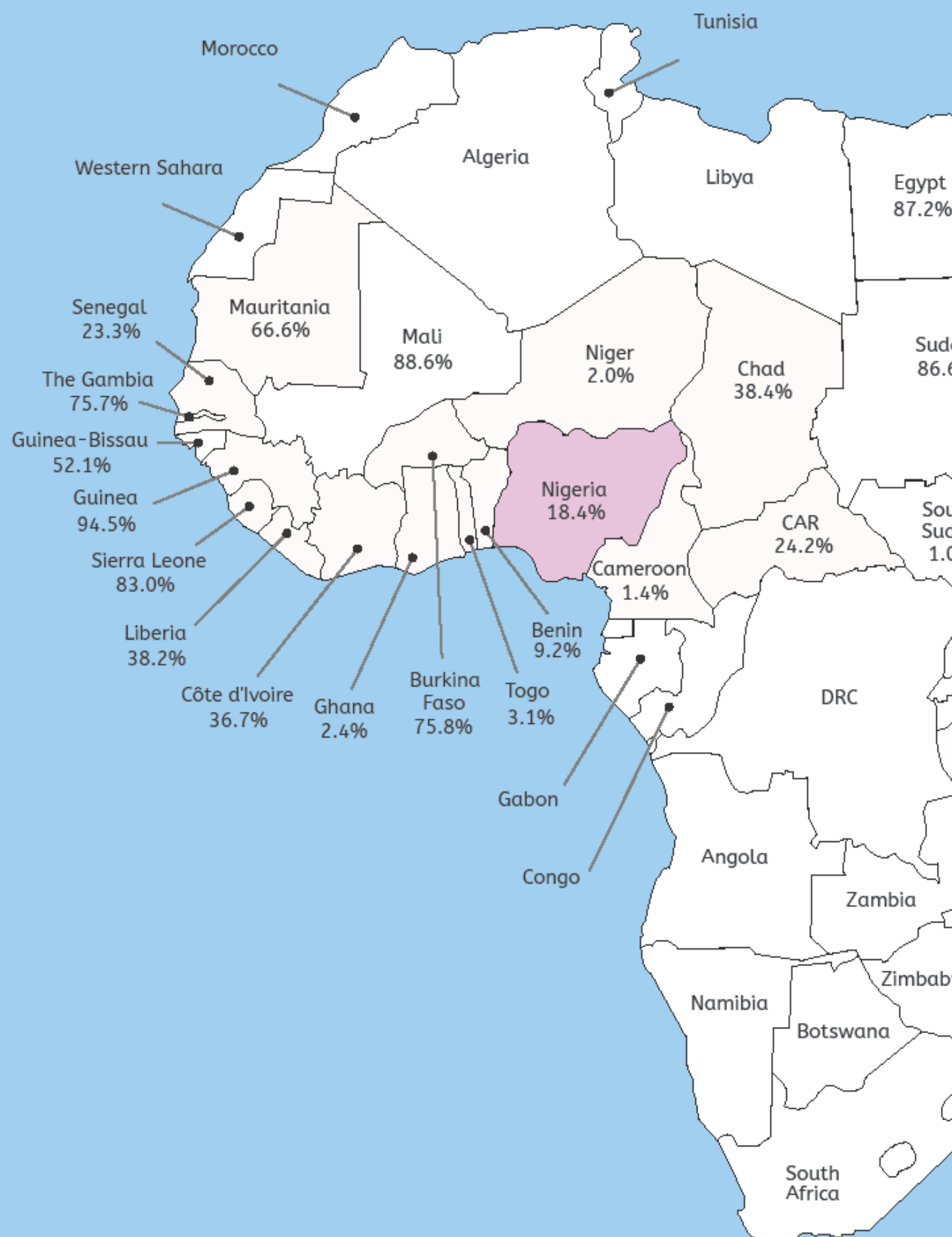
There is concern in the Sahel and Lake Chad regions about the growing strength of IS affiliates, especially as France withdrew its support from Mali to fight insurgents in 2021.⁴⁰ Insurgent groups have taken control of a significant amount of territory in Mali, Burkina Faso, Niger, Chad and Nigeria. According to the West Africa Centre for Counter Extremism, 6,000 West African fighters returned to their own regions from Syria and Iraq when the IS caliphate in the Levant collapsed in 2018.⁴¹ According to Nigerian analyst Muqthar Bukarti, as summarised in a 2021 *Deutsche Welle* article,

*Corruption, a dearth of economic opportunities, investment and social amenities by state actors has pushed mostly young men toward IS-affiliated groups in West Africa.*⁴²

The Impact on FGM/C

Ongoing crises and instability have negative effects on the rights of women and girls. They can have far-reaching consequences in terms of sexual and reproductive health, control of and access to resources, decision-making and influence, and the risk of experiencing violence. Insurgency in the northern parts of Nigeria creates household instability. Girls may be made to miss out on education for fear of them being kidnapped from schools. Access to quality healthcare, protection and security may be lacking. Without access to these basic rights, women and girls become increasingly vulnerable and more likely to be affected by gender-based violence (GBV).⁴³

Figure 1 (following page): Prevalence of FGM/C in Nigeria and surrounding countries



Freedom of Press and Media Access

Article 39 of the **Nigerian Constitution** grants freedom of expression and the freedom to 'hold opinions and to receive and impart ideas and information without interference.'⁴⁴ In practice, however, other laws, such as one criminalising defamation and acts associated with cybercrime, terrorism and national security, may be used to limit these freedoms and punish journalists and media outlets that appear to hold opinions in opposition to those in power.

*In 2022, Nigeria was ranked 129th out of 180 countries in the **World Press Freedom Index**, which is much worse than its rank of 111th in 2015.⁴⁵*

Reporters Without Borders claims that Nigeria is 'one of West Africa's most dangerous and difficult countries for journalists, who are often watched, attacked, arbitrarily arrested and even killed.'⁴⁶ **Censorship** is frequent; for example, Twitter was blocked in the country for seven months after the platform deleted one of President Buhari's tweets.

Four **journalists** have reportedly been killed since 2019; additionally, a reporter received threats while investigating severe violence in Kaduna, and a number of his sources 'were killed or died in suspicious circumstances'.⁴⁷

Print media is in decline in the country, as it is globally, but a plethora of radio and television channels remain. The major publications are *The Punch*, *The Nation*, *Vanguard*, *Guardian* and *The Premium Times*. Reporters Without Borders notes that the economic crisis in news publishing leaves it vulnerable to 'cash for news' situations.⁴⁸ The print media has historically been strongly entwined with political parties, leaving question marks over its objectivity.

These reports paint a worrying picture about the nature of information veracity, control and suppression in Nigeria.

55.6% of Nigerian women aged 15–49 do not have access on a weekly basis to any of the three main types of media listed in the DHS 2018 (**television, radio and newspaper**).

70.2% of women (and 64.5% of men) living in rural areas and 83.9% of women (82.7% of men) in the lowest wealth quintile are not exposed to any of these media on a weekly basis.⁴⁹

Women and men in the South West Zone are the least likely to have access to different forms of media.⁵⁰

Television has often been restricted to the wealthier population, as consistent electrical supply has historically been a difficulty for Nigerians; nonetheless, it is the **most popular medium** among women (32.9% watch at least once a week), while radio is the most popular medium among men (40.1% listen at least once a week).⁵¹

15.7% of women and 35.2% of men in Nigeria used the **internet** at least once in the 12 months prior to the DHS 2018 survey. Of those, approximately 50% use it every day.⁵² These are surprisingly low numbers.

The Impact on FGM/C

A lack of access to the media and important messaging has a negative impact on efforts to change attitudes towards FGM/C. Increasing media infrastructure and distribution allows women and girls to be exposed to opposing ideas about FGM/C (and other harmful traditional practices) and to have better understandings of the risks and consequences associated with it, as well as their human rights.

Nevertheless, greater access to media will not be of help in spreading social messages locally and nationally if they are viewed as subversive or problematic by authorities and if those authorities continue to control information and education resources.

Laws Related to FGM/C

Nigeria has a federal system of government comprising 36 states plus a federal capital territory. It has a mixed legal system of English common law, Islamic law (in 12 northern states) and traditional law. The legal system is complex. Both levels of government (federal and state) play roles in the enactment of laws prohibiting FGM/C in Nigeria: although the Federal Government is responsible for passing general laws, state governments must then adopt and implement those laws in their respective areas.

Constitution of The Federal Republic of Nigeria (1999)

The Constitution of the Federal Republic of Nigeria was passed in 1999. The Constitution does not specifically refer to **violence against women and girls, harmful traditional practices or FGM/C**.

However, Articles 15(2) and 17(2) respectively prohibit **discrimination** and set out **equality of rights**. Article 34(1) provides that every individual is entitled to respect for the dignity of their person and, accordingly, no one 'shall be subjected to any form of torture, inhuman or degrading treatment or punishment'.⁵³

Section 262 of the Constitution permits persons of Islamic faith to determine questions of Islamic personal law by the Sharia Court, in accordance with **Sharia law**. For example, Sharia law does not state a minimum age for marriage, but relies on puberty and physiological maturity to determine age of marriage – both very subjective parameters.⁵⁴

Sharia law was implemented in northern Nigeria in 1999 in Zamfara State. Over time, beginning in 2001, 11 other states implemented it (Bauchi, Borno, Gombe, Jigawa, Kaduna, Kano, Katsina, Kebbi, Niger, Sokoto and Yobe). These Sharia states reinstated Islamic criminal law, Sharia courts and a range of other legislation related to 'un-Islamic behaviour'.⁵⁵

The Constitution does not expressly define the age of 'a child' or prohibit child marriage or betrothal. However, the **age of marriage** is defined under the Child Rights Act as 18 years.⁵⁶

Child Rights Act

The Child Rights Act (CRA) was passed in 2003. While the CRA does not explicitly reference FGM/C, it does legislate against **harming a child**, which is defined as 'the use of harsh language, physical violence, exposure to the environment and any consequential physical, psychological or emotional injury or hurt'.⁵⁷ This could be viewed as criminalising the practice of FGM/C.

However, the CRA must be domesticated in each state to be applicable therein. As of November 2021, 27 of the 37 states and territories have domesticated it.⁵⁸ Those that have not domesticated it are primarily Sharia law states in the northern parts of the country.

Violence Against Persons (Prohibition) Act

The Violence Against Persons (Prohibition) Act (the *VAPP Act*), which came into force on 25 May 2015, criminalises violence against women and specifically prohibits FGM/C.⁵⁹

Clause 6 of the VAPP Act states,

The circumcision or genital mutilation of the girl child or woman is hereby prohibited. A person who performs female circumcision or genital mutilation or engages another to carry out such circumcision or mutilation commits an offence and is liable on conviction to a term of imprisonment not exceeding 4 years or to a fine not exceeding N200,000 or both.

Again, each state must pass ‘**mirroring laws**’ for the VAPP Act to be enforceable at the state level. Without such mirroring laws, the VAPP Act is only effective in the Federal Capital Territory of Abuja. A bill is said to have been passed if, at the joint sitting of both houses at the federal level (the Senate and the House of Representatives) or at the House of Assembly at the state level, it is presented to the president or the governor, as the case may be, and signed ‘assented to’. Once that is done, the bill becomes an act/law. As of October 2022, 32 of the 37 states and territories have passed the VAPP Act. Of those remaining, two states have not yet assented; Lagos and the Ekiti states have, respectively, the Protection Against Domestic Violence and the Gender-Based Violence Prohibition laws, which contain some of the provisions of the VAPP Act.⁶⁰ The states that have not assented to the VAPP Act are primarily Sharia law states in the northern parts of the country.

The VAPP Act has been criticised for not directly addressing **medicalised FGM/C** and not at all addressing **cross-border FGM/C**. Activists have applauded the passing of the law, but urge more active implementation and enforcement.⁶¹

National Action Plan Against FGM/C

The Federal Government’s action plan against FGM/C was for the period 2013–2017.⁶² That plan had committed to:

- reducing the prevalence of FGM/C among women and girls by 5% before 2017;
- increasing the number of health facilities that provide support to FGM/C survivors by 80% before 2017; and
- eradicating medicalised FGM/C by 2015.

In December 2021, the Minister of Women Affairs and Social Development, Mrs Pauline Tallen, announced that the Federal Government would soon be releasing a new action plan for eradicating FGM/C.⁶³ At the time of publication, this action plan has not been released.

The Impact on FGM/C

The VAPP Act, which criminalises FGM/C, was passed in 2015, but, in line with the Nigerian Constitution, to be enforceable the Act must be passed and assented to by each state.⁶⁴

As of October 2022, 32 of the 37 states/territories have passed and assented to the VAPP Act.⁶⁵ However, there is no discernible influence of the VAPP Act on the prevalence of FGM/C.

Between 2013 and 2018, there were large decreases in FGM/C prevalence in the states of Oyo, Ebonyi, Lagos and Abia, where the VAPP Act has been both passed and assented to.⁶⁶ It is possible that the VAPP Act contributed to these particular decreases in prevalence. According to NGOs in Nigeria, however, it has not had a significant impact on prevalence. Local by-laws that are decided in community meetings known as People's Assemblies are reportedly much more effective, because those by-laws are decided by the community and enforced by the community.⁶⁷

Estimates of the number of girls/women affected by FGM/C in each state (made using population data and prevalence statistics) demonstrate a clear need to monitor the incidence of FGM/C if and when the VAPP Act is assented to in each state, but particularly in Kano, where nearly a million girls/women are affected by FGM/C.

National Statistics

Population as at 2002:	127,008,222
Median age:	18.2 years (2016 est.)
Growth rate:	2.45% (2015 est.) ⁶⁸
Population as at 30 March 2022:	215,958,133
Median age:	17.9 years
Growth rate:	2.67% ⁶⁹
Human Development Index rank:	152 out of 188 in 2014 161 out of 189 in 2020 ⁷⁰
SDG Gender Index ranking:	130 out of 144 countries, with a score of 48.4 (2022) ⁷¹
Infant mortality:	72.7 per 1,000 births (2015) 75.7 per 1,000 births (2020) ⁷²
Maternal mortality:	813 per 100,000 (2015) 917 per 100,000 (2020) ⁷³
Literacy:	59.6% (2015) 62.0% (2020) ⁷⁴

The Impact on FGM/C

The population of Nigeria has almost doubled in the last 20 years, from 127 million in 2002 to 215 million in 2022.⁷⁵ During this period the national prevalence of FGM/C decreased among women aged 15–49 from 24.8% in 2013 to 19.5% in 2018.⁷⁶ However, among girls aged 0–14 years, the prevalence increased from 16.9% in 2013 to 19.2% in 2018.⁷⁷ UNICEF estimates that 19.9 million

Nigerians are survivors of FGM/C, which is the third-highest number of women and girls affected globally and represents about 10% of the global estimate.⁷⁸

Over the last decade, very little progress has been made in terms of levels of literacy and infant mortality rates. Furthermore, the risk of maternal mortality has actually increased, resulting in a fall in Nigeria's Human Development Index ranking to 162 out of 189 countries.⁷⁹

Likewise, Nigeria's SDG Gender Index score (48.4) is below that of most other countries in the region: Ghana (56.6), Senegal (52.2), Benin (49.9), Côte d'Ivoire (48.9), Togo (48.6) and Burkina Faso (48.6).

FGM/C: National and Regional Trends

*The prevalence of FGM/C in Nigeria appears to be decreasing. In 2013, 24.8% of women aged 15–49 years had been cut, and in 2018, this figure was down to **19.5%**.⁸⁰*

(Note that the DHS data prior to 2013 cannot be directly compared to the 2018 data, as the definitions used in prior surveys were different.⁸¹)

In 2018, 13.7% of women in Nigeria aged 15–19 had undergone FGM/C, as opposed to 31.0% of women aged 45–49.⁸²

However, although this indicates that there has been significant progress in Nigeria, when the data are broken down into different cohorts, there are also some worrying trends (see Table 1 below).

Prevalence among women aged 15–49 who reside in urban areas has dropped from 32.3% to 24.2%. There has been a similar drop among women in this age group who reside in rural areas, from 19.3% to 15.6% (see Figure 2 below).

Among women of this age group who have no formal education or a primary education only, prevalence has decreased from 21.5% to 19.5%. Among those with secondary or higher levels of education, the figure has dropped from 28.9% to 19.4%.⁸³ This is a very large drop for a five-year period and should therefore be questioned. Although it appears that there has, in fact, been a drop in prevalence in this cohort, there is also some evidence from interviews conducted by Orchid Project in Nigeria that at least part of this result is due to social desirability bias and community self-surveillance of cutting, as a result of which women will be more reluctant to report that they have been cut. It is likely that the introduction of the VAPP Act is one cause of this.

Social desirability bias – a woman's perception of how cutting is viewed by others in her society – will affect how she responds when directly questioned as to whether she is cut and whether she supports the continuation of FGM/C. One study in Ethiopia, using indirect questioning methods, found that 'privately held views in favour of FGC are approximately three times higher than those admitted when asked directly by an interviewer.'⁸⁴ This, unfortunately, can significantly affect the accuracy of survey data.

Over this same period of 2013 to 2018, a worrying trend emerges among girls (aged 0–14 years), of whom 19.2% had been cut in 2018, as opposed to 16.9% in 2013.

Within this age group, there was no change among girls residing in urban areas and those whose mothers had a secondary or higher level of education – prevalence remained about the same. However, among girls aged 0–14 from rural areas, there was an increase in prevalence from 17.0% to 21.1%. Among girls of this age group whose mothers had no formal education, prevalence increased from 19.3% to 24.4%, and for those in the lowest wealth quintile, prevalence increased from 19.4% to 26.6%. (See Table 1.)⁸⁵

Of particular note is that, among girls whose mothers are uncut, the percentage who *have* been cut has doubled – from 8.0% in 2013 to 16.6% in 2018.⁸⁶ This is slightly unusual and a matter of concern. Further research into why this is so, or whether it is simply an irregularity of the survey methodology, would be useful.

Demographic (Women) or Mother's Demographic (Girls)	Women aged 15–49 (2013)	Woman Aged 15–49 (2018)	Girls Aged 0–14 (2013)	Girls Aged 0–14 (2018)
Urban	32.3%	24.2%	16.8%	16.2%
Rural	19.3%	15.6%	17.0%	21.1%
No formal education	17.2%	17.2%	19.3%	24.4%
Primary education	30.7%	25.6%	16.3%	16.7%
Secondary or higher education	28.8%	19.4%	14.2%	14.1%
More than secondary	29.1%	19.5%	9.3%	7.5%
Lowest wealth quintile	16.5%	16.4%	19.4%	26.6%
Highest wealth quintile	31.0%	20.0%	12.6%	9.8%

***Table 1: Prevalence of FGM among various demographics
of women (aged 15–49) and girls (aged 0–14) in Nigeria (2013 and 2018)⁸⁷***

40.9% of the Nigerian population are under 15 years of age, which represents 87,838,000 young people (44,896,360 male/42,943,785 female).⁸⁸ The prevalence of FGM/C among girls aged 0–14 being 19.2% in 2018 means that, given the current population, more than 8.2 million girls have been cut.

In Nigeria, the rural population has been growing steadily at a rate of 0.87–0.94% per year. In 2018, the total number of Nigerians living in rural areas was 97,263,534, representing 50.3% of the total population.⁸⁹ While the prevalence of FGM/C dropped in the adult rural population from 19.3% (2013) to 15.6% (2018), prevalence among girls aged 0–14 in rural areas increased from 17.0% (2013) to 21.1% (2018). As such a significant portion of the population lives in rural areas and this number is increasing every year, a substantial number of girls are at risk.

UNICEF generated a press release in February 2022⁹⁰ raising the alarm over this trend in the data. Currently, the increased prevalence among girls aged 0–14 who reside in rural areas is not reflected in the national prevalence, but by 2030 it will be evident. It is expected that, if the increase were to continue, by 2030 Nigeria would see a surge in overall prevalence, and the actual number of girls and women affected would increase substantially if immediate action is not taken.

In response to this concern, the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation (the *UNJP*) in April 2022 launched a new campaign called the Movement for Good to End FGM. The campaign aims to register pledges to end FGM/C from five million Nigerians in Ebonyi, Ekiti, Imo, Osun and Oyo.⁹¹

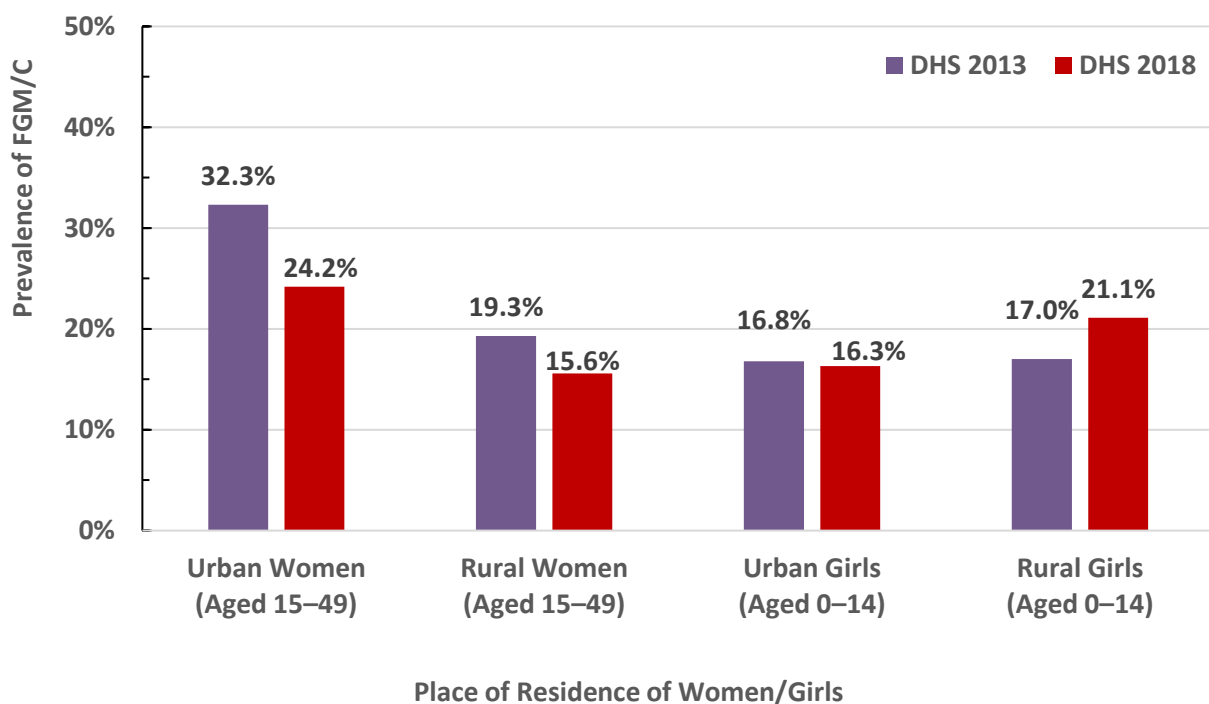


Figure 2: Prevalence of FGM/C in Nigerian women (aged 15–49) and girls (aged 0–14), according to urban/rural place of residence (2013 and 2018)⁹²

Prevalence According to Zone

Clear decreases in prevalence among women aged 15–49 occurred in each of the southern Zones between 2013 and 2018. Prevalence decreased from 49.0% to 35.0% in the South East Zone, from 47.5% to 30.0% in the South West Zone and from 25.8% to 17.7% in the South South Zone.⁹³

In the northern Zones, there was minimal change in prevalence between 2013 and 2018. Prevalence stayed the same in the North Central Zone (9.9%) and in the North West Zone (about 20%). In the North East Zone, there was an increase from 2.9% to 6.1% (Figure 3).⁹⁴

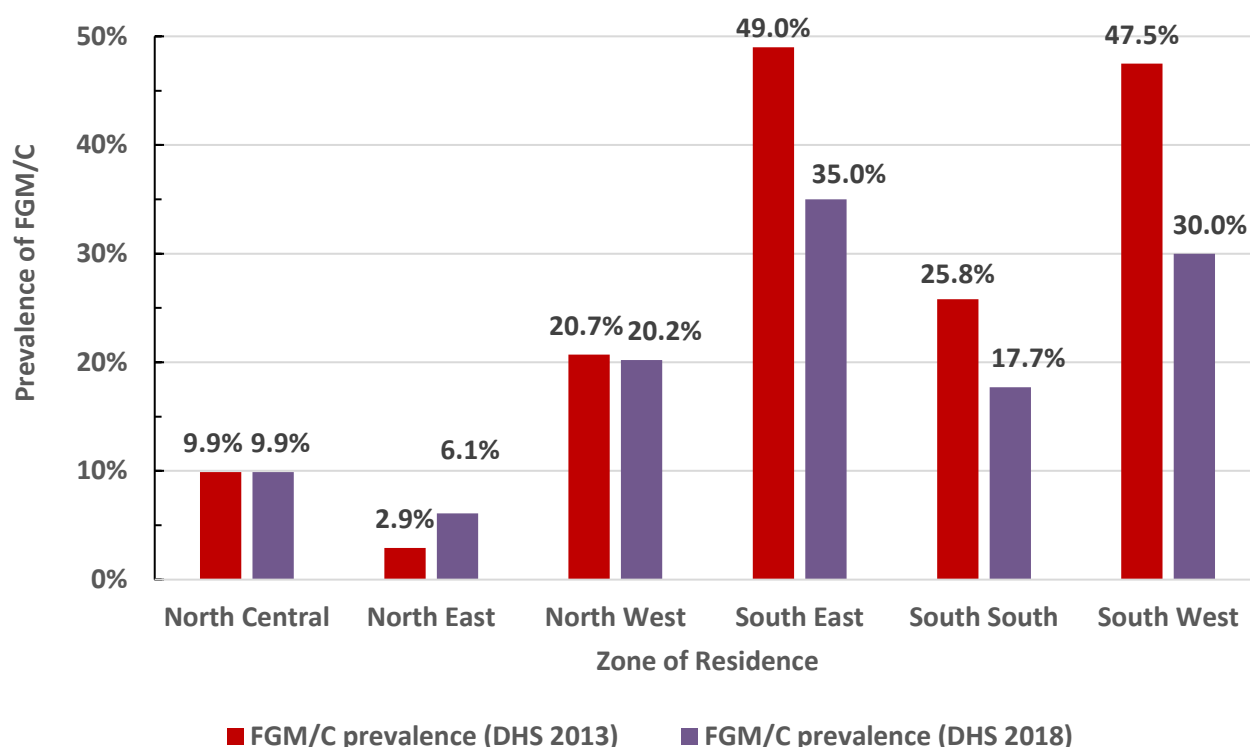


Figure 3: Prevalence of FGM/C in Nigerian women (aged 15–49), according to zone of residence (2013 and 2018)⁹⁵

Importance of Population Estimates in Nigeria

In Nigeria, it is particularly important to use population estimates to understand the number of women affected by FGM/C according to state, Zone or ethnic group. **As demonstrated in the map below, the states with the most women affected by or at risk of FGM/C are not necessarily those with the highest prevalence.** States with higher population numbers but lower prevalence may have a higher number of actual women and girls affected. When population numbers are used, the priority states change from those with the highest percentages (Imo, Ekiti, Ebonyi, Kaduna, Kwara and Osun) to Lagos, Kaduna, Imo, Kano and Oyo. Using numbers instead of percentages presents a substantially different approach to targeting FGM/C in Nigeria, by focusing where the biggest number of girls are at risk.

Prevalence According to State

The states with the highest prevalence of FGM/C among women aged 15–49 include Imo (61.7%), Ekiti (57.9%), Ebonyi (53.2%), Kaduna (48.8%), Kwara (46.0%) and Osun (45.9%) (Figure 4).⁹⁶

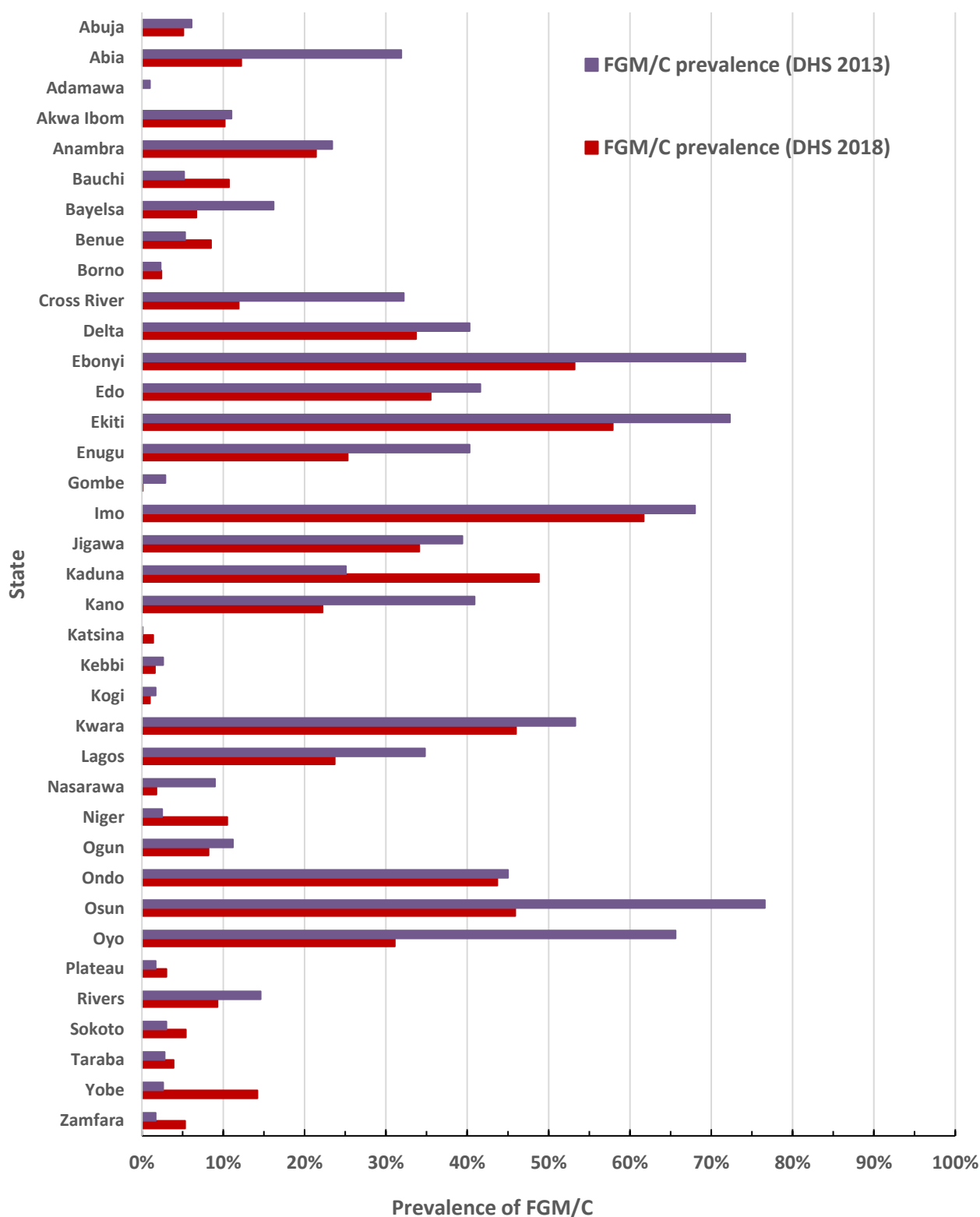
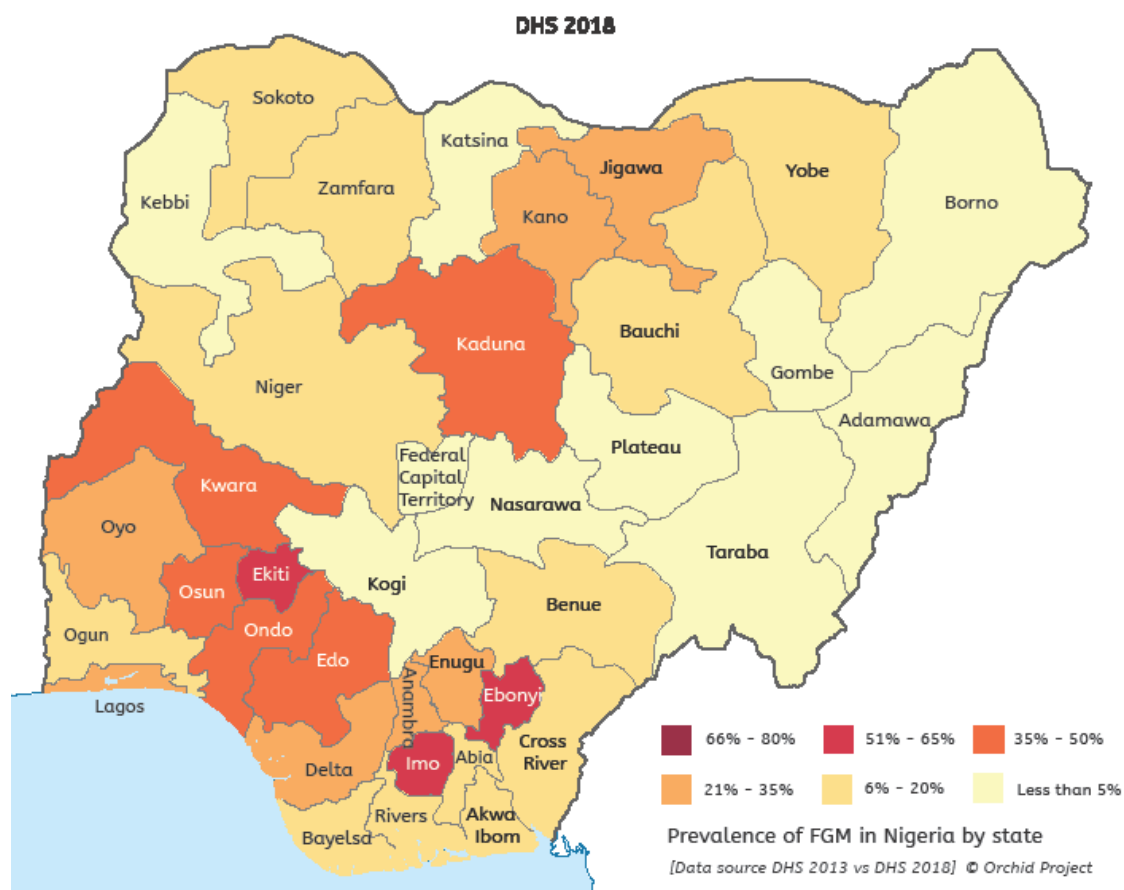
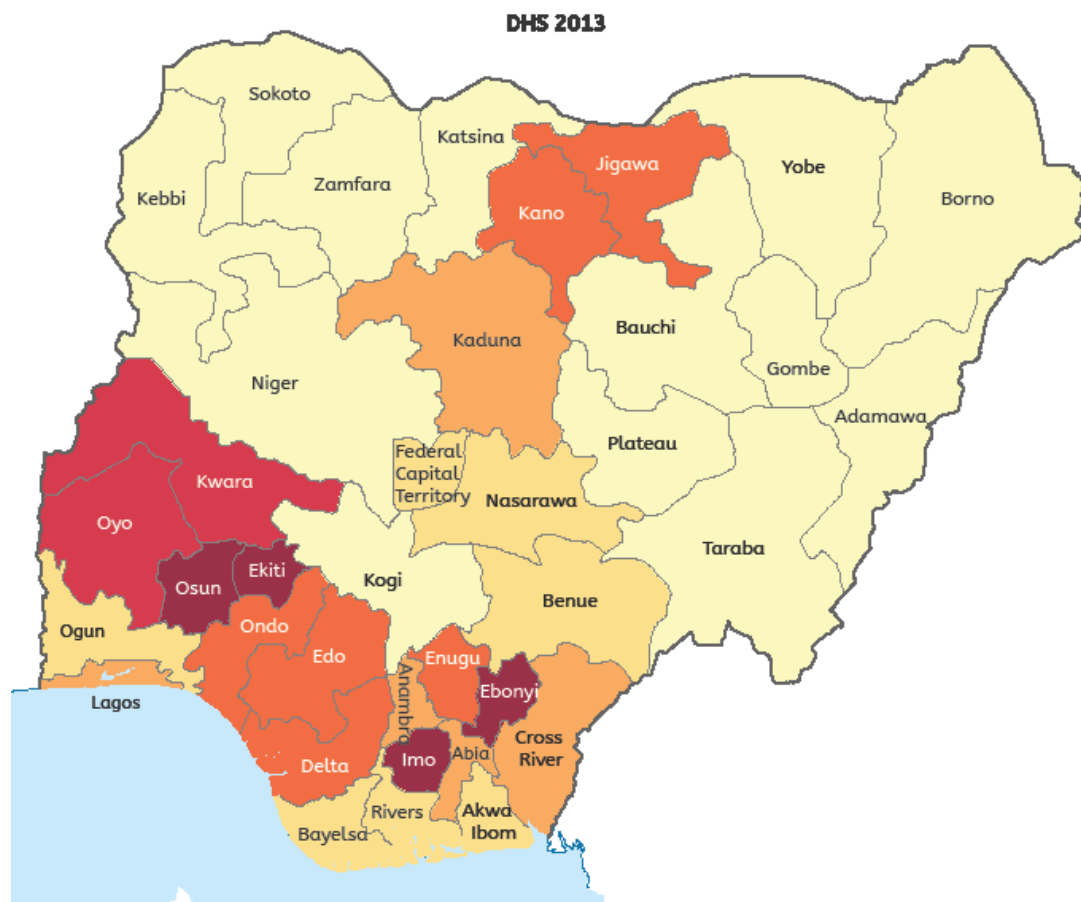
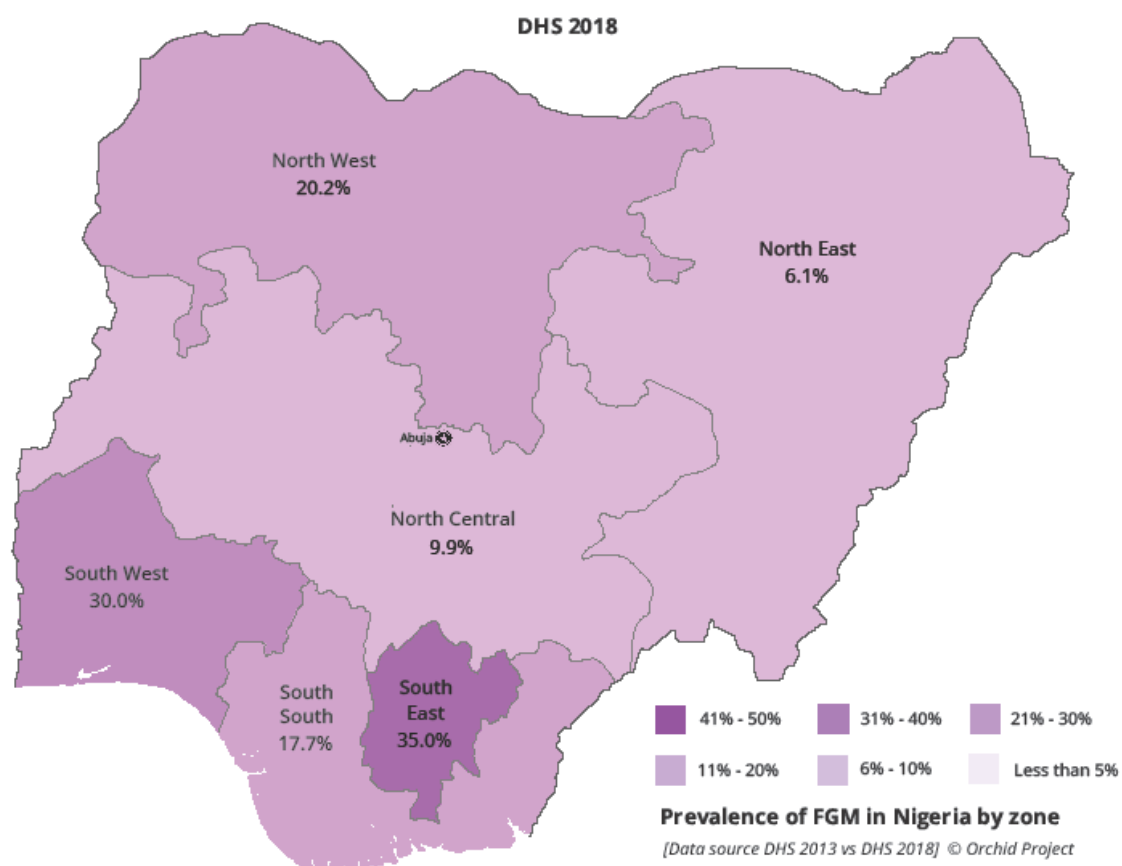
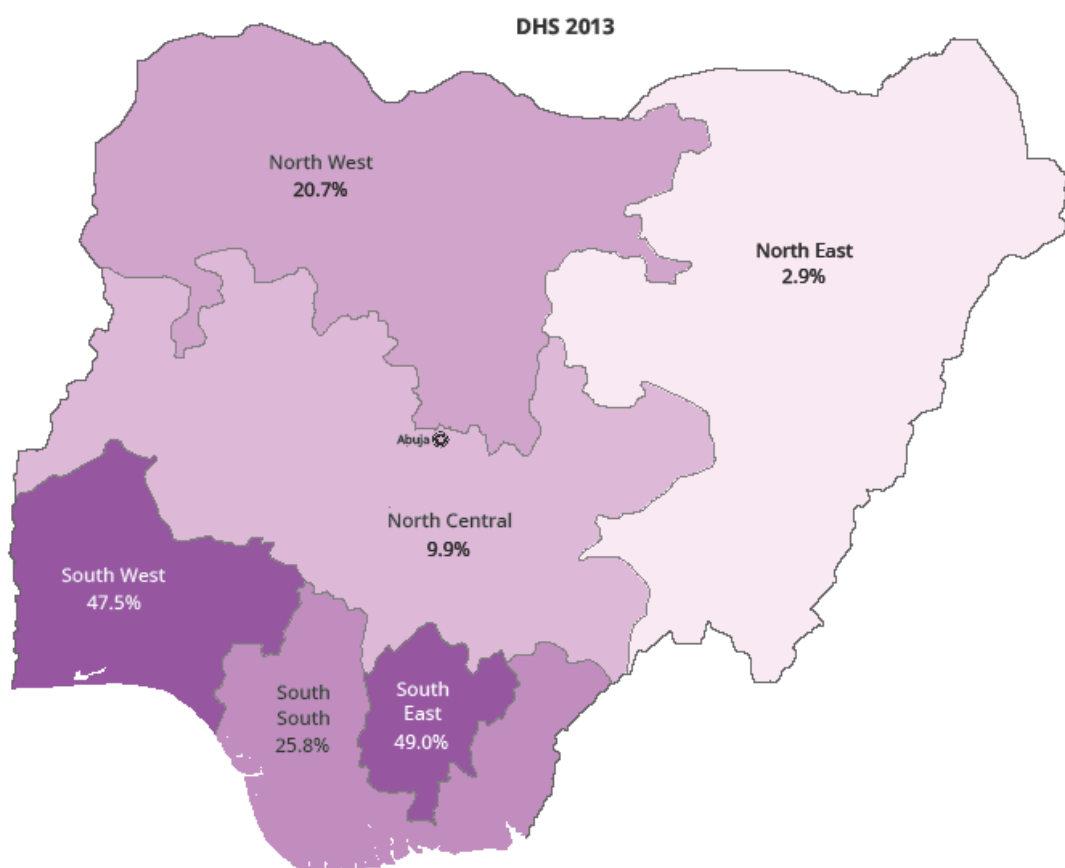


Figure 4: Prevalence of FGM/C among Nigerian women aged 15–49, according to state of residence (2013 and 2018)⁹⁷





FGM/C Prevalence According to Ethnic Group

There are 374 identifiable ethnic groups in Nigeria, each with varying cultural beliefs and practices. The three main ethnic groups are the Hausa (30%), Yoruba (15.5%) and Igbo (15.2%). The Hausa are mainly located in the north, the Yoruba in the south-west and the Igbo in the south-east. Ethnic minority groups include the Fulani (6%), Tiv (2.4%), Kanuri/Beriberi (2.4%), Ibibio (1.8%) and Ijaw (1.8%).⁹⁸

Nigeria also has variations in religious practice. 53.5% of people practise Islam, 45.9% Christianity and 6.0% indigenous religions.⁹⁹

Ethnicity plays a major role in the social and cultural norms of Nigerians and their motivations for continuing practices such as FGM/C.

As noted above, the Zones with the highest prevalence of FGM/C are the South East (35%) and South West (30%); the Zone with the lowest is the North East (6.1%).¹⁰⁰ When studying prevalence in terms of ethnicity, the **highest prevalence is among Yoruba (34.7%) and Igbo (30.7%)** women and girls and the **lowest is among Tiv and Igala** women and girls (less than 1% each).¹⁰¹ The prevalence in each ethnic group is shown in Table 2.

Ethnic Group	Prevalence of FGM (DHS 2013)	Prevalence of FGM (DHS 2018)
Yoruba	54.5%	34.7%
Igbo	45.2%	30.7%
Hausa	19.4%	19.7%
Fulani	13.2%	12.6%
Ekoi	Very small sample size	11.6%
Ibibio	12.8%	9.3%
Ijaw	11.0%	6.9%
Kanuri	2.6%	5.6%
Igala	0.5%	0.9%
Tiv	0.3%	0.8%
Other	13.4%	10.0%

Table 2: Prevalence of FGM/C among Nigerian women aged 15–49, according to ethnic group (2013 and 2016)¹⁰²

Between 2013 and 2018, there were decreases in FGM/C prevalence (among women aged 15–49) in most ethnic groups. This is most obvious in the Yoruba and Igbo groups, among whom prevalence decreased from 54.5% to 34.7% (Yoruba) and from 45.2% to 30.7% (Igbo). Other groups that experienced decreases in prevalence are the Ibibio – 12.8% to 9.3% – and the Ijaw – 11.0% to 6.9%. The remaining groups stayed fairly stable, with the exception of the Kanuri, among whom FGM/C prevalence increased from 2.6% to 5.6%.¹⁰³

Demographic data is politically sensitive in Nigeria. The last census, conducted in 2006, did not collect or analyse data disaggregated by ethnicity, religion or language. Four groups – the Fulani (Fula), Hausa, Yoruba and Igbo – account for around 68% of Nigeria’s total population.¹⁰⁴ Population estimates for the most prominent ethnic groups were used to calculate estimated populations affected by FGM/C. These are represented in Figure 5.

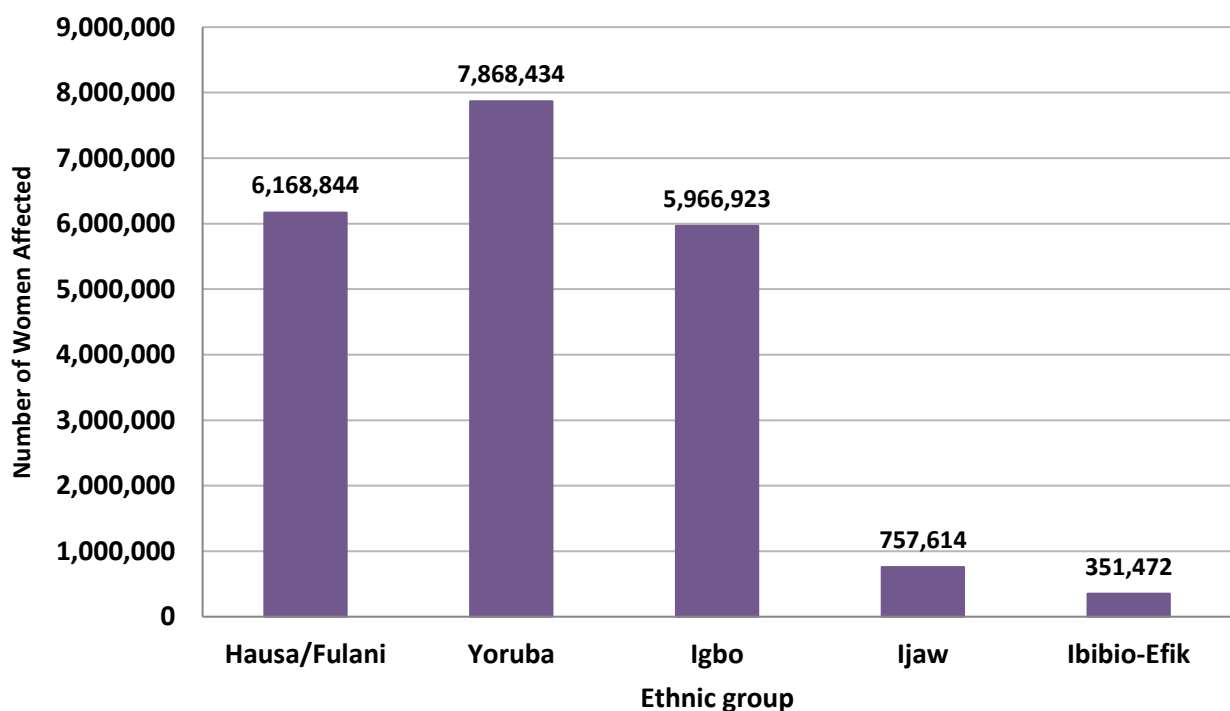


Figure 5: Numbers of Nigerian women and girls affected by FGM/C

Age of Cutting

At the time of the 2018 DHS survey, 85.6% of women (aged 15–49) who had undergone FGM/C stated that they were cut before the age of five.¹⁰⁵

18.3% of the total number of girls (aged 0–14) whose mothers were surveyed were cut before the age of five (19.3% were cut in total) (Figure 6), indicating a decrease in the age of cutting.¹⁰⁶

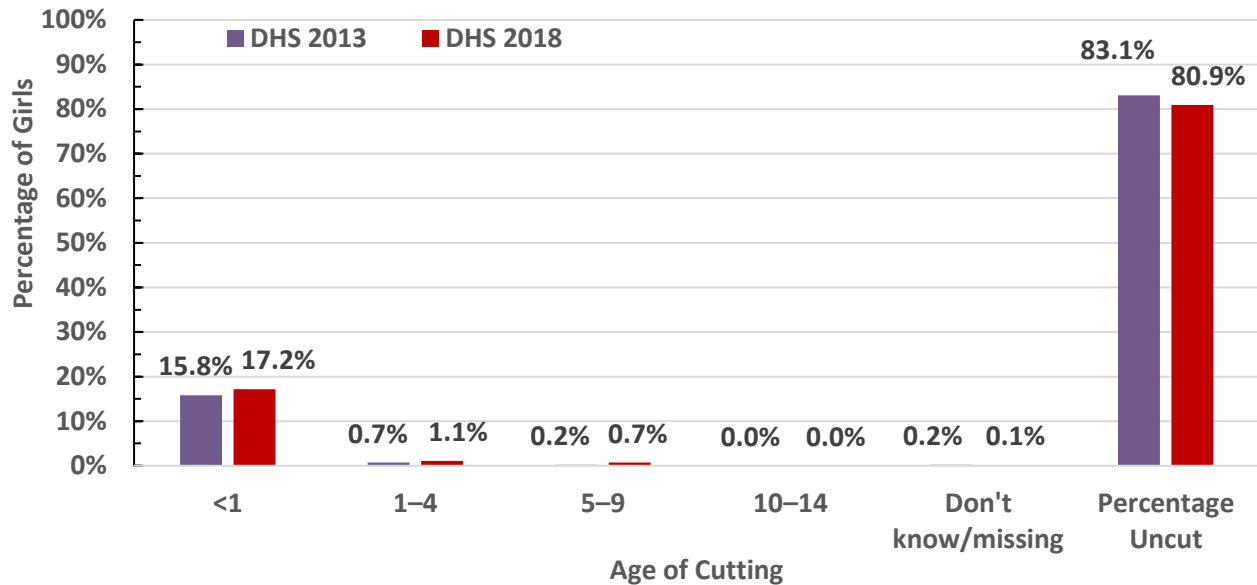


Figure 6: Ages that Nigerian girls aged 0–14 underwent FGM/C (as of 2013 and 2018)¹⁰⁷

The mean age of cutting decreased from 3.1 years in 1999 to 1.7 years in 2018.¹⁰⁸

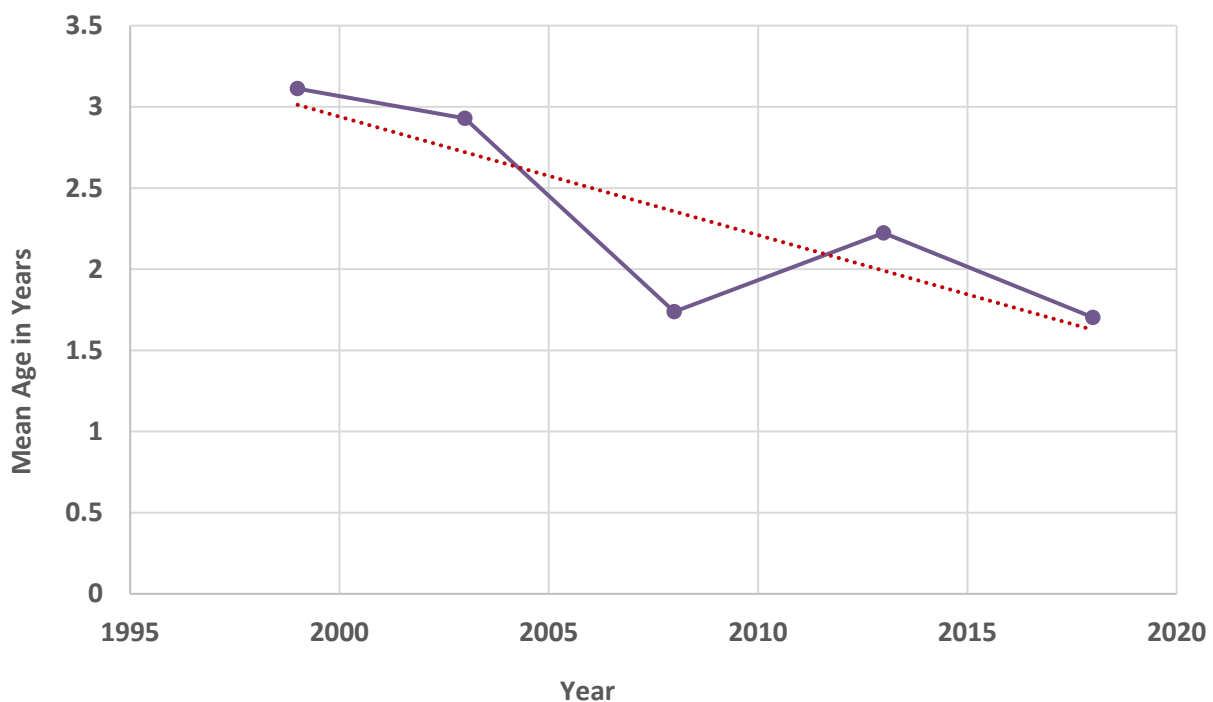


Figure 7: Mean age of cutting for girls aged 0–14 in Nigeria¹⁰⁹

Type of FGM/C

The World Health Organization (the *WHO*) classifies FGM/C into four major types.¹¹⁰ However, the Nigerian DHS surveys ask women aged 15–49 if they were ‘cut, flesh removed’, ‘cut, no flesh removed’ or ‘sewn closed’.

In Nigeria, ‘cut, flesh removed’ is the most common type (40.7% of women who have undergone FGM/C), ‘cut, no flesh removed’ the second (9.6%), and ‘sewn closed’ the least (5.6%).¹¹¹

It should be noted that 44.1% don’t know what type of cut they underwent. This is likely because they were cut at a young age or do not have a full understanding of the different types of cutting. The percentage of women who don’t know what type of cut they experienced has increased from 2013, when this figure was 26.3%.¹¹²

In 2013, 62.6% of women who had undergone FGM/C said they had been ‘cut, flesh removed’; 5.8% had been ‘cut, no flesh removed’, and 5.3% had been ‘sewn closed’.¹¹³

This appears to represent a change in the type of cutting being practised in Nigeria, but this change may also be explained by the increase in the percentage of women who don’t know what type of cut they experienced. As the age of cutting is so low (the mean age in 2018 was 1.7 years), many women will likely have no clear idea what type of cut they have undergone.

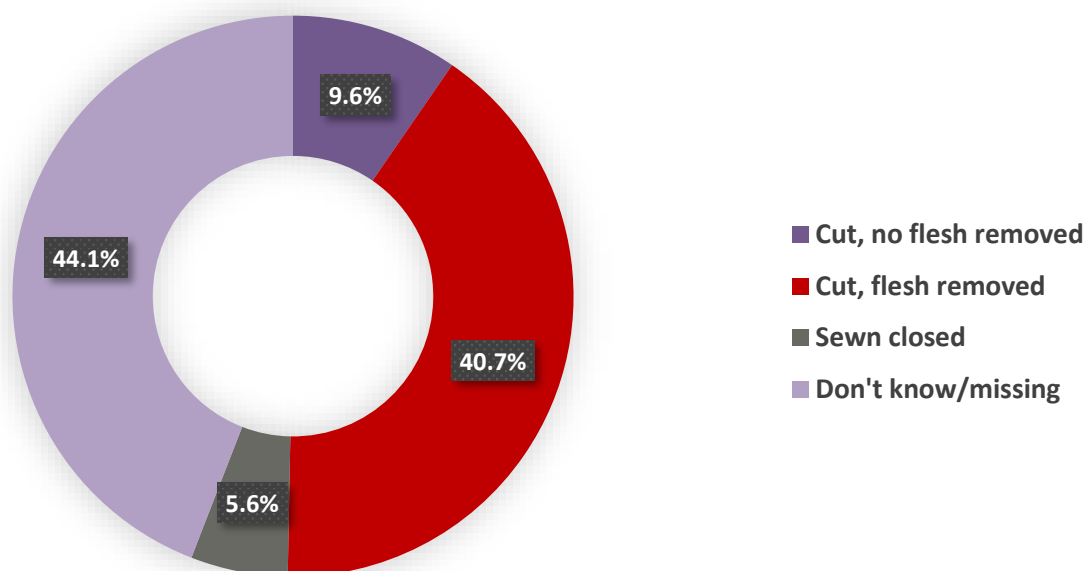


Figure 8: Percentage distribution of type of FGM/C undergone by women aged 15–49 in Nigeria¹¹⁴

Understanding Types of Cutting in Nigeria

The DHS surveys in Nigeria also explore country-specific variations in FGM/C and capture data on the overlaps between the types.

The types of FGM/C peculiar to Nigeria include *angurya* and *gishiri* and the use of corrosive substances. These types could be classified under the WHO's Type 4, but the data suggest that these types of cuts overlap with the other classifications of cutting.

In the DHS 2018, women aged 15–49 who had undergone FGM/C were asked if they experienced any of the distinctive types of cutting. 40.4% experienced *angurya*, 13.0% experienced *gishiri* and 6.6% underwent the application of corrosive substances.¹¹⁵ In 2013, 24.9% had experienced *angurya*, 5.1% had experienced *gishiri* and 5.1% had undergone the application of corrosive substances.¹¹⁶

The data indicate a substantial increase in angurya, from 24.9% in 2013 to 40.4% in 2018.

Angurya in Nigeria involves excision of the hymen, which is thought to be too thick. The hymen is a small piece of mucous membrane that surrounds or partially covers the vaginal opening. This very thin piece of tissue can be stretched, which may lead to bleeding. It is often thought of as a marker of virginity, which gives rise to expectations that a woman's hymen will be 'broken' at her first experience with penetrative sex. It is more accurate to say that the hymen can be stretched to the point of tearing, and such stretching may occur during the course of ordinary activities such as gymnastics or horse riding. Some girls may be born without one. Using its condition as a marker of virginity has therefore been strongly challenged by organisations like the American College of Obstetricians and Gynecologists, as it is not a medically sound idea.¹¹⁷ Additionally, the hymen can protect young girls from infection – harmful bacteria from the anus can get into the vagina because of the small distance between the two, especially in a tiny young body. Cutting or removing the hymen therefore removes any protection it may afford.

Angurya can also include scraping of the vaginal tissue. This type of cutting is most often performed on very young children/babies. It is understood to preclude difficulty with penetration at the time of first intercourse and/or prevent painful sex, because of the mistaken belief that these are caused by the hymen or vaginal tissue being too thick and needing to be reduced.¹¹⁸

Gishiri involves an incision of the posterior or anterior vaginal wall. This cut is also based on a mistaken belief that the vagina is too small and so will cause difficulty for a woman at first intercourse and during childbirth. It is also believed (erroneously) to militate against gynaecological problems (such as itching), infertility and amenorrhea (the absence of menstruation).¹¹⁹

Some women also report having had **corrosive substances** inserted into their vaginas. Contrarily, this practice is incorrectly thought to tighten the vagina.¹²⁰

The type of FGM/C practised differs between ethnic communities in Nigeria. Of the three ethnic groups with the highest prevalence, the types of FGM/C practised are shown in Table 3.

Ethnic Group	Prevalence of FGM (DHS 2018)	Population of Women and Girls Affected by FGM/C	Type (DHS 2018)
Yoruba	34.7%	7,868,434	Cut, no flesh removed (7.1%) Cut, flesh removed (46.2%) Sewn closed (2.4%) Don't know (44.3%)
Igbo	30.7%	5,966,923	Cut, no flesh removed (5.9%) Cut, flesh removed (48.9%) Sewn closed (12.2%) Don't know (33.0%)
Hausa/Fulani*	Hausa: 19.7% Fulani: 12.6%	6,168,844	Hausa: Cut, no flesh removed (13.6%) Cut, flesh removed (23.4%) Sewn closed (1.0%) Don't know (61.9%) Fulani: Cut, no flesh removed (22.8%) Cut, flesh removed (29.2%) Sewn closed (0.5%) Don't know (47.5%)

Table 3: Type of FGM/C undergone by women aged 15–49 in Nigeria¹²¹

**The source population data for these two ethnic groups is not separated. However, other sources state that approximately 30% of the Nigerian population is Hausa and approximately 6% is Fulani.*

Of women aged 15–49 in Nigeria who have been cut, 40.4% report experiencing **angurya**.¹²² The prevalence of angurya within different cohorts is shown in Figures 9 and 10.¹²³

Angurya is more common in the North-East Zone (91.1%) and the North-West (81.4%). Women with no formal education (70.8% of women who have been cut) and those in the lowest and second-lowest wealth quintiles (62.3% and 63.6% respectively) are most likely to have experienced angurya.¹²⁴

There have been increases in prevalence recorded among women in the lowest wealth quintiles, those with the lowest levels of formal education and those in rural areas. The DHS 2018 also shows an increase in angurya overall (24.9% in 2013 to 40.4% in 2018).¹²⁵

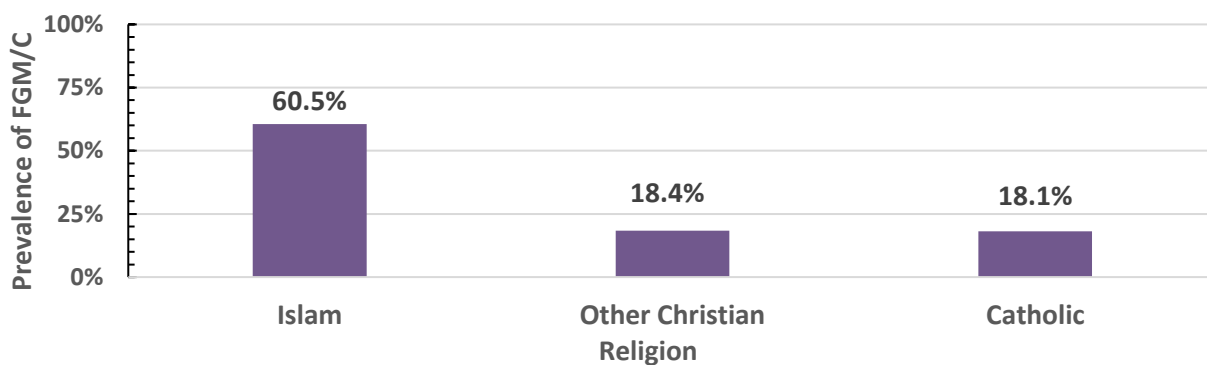


Figure 9: Prevalence of angurya in Nigerian women aged 15–49 who have been cut, according to religious affiliation

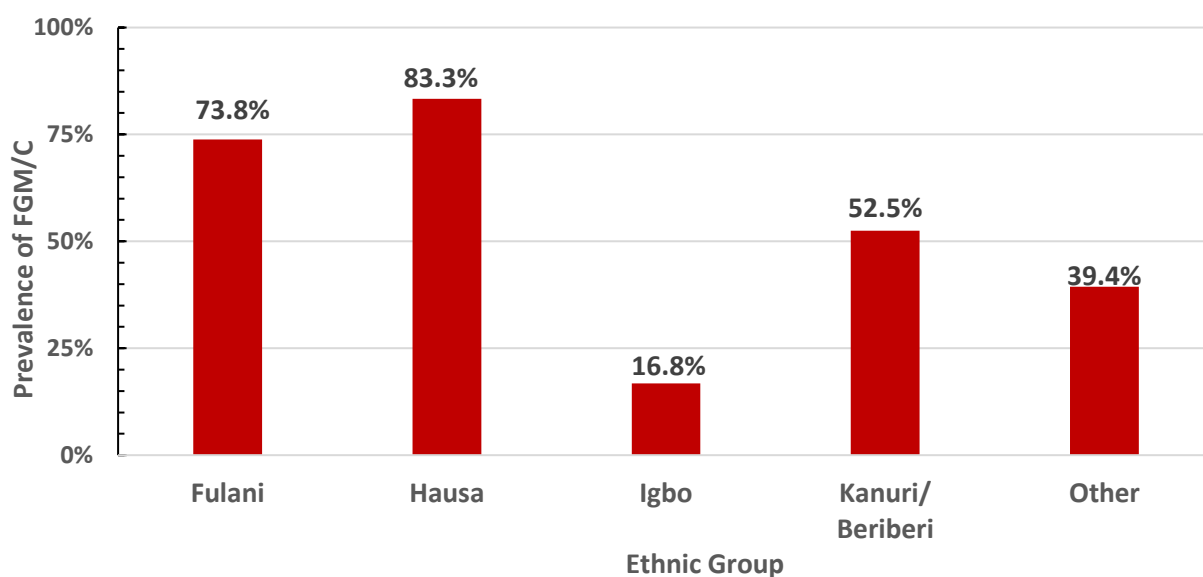


Figure 10: Prevalence of angurya in Nigerian women aged 15–49 who have been cut, according to ethnic group

Of women who have been cut, 13% report experiencing **gishiri**. The prevalence of gishiri within different cohorts is shown in Figures 11 and 12.¹²⁶

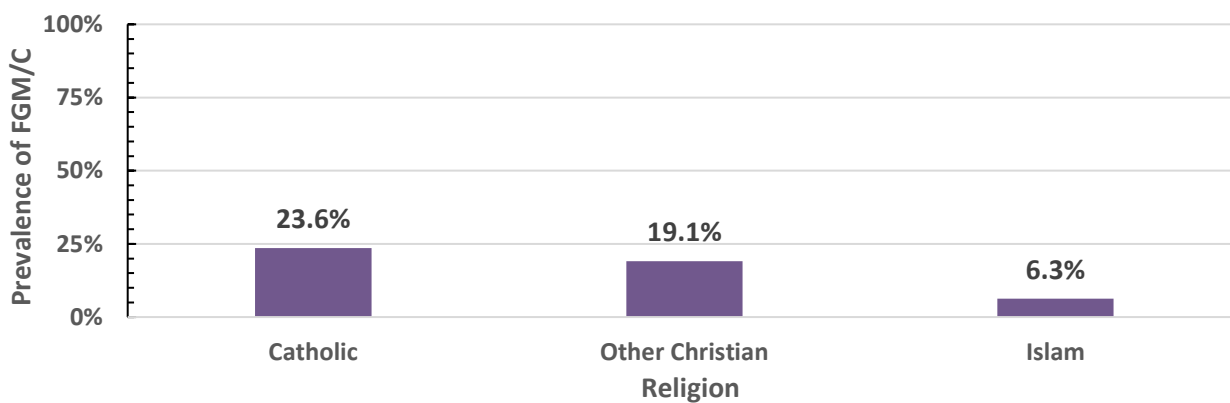


Figure 11: Prevalence of gishiri in Nigerian women aged 15–49 who have been cut, according to religious affiliation

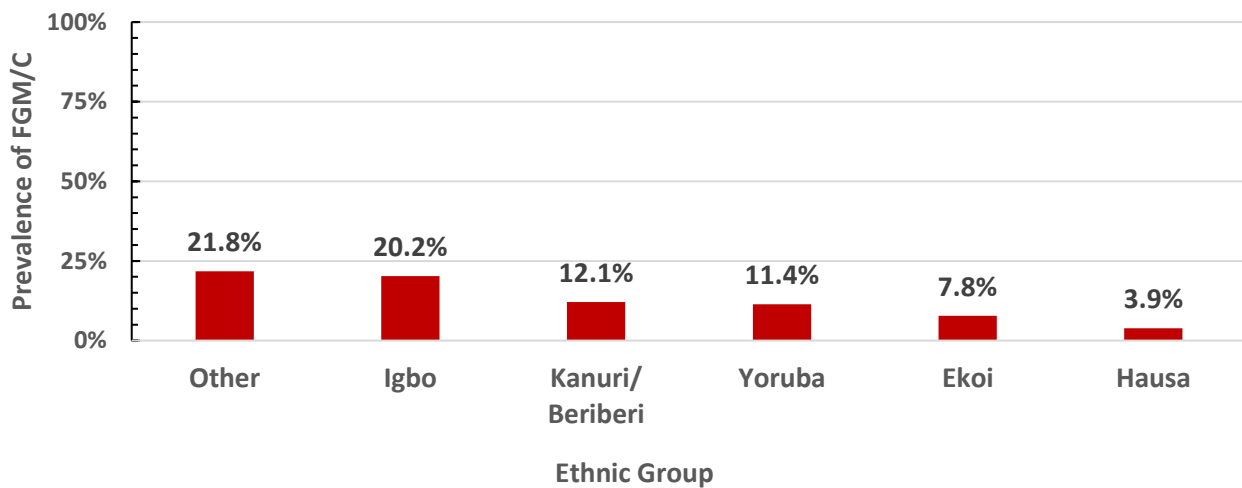


Figure 12: Prevalence of gishiri in Nigerian women aged 15–49 who have been cut, according to ethnic group

Some communities also use **corrosive substances** to try to narrow the vaginal tract. Of women who have been cut, 5.1% report having had corrosive substances used on them. The prevalence of corrosive substance use within different cohorts is shown in Figures 13 and 14.¹²⁷

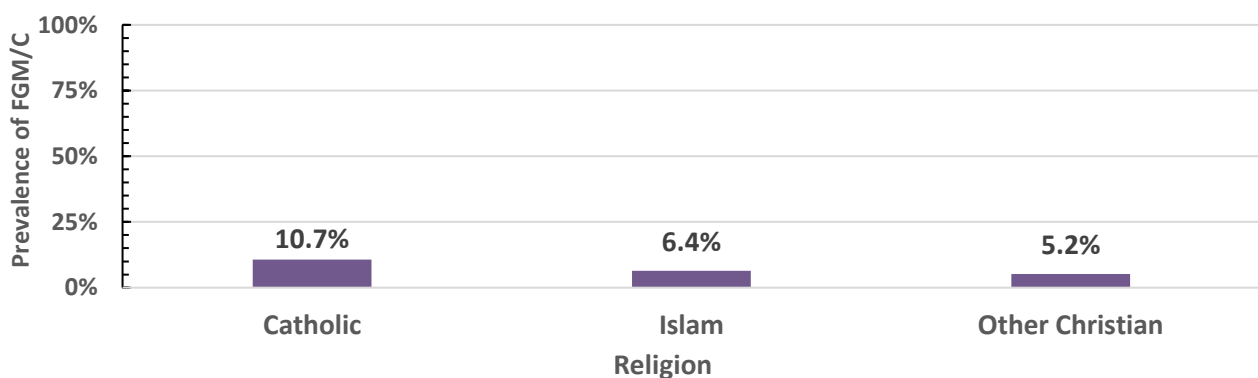


Figure 13: Prevalence of corrosive substance use in Nigerian women aged 15–49 who have been cut, according to religious affiliation

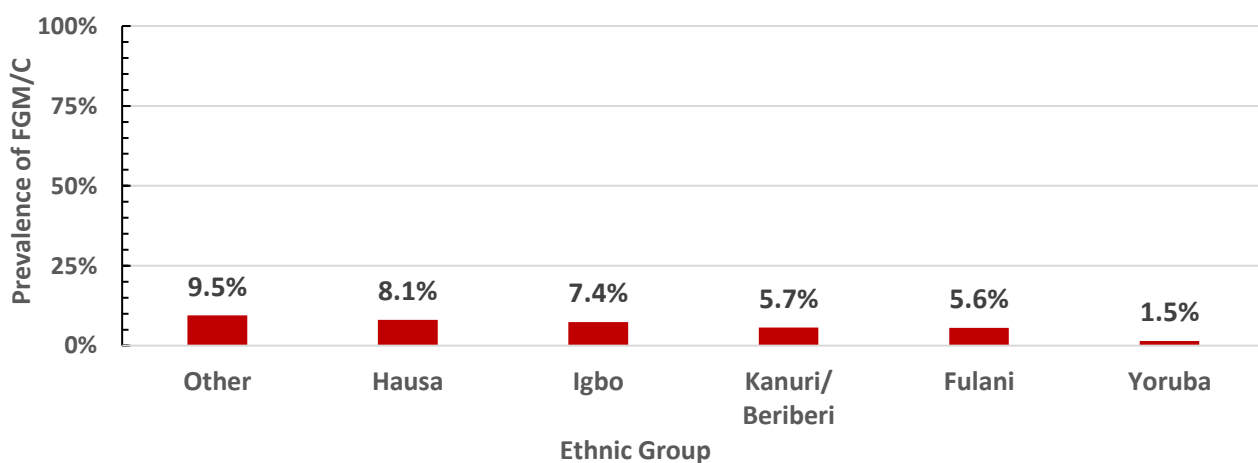


Figure 14: Prevalence of corrosive substance use in Nigerian women aged 15–49 who have been cut, according to ethnic group

Practitioners of FGM/C

Traditional cutters are the primary agents performing FGM/C in Nigeria (85.4% of women aged 15–49 and 92.8% of girls aged 0–14). Approximately 8% of women and girls are cut by traditional birth attendants and a further 7–9% by medical professionals, primarily midwives and nurses.¹²⁸ It should be noted that the traditional cutter role often overlaps with the traditional birth attendant role in Nigeria.

Factors that Influence FGM/C Prevalence

Socio-Economic Status: The prevalence of FGM/C is decreasing among Nigerian women aged 15–49 who are in the highest wealth quintile: 31.0% in 2013 to 20.0% in 2018. Among women in the lowest wealth quintile, prevalence has stayed the same: 16.5% in 2013 and 16.4% in 2018. The gap between the lowest and highest wealth quintiles is closing over time, as shown in Figure 15.¹²⁹

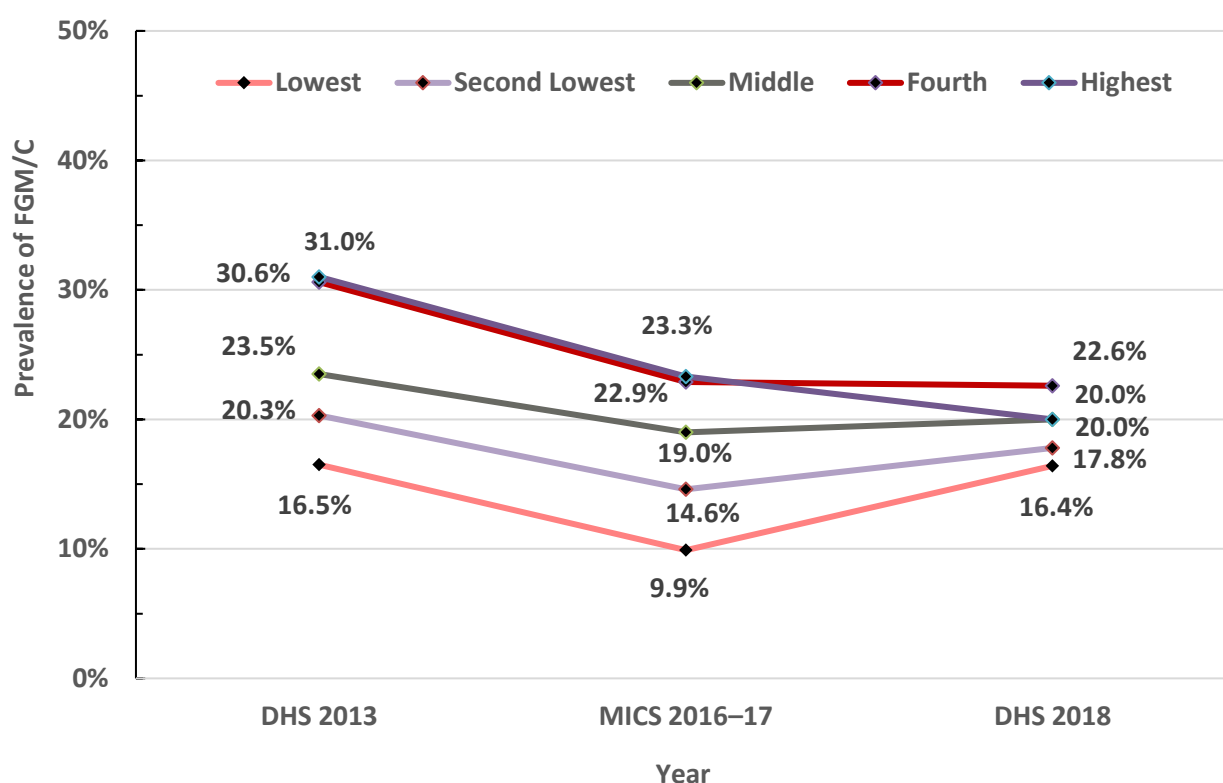


Figure 15: Prevalence of FGM/C among Nigerian women aged 15–49, according to wealth quintile (2013, 2016–17 and 2018)¹³⁰

Education: Among Nigerian women aged 15–49 with a secondary level of education or higher, the prevalence of FGM/C is dropping, as shown in Figure 16). For women with no formal education or only a primary level of education, prevalence is decreasing, but not nearly as quickly. As with wealth quintiles, the gap is closing between women with a secondary or higher level of education and those with no formal education or only a primary level.

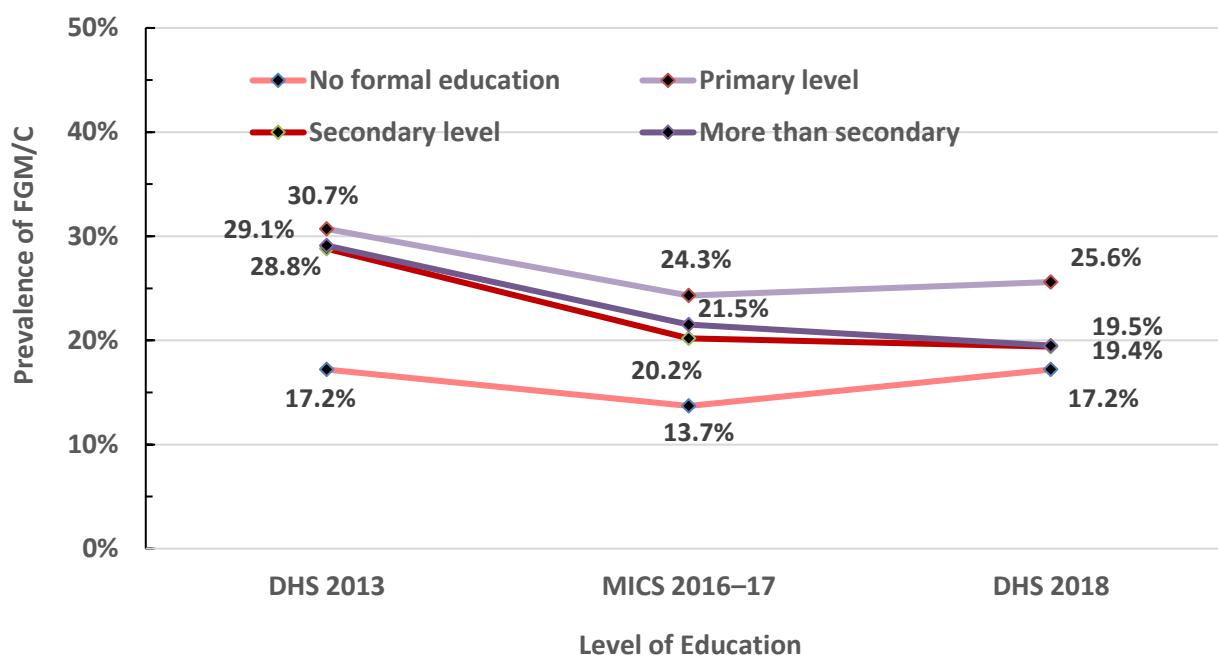


Figure 16: Prevalence of FGM/C among Nigerian women aged 15–49, according to level of education (2013, 2016–17 and 2018)¹³¹

Gender-Based Violence: 29.5% of Nigerian women aged 15–49 who have ever been married report experiencing violence by a current or former partner in the last 12 months. Of these women, 11.8% experienced physical violence, 4.7% experienced sexual violence and 26.7% experienced psychological violence.¹³²

When comparing women who have undergone FGM/C with those who have not, there are minor differences in the likelihood of them experiencing gender-based violence. Women who have undergone FGM/C are more likely to experience physical violence from an intimate partner than those who have not been cut (29.6% compared to 25.2%).¹³³

The Impact on FGM/C Programme Design

What the data show is that there has been progress between 2013 and 2018 in reducing the prevalence of FGM/C among urban, educated women and girls who are in the higher wealth quintiles. This progress should be celebrated and is likely the result of targeted programming and campaigning among these cohorts.

There have been regional shifts in prevalence in the southern Zones and relatively stagnant rates of cutting in the northern Zones. The mean age of cutting has dropped from 3.1 years to 1.7 years.

There is a worrying trend among girls aged 0–14 who live in rural areas and whose mothers have little to no formal education and are in the lowest wealth quintiles: the prevalence of FGM/C is increasing in these cohorts. This trend must be addressed immediately and with clear and targeted interventions to avoid reversing the gains of recent years.

Understanding and Attitudes

60.8% of women in Nigeria aged 15–49 have heard of FGM/C. Women in urban areas are more likely to have heard of it (69.0%) than those in rural areas (53.9%), and women in the northern Zones are more likely to have heard of it than those in the southern Zones. Knowledge of FGM/C appears to increase with age.¹³⁴

Beliefs About FGM/C

Of women in Nigeria who have not undergone FGM/C (80.5% of women aged 15–49 years), a very small percentage believes that there is any benefit to the practice (Table 4). Of those who have undergone FGM/C (19.5% of women aged 15–49), the majority does not believe that there are benefits to the practice.¹³⁵

Perceived Benefit	% of women who have undergone FGM/C who hold belief	% of women who have not undergone FGM/C who hold belief
Improves hygiene	10.7%	1.3%
Improves marriage prospects	11.9%	3.2%
Preserves virginity/chastity	17.9%	3.9%
Increases male pleasure	7.5%	1.5%

Table 4: Beliefs about FGM/C of women aged 15–49 in Nigeria¹³⁶

Women who have undergone FGM/C are more likely to believe that the practice should continue (41.7%) than those who have not been cut (13.2%). Women who adhere to Islam (34.2%) and traditional religions (39.1%) are far more likely to believe that FGM/C should continue than Catholics (10.5%) and other Christians (10.7%).¹³⁷ This supports other data that show the major reason for the continuation of cutting in Nigeria is tradition.

According to a study that included 500 Nigerian women, of which a large percentage had undergone FGM (84.6%), 94.6% said that the reasons they practise FGM/C are cultural or traditional. Other reasons included 'concerns about promiscuity' (48.9%), 'unsightly vulva' (18.2%), 'prevention of future death of male child' (11.0%), 'pressure from relatives' (9.2%), and 'religion' (6.1%). The most common reason women gave for opposing FGM/C was medical opinions against it.¹³⁸

Social Obligation

In a 2013 report, UNICEF emphasised the problem of a 'culture of silence' in Nigeria, in which there is a significant gap between people's personal views on FGM/C and their feelings of social obligation to have girls undergo the cut.¹³⁹ As FGM/C is a deeply taboo subject, speaking out against it can be challenging. Engaging decision-makers in the family – primarily mothers and grandmothers – is critical to shifting perspectives on the practice.

In a study in Enugu State on parents' intentions in relation to their daughters undergoing FGM/C, Ilo *et al.* found the following:

*The finding is consistent with the postulation of the [theory of planned behaviour] that perceived behavioral control is the strongest predictor and the most proximate determinant of intention and actual performance of a behavior. Subjective norms had the second strongest association with intention not to perform FGM, implying that parents perceive strong social support of significant others not to engage in FGM practice.*¹⁴⁰

In Nigerian society, social obligation is the primary reason that women decide to have their daughters cut. However, perceived behavioural control is the leading predictor of actions in this regard. This has significant implications for programming, especially as the gap in practice between women in the highest and lowest wealth quintiles and between those with the highest and lowest levels of education is closing. Where social obligation is strong and women are marginalised by poverty and low educational attainment, women may experience limited agency to choose not to have their daughters cut. The importance of social obligation is reinforced by vulnerability and marginalisation.

Understanding Religious Beliefs and FGM/C

- In Nigeria, women aged 15–49 who have been cut are twice as likely (24.9% of those who have heard of FGM/C) as those who have not (12.2%) to believe that FGM/C is required by their religions.
- Women who live in urban areas (12.0%) are less likely to believe that FGM/C is required by their religions than women in rural areas (21.6%), and fewer urban women believe that FGM/C should be continued (16.0%) than rural women (30.6%).
- Women with tertiary levels of education are less likely to believe that FGM/C is required by their religions (8.6%) than women who have no formal educations (27.7%).
- Women in the highest wealth quintile are less likely to believe FGM/C is required by their religions (8.5%) than those in the lowest wealth quintile (29.3%).¹⁴¹

Historically, Nigeria has followed the opposite trend to other countries where FGM/C is practised. Cutting has primarily been practised by those in the highest wealth quintiles, those with the most education and those who identify as Christian. However, this is starting to change (see Figure 17).

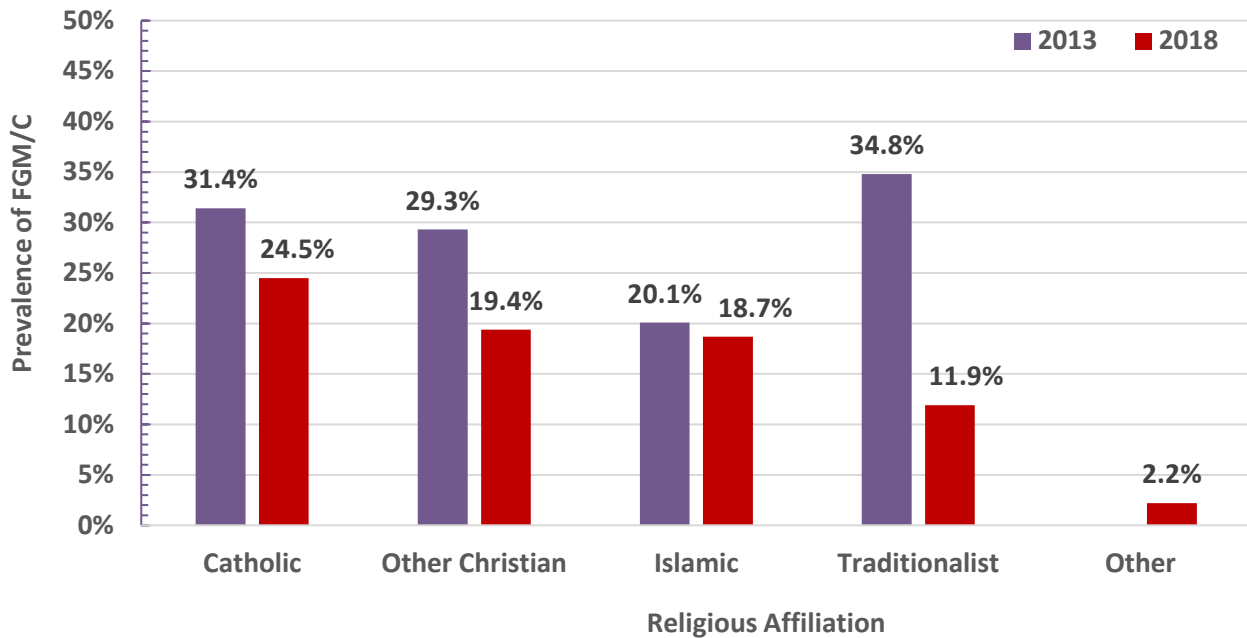


Figure 17: Prevalence of FGM/C according to religious affiliation among Nigerian women aged 15–49 (2013 and 2018)¹⁴²

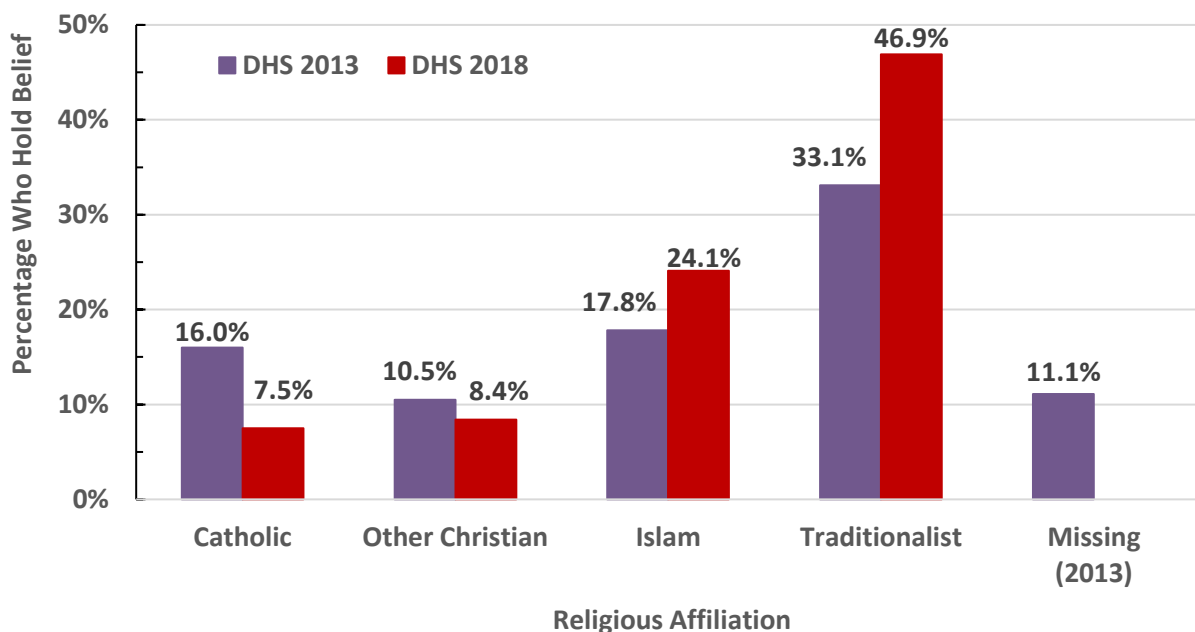


Figure 18: Of Nigerian women aged 15–49 who have heard of FGM/C, percentage who believe that FGM/C is a requirement of their religion (2013 and 2018)¹⁴³

Although Figure 18 shows that the belief that FGM/C is required by one's religion is most common among Traditionalist women, only a very small number of Traditionalist women were interviewed for the DHS surveys. This means that the sample sizes are too small to draw an accurate conclusion.

Rather, the belief that FGM/C is required by one's religion is highest among the Hausa and Fulani ethnic groups (25.7% and 26.6%, respectively).¹⁴⁴ Together, the Hausa and Fulani make up a third of the Nigerian population and are primarily Muslim – many are very devout followers of Islam.¹⁴⁵ The states where the belief that FGM/C is required by one's religion is most common are Kebbi (67.7% of women who have heard of FGM/C), Yobe (58.8%), Niger (50.0%), Ekiti (46.7%) and Zamfara (44.2%). With the exception of Ekiti, all of these states practise Sharia law.¹⁴⁶

The Impact on FGM/C Programme Design

The data is showing some progress between 2013 and 2018 in reducing the prevalence of FGM/C among urban-residing, wealthier and more educated women and girls. This progress should be celebrated and is likely the result of targeted programming and campaigning among these cohorts.

However, there is a worrying trend towards increased prevalence among girls aged 0–14 who live in rural areas, whose mothers have little to no formal education and who are in the lowest wealth quintiles. This trend must be addressed immediately, with clear and targeted interventions, to avoid reversing the gains made in recent years. The age of cutting is also dropping, perhaps to more easily keep the practice a secret as social and legal pressures to stop cutting increase.

Very few women in Nigeria believe that there is a benefit to FGM/C, whether or not they themselves have been cut. This reinforces the understanding that FGM/C in Nigeria is practised as a social requirement, based on ethnic identity, and not because of other perceived benefits.

Sustainable Development Goals

Nigeria is moving away from its Sustainable Development Goals. At 130th out of 144 countries, Nigeria is ranked lower on the Gender Equality Index than many of its neighbouring countries.¹⁴⁷ Although the prevalence of FGM/C is lower in Nigeria than in many other West and Central African countries, the population of the country is much higher, meaning that a higher number of girls are at risk. In terms of goals for education and health, Nigeria has moved backwards in recent years. More school-aged children are out of school and there is a higher maternal mortality rate than ten years ago. Urgent action is needed to move towards the Sustainable Development Goals.

The **2030 Agenda for Sustainable Development** was adopted by all UN member states in 2015, following on from the Millennium Development Goals (the MDGs).

17 **Sustainable Development Goals** (SDGs) make up a call to action for countries to work together to end poverty, improve health, reduce inequality and promote economic growth, while taking care of the environment.¹⁴⁸

The fifth SDG is specifically focused on gender equality, but there are a number of indicators throughout the SDGs that relate to gender. Equal Measures 2030 brought these indicators together to form the **Gender Equality Index (GEI)**, a broader measure of gender empowerment. Nigeria ranks **130** out of the 144 countries on the GEI. Four countries in West Africa – Senegal, Benin, The Gambia and Côte d'Ivoire – rank higher.¹⁴⁹

Using a 0–100 scoring system, the GEI rates countries as 'Excellent' (90–100), 'Good' (80–89), 'Fair' (70–79), 'Poor' (60–69) or 'Very Poor' (59 and below). While much of sub-Saharan Africa falls within the 'Very Poor' category, **Nigeria, at 48.4**, scores slightly below the West African average (48.5) and the average for sub-Saharan Africa (51.1) (see Table 5 below).¹⁵⁰

This means that, by comparison, conditions for women in Nigeria are more challenging than for many others in West Africa and across the wider continent.

Nigeria has made little progress since the previous review in 2015, when it had a score of 49.1.

Region/Country	Score (2019) ¹⁵¹
Global average	65.7 ('poor')
Sub-Saharan Africa	51.1 ('very poor')
West Africa ¹⁵²	48.5 ('very poor')
Nigeria	48.4 ('very poor')

Table 5: Selected results from the 2019 Gender Equality Index¹⁵³

Furthermore, according to the SDG 2020 report, the COVID-19 pandemic has had a devastating impact on gender equality.¹⁵⁴ Unpaid labour demands for women have increased, as well as rates of GBV and, particularly, intimate partner violence (IPV).¹⁵⁵ Economic shocks, school closures and interruptions to reproductive health services have put up to ten million girls at risk of early marriage.¹⁵⁶

There are also reports of increased rates of FGM/C as a result of the pandemic.¹⁵⁷ School closures and more time at home mean increased availability of time for healing and, in some places, for cutters to go door to door to carry out FGM/C.¹⁵⁸

SDG5: Gender Equality

The fifth Sustainable Development Goal (SDG5) aims to 'achieve gender equality and empower all women and girls'.¹⁵⁹ Within SDG5, there is a specific target for FGM/C (Target 5.3), which aims to 'eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation'.¹⁶⁰

Across sub-Saharan Africa, the average percentage of girls and women aged 15–49 who had undergone FGM/C was 29.4% in 2015.¹⁶¹ By 2020, this had reduced to 24.8%. At the last review, in 2018, the rate of FGM/C in Nigeria was 19.5% – below the average for sub-Saharan Africa.¹⁶² However, when Nigeria's population and the number of girls who have experienced or are at risk of experiencing FGM/C are factored in, the scale becomes comparable with all other West African countries (see Table 6 below).

In fact, approximately half of all women and girls impacted by FGM/C in West Africa are Nigerian.

To make progress on SDG5 Target 5.3 in sub-Saharan Africa and regionally in West Africa, it is essential to reduce the rate of FGM/C in Nigeria.

Country	Rate of FGM	Population Potentially Impacted	Year Data Collected
Nigeria	19.5%	19.3 million	2018
Mali	88.6%	9 million	2018
Côte d'Ivoire	36.7%	4.6 million	2016
Gambia	75.7%	0.9 million	2018
Ghana	2.4%	0.4 million	2018
Guinea-Bissau	52.1%	0.5 million	2019
Senegal	25.2%	2 million	2019
Sierra Leone	86.1%	3.3 million	2017
Togo	3.1%	0.1 million	2017

Table 6: FGM/C Prevalence in West Africa¹⁶³

SDG 4: Education

The fourth SDG is related to education and aims to 'ensure inclusive and equitable quality education and promote lifelong learning opportunities for all'.¹⁶⁴

Progress towards the education targets was slow before the COVID-19 pandemic, but that has set things back even further. The pandemic is projected to have an impact on minimum reading levels, causing an estimated 101 million children to fall behind the minimum proficiency level.¹⁶⁵

Access to quality education is often used as a proxy indicator for the empowerment of girls. In contexts where the prevalence of child marriage is high, such as Nigeria, prioritisation of girls' educations, especially into secondary school, marks a shift in perspectives on gender equality. It also serves as a protection mechanism against early marriage.

In Nigeria, the effects of the pandemic have combined with insurgency in the north and the kidnapping of girls from schools, causing a significant number of girls to drop out for fear of abduction.¹⁶⁶ There are currently ten million school-aged children in Nigeria who are out of school; 50% of those are girls.¹⁶⁷ There is a strong link between education and child marriage in Nigeria, as girls who are married young do not complete secondary school.¹⁶⁸ Unfortunately, COVID-19 lockdowns have increased the likelihood that girls who drop out of school won't return. As 40% of child marriages in West and Central Africa occur in Nigeria, supporting girls to complete their educations is critical.¹⁶⁹

The level of education a girl or woman receives often influences how likely it is that she and her daughters will be cut. It is usually an inverse correlation – as education increases, the likelihood of FGM/C decreases. In Nigeria, this is *not* the case. The prevalence among women with more formal education is higher than among those with less or no formal education. However, the gap is slowly closing, with a decrease in prevalence evident among the daughters of those with higher levels of education and a worrying increase in prevalence among the daughters of those with a primary education.¹⁷⁰

SDG 3: Good Health and Well-Being

SDG3 aims to ‘ensure healthy lives and promote well-being at all ages’. Target 3.1 aims to ‘reduce the global maternal mortality ratio to less than 70 per 100,000 live births’ by 2030.¹⁷¹

Globally, there has been substantial progress made towards this goal. The maternal mortality ratio (MMR) was reduced by 38% percent between 2000 and 2017, from 342 to 211 deaths per 100,000 live births worldwide. However, sub-Saharan Africa and Southern Asia account for about 86% of maternal deaths globally.

In Nigeria, however, things are moving in the opposite direction. The MMR has increased from 813 per 100,000 live births in 2015 to 917 per 100,000 in 2020.¹⁷² Nigeria is one of the most dangerous places in the world for a woman to give birth.

The Impact on FGM/C

FGM/C is known to have a negative impact on maternal health, increasing the likelihood of complications during delivery and of infant disability and death.¹⁷³ To improve maternal and infant health outcomes overall, it is important to improve the quality of maternal health services, and vital that health workers know how to respond to FGM/C-related complications during delivery and postpartum. In a health system where it is already dangerous for a woman to give birth, complications resulting from FGM/C can be a significant challenge.

For a summary of all 17 SDGs, please see our **Global Goals** document.

Gender Norms

Gender Equality in Nigeria

The disparities between men and women vary widely in Nigeria, depending on cultural and ethnic ties, religions, and whether a woman lives in an urban or rural location. Lagos state has the highest rates of education (73.5%) and financial inclusion (74.7%) for women, but women in the city of Lagos face considerable challenges with security. Yobe has very low rates of educational attainment among women (10.5% completed secondary school), poor employment (34% of women are employed) and poor financial inclusion (4.8%). 75% of women in Rivers have a secondary education, compared with only 4% in Sokoto. In Kwara, 96.8% of women participate in household decision-making, while only 1.3% report doing so in Sokoto.¹⁷⁴

27 out of 37 states in Nigeria do not have even one female political representative.¹⁷⁵ Nigeria has the lowest number of female parliamentarians in all of sub-Saharan Africa and ranks 133rd in the world for female political representation.¹⁷⁶ Only 7 of 109 senators and 22 of 360 members of the House of Representatives are women.¹⁷⁷

In March 2022, the Nigerian Senate threw out a bill that would have improved female representation in parliament. The bill included clauses for affirmative action that proposed 'the creation of one additional senatorial seat in each state of the federation and Abuja' and 'two new federal constituency seats in each state and Abuja', to be reserved for women.¹⁷⁸ A two-thirds majority is required in the Nigerian Senate to pass a bill, but the bill was rejected with a vote of 44 in support and 43 against (1 abstention).¹⁷⁹

Gender-Based Violence

*According to the DHS 2018, 31% of women aged 15–49 have experienced physical violence and 9.1% have experienced sexual violence.*¹⁸⁰

36.9% of ever-married women aged 15–49 have experienced intimate partner violence.¹⁸¹ 54.6% of women who have experienced violence *did not* seek help to stop it and never told anyone.¹⁸² Numbers are estimated to be much higher in reality, due to under-reporting.¹⁸³

A study that analysed data from the DHS 2013 found that a strong predictor of IPV is men's attitudes towards disciplining their wives and controlling their behaviours at the community level.¹⁸⁴ Even if women have protective factors (for example, a higher level of education, or being older at the age of marriage), collectively-held gender norms among men are more predictive of whether or not a woman will experience IPV.¹⁸⁵

Insurgency in the north-eastern states has led to substantial increases in IPV.¹⁸⁶ This has mainly manifested as reductions in decision-making powers in the household for women and reductions in their overall autonomy, linked to increased controlling behaviours from male intimate partners.¹⁸⁷

Child Marriage

43% of girls in Nigeria are married before they turn 18, and 18.5% are married before the age of 15.¹⁸⁸ Although these rates are lower than in some neighbouring countries in West and Central Africa – Niger (76%), Central African Republic (68%) and Chad (67%) – as the most populous country, Nigeria has the highest actual number of child brides.

*It is estimated that 22 million child brides live in Nigeria, representing 40% of all child brides in the region. By way of comparison, the actual number of child brides in Niger, which has a prevalence of 76%, is 4.1 million.*¹⁸⁹

Child-marriage rates vary considerably between ethnic groups in Nigeria. The ethnic groups with the highest prevalence are the Kambari (74.9%) and Fulfude (74.8%), followed by the Hausa/Fulani (54.8%). These figures are 15–20 times higher than the prevalence among southern ethnic groups such as the Yoruba and Igbo (3.0%–3.6%).¹⁹⁰ The states with the highest prevalence of child marriage are all Muslim-majority states practising Sharia law.¹⁹¹

However, there are also stark contrasts in the prevalence of child marriage between wealth quintiles in Nigeria. 80% of child brides are from the poorest wealth quintile.¹⁹² As child marriage in Nigeria has its roots in social and cultural norms related to paying/receiving a bride price when a girl marries, it is exacerbated in situations of extreme poverty and financial instability.

The Links Between Child Marriage and FGM/C

In Nigeria, child marriage is more common than FGM/C. 43% of girls are married before the age of 18, and 19.5% of women and girls aged 15–49 years have undergone FGM/C.

The mean age of marriage for women who have not experienced FGM/C is 17.7 years and for women who have experienced FGM/C is 19 years. The average age of marriage is therefore slightly higher for women who have experienced FGM/C, which goes against the expected trend.

Sexual and Reproductive Health

The MMR in Nigeria has *increased* from 813 deaths per 100,000 live births in 2015 to 917 deaths per 100,000 live births in 2020.¹⁹³ In comparison, the average MMR in sub-Saharan Africa is 533 deaths per 100,000 live births,¹⁹⁴ and the Sustainable Development Goals Target 3.1 is to reach a global rate of less than 70 deaths per 100,000 live births. Given these numbers, it is reasonable to conclude that Nigeria is one of the most dangerous places for a woman to give birth.

Sexual and reproductive health are partially determined by the age of marriage: for younger women, there is a greater likelihood of complications during delivery, including fistula and obstruction, as well as increased risk of exposure to sexually transmitted infections, including HIV.¹⁹⁵

In the five years preceding the DHS 2018 survey, only 39.4% of births took place in a health facility and 43.3% were attended by a skilled health provider.¹⁹⁶ 67% of women who gave birth to live babies received antenatal care, but only 56.8% attended four or more visits.¹⁹⁷

The Impact on FGM/C Programme Design

Firstly, we know that gender norms influence what decision-making powers women have, how readily they can access resources and support, and what spaces they have influence in. This means that FGM/C is often motivated by patriarchal gender norms that attempt to control women's sexualities, their bodies and how they are accepted in society and within the family.

To address this issue, when the UNFPA and UNICEF reviewed their work to eliminate FGM/C across 17 countries, they recommended a more explicit focus on the transformation of gender norms.¹⁹⁸

Gender transformative programming works to address the root causes of gender inequality and the power dynamics and structures that reinforce gender inequalities. According to a recent report by Orchid Project, 'a gender-transformative approach is defined as one that actively examines, questions and changes harmful gender norms and power structures that give boys and men advantages over girls and women.'¹⁹⁹

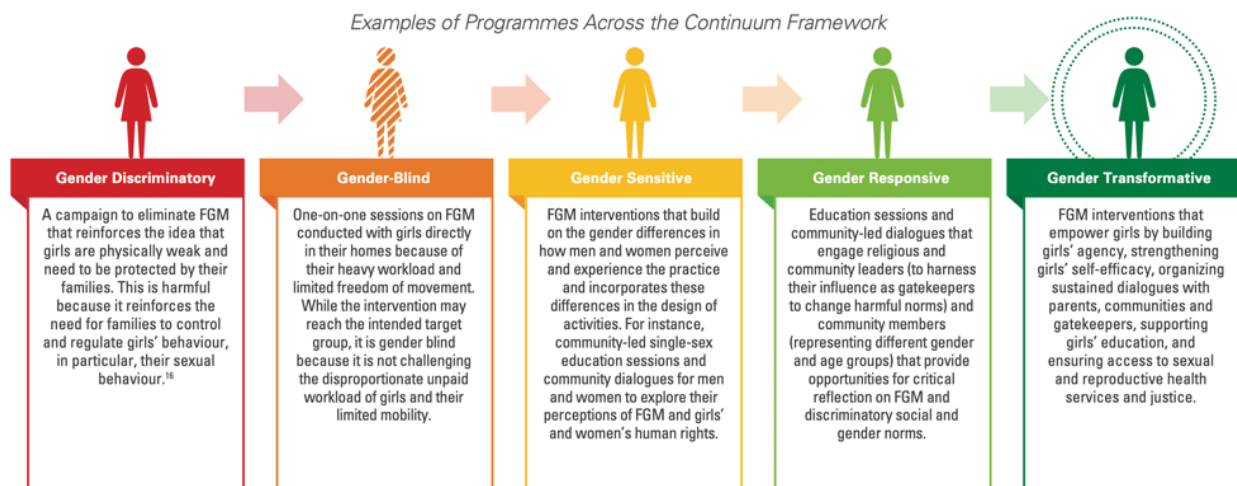


Figure 19: The Gender Equity Continuum²⁰⁰
(UNICEF; reproduced under Creative Commons Attribution–Non-Commercial 3.0 IGO)

Programmatic responses to FGM/C exist on a continuum of gender-discriminatory to gender-transformative (see Figure 19).²⁰¹ Gender-transformative approaches to FGM/C include engaging men and boys to address patriarchal gender norms and engaging in intergenerational dialogues with both women and men. These dialogues may include topics such as social acceptance, marriageability, sexual purity and positive masculinities. Local change agents may also promote alternative gender norms and create opportunities for power-holders to consider and explore new norms.²⁰²

Multi-level approaches are most effective in shifting gender norms. Promoting change to individuals, families and communities and at the regional and national levels supports a true shift in gender norms that can be sustained.

In Nigeria, studies have shown that a strong predictor of IPV is men's attitudes towards disciplining their wives and controlling their behaviours at the community level.²⁰³ The influence of community-wide gender norms is likely to be applicable to FGM/C as well as IPV. When one in three women experience violence at the hands of an intimate partner, there is a clear need for work to shift gender norms that inform masculinities, which in turn will influence both IPV and decision-making about FGM/C for girl children.

There are distinct gaps in maternal health and in access to (or use of) sexual- and reproductive-health services. The MMR is increasing instead of decreasing, only 39.4% of births take place in a health facility and as little as 12% of married women use modern contraceptive methods.²⁰⁴ Although lack of access and infrastructure are likely reasons for this, gender norms have a role to play in contributing to challenges with uptake by women.

Programming that works to explicitly engage men and boys is critical to shifting harmful gender norms and shaping more positive masculinities.



**Part 2:
Update on Responses
to FGM/C**

Challenges

Part 1 of this report provided an update on the current situation and trends in Nigeria, which have implications for the response to FGM/C and how activists focus interventions to reduce the prevalence of the practice.

The following is a summary of the current situation and trends in relation to FGM/C in Nigeria.

A. Actual Numbers vs Percentage Prevalence

The population of Nigeria is very high (215 million), and the overall prevalence of FGM/C is relatively low (19.5%).²⁰⁵ However, when this is viewed in terms of the actual number of women and girls affected by FGM/C, rather than the percentage, Nigeria is one of the top four affected countries in the world (together with Indonesia, Ethiopia and Egypt).

Many programmes target the states that have highest prevalence, which prioritises the following:

- Ekiti (57.9%);
- Imo (57.9%);
- Ebonyi (53.2%);
- Kaduna (48.8%);
- Kwara (46.0%);
- Osun (45.9%); and
- Ondo (43.7%).²⁰⁶

However, the states with the highest actual number of girls and women potentially affected by FGM/C are:

- Lagos (prevalence 23.7% – approximately 2,080,000 women/girls affected);
- Kaduna (48.8% – 1,475,000);
- Imo (57.9% – 1,200,000);
- Kano (22.2% – 988,000);
- Oyo (31.1% – 864,000);
- Osun (45.9% – 772,000); and
- Ondo (45.9% – 772,000).²⁰⁷

Some of these states overlap with the prioritised states listed above, but what emerges from this viewpoint is that a large number of women and girls affected in Lagos, Kano and Oyo may be left out if only prevalence is used to determine priorities.

B. A Change in Practising Cohorts

Nigeria has historically been one country where typical trends in FGM/C are reversed. In the past, FGM/C in Nigeria has been mainly practised by those living in urban areas, those in the highest wealth quintiles and those with the highest levels of education. It has also been practised by primarily Christian/Catholic groups.

However, this trend is now changing. Among girls 0–14 years of age, there is an increase in cutting among those in rural areas, from the lowest wealth quintiles and whose mothers have the lowest levels of formal education. There is also an increase in the number of Muslim women who believe that FGM/C is a requirement of their religion.²⁰⁸

FGM/C was typically practised in the South East and South South Zones of Nigeria. While these remain areas of focus, it should be noted that the data show increases in the North East Zone.²⁰⁹

There is also an increase in angurya, a practice unique to Nigeria that involves scraping the hymen. 40.4% of women who have undergone FGM/C report that they have experienced angurya.²¹⁰

C. Social Obligation Within Ethnic Traditions

Social obligation as a driver of FGM/C in Nigeria outweighs drivers linked to religion, purity/chastity or hygiene. Mothers, mothers-in-law and grandmothers are key protectors of the tradition and impose social pressure on women to have their daughters cut.

Women in the lowest wealth quintiles and with the lowest levels of formal education have less agency than wealthier and better-educated women to resist this social pressure, because of the consequences they may face in doing so.

The major ethnic groups that practise FGM/C are the Yoruba (34.7%), Igbo (30.7%), Hausa (19.7%) and Fulani (12.6%).²¹¹ These four groups represent 68% of the Nigerian population.

D. A Young Age of Cutting

The age of cutting in Nigeria is very young and getting younger. In 2013, the mean age of cutting was 3.1 years, and, as of 2018, the mean age is 1.7 years.²¹²

Age of cutting is strongly linked to ethnicity and to naming ceremonies performed in the first ten days of life. There is also anecdotal evidence from implementing organisations that, in communities that traditionally cut later, the age of cutting is getting younger as adolescents resist the cut later in life.

A very young age of cutting has implications for programming, as it requires focusing on adolescent girls before they become mothers, together with pregnant women and breastfeeding mothers, to shift attitudes and beliefs about FGM/C before their daughters are cut.

E. Assenting To and Implementing The VAPP Act

The Violence Against Persons (Prohibition) Act was passed in the Federal Capital Territory of Abuja in 2015. However, the system of legislation in Nigeria requires that the Act be assented to by each state government before it is enforceable at the state level.

As of October 2022, five states have not yet assented the VAPP Act. Of those, Kano has the highest estimated number of women and girls affected by FGM/C (988,000). Unfortunately, where the VAPP Act has been assented to, it is not consistently implemented.

F. Lack of Progress Towards SDGs

Nigeria is falling behind on numerous Sustainable Development Goal targets, but most notable is its drop on the Human Development Index – the country currently ranks 130th out of 144 countries.²¹³

Of significant concern is the rise of the MMR to 917 per 100,000 live births in 2020. This rate is well above the global average (211 per 100,000) and almost double the average for sub-Saharan Africa (542 per 100,000).²¹⁴

Nigeria has approximately ten million children out of school, 50% of whom are girls.²¹⁵

Additionally, Nigeria has one of the highest rates of child marriage in West and Central Africa: an estimated 22 million girls are affected.²¹⁶

Responses

The following section contains examples of the different types of responses that have been put in place in each of the priority areas. This is not an exhaustive list, but a snapshot of interventions that are having an impact on FGM/C in Nigeria.

(For further details on organisations that are actively responding to FGM/C in Nigeria, see our 2016 Nigerian Country Profile, available [here](#).)

A. Actual Numbers vs Percentage Prevalence

Ten organisations were marked as key stakeholders in the response to FGM/C in Nigeria. Of those ten, only two (**Voices for Change** and **Value Female Network**) are focusing their work in Lagos, wherein the highest estimated number of women and girls is affected by FGM/C.

Only one organisation is working in states in the North East Zone – **Voices for Change**, which focuses on Kaduna and Kano. All other organisations are working in the states with the highest percentage prevalence of FGM/C (Imo, Oyo, Osun, Ekiti, Ebonyi, Cross River and Enugu), some of which do overlap with the states that have the highest estimated numbers of affected women/girls.

Some organisations have national focuses, primarily in advocacy and media-related activities (**Global Media Campaign** and the **Medical Women's Association of Nigeria**).

Although very few organisations are working in the North East Zone states of Kaduna, Kano and Jigawa, **Save the Children** and **Plan International** are responding to the humanitarian crisis in this part of Nigeria. Their work focuses on child protection – protecting the right to education and creating child-friendly spaces for children affected by emergencies to play and learn. Although neither organisation focuses specifically on FGM/C, they are present in the areas where FGM/C prevalence is growing and have track records of experience working with children in circumstances of conflict and emergency.

B. A Change in Practising Cohorts

There are a number of organisations that include rural populations in their work (primarily **SIRP**, **Circuit Pointe** and **Youth Network for Community Development**). These organisations are inclusive of people from all wealth quintiles and levels of education.

Other organisations that focus on national awareness-raising aim to reach these demographics and include the **UNJP**, the **Global Media Campaign** and **Medical Women's Association of Nigeria**.

Society for the Improvement of Rural People Nigeria (SIRP)

SIRP's primary objectives include reducing poverty among rural people in Nigeria and improving the health and wellbeing of vulnerable people in rural areas.

SIRP implements its work to eradicate FGM/C within a framework of poverty-alleviation strategies that include start-up capital for small businesses, rural water supplies and sanitation, and climate-change adaptation. This unique positioning provides an opportunity for SIRP to engage with the changing dynamics of FGM/C in Nigeria and to target women and girls in rural areas, those in the lowest wealth quintiles and those with the lowest levels of formal education.

C. Social Obligation Within Ethnic Traditions

D. A Young Age of Cutting

Circuit Pointe

Circuit Pointe is an NGO operating in south-east Nigeria. Its main objectives is to promote sexual and reproductive health and rights, eradicate GBV (in all its forms) and promote economic empowerment.

Circuit Pointe uses an integrated approach to ending GBV, addressing multiple forms of violence at once, including FGM/C. Its approach for GBV includes five stages:

1. **alliance** – partnering with existing community structures, taking a bottom-up approach. This includes working with traditional birth attendants (TBAs), women's associations and existing people's assemblies (local community meetings/actions);
2. **awareness** – raising awareness of the rights of women and girls, as well as the responsibilities of duty-bearers, and engaging in intergenerational dialogues to shift perspectives on FGM/C and GBV in general;
3. **accountability** – introducing community-based monitoring systems to hold duty-bearers accountable;
4. **advocacy** – utilising the existing structure of people's assemblies to advocate for locally implemented and monitored by-laws against FGM/C; and
5. **adoption** – working with TBAs to abandon the practice and supporting them to develop alternate forms of income (poultry and vegetable farming with small start-up-business grants).

In the South East Zone, many girls undergo FGM/C in the first ten days of their lives, and this is often connected to a naming ceremony and birth announcement. Circuit Pointe prioritises working with youth before they have children to shift perspectives on the practice, but also works with TBAs, women's associations and nursing mothers to try to reduce the prevalence of the practice within this early window.

Intergenerational dialogues provide opportunities to engage mothers and grandmothers, who are the strongest supporters of the practice and from whom the majority of the social-obligation pressures come. Within these dialogue sessions, Circuit Pointe focuses on creating safe spaces, building a case for change, partnering with change champions, leveraging local knowledge and engaging influencers.

Society for the Improvement of Rural People Nigeria (SIRP)

In Enugu State, FGM/C is usually carried out on the eighth day after birth, to coincide with the child's naming ceremony, which is a festive event with gifts and refreshments. Naming and cutting are therefore linked.

SIRP found that poor mothers could not openly resist their girls undergoing FGM/C because it would mean missing out on a naming celebration. SIRP introduced the sponsorship of naming ceremonies for children whose mothers showed commitments not to cut their infant daughters. These women went on to become SIRP's FGM/C Abolition Champions and Peer Educators in their communities, working hard and often facing social persecution.

SIRP are working on a new project to engage mothers-in-law and grandmothers, as these groups are powerful drivers of FGM/C in Nigeria. In some cases, marriages are threatened by mothers-in-law if FGM/C has not been conducted. SIRP hopes to develop work in this area, focusing on community dialogues to shift social and cultural norms.

Centre For Social Value And Early Childhood Development (CESVED)²¹⁷

CESVED is working to eradicate all harmful cultural practices, including FGM/C, primarily in Cross River state. Its primary approach is to train community volunteers, such as health workers, youth corps members and teachers, to advocate against FGM/C in communities. CESVED has also trained media entities on the negative effects of the practice and made public denouncements of FGM/C to motivate change. In addition, girls' clubs have been formed within schools to support girls in accessing information about sexual and reproductive health, their rights, and the negative effects of FGM/C.

Youth Network for Community and Sustainable Development (YNCSD)

The Youth Network for Community and Sustainable Development was previously known as the Youth Network Against FGM/C. YNCSD changed its name three years ago to focus on a more integrated approach to transforming social norms.

YNCSD is actively working to eradicate FGM/C in a number of states across the south, including Imo, Oyo, Enugu and Osun. Its approach is a holistic one: community dialogues led by youth and community-led action to end FGM/C.

YNCSD learned early on that there were two main gaps in the FGM/C response in Nigeria: a lack of quality monitoring and evaluation to capture learning, and public declarations of abandonment of FGM/C that were not accompanied by true changes in mindset and social norms. YNCSD focused on engaging young people through media campaigns, engaging government

stakeholders and providing traditional practitioners with alternative methods of income generation. YNCSD believes that, to truly create changes in social norms, it is critical to engage mothers and grandmothers (as they are often the drivers of social obligation to undergo FGM/C) and youth (before they are pregnant or planning to have children).

Voices for Change (V4C)²¹⁸

The Voices for Change programme was a 2012–2017 partnership between Itad, Palladium, WRAPA and Social Development Direct, supported by DfID. The programme worked across four Nigerian States (Enugu and Lagos in the Christian south and Kaduna and Kano in the Muslim north) and used a social-norms approach. The programme promoted change at three levels – among individuals, in wider society, and in formal arenas such as government legislation and policy, and political structures.

The V4C approach brought together young people into what V4C called ‘intensive safe space dialogues’, which were hosted both online and in person. Training on transformative gender awareness was provided to media personalities, religious and traditional leaders, and any other influencers in young people’s lives. These influencers took learning from the training to promote positive gender behaviours. Media strategies were also employed, including the development of a media campaign called Purple, which promoted gender equality.

Within its approach to gender equality, the programme targeted GBV norms (including FGM/C).

The UNJP²¹⁹

The UNJP works on a community-led movement called The Movement for Good to eliminate FGM/C in five Nigerian states where it is highly prevalent: Ebonyi, Ekiti, Imo, Osun and Oyo.

The programme aims to reach five million adolescent girls and boys, women (including pregnant and lactating mothers), men, grandparents, traditional leaders, legislators and state officials. The movement mobilises communities to take concrete action at the household level against FGM/C and engages stakeholders to take an online pledge to ‘say no’ to FGM/C. It aims to challenge misconceptions about the practice and break the silence on this topic in communities.

The UNJP Nigeria adopted an innovative approach to public declarations by broadcasting community pledges on the radio. It also placed much emphasis on community surveillance – communities establishing monitoring mechanisms following public declarations to help protect girls from FGM/C by reporting cases to the authorities.

E. Assenting To and Implementing The VAPP Act

Society for the Improvement of Rural People Nigeria (SIRP)

SIRP Nigeria has partnered with **The Girl Generation** and the **Global Media Campaign**. A significant focus of SIRP’s work is advocating for the VAPP Act and local by-laws to be enforced as a means of eradicating FGM/C. SIRP has conducted advocacy to have the VAPP Act assented to by states and has created a hotline for cases of FGM/C to be reported.

The UNJP²²⁰

Officers from **the police** and the **Nigeria Security and Civil Defence Corps** were trained by the UNJP on how to implement the VAPP Act. Also participating in training were local government authorities from communities where there had been public declarations against FGM/C and where community-monitoring systems had been established.

Finally, the UNJP has worked with medical regulatory bodies to reduce medicalised FGM/C, which in Nigeria is at 12.7%. This work focuses on the state regulatory health bodies and aims to provide education and to advocate for declarations against the practice.

Advocacy and Awareness-Raising

Global Media Campaign

The Global Media Campaign uses media to engage people and trains media activists to build capacity for activism at various levels. In Nigeria, recent campaigns have included Facebook Live events called Born Perfect, featuring activists and football celebrities; a radio campaign with doctors and religious leaders to disconnect religious beliefs from the practice; and youth-driven campaigns about how change is possible in Nigeria. The Global Media Campaign also works with the **International Federation of Women Lawyers, journalists** and the **National Youth Service Corps**.

An impact study found that 14% of people who heard the media campaigns changed their views on FGM/C and decided not to have their daughters cut. 78% of those attributed that change to the media campaign. 73% said that they practised FGM/C because they felt it was a cultural requirement.²²¹

Value Female Network

Set up in 2015, the Value Female Network initially worked in Osun state and now also works in the neighbouring states of Oyo, Ekiti and Lagos.

The network supports young people and survivors of FGM/C to advocate against the practice and for the rights of the girl child. In addition, the network mobilises high-level advocacy with UN agencies, government stakeholders and other implementing organisations to challenge myths about FGM/C and raise awareness about the issues.

Dr Costly Aderibigbe, the director of the Value Female Network, also serves as the executive secretary of the **Global Youth Consortium against FGM/C**. The Consortium is made up of 1,500 youth ambassadors from 45 countries and was launched after a global youth roundtable in Dakar, Senegal in 2021. The Consortium is focused on raising the voices of youth against FGM/C, but particularly to raise awareness about cross-border initiatives.

Centre LSD

Centre LSD is implementing a men-and-boys-engagement project against GBV and harmful traditional practices in Cross River and Lagos states, with support from the **Spotlight Initiative** and the **EU**.

The project aims to identify male advocates and champions to speak out against GBV and harmful traditional practices and to train female advocates to engage with religious leaders on these topics. Capacity building, stakeholder engagement and the use of media are key training elements.

Medical Women's Association Of Nigeria (MWAN)²²²

MWAN has committed publicly to supporting efforts to reduce FGM/C. It operates through state chapters, which carry out activities to increase awareness of the harmful effects of the practice.

A woman with her arms raised in a sunset landscape. The woman is smiling and looking up, with her arms raised high in the air. She is wearing a black long-sleeved top and several bracelets on her wrists. The background features a sunset with a bright sun low on the horizon, casting a warm glow over a landscape with greenery and distant hills. The sky is filled with dramatic, colorful clouds in shades of orange, yellow, and blue.

Part 3: Next Steps

Next Steps

As outlined above, there are five major challenges that programmatic and legislative responses in Nigeria must address. While there are a number of organisations working to reduce the prevalence of the practice and, ultimately, see it eradicated, as the response to FGM/C is changing in Nigeria, the following aspects must be addressed to effectively reach these goals:

- **focus** programmatic response in the states that have the highest estimated numbers of women and girls affected by FGM/C, which include Lagos, Kaduna, Imo, Kano, Oyo, Osun and Ondo;
- **shift** the focus of programming to include women in rural areas, those in the lowest wealth quintiles and those with the lowest levels of formal education, among whom the practice is increasing;
- **work with** those who serve as protectors of the practice to shift the norms that contribute to women's senses of social obligation to cut (this includes mothers, mothers-in-law and grandmothers, as well as TBAs);
- **target** adolescent girls and pregnant and breastfeeding women with interventions, to shift social norms that influence the cutting of daughters at young ages;
- **promote** assenting to the VAPP Act in all states and effectively implement it, especially in Kano and other states where there are large estimated numbers of women and girls affected by FGM/C; and
- **give urgent attention** to the Sustainable Development Goals and reversing the downward trends in each area, with particular emphases on maternal health and education.

Recommendations

Considering our findings, we recommend that:

- within programming, target states be identified using both prevalence and actual numbers of women/girls affected by FGM/C, to ensure those living in densely populated states are not forgotten;
- within the states identified, women and girls in rural areas, those in the lowest wealth quintiles and those with the lowest levels of formal education be targeted for interventions that support poverty reduction, building of agency and decision-making, and shifts in social norms;
- key demographics within programmes include:
 - adolescent girls and pregnant and breastfeeding women to shift social norms around the cutting of daughters at young ages;

- mothers, mothers-in-law and grandmothers (for community and intergenerational dialogues) to shift norms related to social and ethnic obligations for women and girls to undergo FGM/C;
- humanitarian agencies working with children in the North East Zone of Nigeria (primarily Save the Children and Plan International) allocate resources to intergenerational dialogues on FGM/C, engage with religious (Muslim) leaders to militate against the growth of the practice, and improve access to education and poverty-reduction schemes as means of increasing women's agency and decision-making around FGM/C;
- investment be made to progress towards the SDG targets, especially where progress has reversed in recent years – the SDGs related to poverty, healthcare, gender equality and education are critical;
- advocacy efforts be made to ensure that the VAPP Act is assented to in all states and pressure placed where there are high numbers of girls affected by FGM/C (e.g. Kano state);
- investment be made into evaluating programmes to discover which are most effective; and
- international partners recognise the vital role of local organisations and activists and meaningfully include them in programming, giving them voices in the design and implementation of policies and practices in response to FGM/C in Nigeria.

Call To Action

Government of Nigeria

We call on the Government of Nigeria to:

- **launch** the national action plan against FGM/C in Nigeria as a roadmap for implementing organisations to follow and contribute to;
- **place pressure** on state governments to assent to the VAPP Act where it has not yet been assented to;
- **reverse the trends** in relation to the SDG targets in Nigeria, placing particular emphases on increasing access to education for girls and improving maternal health outcomes.

Stakeholders

We call on stakeholders, including government bodies, non-governmental organisations and others in Nigeria, to:

- **target states** where the greatest numbers of women and girls affected by FGM/C are living;
- **include rural areas** in programmes within the states that are targeted;
- **focus programmes** on shifting the strong social obligation to have daughters cut, by engaging with protectors of the practice (mothers, mothers-in-law and grandmothers),

targeting adolescent girls and pregnant and breastfeeding women, and promoting intergenerational dialogues;

- **embed** poverty-reduction strategies into FGM/C programmes to support increased agency and decision-making among women and girls in the lowest wealth quintiles and with the lowest levels of formal education;
- **evaluate** programmes to understand and **share** best practices for eradicating FGM/C in Nigeria;
- **advocate** for all states to assent to VAPP Act, focusing particularly on Kano, and for local by-laws to be passed that prohibit FGM/C.

Donors

We call on donors to actively support programmes and initiatives that:

- **target** states where the highest estimated number of women and girls are affected by FGM/C;
- **prioritise** work in rural areas, among those in the lowest wealth quintiles and among those with the lowest levels of formal education;
- **focus** on shifting social norms;
- **embed** poverty-reduction strategies;
- **evaluate** and **share** best practices;
- aim to **reverse** the current trends in relation to the SDG targets in Nigeria.

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