



28 TOO MANY
FGM...
let's end it.

**COUNTRY PROFILE:
FGM IN NIGERIA**

October 2016



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FOREWORD

Since 2010, when I had the privilege of volunteering with FORWARD in northern Nigeria, I have keenly watched both the setbacks and opportunities that women and girls face daily throughout the country. Many of the challenges I saw during my time working in a fistula rehabilitation clinic still remain, including limited access in many rural areas to quality education and health facilities, with consequent high infant- and maternal-mortality rates. As reported by Girl Effect (undated), 'Nigeria has two per cent of the world's population, but it carries 10 per cent of the maternal mortality burden'. The country is also still deeply affected by the kidnapping of over 200 schoolgirls from Chibok in the northern state of Borno in 2014, and the continuing practices of child marriage and female genital mutilation (FGM) remain very real challenges across many states.

While the FGM prevalence in Nigeria is by no means the highest in the region, at 24.8% among women aged 15 to 49 (DHS 2013, p.348), it is globally significant in representing some 20 million women and girls who have been cut or are at risk of being cut (UNICEF, 2013 & 2016).



Fig. 1: Graduation following training in Kano State, Nigeria, 2010 (© Dr Ann-Marie Wilson)

As we publish our 11th Country Profile on FGM, there are, however, many reasons to be hopeful for the future in Nigeria. The new Violence Against Persons Prohibition Act (VAPP), which was introduced in 2015, bans practices such as FGM and is therefore a significant step in the right direction. We welcome its introduction. It is now essential that this federal law be adopted and enforced across *all* states in Nigeria, to achieve its full impact. I am delighted that Her Excellency Aisha Buhari, the First Lady of Nigeria has taken up the campaign to end FGM. We look forward to increased efforts across all government levels in Nigeria, including the involvement of key traditional and religious leaders wherever possible.

Throughout our research, I have also been heartened by the increasing determination of so many NGOs working at all levels to tackle the issue of FGM in Nigeria. The case study on page 10 outlines the work of a local NGO, Society for the Improvement of Rural People (SIRP), whose structured and measured approach to programming is to be applauded. I have also been most interested to see how the increasing use of media, and in particular the rising popularity of social media among young people in Nigeria, is offering us new opportunities to educate and advocate for an end to FGM. To this end, the work now being done in Nigeria by our colleagues in the Girl Generation and *The Guardian's* Global Media Campaign to End FGM (GGMC) is both encouraging and inspiring for us all. By forging partnerships at a local level, as demonstrated by the GGMC's work with local activists from NGO The Center for Social Value and Early Childhood Development (CESVED), we can begin to see what is really working in terms of programming.

28 Too Many therefore looks forward to continuing our work beyond this report to support and partner with all those who wish to see an end to FGM in Nigeria.

Dr Ann-Marie Wilson
28 Too Many Executive Director

BACKGROUND

28 Too Many is an anti-FGM charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We are building an information base, which includes detailed Country Profiles for each country practising FGM in Africa and the diaspora. Our objective is to develop networks of anti-FGM organisations, to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

PURPOSE

The prime purpose of this Country Profile is to improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Nigeria, many programmes are making positive, active change.

USE OF THIS COUNTRY PROFILE

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

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28 Too Many carries out all its work as a result of donations, and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced.

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We are grateful to the rest of the 28 Too Many team who have helped in so many ways, including **Sean Callaghan** and **Louise Robertson**. **Mark Smith** creates the custom maps used in 28 Too Many's country profiles. Thanks also go to **Malcolm Crawford** for volunteering his time as proof reader.

Photograph on front cover:

Lodge, Rosemary (2009) *Girl in Selby, Gashaka Gumti National Park, Nigeria* [cropped]. Available at <https://flic.kr/p/a2PnDG> [accessed August 2016]. Creative Commons Licence: <https://creativecommons.org/licenses/by-nc-sa/2.0/>.

Please note the use of a photograph of any girl or woman in this country report does not imply that she has, nor has not, undergone FGM.

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARP	alternative rites of passage
CBO	community based organisation
CEDAW	Convention on the Elimination of Discrimination Against Women
CHW	community health worker
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Surveys Program
ECOWAS	The Economic Community of West African States

FBO	faith-based organisation
FCT	Federal Capital Territory
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDI	Gender Development Index
GDP	gross domestic product
GII	Gender Inequality Index
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HTP	harmful traditional practice
IAC	Inter-African Committee
IDPs	internally displaced persons
ICCPR	International Covenant on Civil and Political Rights
ICESR	International Covenant on Economic, Social and Cultural Rights
INEC	The Independent National Electoral Commission
INGO	international non-governmental organisation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
NBS	National Bureau of Statistics
NGO	non-governmental organisation
PPP	purchasing power parity
PTSD	post-traumatic stress disorder
SDGs	Sustainable Development Goals 2015-2030
SGBV	sexual and gender-based violence
SIGI	Social Institutions and Gender Index
TBA	traditional birth attendant
UDHR	Universal Declaration of Human Rights, 1948
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting
US	United States of America
WFP	World Food Programme
WHO	World Health Organization

INGO and NGO acronyms are found in Appendix I.

A NOTE ON DATA

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries – the DHS and the MICS. For Nigeria, reports were conducted by the MICS in 1995, 1999, 2007 and 2011 and by the DHS in 1999, 2003, 2009 and 2013. This DHS’s 2013 report (published in 2014) is the most recent set of data on FGM available for the country and is referred to throughout this Country Profile as ‘DHS 2013’.

UNICEF (2013, p.24) highlights that self-reported data on FGM ‘needs to be treated with caution’ since women ‘may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice.’ They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age.

DHS data before 2010 does not directly measure the FGM status of girls aged 0 to 14. Prior to 2010, DHS surveys asked women whether they had at least one daughter who had been cut, or whom they intended to have cut. This could not be used to calculate accurately the prevalence of FGM among girls under the age of 15, as they may have been cut after the date of the survey, or the mother may have had several daughters who had been, or would be, cut. From 2010, DHS methodology changed so that women are now asked the FGM status of all their daughters under the age of 15 (UNICEF, 2013, p.25).

Measuring the FGM status of this younger age-group (0 to 14 years), who have most recently undergone FGM or are at most imminent risk of undergoing FGM, may give an indication of the impact of current efforts to end the practice. Alternatively, responses to this question may indicate the effect of laws criminalising the practice, which make it harder for mothers to report that FGM was carried out, as they may fear incriminating themselves or others. Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM after the age of 14 (UNICEF, 2013, p.25).

The Nigerian DHS 2008 (p.300) reported a higher prevalence than the DHS 2003 (p.202) (29.6% compared with 19%), due to the different definitions of FGM used in both surveys. The DHS 2003 did not include the *angurya* and *gishiri* types of FGM that are unique to parts of Nigeria. In 2008 some field teams did include these methods under ‘other’ (Type IV) FGM, while other teams did not include or count them. In 2013 these types of FGM were included by all the DHS field teams as Type IV, which is defined as:

Other forms, including pricking, piercing, or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the opening of the vagina (*angurya* cuts) or cutting of the vagina (*gishiri* cuts); and introduction of corrosive substances or herbs into the vagina to cause bleeding or to tighten or narrow the vagina (DHS 2013, p.346).

The DHS 2013 (p.346) warns that as a result of these variations in definition across the surveys, comparison between surveys should be treated with caution. Except where relevant, this report only presents the 2013 figures.

Population migration is another restraint on data reliability. Prevalence by place of residence is not necessarily an indicator of where FGM is carried out, as a woman may have lived in a different area at the time she underwent FGM. This is particularly relevant in relation to the urban/rural split, as girls or women now living in urban areas may have undergone FGM in their familial village and relocated upon marriage.

In addition to the DHS surveys, data for some sections of this report have been drawn from surveys conducted by the Nigerian Bureau of Statistics (NBS), in particular those related to maternal and child health, and education. Variations between NBS, DHS and UN agencies’ statistics were noted, and where this occurred this report presents statistics from the different sources in tables and graphs, to enable comparison.

EXECUTIVE SUMMARY

20 million girls and women are estimated to have undergone FGM in Nigeria.

This represents 10% of the global total.

(UNICEF, 2013; 2016)

This Country Profile provides comprehensive information on female genital mutilation (FGM) in Nigeria, detailing the current research and discussing the political, anthropological and sociological contexts in which FGM is practised. It also reflects on how to strengthen anti-FGM programmes and accelerate the eradication of this harmful practice. The purpose of this report is to enable those committed to ending FGM, through the information provided, to shape their own policies and practices to create positive, sustainable change. This report also considers FGM in the context of the new Sustainable Development Goals 2015-2030.

In Nigeria the estimated prevalence of FGM among women aged 15 to 49¹ is 24.8% (DHS 2013, p.348). This figure has not changed significantly in recent years. In the DHS 2008 (p.300) it was 29.6%, which meant Nigeria was classified as a 'moderately low prevalence' country by UNICEF (2013, pp.26-7). This 4.8% reduction has now moved it into UNICEF's 'low prevalence countries' classification.

Determining incidence rates of FGM, however, is problematic because the DHS used different methods of measurement in its surveys of 2003, 2008 and 2013. In 2003 the types of cutting distinct to Nigeria – *angurya* (scraping of tissue surrounding the opening of the vagina) and *gishiri* (cutting of the vagina), both forms followed by the introduction of herbs or corrosive substances to narrow the vagina – were not taken into account. In 2008 some, but not all, of the research teams did include these forms of FGM under 'Type IV'; this had the effect of significantly increasing the prevalence recorded from 19% in 2003 to 29.6% in 2008. In 2013 all teams classified these distinct forms of FGM as Type IV.

Specific practices in relation to FGM and its prevalence vary across all regions, ethnic groups and religions in Nigeria. There is a variation in FGM prevalence according to place of residence, with 32.3% of women living in urban areas having undergone FGM, compared with 19.3% of women living in rural areas. There is also variation across Nigeria's six Zones and 36 states. South East and South West Zones have the highest prevalence (49% and 47.5% respectively). This is further evidenced by Ebonyi State in South East and Osun State in South West having the highest prevalence by state (74.2% and 76.6% respectively). North East is the Zone with the lowest prevalence, at 2.9%, and Katsina (in North West Zone) is the state with the lowest prevalence, at 0.1% (DHS 2013, pp.349-50).

This variation broadly corresponds to the spread of Nigeria's ethnic groups. The Hausa-Fulani, largely based in North East and North West, have an average prevalence of 16.3%, while the Yoruba, mainly based in the South West, have a prevalence of 54.5%, and the Igbo, mainly based in the South East, have a prevalence of 45.2% (p.349). However, social and physical mobility means the lines between ethnic groups and their locations are becoming increasingly blurred in modern Nigeria.

North West and North East Zones tend to be inhabited by Muslim women, among whom the prevalence of FGM is 20.1%. The south and a central belt (running from north to south) is inhabited by Catholics and other Christians, among whom prevalence is 31.4% and 29.3% respectively; the south is also inhabited by many women who practise traditionalist religions, among whom prevalence is highest at 34.8% (p.349).

In the DHS 2008 (p.306), the most commonly-reported perceived benefit of FGM is 'preserve virginity/prevent premarital sex', cited by 11.2% of women and 17.3% of men. However, 58.1% of women and 51.8% of men believe that FGM has no benefits. Questions about perceived benefits of FGM were not asked of respondents during the DHS 2013, which instead asked whether respondents believe it is a requirement of their religion (p.359). 15% of women and 23.6% of men believe that it is a requirement, and men and women who practise traditionalist religions are the most likely to give an affirmative response to this question.

¹NB: all figures listed in this Executive Summary are for men and women aged 15 to 49, unless otherwise specified.

Looking back over the fourteen years from when the first Nigerian DHS survey was conducted in 1999 to the latest in 2013, there has been a steady decline in support for FGM. In the DHS 1999 (p.139), 47% of women said it should be discontinued (men's views were not sought); in the DHS 2013 (p.362), 64.3% of women (and 62.1% of men) said that it should be discontinued.

In Nigeria, although the prevalence of FGM appears to be highest among the wealthier, better-educated women who live in urban areas, these same women are the least likely to have their daughters cut before the age of 15, which suggests a decline in the practice from generation to generation in these families. This same group of women is also most in favour of discontinuing the practice. Conversely, although the prevalence of FGM is lowest among poorer women with little or no education who live in rural areas, these women are more likely to have their daughters cut. In other words, this cohort is the most likely to continue the practice, and shows the highest level of support for the continuation of FGM (see DHS 2013, pp.361-2).

FGM is most likely to take place in Nigeria during childhood. The major exception is when women in certain ethnic groups undergo FGM during the birth of their first child, because of a belief that it is critical that a baby not touch its mother's clitoris (Alo & Babatunde, 2011). Many girls are cut as infants (16% of girls aged 0 to 14 undergo FGM before their first birthday), and most women (82%) aged 15 to 49 who have had FGM state that they were cut before the age of five (DHS 2013, pp.352-3).

The most common type of FGM in Nigeria is 'cut, flesh removed', with 62.6% of women who undergo FGM experiencing this type. 'Cut, no flesh removed' is experienced by 5.8% of women who undergo FGM, and 'sewn closed' (i.e. Type III – infibulation) is experienced by 5.3% of women who undergo FGM (DHS 2013, p.350). *Angurya* cuts are performed on 24.9% and *gishiri* cuts on 5.1% of women who experience 'other' or 'unclassified' types of FGM (p.351). Among girls aged 0 to 14 who undergo FGM, 2.7% are 'sewn closed' (Type III) (p.357).

Most instances of FGM are carried out by traditional practitioners; the remainder are carried out by medically trained personnel (or by unknown parties) (p.357). The slight increase in the use of traditional practitioners that is evidenced through the DHS data may be indicative of the laws against FGM put in place in some states, as doctors and nurses become more reluctant to take part in the practice.

The evidence suggests that, of younger women with daughters aged 0 to 14, those with a higher level of education are less likely to have their daughters cut (p.354). Education is therefore vital, but access to it is particularly restricted in rural areas, and the rural north shows the greatest gender disparity in schooling. Most of the data sources consulted for this Country Profile report that the lowest school-attendance rates are in the north-east, and the highest are in the south-east. It appears that, in general, attendance declines with increasing age, especially over the age of 16, and, significantly, the rate of decline increases more quickly for females over the age of 15 than for males (pp.28-9).

A module on how to deal with the effects of FGM was recently included in the curricula for training of doctors and nurses (Chatora, 2016). With the inclusion of a target for the elimination of FGM in the Sustainable Development Goals (SDGs), the World Health Organization (WHO) has issued new guidelines on the management of health complications arising from FGM. These provide standards to be used in the designs of professional training curricula for health workers, and give guidance to policy makers and those involved in developing and implementing health policies and protocols.

In May 2015, a federal law was passed banning FGM and other harmful traditional practices (HTPs), but this Violence Against Persons Prohibition Act (VAPP) only applies to the Federal Capital Territory (FCT) of Abuja. It is up to each of the 36 states to pass similar legislation in its territory. 13 states already have similar laws in place (listed in Appendix II); however, there is an inconsistency between the passing and enforcement of laws, the improvement of which depends on state and federal police capacity and willingness (The Guardian, 2016b).

Although freedom of press in Nigeria is limited, social media is taking a strong hold across the country and has been used effectively to draw the attention of Federal and State Governments to violence against women and girls. Her Excellency Aisha Buhari, the First Lady of Nigeria has been active in encouraging

female leaders and the wives of state governors to take up the issue of FGM, and introduce and implement the laws against FGM and child marriage in their states. *The Guardian's* End FGM Global Media Campaign (GGMC) has, alongside other projects that target influencers, recently run a successful Media Training Academy for activists, journalists and religious broadcasters, training them on effective ways to use the media in activism against FGM. Immediately after this, a number of new projects were begun by graduates.

Nigeria is one of the 17 countries included in the UN Joint Programme (UNJP) to end FGM within a generation. Both international and smaller organisations in Nigeria are able to work openly on anti-FGM programmes and their endeavours have been supported by the previous and current Federal Governments. Non-governmental organisations (NGOs) use a variety of strategies in their work, including community-dialogue approaches (often aiming to include traditional and religious leaders in discussions), addressing the health risks of FGM, raising awareness in schools, equipping traditional practitioners with new skills and sources of income, and using media (in various forms) to spread messages further. Examples of these strategies include the work of grassroots organisations Safehaven Development Initiative, CHCEEWY, AHI and SIRP. Nationally, Girl Effect have been working to encourage the inclusion of education on HTPs in school curricula and teacher training. There are also good examples of partnerships between organisations, including the collaboration between the GGMC and activists from NGO CESVED, who work in Cross River State. A detailed overview of NGOs and their strategies is included in this report at page 55.

We propose the following measures:

- *Adopt culturally relevant programmes.* There is a strong national message against FGM, but this needs to be reinforced at state and district levels, to ensure changes in behaviours and attitudes towards FGM take hold within communities.
- *Provide long-term funding.* Funding is a common problem across the development sector. Organisations working against FGM need sustained and committed support from government programmes, particularly given the conflict in parts of the country, which increases the vulnerability of girls and women. They also need to continue reaching out for partnership and networking opportunities among themselves, across states, and with other national and international organisations.
- *Consider FGM in response to the SDGs.* The SDGs contain a specific target for the elimination of FGM by 2030. This will be an incentive to countries to take more positive action against the practice.
- *Improve access to education.* Facilitating education and supporting girls through secondary and further education is vital, as current figures indicate that better-educated mothers are less likely to have their daughters cut.
- *Increase health resources, improve access to healthcare and provide healthcare professionals training and guidance on managing health complications related to FGM.*
- *Introduce and increase enforcement of relevant laws at state level, and ensure those responsible for FGM are prosecuted.*
- *Foster effective and diverse media campaigns.* Effective campaigns reach out to various regions and sections of society, especially women, and/or take advantage of the recent social media boom.
- *Encourage faith leaders and faith-based organisations to act as agents of change, challenge misconceptions that FGM is a religious requirement and be proactive in ending FGM.*
- *Engage with men and boys when conveying the anti-FGM message.*
- *Government facilitation of a federal-wide and cross-state network of organisations working towards the elimination of FGM.* This may be done in collaboration with UNFPA and UNICEF, as part of the UNJP, and would encourage learning and provide a framework for coordinating resources and action.

Further work and research is required to inform anti-FGM programmes and analyse trends and practices across Nigeria. Consistency in the questions asked and the age cohorts of subjects will allow for more accurate analysis. The challenge of collecting reliable data on an illegal practice needs addressing at both a national and global level.

IMPACT CASE STUDY:

SOCIETY FOR THE IMPROVEMENT OF RURAL PEOPLE (SIRP)

How does our society purge parents, majority of whom are in rural areas, of the ignorance that encourages them to mutilate the genitals of their female children without qualm?

Behaviour Change Communication: Reflections on the Campaign against FGM (SIRP, undated)

Understanding the deep-rooted reasons behind the continuation of FGM in Nigeria has been the foundation of the work of Nigerian NGO Society for the Improvement of Rural People (SIRP). As they point out, even though campaigns to date have focused on the health implications of FGM and its futility as a means of curbing female promiscuity, the practice still continues in many communities.

To achieve greater impact and value for money for donors (in their case RAINBO UK), SIRP began its work on the project 'Targeted Education, Communication and FGM training programme in Enugu and Ebonyi State' with a Pre-Programme Implementation Survey to understand first-hand the reasons for FGM's continuation in the south-eastern areas of Nigeria. The findings then informed the first phase, which included:

- Radio programmes in both Igbo and English explaining sexual and reproductive rights and addressing many of the myths and misconceptions that arise from the survey, such as 'FGM allows for a quicker and easier delivery at childbirth' or 'uncircumcised women are unclean'. Testimonials from those who had suffered FGM were used and communities were informed in advance of broadcasts so that they could listen in.
- The production and distribution of information and educational materials, including a poster campaign in the targeted communities.
- Advocacy visits to five communities: Ugbawka, Ndeaboh and Nenwe in Enugu State, and Ohafia-Agba and Afikpo in Ebonyi State.

The next phase aimed to understand how these interventions had impacted on the communities. Focus group discussions, including a Post-Implementation Survey, were held, through which SIRP attempted to promote dialogue and identify changes. They asked questions such as 'can FGM

now be discussed more freely in the community and in the media?', 'are some of the myths around FGM now being clarified?', 'are people seeking more information on FGM?' (SIRP have since recorded an increasing number of enquiries), 'is the discussion around FGM spreading to public institutions such as schools?' and 'have new groups (such as women's or church-based ones) heard the radio programmes and joined the debate?' (evidence in Enugu State suggests this is the case).

SIRP concluded from this work that the incidence of FGM is falling in these communities, but there remains some resistance, particularly from traditional leaders and some men in communities where FGM is performed as a rite of passage into adulthood. There are also challenges where FGM is linked to babies' naming ceremonies (see 'Strategies').



Fig. 2: Focus groups are a key part of SIRP's work (© SIRP)

Overall, the work of SIRP is a huge step forward, as more communities are brought into the discussion about stopping FGM in Nigeria. Women are demanding respect for their sexual and reproductive rights and members of these communities are now empowered to discuss FGM and enact local by-laws to stop the practice. Respondents to SIRP's follow-up survey felt that the campaign should be ongoing for at least three years, that radio programmes are effective and that they should seek as a priority to involve church leaders. They also supported focus group discussions as an essential tool for encouraging dialogue. SIRP's vision is to replicate this programme throughout south-eastern Nigeria.

INTRODUCTION

It is now widely acknowledged that FGM functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.

(The General Assembly of the United Nations, 2009, p. 17)

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the World Health Organization (WHO) (2015a) as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia (UNICEF, 2016, p.2).

HISTORY OF FGM

FGM has been practised for over 2,000 years (Slack, 1988, p.439). Although it has obscure origins, there has been anthropological and historical research conducted on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision' (Slack, 1988, p.444). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders, as a custom among

stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein in Wilson, 2013, p.4).

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently among different peoples (Lightfoot-Klein in Wilson, 2013, p.4), aided by Egyptian slave raids from Sudan for concubines and the trading of maids through the Red Sea to the Persian Gulf (Mackie in Wilson, 2013, p.4).

GLOBAL PREVALENCE AND PRACTICES

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North and South America, Australasia and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past, and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

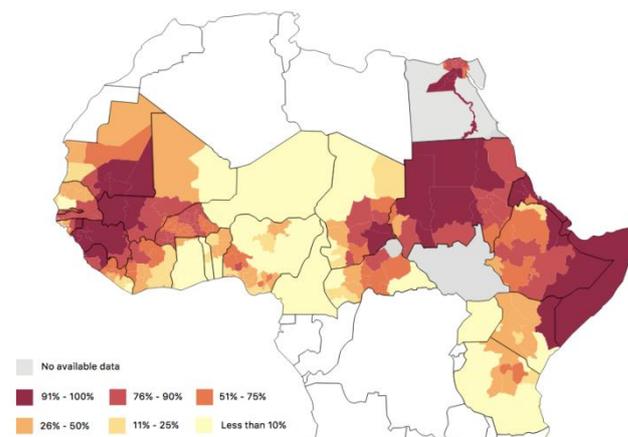


Fig. 3: Prevalence of FGM in Africa

(Click for source document: Burkina Faso: DHS 2010; Benin: DHS 2011-12; Cameroon: DHS 2004; CAR: MICS 2010; Chad: EDS-MICS 2014-15; Côte d'Ivoire: DHS 2011-12; Djibouti: MICS 2007; Egypt: EHS 2015; Eritrea: EPHS 2010; Ethiopia: DHS 2016; Ghana: MICS 2011; Guinea: DHS 2012; Guinea-Bissau: MICS 2014; Kenya: DHS 2014; Liberia: DHS 2013; Mali: DHS 2012-13; Mauritania: MICS 2015; Niger: DHS 2012; Nigeria: DHS 2013; Senegal DHS-Cont 2015; Sierra Leone: DHS 2013; Somalia: MICS 2006; Sudan: MICS 2014; Tanzania: DHS 2015-16; The Gambia: DHS 2013; Togo: DHS 2013-14; Uganda: DHS 2011.)

The WHO classifies FGM into four types (WHO, 2008, p.4):

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious scripts require the practice, practitioners often believe it has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic (WHO, 2008, p.1). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in

the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2015a).

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive Country Profiles for each of the 28 countries in Africa where FGM is practised. The reports provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use regarding diaspora communities that migrate and maintain their commitment to FGM.

The Country Profile also offers an analysis of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information base which can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research we have connected with many anti-FGM campaigners, CBOs, policy makers and key influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM, locally and internationally.

GENERAL NATIONAL STATISTICS

This section provides an overview of the general situation in Nigeria and highlights a number of indicators of the country's context and development status. (All statistics are taken from the CIA World Factbook, September 2016, unless otherwise stated.)

POPULATION

>180 million (Country Meters, 13 September 2016)

Median age: 18.2 years

Growth rate: 2.45% (2015 est.)

HUMAN DEVELOPMENT INDEX

Rank: 152 out of 188 in 2014

HEALTH

Life expectancy at birth (years): 53.02

Infant mortality rate (per 1,000 live births): 72.7 deaths (please also refer to page 31)

Maternal mortality rate: <814 deaths/100,000 live births (2015 est.) (please also refer to page 31)

Fertility rate, total (births per women): 5.19 (2015 est.)

HIV/AIDS – adult prevalence: 3.17% (2014 est.)

HIV/AIDS – people living with HIV/AIDS: 3,391,600 (2014 est.); country comparison to the world: 1

HIV/AIDS – deaths: 174,300 (2014 est.)

GDP (IN US DOLLARS)

GDP (official exchange rate): \$490.2 billion (2015 est.)

GDP per capita (PPP): \$6,100 (2015 est.)

GDP (real growth rate): 2.7% (2015 est.)

LITERACY (AGE 15 AND OVER WHO CAN READ AND WRITE)

Total: 59.6%

Female: 49.7% (2015 est.); Male: 69.2%

Youth (15-24 years): 66%

Female – 58%; Male – 76% (World Bank, 2014, p.2)

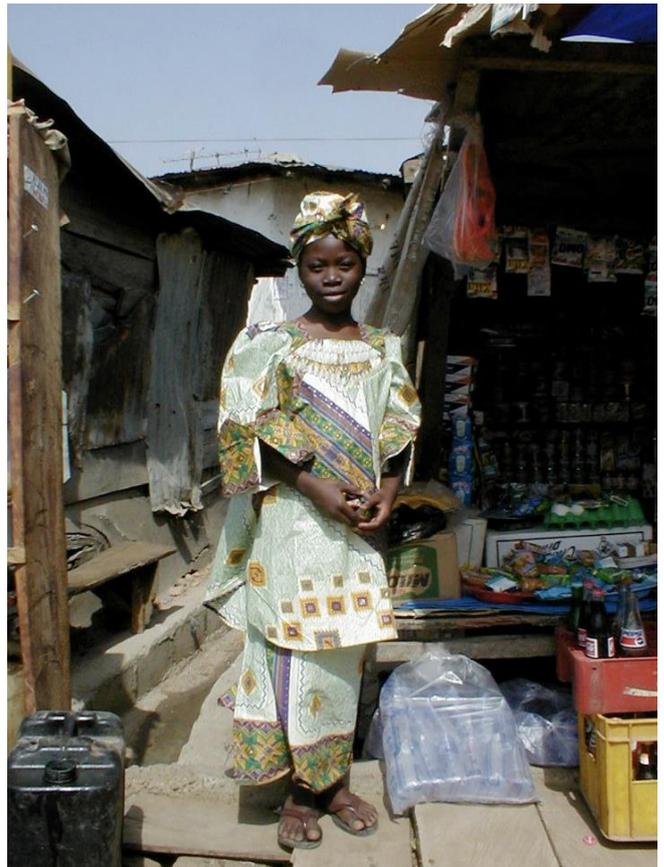


Fig. 4: A girl working in Wuse market (Photographer: Jeff Attaway)

URBANISATION

Urban population: 47.8%

Rate of urbanisation: 4.66% annually (2010-15 est.)

ETHNIC GROUPS

The main groups are Hausa, Fulani, Yoruba, Igbo, Kanuri, Tiv, Edo, Nupe, Ibibio and Ijaw

RELIGIONS

Muslim 50%, Christian 40%, indigenous beliefs 10%

LANGUAGES

English (official), Hausa, Yoruba, Igbo, Fulani, plus over 500 additional indigenous languages

SUSTAINABLE DEVELOPMENT GOALS

The eradication of FGM was pertinent to six of the UN's eight Millennium Development Goals (MDGs), which reached their deadline in 2015. In September 2015, the UN adopted the Sustainable Development Goals (SDGs), which replaced the MDGs and have a deadline for achievement of 2030. The 17 SDGs focus on five 'areas of critical importance for humanity and the planet' – people, planet, prosperity, peace and partnership (UN Department of Economic and Social Affairs, 2015).



Fig. 5: The Sustainable Development Goals

A document entitled *Transforming our World: the 2030 Agenda for Sustainable Development* (UN Department of Economic and Social Affairs, 2015), details the SDGs and states that they

seek to build on the Millennium Development Goals and complete what these did not achieve. They seek to realise the human rights of all and to achieve gender equality and the empowerment of all women and girls.

Although Nigeria signed up to the MDGs, it did not really implement them until savings from the Paris Club Debt Relief Deal in 2005 could be allocated to funding. Monitoring did not start for a further four years, and statistics are reportedly unreliable (Igbuzor, 2011, p.7).

The SDGs go further than the MDGs and make explicit reference to the elimination of FGM. This will strengthen the hands of governments, NGOs and multi-lateral organisations when implementing anti-FGM policies and legislation.

5 GENDER EQUALITY



Sustainable Development Goal 5:

Achieve gender equality and empower all women and girls

Goal 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation practices.

Other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, particularly those related to education, health and gender equality, such as Goals 3 and 4.

In addition to the SDGs, the African Union has declared the years 2010 to 2020 to be the African Women's Decade (African Union, 2011, p.2). This declaration will assist in promoting gender equality and the eradication of FGM and other forms of gender-based violence in Nigeria.

For a summary of all 17 SDGs, please see our [Global Goals](#) document.

POLITICAL BACKGROUND

HISTORICAL

Nigeria is Africa's most populous country, with more than 180 million people. Until 1914 the area now known as Nigeria was a patchwork of kingdoms and emirates made up of various ethnic and linguistic groups, each with their own system of government. Dominant among these were the Hausa in the north, Yoruba in the south-west, and Igbo in the south-east.

Britain began annexing parts of Nigeria in the early 19th century, starting in the south-west and moving northwards over the following hundred years. At that time Nigeria was effectively divided in two: the south was largely a Christian colony, and the

north was an Islamic protectorate. In 1914 Britain amalgamated these northern and southern regions to form one nation state under a crown-colony form of administration. In the 1950s Nigerians achieved partial independence, going on to gain full independence in 1960 with a constitution that provided for a parliamentary system of government.

In October 1963 Nigeria became a republic, with a federal state system. During the late 1960s the earlier divisions between the northern and southern regions reappeared, leading to the three-year Biafran war, in which the Igbo-dominant states in the south-east sought independence; they capitulated in 1970. The following decades, until early 2000, were marked by a series of military coups and flawed, often violent elections.

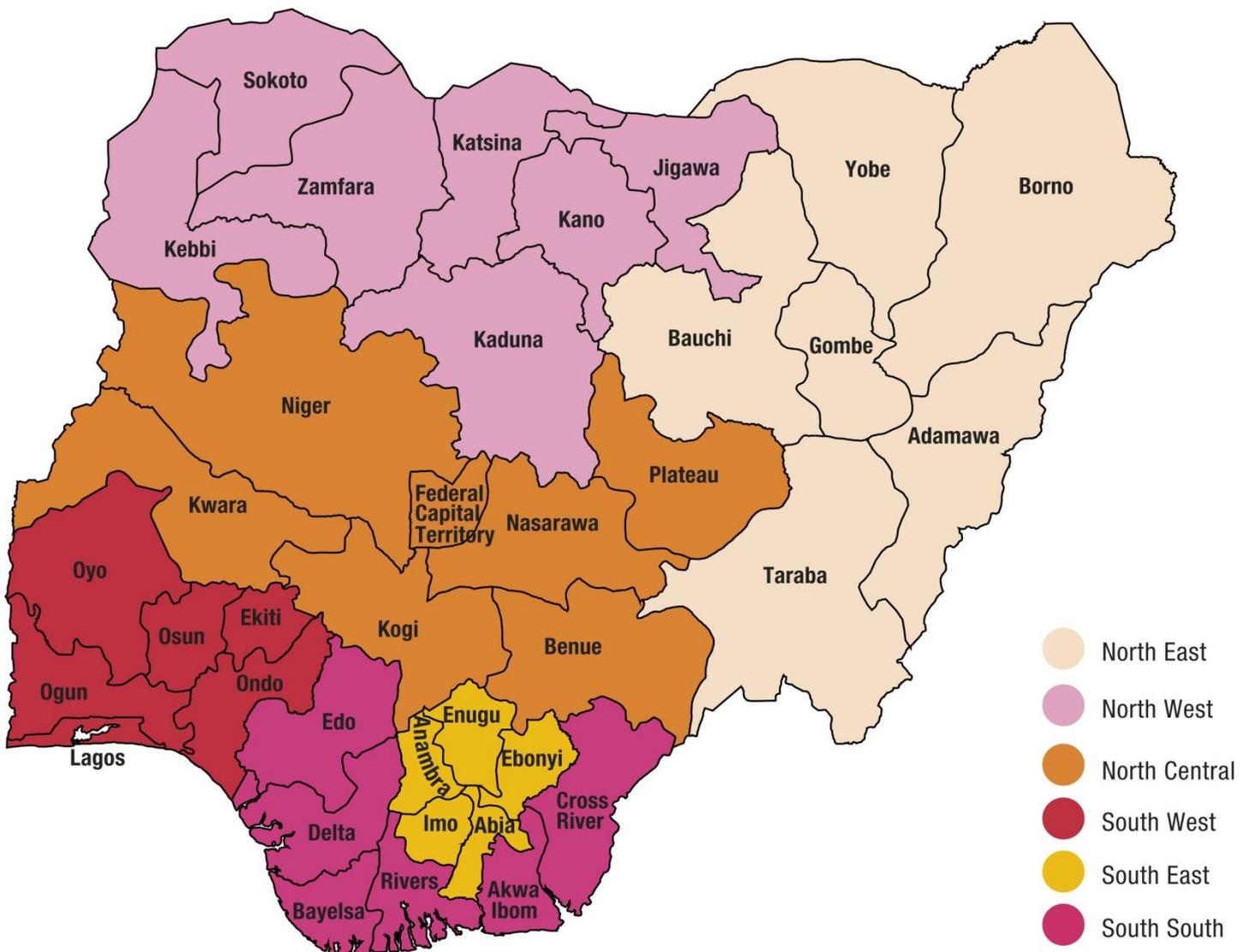


Fig. 6: Map of Nigeria's states and Zones (© 28 Too Many)

The end of military rule came in 1999, when the People's Democratic Party won the election and retained power until 2015, winning consecutive elections in 2003, 2007 and 2011. Despite allegations by international observers that election processes were flawed, the 2007 elections marked the first civilian-to-civilian transfer of power in Nigeria's history, when Umaru Yar'Adua was elected president in place of Olusegun Obasanjo (BBC News, 2015a; CIA World Factbook, 2016). President Umaru Yar'Adua, who came from the northern state of Katsina, where he had strong Hausa-Fulani support, died in 2010. Vice President Goodluck Jonathan, from the southern state of Bayelsa, succeeded him and won the following election in 2011.

CURRENT POLITICAL CONDITIONS

Jonathan remained in power until 2015, when General Muhammadu Buhari of the All Progressives Congress party (APC) was elected President, and Professor Yemi Osinbajo of the same party was elected Vice President.

Buhari, like Yar'Adua, is from Katsina State in the north. He is a retired major general of the Nigerian army, and was formerly Head of State of Nigeria for two years, following his leadership of a military coup in 1983. There was a peaceful handover of power from Jonathan to Buhari in May 2015.

Elections are held every four years, with the next round due in 2019. Presidential office-holders can stand for a maximum of two terms. There have been several amendments to the Constitution over the years, but Nigeria remains a democracy and federal republic.

The National Assembly comprises two houses: a Senate, with three elected representatives from each of the states and one from the Federal Capital Territory (FCT); and a House of Representatives with 360 members, who are directly elected in single-seat constituencies by simple majority vote to serve four-year terms (CIA World Factbook, 2016). Since May 2015 the APC has been the majority party in both houses.

Nigeria comprises 36 states plus the FCT, in which the capital city, Abuja, is located. States are grouped into six geopolitical zones: North East and

North West, South East and South West, North Centre and South South. Each state has an elected House of Assembly and governor, appointed for a four-year term (Nigerian High Commission, London, 2009-2016). States are further subdivided into 774 local government authorities, which form the third tier of government.

Although the 2015 elections and handover of power were peaceful, it is estimated that there are over two million internally displaced persons (IDPs) across the country. They have largely been displaced as a result of attacks by the Islamic militant group Boko Haram and counter-insurgency efforts in the north, and violence between Christians and Muslims in the central region of the country (CIA World Factbook, 2016).

CURRENT ECONOMIC CONDITIONS

Nigeria was an agricultural economy until the mid-1950s, when oil was discovered offshore. Since then, economic dependence has gradually shifted from agriculture to petroleum and gas exports (DHS 2013, p.2). Nigeria is currently regarded as Africa's largest economy, with a 2015 GDP estimated at US\$490.2 billion, and annual growth rates of 6-8% per annum. This strong growth has not translated into reduced poverty levels, however, and over 60% of Nigerians continue to live in extreme poverty (CIA World Factbook, 2016).



Fig. 7: Ms Amina J. Mohammed, Minister of Environment, is one of only six female ministers under the current administration (UNIDO)

ANTHROPOLOGICAL BACKGROUND

Nigeria's population comprises more than 250 ethnic groups. Nearly 80% is made up of ten ethnic groups. The largest and most influential of these are the Hausa-Fulani, who together comprise approximately 30%; the Yoruba (21%); and the Igbo (18%) (CIA World Factbook, 2016; One World, 2014). The population is concentrated in the south and in an area of dense settlement around Kano, the capital of the northern Kano State (Nigerian High Commission, 2016).

English is the official language, but Hausa, Yoruba, Igbo (Ibo), and Fulani are also widely spoken (CIA World Factbook, 2016).

ETHNIC TENSIONS

Ethnic disaggregation is a complex issue in Nigeria. Distinctions between many ethnic groups in modern Nigeria have become blurred as a result of intermarriage and physical and social mobility (28 Too Many, 2016a). This report gives a breakdown of the major ethnic groups (see below). However, as a result of said blurring, and the economic, political and social pressures of modern life, it is often the case that the traditional practices and societal structures mentioned in the breakdown are no longer adhered to (28 Too Many, 2016a). As Nigerian writer Chimamanda Ngozi Adichie (2009) warns, lives and cultures 'are composed of many overlapping stories' and there is danger in the single story.

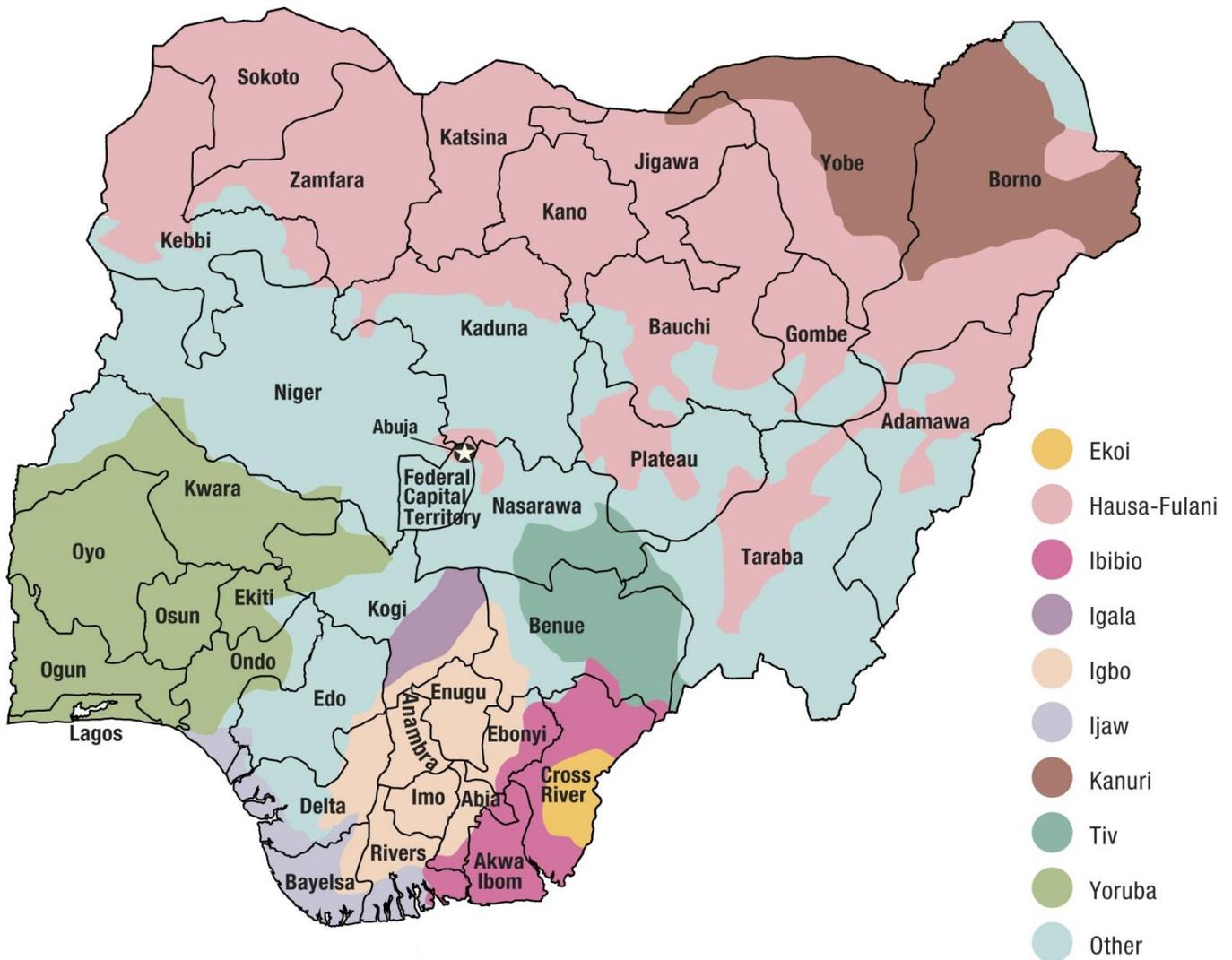


Fig. 8: Ethnic groups in Nigeria (© 28 Too Many)

Bearing in mind these relationships and overlaps between ethnic groups in Nigeria today, northern Nigeria is, ostensibly, largely Muslim, and the south Christian. The Hausa-Fulani groups are mostly based in the north, particularly in the areas bordering Niger and Chad; the Yoruba in the south-western and northern-central areas; and the Igbo in the south-east. These broad divisions have contributed to political disagreements and suspicions since colonial times (Ochunu, 2014).

In 1967 three eastern states, mainly populated by the Igbo, seceded under the name Republic of Biafra. This initiated a three-year civil war, but eventually the attempt to break away failed and the region was re-integrated into Nigeria in 1970. Rule by successive military regimes reportedly kept violence among ethnic groups 'in check', but this ended in 1999, when Nigeria returned to civilian rule (Handley, 2010).

Adetoye and Omilusi (2015, p.54) write:

Ethno-religious violence appears to be the most common form of armed violence in post-military Nigeria. The recent reoccurrence of ethno-religious armed violence in the north region has led to extensive killings and material destruction.

Land disputes have been another source of ethnic tension. For example, in Taraba State, bordering Cameroon, there has been violence between semi-nomadic, cattle-raising groups like the Fulani, and settled farmers – for example, the Jukun. As Fulani settlers are likely to be Muslim, and other groups in the area are, like the Jukun, mostly Christian, religious issues sometimes colour these disputes (The New York Times, 2013).

ETHNIC GROUPS

The following are the ten main ethnic groups listed in the DHS 2013, which make up nearly 80% of the population.

EKOI (EJAGHAM)

The Ekoi reside in an area that extends from south-eastern Nigeria, in Cross River State, into northern Cameroon (ArtTribal.com, undated).

Historically, descent among the Ekoi was patrilineal (Ndoma, 2014), and their social, economic and political organisation revolved around secret societies and associations. While it is no longer an absolute requirement, clitoridectomy (Type I) is traditionally part of initiation into the *Monenkim* (or *Moninkim*) women's society.

FGM prevalence among the Ekoi is reported by the DHS (2013, p.349) as 56.9% (for women aged 15 to 49, as are all the figures for FGM prevalence given below in this chapter); however, this figure is based on a very small sample (22) of Ekoi women (p.350).

FULANI (FULA/FULBE/PEUL)

11% of Nigeria's population are Fulani (One World, 2014). They are historically a pastoral, nomadic people, and are found throughout West Africa. They have had considerable interaction with other groups (including marriage), particularly with the Hausa in northern Nigeria, such that these groups are often referred to as 'Hausa-Fulani'.



Fig. 9: Fulani baby at the market (Photographer: Rosemary Lodge)

Fulani settled in urban areas are predominantly Muslim (EB, 2016b). There is also a Christian minority (28 Too Many, 2016b).

Traditionally the Fulani have practised polygyny, and male family members would usually choose a girl's spouse when she is in her early to mid-teens (WCE, 2016d).

FGM prevalence is 13.2% (DHS 2013, p.349). Like the Hausa, they often practise *Yankan Gishiri* (salt cut), which is classified as Type IV (Kandala, Nwakeze and Kandala, 2009).

HAUSA

The Hausa are one of the largest ethnic groups in Africa, primarily living in northern Nigeria and south-eastern Niger. They make up around 21% of the population of Nigeria (One World, 2014).

The Hausa were historically recognised as successful traders. Islam has had a strong influence on their culture, including their language and marriage rites (WCE, 2016b; EB, 2016a). There is also a significant number of Christians among the Hausa in Nigeria (28 Too Many, 2016b).

Descent is patrilineal and, traditionally, early and polygynous marriage was not uncommon, often between close kin (EB, 2016a).

In present-day Nigeria, the Hausa's frequent interaction and inter-marriage with the Fulani has resulted in both groups being increasingly referred to as the 'Hausa-Fulani'.

FGM prevalence is 19.4% (DHS 2013, p.349). The Hausa often practise Type III or, like the Fulani, they may practise *Yankan Gishiri* (salt cut), which is classified as Type IV (Kandala, Nwakeze and Kandala, 2009).

IBIBIO



Fig. 10: Ibibio Traditional Attire of Akwa Ibom State, Nigeria (Akan1)

The Ibibio make up about 7% of Nigeria's population (One World, 2014) and largely reside in

the south-east. They are famous for their wood-carving skills.

Historically Ibibio villages are united by common descent and secret societies have traditionally been important socially, religiously and politically for both men and women. For example, the primary purpose of the principal *Ebre* society for women is 'to safeguard the virtues of honesty, integrity and industry of women' (Anam, 2014).

Although modern economic and religious expectations impact on traditions, the marriage ceremony remains an important cultural and social ceremony for the Ibibio (Ubong, 2010).

FGM prevalence is 12.8% (DHS 2013, p.349).

IGALA/IGARA

The Igala are largely situated in western Kogi State, but also reside in the Anambra, Delta, Enugu and Edo States.

They are an agrarian society and largely Muslim, although there is a smaller Christian group. Their ruler is the *Attah Igala* (the 'Father of Igalas').

They are a patrilineal society and polygyny was traditionally practised in rural farming communities (kwekudee, 2014).

FGM prevalence is 0.5% (DHS 2013, p.349).

IGBO (IBO)

The Igbo constitute 18% of Nigeria's population (One World, 2014) and are largely found in south-eastern Nigeria, in the Niger Delta region.

The traditional Igbo religion is still practised; however, the majority of Igbo are now Christians (Njoku and Uzuoku, 2014, p.1).

Traditionally the Igbo marriage process was 'a long, elaborate one' (WCE, 2016c) and polygyny was practised. However, the practicalities of continuing such traditions in Nigeria have been challenged by, for example, the rising cost of living and the influence of different religions, including Christianity.

FGM prevalence is 45.2%, and almost three-quarters of the Igbo practice 'cut, flesh removed' (DHS 2013, p.349).

IJAW (IJO/IZON)

The Ijaw constitute 10% of Nigeria's population (CIA World Factbook, 2016), and mostly reside across the Niger Delta in southern Nigeria. Their economy is historically based on the cultivation of the flood-land, the collection of palm-oil and fishing (EB, 2016g).

They tend to practise either Christianity or their traditional animist religion (Gbaramatu Kingdom, undated). Historically, groups and villages were governed by assemblies of elders, who were often in turn overseen by priests (EB, 2016g). The coast and river are the focus of many Ijaw traditions, including meals, festivals and marriage ceremonies (Ekeh, 2015).

FGM prevalence is 11% and the Ijaw are the most frequent practitioners of Type III (18.8% of women aged 15 to 49) (DHS 2013, p.349-50).

KANURI (KANOURI/KANOWRI/YERWA)

The Kanuri constitute about 4% of the population of Nigeria (One World, 2014). A large number reside in the north-east of Nigeria, as well as in Niger and Cameroon.

The Kanuri are historically crop farmers and experienced commercial traders. They are largely Muslim, although there is a Christian minority. In rural areas, families live in compounds. Early marriage and polygyny have historically been common, although this is less prevalent with large numbers of Kanuri now living in urban areas (EB, 2016d; Joshua Project, 2016).

FGM prevalence is 2.6% (DHS 2013, p.349).

TIV

The Tiv constitute approximately 3% of Nigeria's population (One World, 2014) and mainly live along both sides of the Benue River (EB, 2016e).

Traditionally, their society was egalitarian, with no central authority until, in 1948, the British administration introduced a 'paramount chief'. Societal organisation was based on patrilineages and territorial kinship groups and included complex marriage systems (EB, 2016e).

The majority of Tiv continue to practise their traditional religion, although many Tiv have

converted to Christianity and a lesser number to Islam (EB, 2016e; 28 Too Many, 2016b).

Prevalence of FGM among the Tiv is the lowest, and given in the DHS (2013, p.349) as 0.3% (DHS 2013, p.349). However, in correspondence with 28 Too Many (2016b), a Tiv woman writes that she is not aware of FGM being practised by the Tiv, and suggests that the figure of 0.3% may have arisen as a result of interviews being conducted with women who were subjected to peer pressure to have FGM in their area of residence, rather than as a feature of their ethnicity.

YORUBA

The Yoruba are the largest ethnic group in Nigeria, constituting approximately 21% of Nigeria's population. They are mainly based in the south-western and northern-central regions (WCE, 2016a; CIA World Factbook, 2016).

Traditionally, the Yoruba lived in clans based on patrilineal descent and practised polygyny (WCE, 2016a). However, 'Yoruba culture is not static' (International Encyclopedia of Marriage and Family, 2003), as contact with Islam and the West, for instance, impacts on traditions such as courtship and marriage.

Up to 20% of the Yoruba practise their traditional religion. Those remaining who practise a religion are divided nearly equally between Islam and Christianity; however, almost all Yoruba will observe certain traditional festivals and religious practices, regardless of their religion (WCE, 2016a).

FGM is usually performed in the first month after birth (WCE, 2016a). The prevalence of FGM among the Yoruba is the second highest, at 54.5% (DHS 2013, p.349). They mainly practice Types I and II (Kandala, Nwakeze and Kandala, 2009).



Fig. 11: Yoruba women in Ondo State (Photographer: Lisa Goldman)

OVERVIEW OF FGM IN NIGERIA

This section gives a broad picture of the state of FGM in Nigeria. Other sections of this report give more detailed analyses of FGM prevalence, set within sociological and anthropological frameworks, and of efforts towards its abandonment.

in turn is approximately 10% of the total number of women and girls on the African continent who undergo FGM (UNICEF, 2013, opening pages; 2016).

In May 2015 the Federal Government of Nigeria passed the Violence Against Persons Prohibition Act (VAPP), which outlaws FGM and other harmful traditional practices. While this is an important

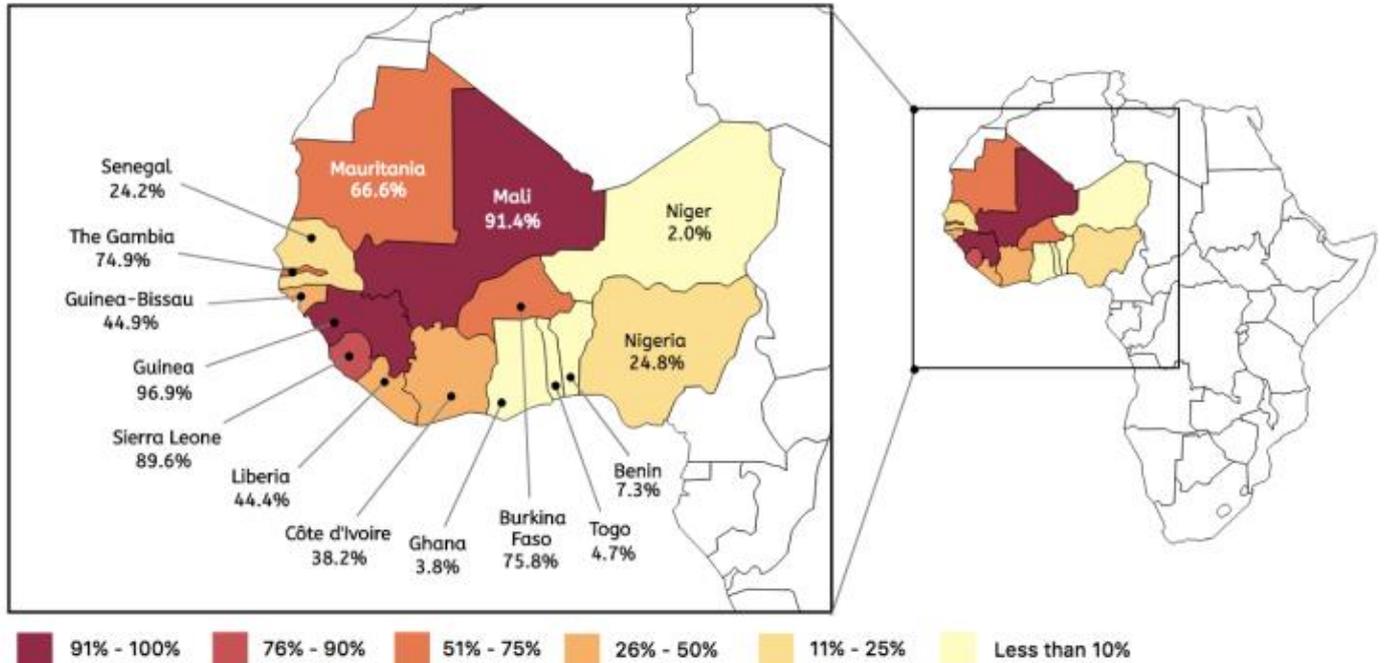


Fig. 12: Prevalence of FGM in West Africa

(Click for source document: Benin: DHS 2011-12; Burkina Faso: DHS 2010; Côte d'Ivoire: DHS 2011-12; Ghana: MICS 2011; Guinea: DHS 2012; Guinea-Bissau: MICS 2014; Liberia: DHS 2013; Mali: DHS 2012-13; Mauritania: MICS 2015; Niger: DHS 2012; Nigeria: DHS 2013; Senegal DHS-Cont 2015; Sierra Leone: DHS 2013; The Gambia: DHS 2013; Togo: DHS 2013-14.)

NATIONAL STATISTICS AND TRENDS

RELATING TO FGM

Based on the previous DHS survey in 2008 and the MICS survey of 2011, Nigeria was classified by UNICEF as a 'moderately low prevalence' country with a prevalence of 27% (UNICEF, 2013, pp.26-27). However, the most recent DHS survey for Nigeria (2013, p.349) puts prevalence among women aged 15 to 49 at 24.8%, which would re-classify it just inside the category of 'low prevalence countries'. While this is an improvement, because Nigeria is Africa's most populous country with over 180 million people (World Population Review, 2016), that figure represents more than 20 million Nigerian women who have been cut. This

step forward, this law only applies to the FCT. The other 36 states have the authority to pass mirror legislation, and some have already done so, but in the majority of states FGM is still not criminalised (see 'Laws Relating to FGM', at page 50, and Appendix II, at page 68).

In February 2016 Her Excellency Aisha Buhari, the First Lady of Nigeria appealed to the wives of state leaders to support her when she launched a national programme to end FGM within a generation. The programme is a collaboration between the Federal Government, state governments and certain UN agencies (Ogundipe, 2016a).

PREVALENCE OF FGM IN NIGERIA BY PLACE OF RESIDENCE

While about a quarter of women and girls across the whole of Nigeria have undergone FGM, there are distinct regional differences in prevalence, as shown in Figures 14 and 15 below.

Nigeria is divided into six Zones and 36 states, and there is large variation in FGM prevalence across Zones and states, from 49% (of women aged 15 to 49) in South East Zone to 2.9% in North East Zone, and from 76.6% in Osun State (in South West Zone) to 0.1% in Katsina State (in North West Zone) (DHS 2013, p.349).

The majority of Nigeria's population (57%) live in rural areas. The most densely populated Zone, with 30% of Nigeria's population, is North West, where FGM prevalence averages 20.7% (DHS 2013, p.32).

It is often assumed that FGM is more likely to occur in rural areas, where community ties and traditions are stronger and social norms more influential. According to the DHS 2013 (p.349), 32.3% of Nigerian women aged 15 to 49 and living in urban areas have undergone FGM, compared with 19.3% of women living in rural areas. Prevalence by current place of residence may not be a telling factor, however, as a woman may have moved since undergoing FGM, particularly if she was cut at a young age. For this reason it is more helpful to look at prevalence among young girls according to their place of residence (UNICEF, 2013, p.37). In Nigeria, the prevalence of FGM among girls under 14 is almost equal between those living in urban areas (16.8%) and those in rural areas (17%) (DHS 2013, p.354).

Although for older women the possibility of migration between rural and urban areas must be taken into account, the above figures do suggest that there has been a significant decline in FGM being carried out on girls and women living in urban areas, while the situation has remained almost unchanged for those living in rural areas.

Prevalence figures according to place of residence may not be an indicator of where FGM is actually taking place. According to 28 Too Many's Nigerian contacts, urban-residing families frequently take

their daughters back to their rural, familial homes for FGM to be carried out.

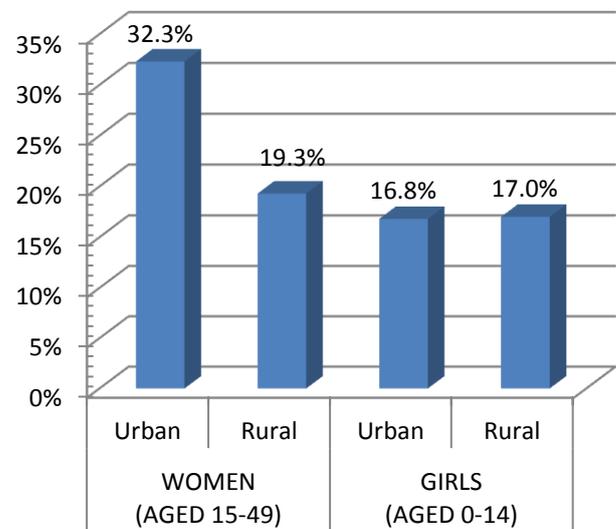


Fig. 13: Prevalence of FGM among women and girls by current place of residence (DHS 2013, pp.349&354)

PREVALENCE OF FGM IN NIGERIA BY AGE

Girls in Nigeria are most likely to undergo FGM in their first five years, and this practice appears to be growing more common. It has been suggested (Chikhungu & Madise, 2015, p.9) that, once FGM is criminalised in a country, more infants may be cut as they are unable to report parents or excisors to authorities. 90.2% of young women (aged 15 to 19) who have had FGM recall being cut before they were five years old, and only 1.4% recall being cut after the age of 15. Of older women who have had FGM, those aged 45 to 49, 79.8% say they were cut before the age of five and 9.2% report being cut after the age of 15 (DHS 2013, p.352). Results such as these may of course be inaccurate if older women cannot correctly recall when they were cut.

The DHS 2013 also surveyed mothers about the FGM status of their daughters. 15.8% of daughters are reportedly cut before they reach their first birthday, but 83.1% of daughters aged 0 to 14 have not undergone FGM, according to their mothers (DHS 2013, p.353). The DHS's comparison of the ages at which women (aged 15 to 49) and girls (aged 0 to 14) underwent or undergo FGM shows that a higher proportion of women than girls have been cut at a young age (DHS 2013, pp.353-3). This

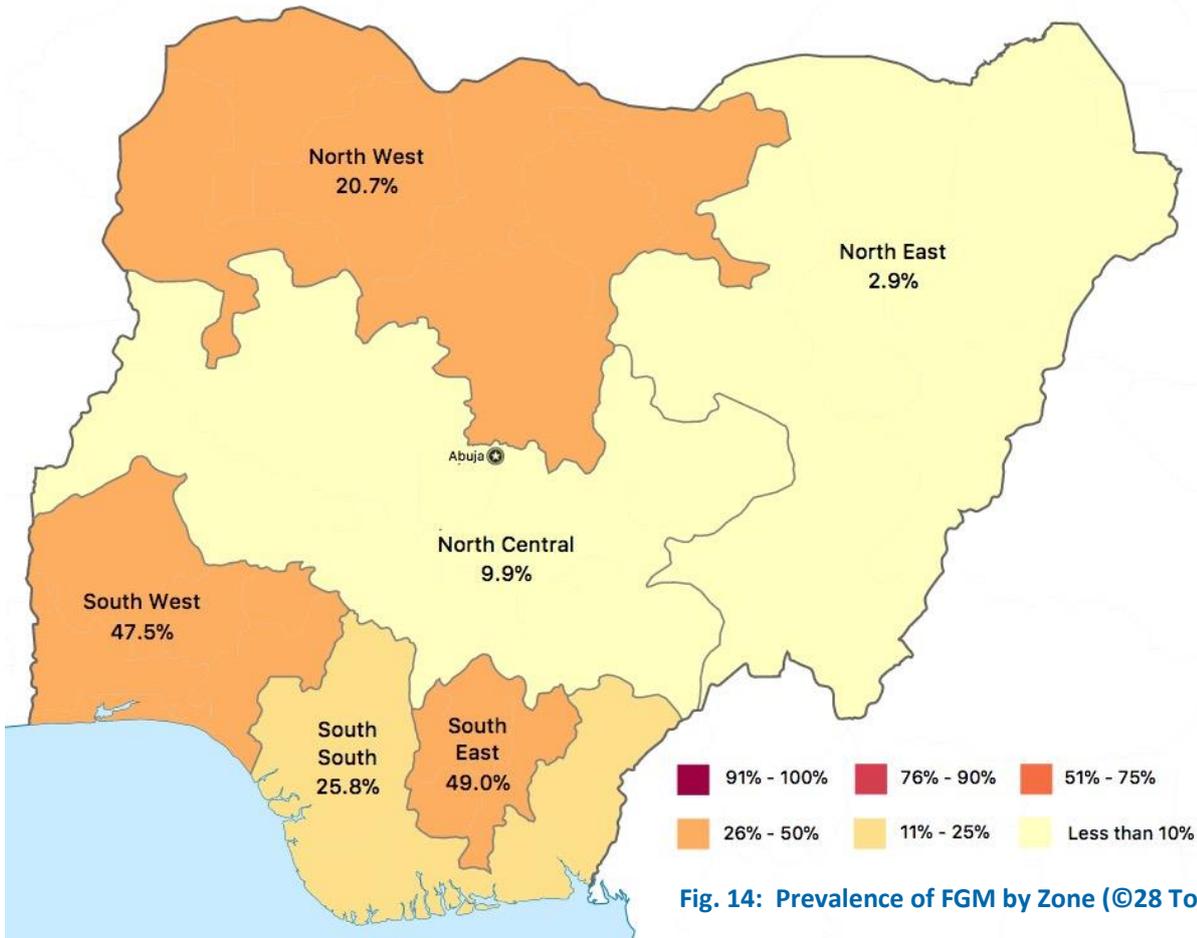


Fig. 14: Prevalence of FGM by Zone (©28 Too Many)

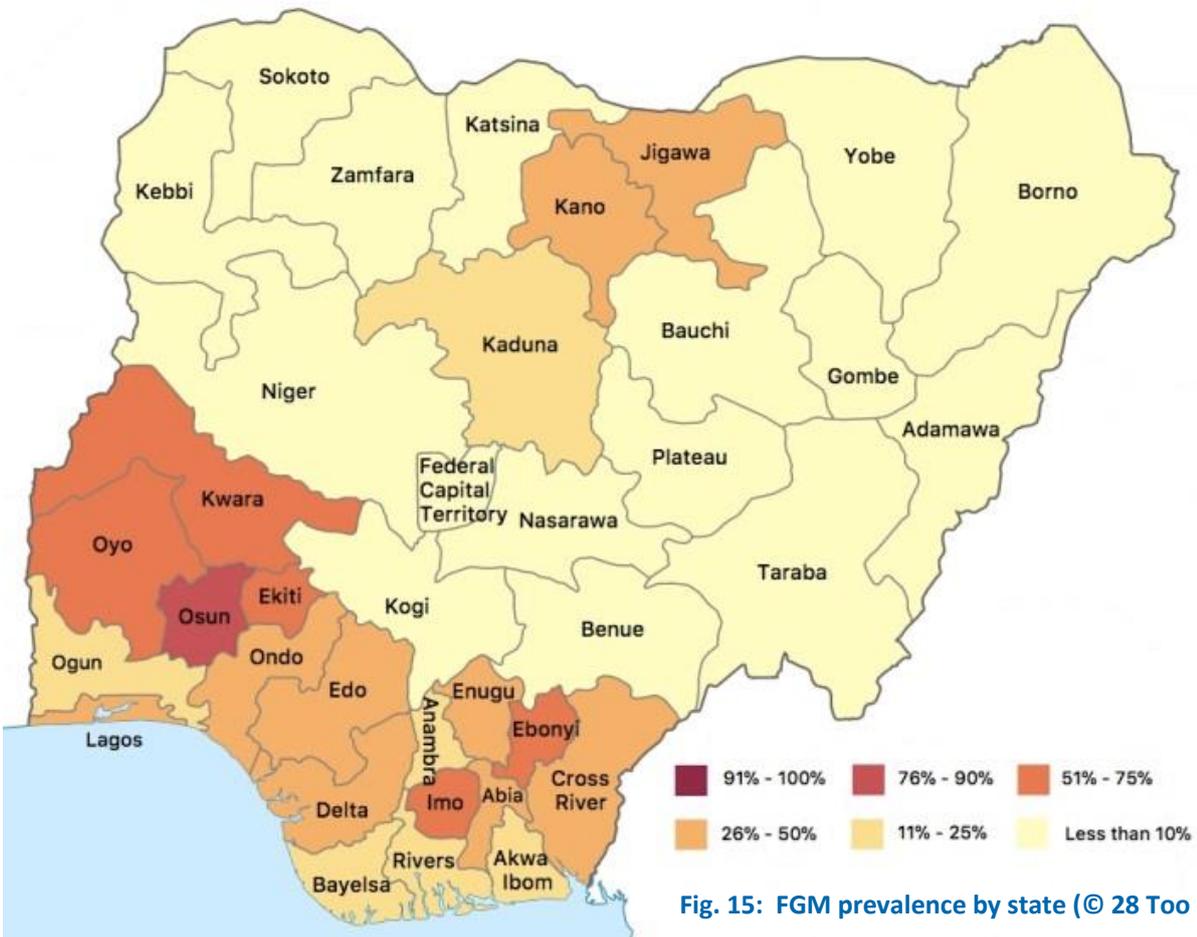


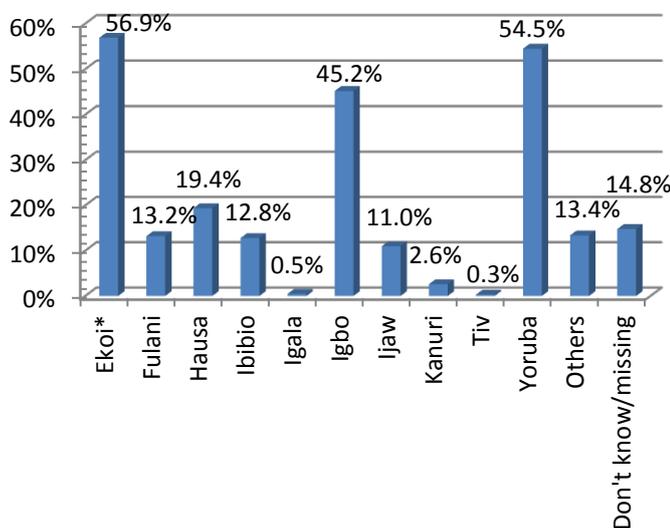
Fig. 15: FGM prevalence by state (© 28 Too Many)

suggests that there has been a decline in the practice, as more girls are reaching 15 years of age without having undergone FGM, after which time they are less likely to be cut.

PREVALENCE OF FGM IN NIGERIA BY ETHNICITY

Nigeria is ethnically diverse, with over 250 ethnic groups, ten of which comprise 80% of the country's population. Only these ten are listed in the DHS 2013 with their FGM prevalence figures.

Social and physical mobility have blurred the lines between ethnic groups and the parts of the country they now occupy. Broadly speaking, the Hausa-Fulani (who constitute 30% of the population) are located in North East and North West Zones, the Yoruba (21%) in South West, North Central and Central Zones, and the Igbo (18%) in South South and South East Zones. FGM prevalence among Yoruba women aged 15 to 49 is 54.5%, among Igbo it is 45.2%, and among Hausa-Fulani combined it is approximately 16.3%. FGM is virtually unknown among Igala (0.5%) and Tiv women (0.3%) (DHS, 2013, p.349).



* This figure is based on a very small sample (22) of Ekoi women (DHS 2013, p.350)

Fig. 16: Prevalence of FGM among women aged 15 to 49 by ethnic group (DHS 2013, p.349)

PREVALENCE OF FGM IN NIGERIA BY RELIGION, EDUCATION AND WEALTH

FGM prevalence in Nigeria is highest among women practising traditionalist religions (34.8%) and lowest among Muslim women (20.1%). Prevalence among Catholics is 31.4% and among other Christians is 29.3% (DHS 2013, p.349). However, Muslim girls are more likely to undergo FGM before they reach the age of five (DHS 2013, pp. 352 and 354).

In most African countries, a mother's level of education is a determining factor in whether her daughters will be cut (UNICEF, 2013, p.39). The usual expectation is that higher education, presumably giving greater exposure to information on health and wider social interactions, is linked to a lower likelihood of FGM. However, Nigerian women aged 15 to 49 with 'no education' are notably *less* likely to have undergone FGM (17.2%) than those with a primary-level education (30.7%), secondary-level education (28.8%) or higher education (29.1%) (DHS 2013, p.350).

Incongruously, mothers with 'no education' are more than twice as likely to have their daughters cut before they reach the age of 15 (19.3%) than mothers with higher education (9.3%). 16.3% of women with primary-level education and 14.2% of those with secondary-level education are likely to have their daughters cut before they reach the age of 15 (DHS 2013, p.355).

A similar situation is noted in relation to women's economic statuses. 31% of women in Nigeria (aged 15 to 49) in the highest wealth quintile have undergone FGM, compared with 16.5% in the lowest quintile. There is a steady graduation between these rates for the intermediate quintiles (DHS 2013, p.350). Conversely, 12.6% of girls aged 0 to 14 and born to mothers in the wealthiest quintile have undergone FGM, compared with 19.4% in the lowest quintile and 20.4% in the second-lowest quintile (DHS 2013, p.355).

This indicates that, whereas wealthier, better-educated women aged 15 to 49 are more likely to have undergone FGM than poorer, less-educated women in the same age-range, girls born to wealthier and better-educated women in Nigeria today are less likely to be cut than girls born to poorer, less-educated women.

TYPES OF FGM AND PRACTITIONERS

The most common type of FGM reported in Nigeria by women aged 15 to 49 is 'cut, flesh removed', at 62.6% (see Figure 17 below). 'Cut, no flesh removed' is reported by 5.8% and 'sewn closed' (Type III) by 5.3%. The highest rate of Type III is in the Ijaw ethnic group – 18.8% of Ijaw women aged 15 to 49 who have undergone FGM have had this type (DHS 2013, p.350).

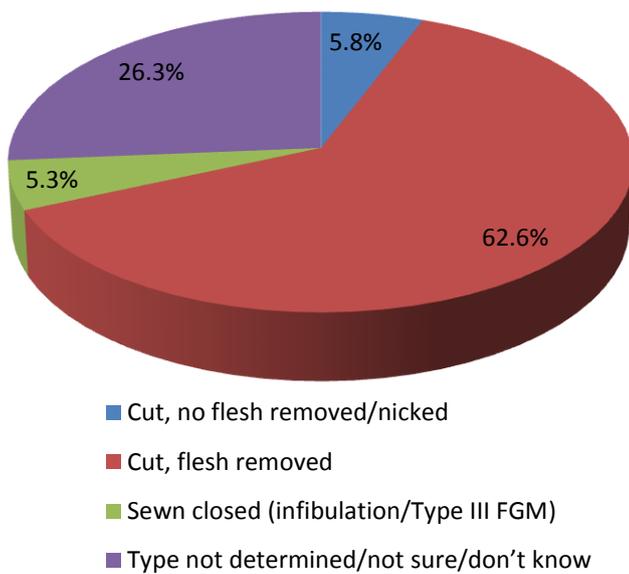


Fig. 17: Percentage distribution of FGM according to type for women aged 15 to 49 (DHS 2013, p.350)

A quarter of Nigerian women (26.3%) do not know what type of FGM they have undergone. It is possible that they may have experienced Type IV ('Other'/'Unclassified'). The DHS 2013 (p.351) reports that in Nigeria 24.9% of women (aged 15 to 49) who have experienced Type IV FGM experience *angurya* cuts, 5.1% *gishiri* cuts and 5.1% the use of a corrosive substance (see Figure 18 below).

Angurya (scraping of the vaginal tissue) appears to be most commonly practised by the Hausa and Fulani in areas of northern Nigeria. Women who have experienced *angurya* cuts are also more likely to live in rural rather than urban areas, have lower levels of education and be in the lower wealth quintiles (DHS 2013, p.351).

For girls (aged 0 to 14) and women (aged 15 to 49) who have undergone FGM, the most common type of practitioner is the 'traditional agent' (86.6% for girls; 79.5% for women). The majority of these 'traditional agents' are 'traditional circumcisers', but 'traditional birth attendants' cut 2.5% and 7% of these girls and women respectively (DHS 2013, p.357). This suggests that 'traditional agents' are now being used slightly more often. Medical professionals (doctor, nurse/midwife, other health professional) cut 11.9% and 12.7% of these girls and women respectively (DHS 2014, p.357), which is not a significant enough difference to definitively conclude from those figures that there has been a decrease over time in the number of medical professionals performing FGM.

Under the VAPP, a person who performs or tries to perform, or incites or aids another to perform FGM will be prosecuted, and if convicted may be imprisoned for up to four years and/or fined up to 200,000 Naira (approx. US\$1,000). However, for many traditional cutters (who, it should be noted, may be either male or female), FGM is their livelihood. One described it as 'a lucrative job that has discouraged many young men in [my lineage] from pursuing formal education' (cited in Olutosin, 2015).

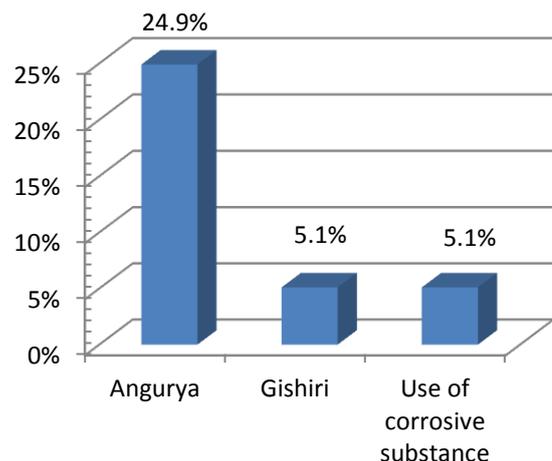


Fig. 18: Of women aged 15 to 49 who have undergone Type IV/'unclassified' types of FGM, percentage who have undergone the types particular to Nigeria (DHS 2013, p.351)

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN

Sections 15(2) and 42 of Nigeria's 1999 Constitution prohibit discrimination on the grounds of sex; however, customary and religious laws continue to restrict women's rights. In 2007, Nigeria adopted a National Gender Policy that focuses on women's empowerment and makes a commitment to eliminating traditional practices that are discriminatory and harmful to women (JICA and MUFJ, 2011, p.10). However, in March 2016 a Gender Equality Bill was presented to the National Assembly and rejected for the third time (Daily Trust, 2016).

The 2014 Social Institutions & Gender Index (SIGI, 2016) categorises the level of gender inequality in Nigeria as 'High', and notes:

Significant gender gaps in education, economic empowerment and political participation remain in Nigeria. . . . Discriminatory laws and practices, violence against women and gender stereotyping continue to hinder greater progress towards gender equality.

The SIGI 2014 Synthesis Report (2014, p.10) describes FGM as 'a common practice' in its list of features of countries that have 'High' levels of gender discrimination in social institutions. It defines these countries as being

characterised by discrimination embedded in customary laws, social norms and practices and by inappropriate legal protections against gender discrimination in all dimensions of social institutions.

These countries also have a high level of acceptance of domestic violence (SIGI, 2014, p.11).

The Gender Development Index (UNDP, 2015a) scores countries according to 'equality in [Human Development Index (HDI)] achievements between women and men' (p.223). Scores are 'a direct measure of gender gap showing the female HDI as a percentage of the male HDI' (UNDP, 2015b). Nigeria scores 0.841 (UNDP, 2015a, p.222). This puts it in group 5 – countries with 'low equality . . . (absolute deviation from gender parity

of more than 10 percent)' (p.223).

There are three forms of marriage recognised in Nigeria: monogamous marriage registered under civil marriage law, marriages performed under customary law and marriages performed under Islamic law. While polygamy is prohibited in civil marriages, it is legal under customary and Islamic law and is relatively common. Men may take up to four wives (SIGI, 2016). According to the DHS 2013 (p.53), 33% of married women are married to men in a polygynous relationship. Poorer women with less education are more likely to have co-wives than wealthier and better-educated women (p.55).

The DHS 2013 (p.53) reports that about 30% of girls aged 15 to 19 are married (or living with a partner), separated, divorced or widowed, and 42.8% of women between the ages of 20 and 24 were married or in a union before they were 18 (p.57). The Child's Right Act of 2003 sets the minimum age of marriage at 18, amending the Constitution. However, the Act has only been adopted by 24 of the 36 states. Hence, in the south, the minimum legal age ranges from 18 to 21 years, but in the north it ranges from 12 to 15 years (SIGI, 2016). The median age for marriage of women is lowest in North West Zone, at 15.3 years. Two states in North West Zone reported a median under 15 years (DHS 2013, p.58). Girls in Kano, for instance, have been known to marry as young as ten and have their first child at age 12.

As a result of certain states' failures to adopt the Child's Right Act and uphold the federal official minimum age for marriage, early and forced marriages remain common, especially in the north (US Department of State, 2014, p.36).

PHYSICAL INTEGRITY

The VAPP was signed into law on 25 May 2015. It is aimed at protecting women and girls from all forms of violence, including FGM. However, its implementation requires separate enactment by each of the 36 states. The VAPP is discussed further in 'Laws Relating to FGM' at page 50.

Domestic violence in Nigeria is widely recognised as a great concern. While the VAPP prohibits acts of domestic violence, Nigeria's Penal Code at Section 55(d), in relation to northern states,

legalises the corrective beating of a child, pupil, servant or wife as long as this does not cause grievous bodily harm. According to the DHS 2013, 28% of women aged 15 to 49 experience physical violence at least once after the age of 15 (DHS 2013, p.301) and the CLEEN Foundation's National Crime and Safety Survey for 2013 reported that 30% of respondents countrywide claim to have been victims of domestic violence (cited in US Department of State, 2014, p.32). The DHS 2013 reports (p.293) that more than a third of women (35%) believe that a husband is justified in beating his wife in certain circumstances, a decline from 43% in the DHS 2008.



Fig. 19: Woman selling grain maize in Bodija market, Ibadan (International Institute of Tropical Agriculture)

The mistreatment and abuse of widows in Nigeria is commonplace (US Department of State, 2014, p.33). 15% of widows report that they have been maltreated by their late husband's relatives. 12% of widows report that they have experienced physical or verbal abuse, and 11% that their

children have been maltreated by their late husband's relatives (DHS 2013, p.328).

Organisations like Project Alert on Violence Against Women, a Lagos-based NGO, run programmes to help in the campaign against domestic violence, including 'training programs for police on domestic violence, support groups for women, programs for male abusers and assistance to faith-based organisations in counselling victims' (US Department of State, 2014, p.32). Project Alert also opened a shelter, Sophia's Place, providing counselling and legal aid to victims of domestic violence. The Women's Rights Advancement and Protection Alternative (WRAPA) and the Nigerian Women's Trust Fund also lead in the campaign to eliminate gender-based violence (p.32).

The law criminalises rape under both the Criminal and Penal Codes but does not recognise spousal rape. Although accurate prevalence figures are unavailable, rape and sexual violence is recognised as a widespread, serious problem in Nigeria. According to the DHS 2013 (p.307), 7% of women aged 15 to 49 report that they have experienced sexual violence at some time in their life. However, societal pressures and the stigma associated with rape reduces the percentage of rapes reported and the penalties imposed for conviction (US Department of State, 2014, p.31; Folayan *et al*, 2014).

Sexual harassment is also recognised as a widespread problem. The founder of the NGO Delta Women (cited in US Department of State, 2014, p.33) estimates that 80% of women experience sexual harassment. There is no law specifically prohibiting sexual harassment, but authorities may prosecute harassment under Section 5 of the VAPP and assault statutes such as Section 285 of the Penal Code.

RESOURCES AND ENTITLEMENTS

The Nigerian Constitution gives equal property rights to women (Constitution 17(2)(a), 42(1), 43). However, tradition and women's low social and economic statuses limit their ownership of assets. Certain customary laws come into play, which dictate that the right to inherit and own land

belongs solely to men. For women without independent financial means, the result is that property ownership often only occurs through marriage or family (SIGI, 2016).

The way land is owned and accessed in Nigeria can be an amalgam of statutory legislation, customary law and Sharia (Islamic) law, resulting in wide variations of practise from region to region (Nwaebuni, 2013). Data from the DHS 2013 (p.285) indicates a significant gender gap when it comes to land ownership. 82% of women do not own a house and 85% of women do not own land. This low level of land ownership is one factor that limits women's ability to exploit land-based livelihoods. It affects their ability to access finance, for example, and often delays investment decisions or reduces the earning potential of agriculture (British Council Nigeria, 2012, p.20).

Limited financial resource and lack of collateral restrict women's access to formal financial services, including bank loans (British Council Nigeria, 2012, p.21). Data from the Nigerian National Bureau of Statistics (NBS) (as at 2009; cited in British Council Nigeria, 2012, p.21) show that men are more than twice as likely to secure finance through formal channels as women.

Few women have bank accounts and instead use informal or other formal micro-financers for access to capital (British Council Nigeria, 2012, p.21). One study (Halkias *et al*, 2011, pp.228-229) found that formal financial institutions have not supported female entrepreneurs as much as they could have.

CIVIL LIBERTIES

The Constitution and law provide for a woman's freedom of movement and access to public space, the right to choose her domicile and confer her citizenship. Married and unmarried women may apply for passports and national ID cards (SIGI, 2016).

However, the DHS 2013 (p.288) section on decision-making shows that women still face restrictions on choice. Only 6% of currently-married women make decisions by themselves about their own healthcare, and three in five

women report that their husbands mainly make such decisions. 62% of women say that the husband is the main decision-maker on large household purchases, while 32% say that themselves and their husband jointly make such decisions. 52% of women report that decisions to visit family or relatives are made mainly by their husbands. Purdah, the cultural practice of secluding women and pubescent girls from unrelated men, and 'confinement' for widows, continue in various parts of the north in Muslim communities (US Department of State, 2014, p.33; Yusuf, 2014).



Fig. 20: A group of young women in Abuja, Nigeria (Photographer: Mark Fischer)

Women and men have the same rights to vote and stand for election in Nigeria; however, women comprise only a small percentage of elected officials. While Nigeria has no legislated quotas at the national or sub-national levels to promote women's participation in politics, the Independent National Electoral Commission (INEC), in collaboration with the previous government administration, developed a framework for the implementation of a '35% affirmative action' plan, aiming to have 35% of ministerial and ambassadorial positions filled by women (SIGI, 2016). However, the current president, Muhammadu Buhari, opted out of this plan (Johnson, 2015). Only six of the 36 ministers comprising the current Cabinet are women, and the outcome of the elections to the Senate in May 2015 was a reduction of female representatives from eight to seven out of 109 (Premium Times, 2015).

HEALTHCARE SYSTEM

Nigeria's first comprehensive health policy, the National Health Policy and Strategy, was implemented in 1988. Subsequently, the Primary Health Care Under One Roof policy was instituted in 2011 and the National Health Act finally came into being at the end of 2014, four years after the bill was passed.

Nigeria's national healthcare system provides three tiers of care: primary, secondary and tertiary. The responsibility for most tertiary care lies with the Federal Ministry of Health, which also develops 'policies, strategies, guidelines, plans and programmes' (IANPHI, 2013) for the National Health Care Delivery System. 37 State Ministries of Health (including the Federal Capital Territory Administration) provide secondary care and 774 local government areas (LACs) provide primary care (including vaccinations) (IANPHI, 2013; McKenzie, Sokpo and Ager, 2014, p.82). However, the complex system of healthcare provision, operated by three levels of government without clear definitions of responsibilities, has made it difficult for Nigeria to fulfil its commitment to providing universal healthcare (McKenzie, Sokpo and Ager, 2014, p.82).

The inadequacies of the healthcare system that result from this confusion over different parties' responsibilities have led to people turning to the private system, as well as traditional and spiritual healers (Federal Ministry of Health, 2002, p.11). Additionally, the irregular release of budgets causes problems in healthcare financing (for both the provision and monitoring of services), as well as 'significant poor implementation of programme activities' (Uzochukwu *et al*, 2015, p.441).

One of the problems Nigeria faces is achieving a good mix of financing sources in its attempts to provide universal health coverage. While a National Health Insurance System was introduced in 2005, only those employed in the formal sector and Federal Government departments (less than 5% of the working population) have taken it up. Around 1% of Nigerians are covered by private-

company health insurance, and community-based health insurance has been implemented in a few pilot areas. Out-of-pocket payments continue to be the main source of financing, at around 70%, accounting for 95.9% of private expenditure (in 2007) – one of the highest rates in the world. This reliance on out-of-pocket payments has led to inequalities in healthcare provision and take-up, pushing the poorest even further into poverty (Uzochukwu *et al*, 2015, p.441).

The Nigerian Government has implemented various policies to address the matter of health financing, including the National Health Policy, Health Financing Policy, National Health Bill and National Strategic Health Development Plan (2010-2015) (Uzochukwu *et al*, 2015, p.439), and life expectancy in Nigeria has risen from 41 in 1970 to 53 in 2013 (UNICEF, 2014, p.64). Despite this, there continues to be inadequate Government funding for healthcare. In 2015, Government expenditure on health was only 5.5% of the national budget, as opposed to the 15% proposed in African Union's Abuja declaration of 2001 (p.441).

Nigeria was, however, commended by the WHO (2014) for its strong leadership and effective coordination of resources during the Ebola crisis that began in 2014. Important factors cited in the successful containment of the outbreak in Nigeria were the establishment of an Emergency Operations Centre, the Government's public awareness campaigns and its early engagement with traditional, religious and community leaders.

HEALTH AND THE NEW SUSTAINABLE

DEVELOPMENT GOALS

Although statistics are reportedly unreliable (Igbuzor, 2011, p.7), it appears that Nigeria saw significant improvements in the period 2000 to 2015 in areas relevant to the health-related MDGs. These improvements, together with Nigeria's confirmed commitment to the newly-agreed SDGs (Vanguard, 2015), provide a good base for future improvements to the healthcare system.

GOAL 4: REDUCE CHILD MORTALITY

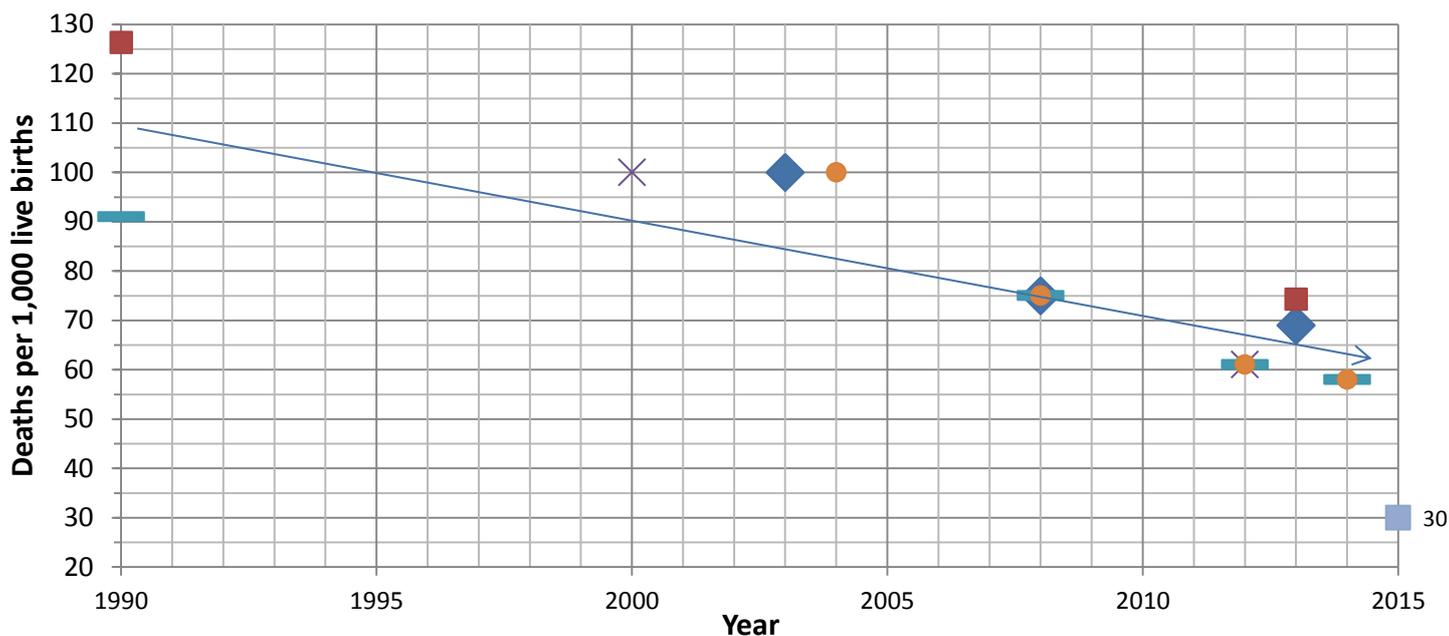


Fig. 21: Infant mortality rates as reported by various sources, 1990-2015, showing an overall downward trend

LEGEND FOR FIGURES 21 AND 22

	Millennium Development Goal for infant/under-five mortality for 2015
	DHS 2013, p.119
	UN IGME, 2014, p.49. (Also cited in UNICEF, 2014, p.39.) <i>The Inter-agency Group for Child Mortality Estimation (UN IGME) constitutes representatives of the United Nations Children's Fund, the World Health Organization, the World Bank and the United Nations Population Division.</i>
	UNECA et al, 2014, p.64. (Sourced from: Office of the Senior Special Assistant to the President on the MDGs, 2013; Federal Government of Nigeria and National Bureau of Statistics, 2013.)
	OSSAP, 2015, p.6. (Sourced from: Office of the Senior Special Assistant to the President on the MDGs (OSSAP); UN Development Programme; UK Aid/DFID.)
	National Bureau of Statistics/Federal Republic of Nigeria, 2014, pp.8, 11 and 19.

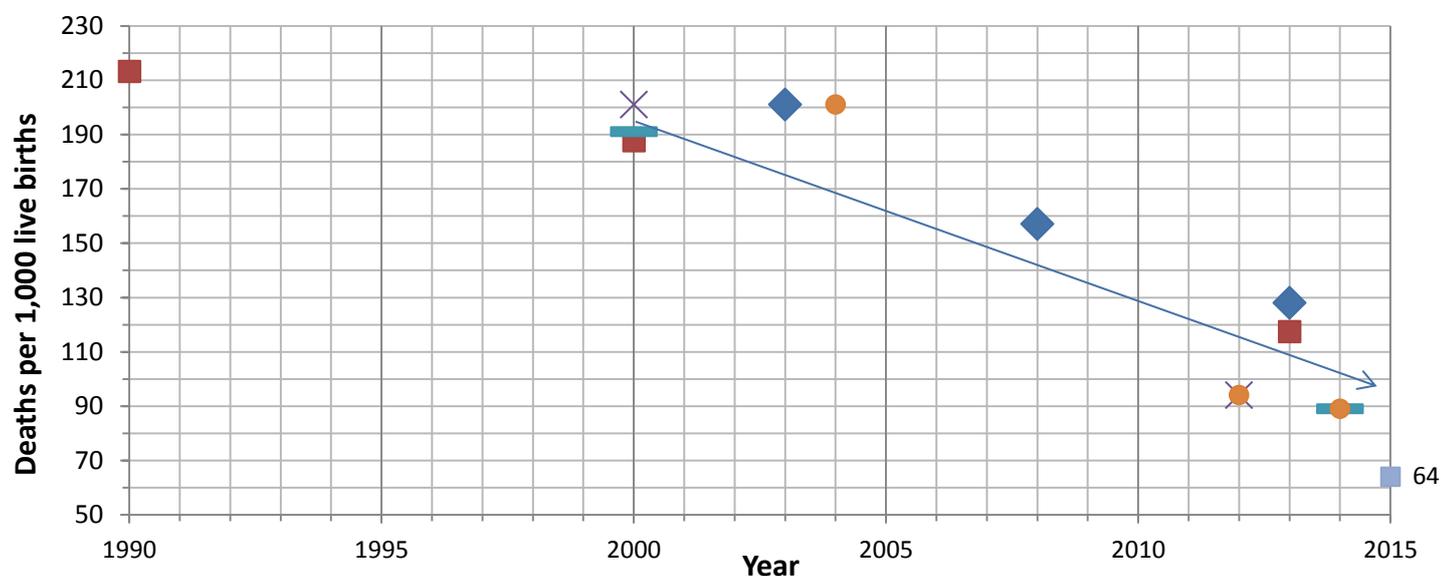


Fig. 22: Under-five mortality rates as reported by various sources, 1990-2015, showing an overall downward trend

As Figures 21 and 22 show, there are discrepancies between the rates for infant mortality and the rates for under-five mortality reported by various institutions. It is clear, however, that both rates have fallen since 1990 but have not met the 2015 MDGs targets of 30 and 64 deaths per 1,000 live births, respectively. The lowest reported figures, from the NBS and the Nigerian Federal Government in 2014 (NBS/FRN, 2014, pp.8,11 and 19), are 58 deaths per 1,000 live births for infants and 89 for under-fives.

Malaria is the main cause of death for children under five (WHO, 2012, p.2). In 2013, 59% of one-year-olds received a measles immunisation, against a target of 90% (WHO, 2015b, p.26). In July 2015 Nigeria marked one year without a single case of polio (BBC News, 2015b).

GOAL 5: IMPROVE MATERNAL HEALTH

According to the DHS 2013 (p.273), the risk of maternal death for Nigerian women is one in 30, and about 14% of maternal deaths globally occur in Nigeria.

Although all the sources of data consulted for this report show an improvement since 1990 in maternal health, antenatal care and attendance by professional health workers at births, there are discrepancies between the reported figures for maternal mortality, which are shown in Figure 23 below. However, the WHO (2014, p.26) estimates a 53% reduction in maternal mortality over the period 1990 to 2013, against the MDG target of 75%.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Adult HIV prevalence in Nigeria fell from 5.8% in 2001 to 4.1% in 2010 (DHS 2013, p.223), with a further fall to 3.2% in 2013 (UNICEF, 2014, p.57). However, due to its large population, Nigeria represents 9% of the global burden of HIV/AIDS worldwide, second only to South Africa. 26% of women and 37% of men had a comprehensive knowledge of HIV/AIDS in 2013 (DHS 2013, p.223).

2015-2030 – CHALLENGES AND OPPORTUNITIES

The MDGs have now been replaced by the SDGs, which have a deadline for achievement of 2030. For the full set of SDGs, please see our [Global Goals](#) document.

In addition to Goal 5.3 (*Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation*), which makes specific reference to the elimination of FGM by 2030, several other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, in particular those related to education, health and gender equality; for example:

Goal 3 (*Ensure healthy lives and promote wellbeing for all at all ages*) aims to

- (3.2) End preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births

and achieve

- (3.7) Universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

According to Dr Amina Shamaki, the Permanent Secretary for the Federal Ministry of Health, Nigeria hopes to achieve the SDGs through universal health coverage using the National Health Act, the ongoing National Health Policy Review, the 2nd National Strategic Health Development Plan, the National Health Insurance Scheme and State Supported Health Insurance Scheme, the Save One Million Lives Programme for Results, and the Primary Health Care Under One Roof policy (Ugwu, 2015).

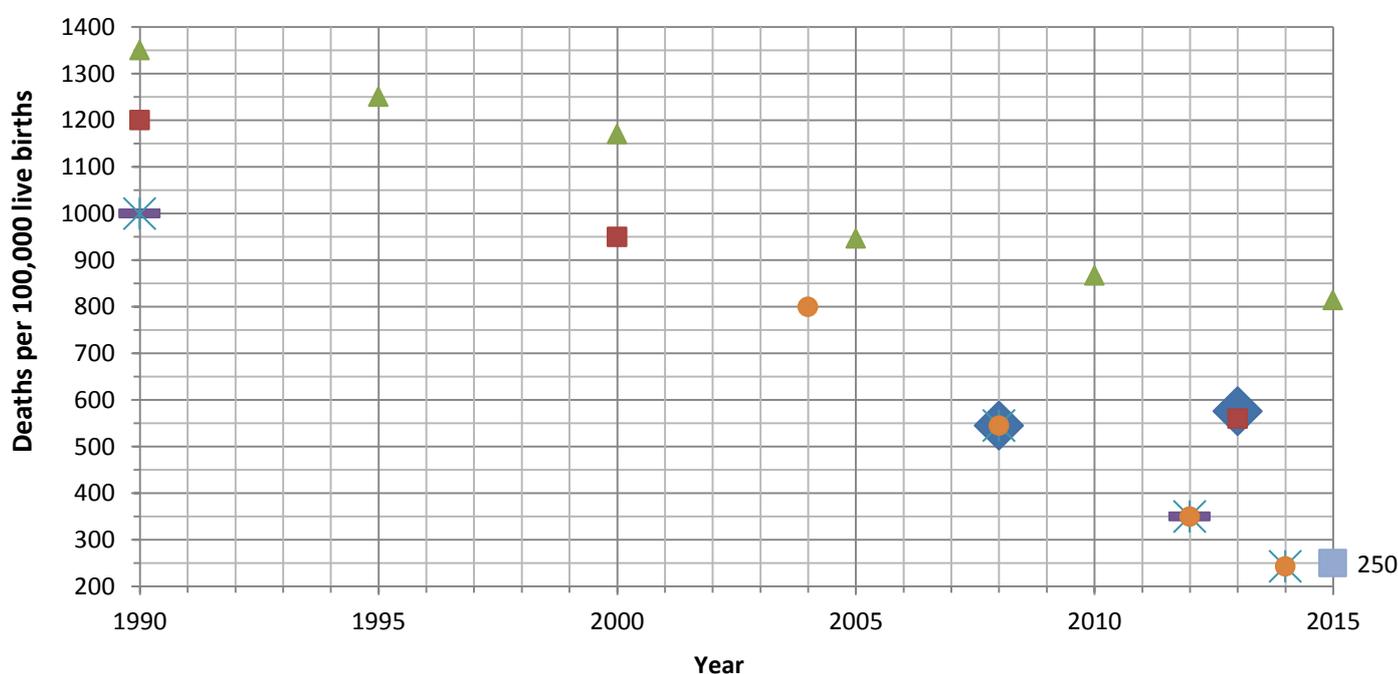
WOMEN'S HEALTH

The reproductive and sexual health of girls and women is affected by a number of factors such as their age when married; access to family planning and contraceptive advice; antenatal, obstetric and postnatal care; access to treatment for sexually transmitted infections; and the prevention of unsafe abortions.

Particularly in the north of Nigeria, early marriage is common, with the reported prevalence of child marriage as high as 76% in the north-west. This is despite the Child's Right Act of 2003, which sets the

minimum age of marriage at 18 (Girls Not Brides, 2016).

The fertility rate in Nigeria is 5.5 births per woman, which has reduced slightly from the figure of 5.7 recorded in 2003 and 2008 (DHS 2013, p.65). Significantly, as a woman's age when she first gives birth is a key factor in terms of maternal health risks, the DHS 2013 (p.65) reports that 23% of women aged 15 to 19 have begun childbearing, and 32% of women in the age-range 25 to 49 gave birth by the age of 18, with the median age for first birth being 20.2 years.



	Millennium Development Goal for maternal mortality for 2015
	DHS 2013 , pp.273 & 278
	WHO, 2015b , p.66. (Sourced from estimates by the WHO, UNICEF, UNFPA, UN Population Division and World Bank Group for 1990-2013.)
	WHO et al, 2015 , p.95. (Estimates by the WHO, UNICEF, UNFPA, World Bank Group and the UN Population Division.) NB: the figure for 2015 is an estimate.
	UNECA et al, 2014 , p.64. (Sourced from: Office of the Senior Special Assistant to the President on the MDGs, 2013; Federal Government of Nigeria and National Bureau of Statistics, 2013.)
	OSSAP, 2015 , p.7. (Sourced from: Office of the Senior Special Assistant to the President on the MDGs (OSSAP); UN Development Programme; UK Aid/DFID.)
	National Bureau of Statistics/Federal Republic of Nigeria, 2014 , p.22. (NB: all figures are for ages 15 and up except for 2014, which is for ages 14 to 49.)

Fig. 23: Maternal mortality rates/ratios from various sources, 1990-2015, showing an overall downward trend

REPRODUCTIVE HEALTHCARE

In 2000, Nigeria had one of the highest rates of maternal mortality in the world, estimated at 800-1800 deaths per 100,000 live births (Yar'Zever, 2014, p.62). In addition, the WHO (cited in Mojekwu and Ibekwe, 2012, p.136) ranked the performance of Nigeria's healthcare system at this time as 187th out of 191 United Nations member states.

By 2014, the NBS and the Federal Government (OSSAP, 2015, p.7; NBS/FRN, 2014, p.22) reported that the maternal mortality rate had fallen dramatically to 243 per 100,000 live births. This is inconsistent, however, with the DHS 2013 (pp.273&278) figure of 576 for 2013, the WHO's (2015b, p.66) figure of 560 for 2013 and an inter-agency estimate of 814 for 2015 (WHO *et al*, 2015, p.95) (see Figure 23 above).

The maternal mortality rate is far from uniform across the country. Rates are estimated to be as high as 1,271 maternal deaths per 100,000 live births in four states of northern Nigeria: Jigawa, Katsina, Yobe and Zamfara States (Okereke *et al*, 2015, p.2). Incidents of maternal deaths therefore appear to be more concentrated in the north.

Poor access to safe childbirth services and lack of adequate and affordable emergency obstetric care are the main reasons for the high incidence of maternal mortality in Nigeria (British Council Nigeria, 2012, p.vi). Many initiatives have been implemented over the years to address maternal health, including the National Health Policy and Strategy in 1988, the National Reproductive Health Policy and Strategy in 2001, the National Child Health Policy in 2006 and the Integrated Maternal, Newborn and Child Health Strategy in 2007 (Federal Republic of Nigeria Ministry of Health, 2011, pp.59-60). In addition, there have been several initiatives aimed at improving maternal and child healthcare, particularly in the period 2000 to 2015. These include:

- the PRRINN-MNCH scheme (2006-2014), addressing child/maternal health in the context of primary healthcare in certain northern states (Oyedele, 2013);

- the Midwives Service Scheme (2009-present), to boost the number of midwives in rural areas and increase skilled professional attendances at births (Ibeh, 2015);
- Agbebiye (the Safe Motherhood Programme) (A.K.A. Abiye Initiative) (2010-present), providing pregnant women/young children in Ondo State with healthcare through the Health Rangers, and with communication and transportation (Okechukwu, 2013; Ondo, 2015); and
- the Sure-P MCH (2012-2015), set up by the Federal Government to improve maternal/child health in rural and other disadvantaged areas (Sure-P, 2013).

Apart from the Agbebiye Initiative, which was immensely successful and even praised as 'a role model and benchmark for the African continent in tackling infant and maternal mortality rate' (Ogundipe, 2011), the schemes all encountered problems with implementation, coordination, leadership, funding and corruption. However, all of these schemes had elements of success and all showed clear improvements in the provision of maternal and child healthcare.



Fig. 24: Girls being trained to become health workers in a DFID-funded programme in northern Nigeria (DFID)

A number of NGOs have included reproductive and sexual-health education (including the impact of FGM) in their programmes; for instance, FORWARD, the Initiative for Food, Environment and Health Society and Adolescent Health and Information Projects have all worked in northern Nigeria (the latter specifically includes traditional and religious leaders in their training workshops).

Despite the difficulties in reporting, all the data considered for this report show that there have been improvements in maternal and child health over the last few years.

While knowledge of contraception in Nigeria is common (in 85% of women and 95% of men), only around 15% of married women use a contraceptive method. The unmet need for family planning marginally improved from 20% in 2008 to 16% in 2013 (DHS 2013, p.89).

Various organisations (DHS 2013, p.130; WHO, 2015b, p.94; UNICEF, 2014, p.81) report that, overall, approximately 51% of pregnant women attend at least four antenatal visits, while OSSAP (2015a, p.7) and the NBS/Federal Government (NBS/FRN, 2014, p.25) report that the figure is closer to 60%. The DHS (2013, p.130) reports that 34.2% of pregnant women attend no antenatal visits; the NBS/Federal Government (NBS/FRN, 2014, p.25) reports the figure for the same in 2014 as 25%; both draw attention to the differences between regions – vastly more women in the south of the country attend antenatal visits than those in the north, and the north-west has the lowest rate of attendance. The DHS (2013, p.127) also draws attention to the significant variation according to wealth – 95% of pregnant women in the highest wealth quintile receive antenatal care as opposed to 25% in the lowest wealth quintile. The British Council Nigeria (2012, p.43; figures as at 2008) also notes that education is a major factor in women’s uptake of antenatal care – 24.5% of pregnant women with no education seek antenatal care as opposed to 94.5% of women with a higher education.

The DHS (2013, p.127) and UNICEF (2014, p.81) report that the rate of delivery in a healthcare facility is 35% (as at 2013). Various organisations (DHS 2013, p.127; WHO, 2015b, p.94; UNICEF, 2014, p.81; UN Economic Commission, 2014, p.63) report the rate of skilled attendance at birth to be 35-39%, while the OSSAP (2015a, p.7) and NBS/Federal Government (NBS/FRN, 2014, p.23) give a projected 2014 figure of 58.6%. Again, there is a divide between north and south, with the north-west region having the highest number of unattended births. Education is a key factor when it comes to place of delivery – only 7.8% of those

with more than a secondary-level education undergo a home birth, as opposed to 87.7% of those with no education at all (DHS 2013, p.136). Importantly, the DHS (2013, pp.133-5) reports that women under the age of 20 are more likely to have a home birth (74% of them) and less likely to be assisted at birth by a skilled attendant (25.5%, as opposed to 41% of women aged 20-34).

Reasons given by women for not giving birth in a health facility include ‘felt it was not necessary’ (29%), ‘distance from facility’ (13%) and ‘cost’ (8%). There are regional differences; for example, 12% of women in the south-west stated that their husbands or family would not allow them to deliver in a health facility (DHS 2013, pp.137-8). The DHS (cited in IRIN News, 2015) found that, in the north-east, 90% of women (who conceived during the period 2009 to 2013) did not attend medical check-ups, either before or after giving birth, for fear of attacks from Boko Haram or intimidation at checkpoints, or because local clinics had been destroyed. The BBC (Ewokor, 2016) reports that in Cross River State, women frequently give birth in traditionalist churches because they believe that the church gives them greater protection during childbirth than hospitals or health centres. They are told that in hospitals and health centres deliveries are performed solely by caesarean section, and they are therefore at risk of dying from subsequent heavy bleeding. In all regions, the main reason given for delivering at home was that the child was born suddenly, which may indicate problems in the care of pregnant women and inaccuracy of estimated delivery dates (DHS 2013, p.137).

REPRODUCTIVE HEALTH COMPLICATIONS

Contrary to the belief in some parts of Nigeria that FGM can ease childbirth (Ashimi and Amole, 2014, p.698), a study carried out for the WHO in 2006 in six African countries (including Nigeria) reported that women who had undergone FGM had significantly more problems at childbirth than those who had not undergone FGM, including ‘caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant and inpatient perinatal death’ (WHO, 2006, p.6).

Other complications caused by FGM are well documented and include sepsis, an increased risk of stillbirth (Lawani *et al*, 2014, p.127), urinary tract infections, hepatitis, pelvic inflammatory diseases, infertility, a higher risk of HIV, obstructed labour, vesico vaginal fistula (VVF – opening of passages between the vagina and bladder or anus) and recto-vaginal fistula (RVF – breakage in the birth canal wall allowing uncontrollable leakage from the bladder to the vagina or uncontrollable leakage of faeces) (UNICEF, 2015a, p.3). According to *Vanguard* (Ayansina, 2015), Nigeria has the highest worldwide prevalence of VVF, with around 800,000 cases, 90% of which remain untreated, and many Nigerians are unaware of the problem.

The risk of maternal and infant mortality is increased because, according to the British Council Nigeria (2012, p.vi), only 36% of births in Nigeria take place in a health facility or with a skilled attendant present.



Fig. 25: Doctor weighing baby in the Evangel Hospital in Jos, Plateau State, which also carries out fistula repair surgery (Photographer: Mike Blyth)

EngenderHealth has provided obstetric fistula care in Nigeria since 2007 through the Fistula Care Plus project, training health professionals to perform fistula repair surgery and working with hospitals and health facilities to improve emergency obstetric care (EngenderHealth, 2005-2016).

As well as physical problems, FGM may cause mental and psychological problems both before and after it is performed (Okeke, Anyaehi and Ezenyeaku, 2012, p.72). A study of the psychological implications of FGM showed that it is associated with various degrees of psychological morbidity, including loss of trust, lack of bodily well-being, PTSD and depression, as well as experiencing a sense of betrayal and feelings of anger, guilt, shame and inadequacy during sexual intercourse, (Whitehorn, Ayonrinde & Maingay, 2002, pp.165-167).

FGM AND THE HEALTHCARE SYSTEM

Although in Nigeria FGM is generally carried out by traditional cutters, including traditional birth attendants and local barbers (Online Nigeria, 2016), a 2004 study (Ugboma, 2004, Abstract) reported that 34.5% of FGM cases in Nigeria are carried out by medical doctors.

The DHS 2013 (p.357), however, reports that 11.9% of girls (aged 0 to 14) and 12.7% of women (aged 15 to 49) who have undergone FGM have had the procedure performed by a medical professional; that is a doctor, nurse/midwife or other health professional.

28 Too Many is aware that, anecdotally, it is not common in Nigeria for medical professionals to perform FGM; however, it may be that medical professionals are carrying out FGM secretly, or simply that the results of the 2004 study are no longer accurate.

For more information on the medicalisation of FGM, please see <http://28toomany.org/fgm-research/medicalisation-fgm/>.

In February 2016 it was announced that a course would be introduced into Nigeria's medical curriculum for doctors and nurses, aimed at helping medical staff to support victims of FGM (Chatora, 2016).

GUIDELINES FOR MEDICAL PROFESSIONALS

Health workers have a crucial role in helping address this global health issue. They must know how to recognize and tackle health complications of FGM.

*~Dr Flavia Bustreo,
WHO Assistant Director General
(WHO, 2016a)*

Following the inclusion of a target for the elimination of FGM in the Sustainable Development Goals, the WHO has issued new guidelines on the management of health complications arising from FGM. These aim to provide up-to-date, evidence-informed recommendations for the treatment of obstetric complications resulting from infibulation, mental-health disorders arising from the experience, sexual dysfunction, and information and education on deinfibulation.

The guidelines are also intended to provide standards that may serve as a basis for designing professional training curricula for doctors, nurses, midwives and public-health workers with the responsibility for caring for girls and women who have undergone FGM. Additionally, the document provides guidance for policy-makers, healthcare managers and others in charge of planning, developing and implementing national and local healthcare protocols and policies.



Fig. 26: Schoolchildren in Ibadan, Oyo State (© Soteria Trust)

EDUCATION

Quality, universal education is a vital step in the eradication of FGM in Nigeria, as it is everywhere, and a good level of literacy in the population makes the anti-FGM message easier to spread.

A survey by the NBS in Nigeria (cited in UNESCO, 2012, p.1) estimates Nigeria's adult literacy rate to be 56.9%; however, UNICEF (2015) found the rate for 2009-2013 to be 51% and the DHS 2013 (p.36) found it to be 75% for men and 53% for women (aged 15 to 49). The NBS (cited in UNESCO, 2012, p.1) found large variations in literacy rates between states (Lagos – 92%; Borno – 14.5%), residential regions (urban – 74.6%; rural – 48.7%) and sexes (male – 65.1%; female – 48.6%). According to UNICEF (2015b), the youth literacy rate (age 15 to 24) from 2009 to 2013 was 76% for males and 58% for females.

The Nigerian education system has five main levels. Pre-primary is three years from the age of three; primary is six years from the age of six; junior secondary is three years from the age of 12; and senior secondary is three years from the age of 15. Subsequent to this is university (a Bachelor in four years) or non-university tertiary education (UNESCO/UNICEF, 2012, p.3).

The majority of education in Nigeria is provided by the public sector, and all three tiers of government (federal, state and local) have responsibilities. 51% of students attend state schools, 18.5% private schools and 16.5% local-government schools. 5.4% of students' education is provided by religious bodies. The local-government education authorities report to the State Universal Education Boards, which support primary and secondary schools. The National Commission for Mass Literacy, Adult and Non Formal Education, as the name suggests, is responsible for adult and non-formal education, and tertiary education is largely the responsibility of the Federal Government (British Council, 2012, p.26).

The private sector, however, is a significant provider, and an even larger provider in certain poor, urban areas than the state sector (British Council, 2012, p.26); for example, in Lagos it is estimated that two-thirds of enrolment (1.5 million

children at primary and junior-secondary levels) is in privately-run schools. There are estimated to be around 18,000 private schools in Lagos alone (DFID, 2013, pp.1-2). The public perception is that they are better than Government schools because teachers work longer hours (p.3). There are high- and low-cost private schools, and nearly a third of children attending private schools in Lagos come from households living below the absolute poverty line (p.2).

ENROLMENT AND ATTENDANCE

The Nigeria Education Data Survey (NEDS) (2015) gives a net attendance ratio (NAR) (i.e. the number of children of the appropriate age for primary school who are attending, as a percentage of all Nigerian children of that age) of 63% in 2010 and 67% in 2015, showing a marginal increase. The NAR for junior-secondary schooling was 33% in 2010 and 40% in 2015, also showing an increase. Overall literacy rates, however, were reported as 56% for 2004, 52% for 2010 and 47% for 2015, suggesting a significant decline (p.5).

UNICEF (2015) gives higher ratios of attendance (for the period 2008 to 2012): 72% of boys and 68% of girls at primary and 54.2% of boys and 54.3% of girls at junior secondary. UNICEF also gives primary-school net enrolment ratios of 60.1% of boys and 54.8% of girls.

There are vast disparities in the rates of attendance (from various data sources) according to wealth quintile and place of residence. Rural areas consistently fall below urban areas in rates of educational attendance and attainment. Global Education First Initiative (2013, p.5) reports that 34% of girls and 25% of boys of primary-school age in the northern, rural areas do not attend school, compared with less than 4% of girls and 3% of boys in the southern, rural areas. The NEDS (2015, pp.11&13) gives the following attendance figures:

PRIMARY	Urban	Rural
Male	81%	59%
Female	80%	55%
JUNIOR SECONDARY		
Male	50%	31%
Female	53%	29%

Table 1: Net attendance ratio by gender and residence for primary- and junior-secondary-aged children in Nigeria (NEDS, 2015, pp.11&13)

The NEDS (pp.11&13) also records that, for those in the lowest wealth quintile, the primary NAR is 34% and the junior-secondary is 9%. By comparison, for those in the highest wealth quintile, the primary NAR is 84% and the junior-secondary is 62%.

Access to education is also a problem, particularly in the northern, rural areas, lessening a child's chances of completing primary school. UNESCO (2015, pp.81-2) reports that access in rural areas worsened between 2003 and 2013. A child's chances of completing primary school if he or she is in the lowest 20% wealth quintile is decreasing. '[P]rimary attainment among the poorest households actually fell, from 35% in 2003 to 22% in 2013 . . .' (p.83). UNESCO (2012, p.1) reports elsewhere: 'There are also 3.5 million nomadic school-aged children with only 450,000 of them accessing any form of schooling.'

Most of the data sources consulted report that the lowest attendance rates are in the north-east, and the highest are in the south-east.

Overall, it appears that attendance declines with increasing age, especially over the age of 16, and, significantly, the rate of decline increases more quickly for females over the age of 15 than for males (DHS 2013, pp.28-29).

Factors affecting school attendance may be a family's socio-economic position, religious beliefs or traditional practices. A child's gender is also a major factor. Parents 'tend . . . to enroll boys instead of or before girls' (Global Education First Initiative, 2013, p.10). Additionally, 'girls in the North marry about four years earlier, at age 16, than their Southern counterparts' (p.10). Early marriage and pregnancy significantly reduce a girl's chances of completing even a basic education – of girls aged 15 to 19, 2% of those who are married attend school as opposed to 69% of those who are not (p.10).

Fears of kidnapping and sexual assault reportedly discourage many parents from sending their female children to school, especially when the school is far from home (p.10). The Boko Haram attack in April 2014, where almost 300 girls were abducted from a school, demonstrates that this is a real barrier to the attainment of education for girls. The Government ordered the closure of all schools in Borno State in 2014 after a series of attacks by Boko Haram across the north-eastern states (International Medical Corps UK, undated). Some of these schools were used to house thousands of IDPs, including children. After two years, in February 2016, a decision was made to reopen all public schools in Borno State, as IDPs were re-located to established camps (Okonkwo, 2016).

Although the Federal Child's Right Act sets 18 years as the minimum age for employment, the Act has not been adopted in many states. The Labour Act, which is in force in all 36 states, sets the minimum age at 12 years, and children may even work at a younger age alongside a family member engaged in agriculture, horticulture or domestic service. A range of policies are in place at federal and state levels to deal with child labour exploitation, but UNICEF (undated) estimates that some 4.7 million young children in Nigeria are not attending primary school, and the number of working children under 14 years of age is 15 million. Girls in rural areas are particularly likely to be out of school and working at a young age as domestics. UNICEF also estimates that over eight million Nigerian children are orphaned and suggests that many of these children are unlikely to attend school and are in danger of trafficking and sexual assault. Another

report (USDoL, 2014, p.1) estimates that 26.8% of children aged 7 to 14 are combining work and school.

GENDER PARITY

According to UNICEF (2015), for the period 2008 to 2012, 54.8% of girls of official primary-school age were enrolled in primary school, as opposed to 60.1% of boys.

The rural north of Nigeria consistently evidences the greatest gender disparity (Global Education First Initiative, 2013, p.5; UNICEF, undated[a]; British Council Nigeria, 2012, p.v). According to Global Education First Initiative (2013, p.5), approximately 34% of girls of primary-school age who live in northern rural areas do not attend school, compared with 25% of boys. In the southern rural areas, however, 4% of primary-school-aged girls and 3% of boys do not attend. By contrast, in southern urban areas, less than 1% of both primary-school-aged boys and girls are out of school.

The highest gender disparity in Table 1 above is also between girls and boys living in rural areas. It is interesting to note, however, that for junior-secondary-level education, girls living in urban areas have a higher attendance ratio than boys in urban areas.

The British Council Nigeria (2012, pp.1&2) reports that only 4% of women complete secondary school in the north, as 'over half of all women in the North are married by the age of 16 and are expected to bear a child within the first year of marriage.' Other reasons for non-completion include poor sanitation, a shortage of female teachers and the additional costs associated with education beyond school fees; for example, arts-and-crafts or cooking supplies (p.v).

In an attempt to address low school-attendance and illiteracy, in 1999 the Government introduced Universal Basic Education, a programme of free education for children of school age for their first nine years, up to junior secondary. Since 1999, the Government has introduced several other education policies and initiatives which may help to address gender disparity, and the notable ones are summarised in Table 2 below.

POLICY INITIATIVE	YEAR	INTENTION
National Policy on Women	2001	Enhanced access by locating facilities close to communities; enhanced teacher recruitment; provided incentives for girls to study maths and science
Education For All – Fast Track Initiative	2002	Increased support for basic education
Strategy for Acceleration of Girls' Education in Nigeria	2003	Led to the launch in 2004 of the Girls' Education Project; focused on an integrated approach to achieving gender parity
Universal Basic Education Act	2004	Provided pre-primary education; confirmed universal right to primary and early secondary education

Table 2: Key policy initiatives with a gender/education focus in Nigeria (Source: British Council Nigeria, 2012, p.27)

EDUCATION AND THE NEW SUSTAINABLE DEVELOPMENT GOALS

The two Millennium Development Goals most pertinent to the campaign to stop FGM were 2 and 3: *Achieve Universal Primary Education* and *Promote Gender Equality and Empower Women*.

In 2007, the Nigerian Federal and State Governments jointly introduced the Conditional Grants Scheme 'to accelerate progress towards achieving the MDGs in Nigeria... The scheme leverages high financial and human capital resources from the federal, state and local governments' (UNECA *et al*, 2014, p.64). UNESCO (2015, p.109) notes that Nigeria is one of three

countries to make lower-secondary education compulsory in the period 2000 to 2012. However, Nigeria is one of only 11 countries in Africa to have a net primary enrolment rate below 75% (UNECA *et al*, 2014, p.34).

The Government's Millennium Development Goals End-Point Report (OSSAP, 2015, pp.4&5) states that net enrolment had a fluctuating but generally upward trend to the mid-point assessment year. However, the trend 'halted in later years as a result of the disruptions brought about by the Boko Haram insurgency... Consequently, the net enrolment of 60% in [the] 1995 Nigeria 2015 End-Point Report 5 declined to the end-point net enrolment of 54% in 2013'. The same document reports that the 'primary six' completion rate rose steadily; however, there are variations across states that must be addressed. The north-east has the highest rate of illiteracy, and the insurgency is thought to compound the problem (UNECA *et al*, 2014, p.5).

While enrolment rates are useful, many children are enrolled in school but do not attend, for various reasons; therefore, the attendance rates and primary-school completion rates given above are more useful indicators of Nigeria's progress in terms of MDG 2.

For the school year ended 2012, UNESCO (2015, p.233) ranks Nigeria 103 out of 113 countries in terms of its Education for All Development Index, with a 'Low EDI', which means it is 'far from [Education For All] overall achievement (<0.80)'.

UNESCO (cited in UNECA *et al*, 2014, p.40) states that gender parity is achieved when the Gender Parity Index (GPI) is between 0.97 and 1.03. The UN Economic Commission for Africa's report (UNECA *et al*, 2014, p.42) states that the Nigerian GPI in 1990 was a little over 0.6, but by 2010 was a little over 0.9, and that Nigeria is one of 12 African countries to have achieved 'appreciable progress' (p.43) towards gender parity in primary enrolment, i.e. a parity index between 0.80 and 0.94. However, the same report at page 64 states, 'Gender parity in primary and secondary school enrolments was achieved in 2012.'

The Millennium Development Goals End-Point Report (OSSAP, 2015, p.5) records 'strong progress' towards gender parity in 'basic education', with an

end-point status of 0.94 (compared to 0.82 in 1991). It notes that this achievement, however, has not been replicated for higher levels of education.

UNESCO (2015, pp.158&233) reports that Nigeria has crossed the 0.9 mark into gender parity, but for the school year ended 2012 gives a Gender Specific Education For All Index (an average of the GPIs of the primary and secondary gross-enrolment ratios and of the adult-literacy rate) of 08.26.

The British Council Nigeria's Gender In Nigeria Report 2012 (p.1) found that:

- 'In eight Northern States, over 80% of women are unable to read (compared with 54% for men). In Jigawa State, 94% of women (42% of men) are illiterate.'
- 'Nigerian girls who enrol in school leave school earlier than their male counterparts.'
- 'More than two thirds of 15–19 year old girls in Northern Nigeria are unable to read a sentence compared to less than 10% in the South.'

2015-2030 – CHALLENGES AND OPPORTUNITIES

Goal 4 of the New Sustainable Development Goals is relevant to FGM in that it relates to education:

Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.

The targets for Goal 4 make specific reference to ensuring girls and other vulnerable people receive equitable early-childhood development, inclusive and effective schooling at all levels, and vocational training and university education; they also include aspirations for adult women and men to receive equal skills training to achieve literacy and numeracy and enable them to take up decent jobs and start businesses.

Of particular importance in relation to the elimination of FGM is Target 4.7:

By 2030 ensure all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence,

global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.

FGM is a violation of human rights, and progress towards achievement of this target will be supported by the subject's inclusion in school curricula, building on the work undertaken on this to date.



Fig. 27: One Laptop Per Child (OLPC) scheme in Galadima school, Abuja (One Laptop per Child)

EDUCATION AND FGM

It is clear from previous research undertaken by 28 Too Many that the inclusion of FGM education in schools is an essential element in addressing the issue. This view is also reflected in other studies; for instance, a survey of secondary-school teachers in North Central Nigeria (2015) put forward the opinion of the participating teachers that awareness of FGM and its implications should be taught in schools (Adeniran *et al*, 2015).

Work is being done by various NGOs in Nigeria to ensure that FGM education is included in school curricula. The Girls' Power Initiative provides information for adolescent girls both in their centres (in Calabar, Uyo, Benin and Asaba) and by conducting lessons in selected schools. This outreach programme aims to educate girls on gender and reproductive-health issues, including

issues around GBV and FGM, and aims to train teachers to further this work by continuing lessons and running GPI clubs in their schools (GPI, 2016).

The Centre for Healthcare and Economic Empowerment for Women and Youth (CHCEEWY) also attempts to advance FGM education in the school curriculum in Plateau, Benue and Enugu States, where it operates. In partnership with others, it trains teachers to deliver the Family Life and HIV Education and Family Life and Emerging Health Issues programmes, which are approved by the Federal Government. Again, the formation of clubs in schools to continue this education is proving successful and being supported by a number of international donors such as Oxfam (CHCEEWY, 2016).

The Child Health Advocacy Initiative (CHAI) advocates for more FGM education in schools and through clubs in Lagos, Osun, Ekiti, and Ogun States, where it works. The Center for Social Value and Early Childhood Development (CESVED) also raises awareness in schools and holds workshops for school head-teachers in Cross River State (Augustine, 2016).

Please see page 24 for a discussion of important links between education level, wealth quintile and FGM.

GIRL EFFECT NIGERIA

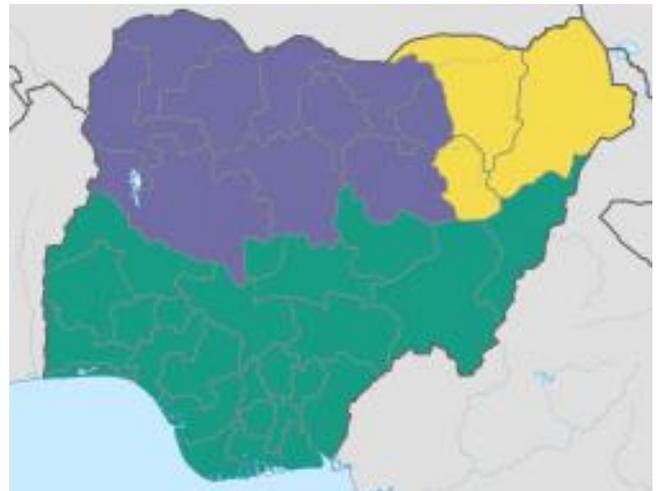
Girl Effect Nigeria (www.girleffect.org) has set up a technical working group to develop a national curriculum on the critical life-skills that girls need to be empowered. The curriculum will include information about their rights, and will look at HTPs, including FGM. The aim is to develop standard, comprehensive content for use nationally through a 'safe spaces' programme for girls in both formal and informal learning environments.

The curriculum is in the very early stages of development. Key stakeholders have been consulted and the concept has been well received. The detailed curriculum will shortly be drafted; it will then be piloted, and eventually endorsed by the Nigerian Government for inclusion in the national school curriculum. (Girl Effect, 2016.)

RELIGION

Nigeria is a religiously diverse country. In January 2016 it was estimated that 50% of the population is Muslim (mainly Sunni), 40% Christian, and 10% hold indigenous beliefs (CIA World Factbook, 2016). 'Indigenous beliefs' describes an array of mainly traditional, pre-colonial, and animist religions. It should be noted that there are variations in the available data. The DHS 2013 (p.31) puts the figures at Muslims – 51%, Christian – 47% (almost a quarter being Catholic) and 'Traditionalist' – 1%. There are also a growing number of Nigerians following other religions such as Eckankar and the Grail Movement. Very broadly, the northern areas of Nigeria have the greatest number of Muslims, with Christians more concentrated across the central and southern areas.

Although the Constitution of Nigeria (1999) is secular, Sharia (Islamic) law is practised in 12 states, forming a band across the northern half of the country, as shown in Figure 28 below:



Use of Sharia in Nigeria:

- Sharia plays no role in the judicial system
- Sharia applies in personal status issues only
- Sharia applies in full, including criminal law

Fig 28: Relationship between Sharia Law and the Nigerian judicial system by area (Wikimedia Commons)

Religious tensions have occurred in Nigeria since the mid-1980s and violence has increased in some locations over the last 20 years (for example, in the northern and central areas). Instances of violence, however, are often due to a mix of political, ethnic,

cultural and judicial issues and not solely related to religious issues (see Markoe, 2012).

RELIGION AND FGM

From available data, FGM prevalence appears to be highest among those practising traditionalist religions and Christianity (see Table 3 below).

Religion	% of women with FGM (15 to 49 years)
Catholic	31.4
Other Christian	29.3
Islam	20.1
Traditionalist	34.8

Table 3: Prevalence of FGM according to each of the major religions (DHS 2013, p.349)

Prior to 2013, DHS surveys did not ask respondents' religion for the sections of the report related to FGM, so a comparison with earlier years of religion as a feature of FGM practice is not possible.

According to the DHS 2013 (p.349 – see Table 4 below), the types of FGM experienced by the women surveyed (who were aged 15 to 49) is similar for all religions, but with fewer Muslim women experiencing the most severe form of FGM.

Religion	% Cut, no flesh removed	% Cut, flesh removed	% Sewn closed	% Don't know/missing
Catholic	5.3	73.2	6.7	14.7
Other Christian	3.9	69.3	6.5	20.3
Islam	8.2	51.6	3.6	36.6
Traditi-onalist	1.3	82.3	6.1	10.3

Table 4: Percentage distribution by type of FGM of women with FGM, according to religion (DHS 2013, p.349)

An analysis of women (aged 15 to 49 years) in Nigeria who have experienced 'unclassified' types of FGM, such as *angurya* or *gishiri* cuts, or the use of a corrosive substance (see page 6 for further information), shows that over half of Muslim

women who have had FGM experienced one of these types (see Table 5 below).

Religion	% Angurya	% Gishiri	% Use of Corrosive Substance
Catholic	3.2	6.7	9.4
Other Christian	3.2	5.2	4.8
Islam	54.4	4.6	3.9
Traditionalist	13.5	1.7	8.1

Table 5: Percentage of women aged 15 to 49 with FGM who have an unclassified type of FGM, according to religion (DHS 2013, p.351)

Muslim women aged 15 to 49 are more likely to have undergone FGM before their fifth birthday (88.3% of women who have been cut) than Catholic (82.2%) and other Christian women (76.3%), or women practising traditionalist religions (64.6%). Of those women who practise traditionalist religions, seemingly larger proportions than of those from other religions were cut between the ages of 10 and 14 (10.3%) and from the age of 15 onwards (18.6%); however, these figures should be treated with caution as only a small number of traditionalist women were surveyed (DHS 2013, p.352).

Of girls aged 0 to 14 at the time of the DHS 2013, 21% of those born to Muslim mothers were cut, as were approximately 10.2% of girls born to Catholic mothers, 10.6% to 'other' Christian mothers, and 11% to mothers who practise a traditionalist religion (DHS 2013, p.354). Comparing these figures with Table 3 above, prevalence appears to have remained consistent for Muslim women and girls, but for Catholic and 'other' Christians these figures suggest a decline, as girls are unlikely to be cut after the age of 15.

Although FGM is not required by any religious script, when the DHS 2013 (p.359) asked women and men, 'Do you believe that female circumcision is required by your religion?', 15% of women and 23.6% of men who had heard of FGM said they believe it is. Traditionalists are more likely than other religious groups to believe it is required, and 'other' Christians are least likely (see Table 6 below).

Religion	Women (%)	Men (%)
Catholic	16.0	22.2
Other Christian	10.5	15.5
Islam	17.8	30.0
Traditional	33.1	39.9

Table 6: Percentages of women and men who believe FGM is required by their religion (DHS 2013, p.359)

While the majority of DHS 2013 (p.361) respondents across all religions express the opinion that FGM should be discontinued, there are variations between religions. For instance, about 74% of Catholic and ‘other’ Christian women and 55% of Muslim women think FGM should not continue, but under half (48%) of women practising traditionalist religions express the same opinion. The figures reflect similar levels of opinion among men from the different religions.



Fig. 29: Nigerian NGO IFEHS includes local community and religious groups in its discussions around FGM (© IFEHS)

The involvement of religious leaders in projects to end FGM in Nigeria is a key element in both the UNJP and the work of grassroots NGOs. The work of Action Health Incorporated (AHI), for example, is supported in six states across Nigeria by the UNFPA, and targets traditional and religious community leaders as part of a community-dialogue approach. CHAI also visits religious leaders in communities in Lagos State to raise awareness and educate on the harms of FGM. Further communications by 28 Too Many with grassroots NGOs within Nigeria during the course of researching this report have revealed anecdotal evidence that some male circumcisers associate their work with both cultural and spiritual values and consider the campaigns to end FGM as an ‘attack’ on the work of God.

MEDIA

By giving voice and visibility to all people – including and especially the poor, the marginalized and members of minorities – the media can help remedy the inequalities, the corruption, the ethnic tensions and the human rights abuses that form the root causes of so many conflicts.

~Former UN Secretary General, Kofi Annan
(cited in Adekunle, 2014, p.195)

PRESS FREEDOM

Reporters Without Borders ranks Nigeria 111th out of 180 countries in its 2015 World Press Freedom Index, and has previously referred to the country as ‘one of the most dangerous countries in Africa for journalists’ as a result of Government restrictions on security information and its lack of controls over the actions of state governors (Reporters Without Borders, 2012 and 2015). The Media Foundation for West Africa (2015) has reported that Nigeria has the most instances of press-freedoms violations in West Africa.

In respect of women’s rights, the Nigerian media suffers from a dearth of female journalists. One estimate suggests that over 80 percent of journalists in the country are male (Oyinade and Daramola, 2013, p.28). While organisations designed to address this problem do exist, such as the Nigeria Association of Women Journalists (UN Development Program, 2012), male perspectives continue to dominate the Nigerian media. In print media, particularly, women are often ‘seen but not heard’; they appear in the media in photographs but they are rarely given a voice (Oyinade and Daramola, 2013, p.28). This is true even in relation to women in elected office, whose visibility in the media is much lower than the number of women in such positions would suggest (p.29). As women’s voices and issues receive little attention in the Nigerian media, Nigerian journalists are unlikely, under current conditions, to be instruments for change when it comes to women’s rights in general and FGM in particular.

MAIN NEWS OUTLETS IN NIGERIA

In 2015, the BBC reported that Nigeria's media scene is one of the most vibrant in Africa. There is almost national coverage by both state radio and television, and all 36 states run at least one radio network and one TV station.

Popular newspapers in Nigeria include privately-owned dailies *Guardian* and *Punch*, Lagos-based dailies *Vanguard*, *Daily Independent*, and *The Daily Sun*, and Abuja-based dailies *Premium Times*, *Daily Trust*, and *Leadership*.

Radio providers include the state-run Federal Radio Corporation of Nigeria, which offers broadcasting in 15 languages, and private providers such as Ray Power and Freedom Radio. International broadcasters, such as the BBC, are also popular (BBC, 2015).

Television, similarly, is provided by the state, through the Nigerian Television Authority, and privately-owned providers such as AIT, Silverbird TV, and Galaxy TV (BBC, 2015).

ACCESS TO MEDIA

Over 50 different newspapers are published in Nigeria, yet research suggests that exposure of Nigerians to print media remains low. Only 9% of women and 20% of men read a newspaper at least once a week (DHS 2013, p.39). It is unlikely that this is related to literacy, since (according to the DHS) in Nigeria 53% of women and 75% of men aged 15 to 49 are literate (p.36).

Radio is the primary source of media access for Nigerians, listened to at least once per week by 39% of women and 55% of men (p.39). Radio's popularity as a source of information is likely because it is accessible in both rural and urban areas, and generally provides programmes in local languages (Come to Nigeria, 2016). Congruently, 61.3% of rural and 77.7% of urban households in Nigeria possess a radio (DHS 2013, p.15). While international broadcasters such as the BBC are also accessible to Nigerians, rebroadcasts of foreign radio programs are banned by the Government (BBC, 2015).

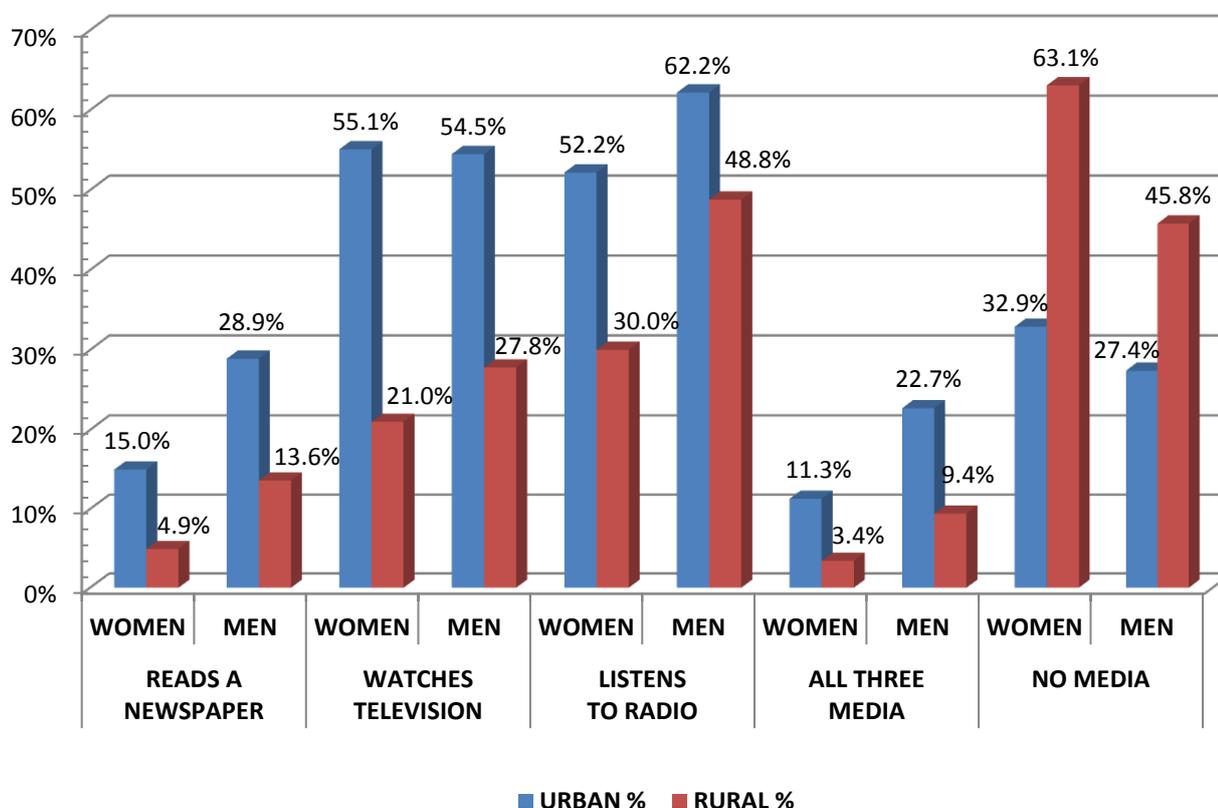


Fig. 30: Exposure to media at least once a week in Nigeria by place of residence (DHS 2013, pp.40-41)

Unlike radio, access to television is more concentrated in urban areas. 73.2% of households in urban areas have a television, while only 28.2% of households in rural areas do (DHS 2013, p.15). Again, though many international satellite channels such as CNN, BBC, and FOX are accessible to Nigerians, the amount of foreign programming that national stations can broadcast is limited by legislation. In particular, outlets cannot air foreign news (BBC, 2015).

As of 2014, over 67 million Nigerians were able to access mass media via the internet. The majority of these are young, educated and live in urban areas. While only 14.4% of urban households and 4.3% of rural households possessed computers as of 2012/13, many internet users rely on their mobile phones to access the web (BBC, 2015). As of 2013, 88.6% of urban households and 64.8% of rural households possess a mobile phone (DHS 2013, p.15), although the percentage of these connected to the internet is unknown.

Africappractice (2014 p.4) reports that in 2013, 72% of internet users were accessing social-networking sites. The BBC (2015) reports that Facebook is the most popular, used daily by at least 7.1 million Nigerians.

Exposure to media is amplified with increased education and wealth. For example, 9.7% of women (aged 15 to 49) with 'no education' watch television at least once a week, as opposed to 73.2% of women with more than a secondary-level education. 2.1% of women (aged 15 to 49) in the lowest wealth quintile watch television at least once a week, as opposed to 71.2% of women in the highest wealth quintile. Out of the three media (newspaper, television and radio), the greatest percentages of less-wealthy and less-educated women listen to the radio at least once a week; the greatest percentages of wealthier and more highly educated women watch television at least once a week (DHS 2013, pp.40&41).

THE RISING INFLUENCE OF SOCIAL MEDIA

Social media has been credited with encouraging more young people to participate in Nigeria's 2015 elections, and influencing the outcome. In his inaugural speech, newly-elected President Buhari thanked 'Those who tirelessly carried the campaign on the social media' (cited in Taiwo, 2015).

Social media has also influenced Government decisions, notably in raising awareness of GBV. The Minister of Youth Development and a member of the House of Assembly urged authorities to act following the circulation of a video via Twitter showing a gang rape, about which the police had previously failed to take any action, even when it was reported by the woman involved (Akinbobola, 2011).

Debates on FGM in Nigeria are also increasingly visible on social media. In July 2015 the UNFPA, in partnership with Youth Hub Africa and others, held a Twitter event to target young people in Nigeria and sensitise them to the dangers of FGM (see Figure 31). Question-and-answer sessions using the hashtag #EndFGMng encouraged discussion and it was estimated that over 1.1 million people were reached during the event (One Life Initiative, undated). *The Guardian* and its partners also used Facebook and Twitter to promote anti-FGM campaign activities in Nigeria during May of 2016.

Fig. 31: Advertisement for the UNFPA/Youth Hub Africa #EndFGMng Twitter event

MEDIA AND ANTI-FGM CAMPAIGNS

To date, there has been little interest from the Nigerian media regarding the issues around FGM. Ordinarily, obtaining media coverage in Nigeria comes at a high financial cost. Despite this, there is a history of anti-FGM campaigners using media to spread their messages locally, nationally and internationally. Recently, and perhaps partly due to the rise of social media and the use of mobile phones across Nigeria, the use and effectiveness of media has greatly increased.

While the Nigerian media faces a number of challenges when it comes to reporting on women's issues, two international, anti-FGM media campaigns have recently been initiated that are furthering discussions and extending the reach of the anti-FGM message.

The first is *The Guardian's* End FGM Global Media Campaign (GGMC), which was initiated in February 2014 to explore ways in which the media could be used to keep FGM at the top of political and social agendas, and to create platforms for dialogue and the dissemination of important information among affected communities at a grassroots level. With the backing of the Human Dignity Foundation, GGMC has used *The Guardian* platform and its influence to support journalists to report on FGM and shed light on its consequences (Topping, 2015).

To date, *The Guardian* has posted a number of articles and videos about FGM in Nigeria on its website, and in February 2016, in partnership with the UNFPA, the newspaper hosted a ceremony in Abjua, Nigeria to honour the winner of the inaugural Efuia Dorkenoo Pan Africa Award for Reportage on FGM. The ceremony was part of the first ever national conference in Nigeria on FGM. The prize was awarded to Kenyan journalist Diana Kendi for her short film, *The Bondage of Culture*. Screened at the conference was another powerful film, *Why Did You Cut Me?*, which showed that the practice of FGM continues on 15- and 16-year-old girls in Cross River State.

These media-related undertakings, which are only the beginning of *The Guardian's* campaign, have already been successful in engaging a number of

key figures in Nigeria, including the president of the Circumcision Association, governors' wives, religious leaders, the police and popular media figures. This work to identify and engage influencers will be complemented by a campaign to place giant billboards at key locations and recruit local activists, who will be trained and equipped with audio and editing applications so that they can produce FGM information (for example, for radio programmes) in English and local languages.

The Guardian has already worked closely with local activists Abu and Gift Augustine, a married couple who run the NGO Center for Social Value and Early Childhood Development and who travel throughout Cross River State, speaking out about the dangers of FGM and why it must stop, and teaching cutters alternative skills by which to earn their living (see their video, *Nigerian couple's journey to end FGM*, at [GGMC's website](#) [The Guardian, 2016c]).

The Augustines have used media in their work to great effect. Recently, they showed a video of a girl undergoing FGM to a local chief in Agwagune. He immediately sent out town criers to condemn FGM and explain to the women that it must stop (Rahim, 2016).

Most recently, in May 2016, *The Guardian* completed the first Media Training Academy in Ibadan, Nigeria, working with 35 activists, journalists and religious broadcasters to share skills and learning on the best media approach to help accelerate an end to FGM. Highlights included modules delivered by *Premium Times* Managing Editor Musikilu Mojeed and Change.org on building alliances and converting ideas into activism.



Fig. 32: The Guardian's End FGM Global Media Campaign held a successful Media Training Academy in Ibadan in May 2016 (© The Guardian)

Already, Academy graduates are networking through a WhatsApp group, several religious broadcasters are working together to challenge misconceptions about FGM in relation to Christianity and Islam, and other graduates have either applied for funding or used their own funds to create radio programmes and videos to spread anti-FGM messages. 'All in all,' says *The Guardian* journalist and film producer/director Mary Carson (2016a), 'it was a very successful event.'

The second international campaign to be initiated recently is that of NGO The Girl Generation. Launched in late 2014 and supported by the UK Government, the Girl Generation is an African-led initiative that supports national communications and advocacy campaigns to end FGM globally. It began with campaigns in the ten most-affected countries in Africa, which included Nigeria, by focusing on communicating stories of positive change, initiating media advocacy campaigns, and supporting ambassadorship programmes and similar efforts of African diasporas to impact FGM in their countries of origin (Equality Now, undated). In Nigeria specifically, The Girl Generation held an event on International Youth Day 2015, at which young campaigners spoke to the media and issued a call to action to end FGM in Nigeria (The Girl Generation, 2015). The Girl Generation has recently announced the launch of a grants programme, supported by the Human Dignity Foundation, to fund poorly-resourced grassroots organisations working to end FGM (The Girl Generation, 2016a). The Girl Generation also collaborates with GGMC to identify organisations working to stop FGM in Nigeria and determine how media can contribute to their programmes' aims.

Popular Nigerian actress Funmi Fubrisima recently produced *Onikola* ('The Circumciser'), a film about FGM. *Onikola* is set in Oyo State and tells the stories of two girls: Kumbi, who is determined not to undergo FGM and risks being rejected by her mother and community; and Omosewa, who is cut and then ridiculed by her husband, but eventually finds the courage to speak out against the tradition. Funmi Fubrisima (cited in James, undated) noted after the premiere that hearing the crowd's response to the film was extremely encouraging.

ATTITUDES AND KNOWLEDGE

RELATING TO FGM

The DHS 2013 shows that the majority of women and men in Nigeria (aged 15 to 49) have knowledge of FGM. Knowledge is most common among women and men aged 45 to 49 (approximately 80%) (DHS 2013, p.346). This indicates an increase in awareness among women, as the DHS survey carried out in 2008 (p.300) gave a figure of 61.1% for women of the same age-group. (Men were not asked this question in 2008.) Knowledge is least common among youths (15 to 19 years), with only 51.8% of young women and 34.7% of young men having heard of the practice (p.347).

Knowledge is more common among women living in urban areas (75.7%) than rural areas (61.6%) (DHS 2013, p.347). This aligns with the greater FGM prevalence among urban women (32.3%) than among rural women (19.3%) (p.349). 85.3% of Yoruba and 82.4% of Igbo women have heard of FGM, compared with about 28% of Igala and Tiv women. There is high awareness among women in South East (83.6%) and South West (80.4%) Zones, where Igbo and Yoruba women primarily reside, while only 34.7% of women in North Central Zone have knowledge of the practice. Approximately two-thirds of women from each of the religions listed in the survey have knowledge of FGM (p.347).

Women with an education level higher than secondary have a greater awareness of FGM (84.3%) than women with 'no education' (64%) (p.348). Women in the highest wealth quintile (78%) have more knowledge of FGM than those in the lowest (64.6%) (p.348). Similar variations apply to men's knowledge of FGM. Again, these figures correspond with the historically higher prevalence of FGM in Nigeria among wealthier and better-educated women (approximately 30%) than among poorer, uneducated women (approximately 17%) (p.350) (see discussion on page 24 of this report).

Attitudes towards FGM are varied among women aged 15 to 49. 50% of women who have undergone FGM believe the practice should cease, compared to 76.2% of women who have had not had FGM (DHS 2013, p.361). Overall, 64.3% of women want to see FGM stopped (p.362),

indicating a slight improvement from 62.1% in the DHS 2008 (p.308). Among men, however, there has been a slight decrease in the number who want to see FGM stopped, from 64.2% in the DHS 2008 (p.309) to 62.1% in the DHS 2013 (p.362). Approximately three-quarters of Christian women believe it should stop, compared to just under half of women who practise a traditionalist religion (DHS, 2013, p.361). Continuation is supported by almost a third of Hausa-Fulani and Yoruba women (p.361).

Figure 33 below also shows attitudes according to other socio-economic factors; for example, 72.4% of women in the highest wealth quintile and 79% of women who have an education beyond secondary level want FGM to stop, compared to 49.2% of women in the lowest wealth quintile and 52.8% among those with no education. Support for its discontinuation is similar among men according to wealth and education (p.362).

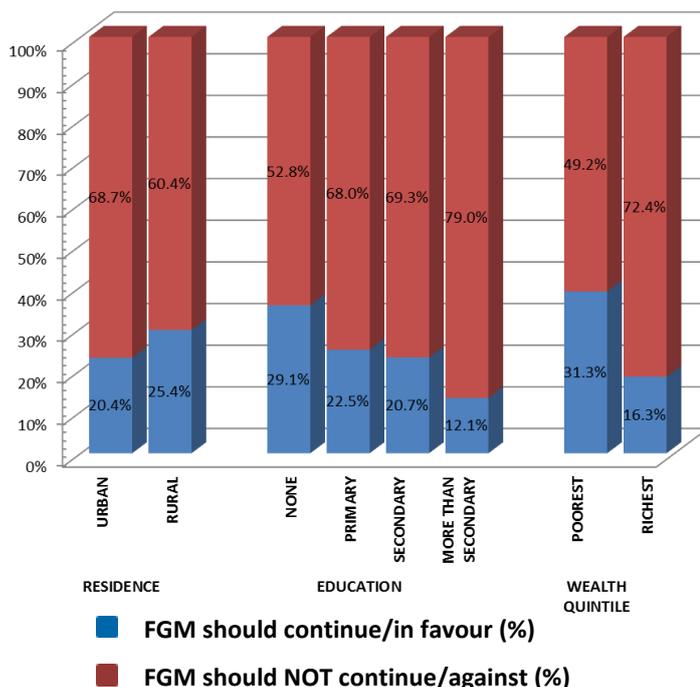


Fig. 33: Attitudes of women aged 15 to 49 according to residence, education and wealth indicators (DHS 2008, pp.361-2)

Based on a question to mothers as to if and when their daughter(s) had been cut, the DHS 2013 (pp.354-5) notes that daughters of better-educated women are less likely to be cut (9.3% of girls aged 0 to 14) than daughters of women with 'no education' (19.3% of girls aged 0 to 14). Similarly, daughters of mothers in the highest wealth quintile

are less likely to be cut (12.6% of girls aged 0 to 14) than daughters of mothers in the lowest wealth quintile (19.4% of girls aged 0 to 14). However, daughters of mothers who have undergone FGM are nearly six times as likely to be cut (47.4% of girls aged 0 to 14) as daughters of mothers who have not undergone FGM (8% of girls aged 0 to 14) (p.355).

This reveals an apparent contradiction in Nigeria: FGM prevalence is higher among the better-educated and wealthier women in the 15-to-49 age-group (p.350), and the greatest level of support for stopping the practice is from this same group of women (p.362); however, it is women who have been cut (a significant number of whom are these wealthier and better-educated women) who are more likely to have their daughter(s) cut.

REASONS FOR PRACTISING FGM AND ITS PERCEIVED BENEFITS

A study by Alo and Babutunde (2011) on the Yoruba found that 'most of the respondents who disapprove the practice still cut their daughters'. One reason given was: '[T]hat is the demand of our tradition and culture. My husband makes decision regarding every issue like this at home.' FGM is a social norm – a deep-rooted cultural tradition and a behavioural expectation that is often reinforced by community or peer pressure, and failure to conform carries the threat of stigma, shunning or even eviction.

The DHS 2008 asked women and men who had heard of FGM what they saw as its benefits in terms of cleanliness/hygiene, social acceptance, better marriage-prospects, the preservation of virginity and prevention of pre-marital sex, greater sexual pleasure for men and religious approval. The DHS 2013 only asked respondents whether they believe FGM is required by their religion. The DHS 2008 (pp.306-7), however, reports that 58.1% of women and 51.8% of men believe that FGM has no benefits, and this is expressed most strongly by both sexes in the 25-to-29 age-group.

FIDELITY/VIRGINITY AND MARRIAGE PROSPECTS

According to a study by Ayenigbara, Aina and Framakin (2013, p.9), FGM is regarded in Nigeria

'as a means of curbing promiscuity, preserving Virginity [*sic*], (particularly in the case of infibulations) and so avoiding disgrace to the girl's family, and enhancing marriage prospects.' In a study looking at the root causes of gender inequality in Nigeria (Otiye-Igbuzor, 2014, p.17), it was found that FGM is largely perpetuated by myths such as 'FGM prevents pre-marital sex', 'the thickened hymen resulting from FGM makes sexual penetration difficult' and 'uncircumcised girls are promiscuous'.



Fig. 34: Family and community expectations continue to reinforce the tradition of FGM in Nigeria (© IFEHS)

According to the DHS 2008 (pp.306-7), 11.2% of women and 17.3% of men who have heard of FGM claim that 'preserve virginity/prevent premarital sex' is a benefit of it, making this the most commonly cited supposed benefit of FGM. It is men and women in the oldest age group (45 to 49 years) who most commonly cite this as a benefit. The second-most-common benefit cited by men is 'more sexual pleasure for the man' (7.2%), and by women is 'social acceptance' (7.9%) closely followed by 'better marriage prospects' (7.8%). Social acceptance and better marriage prospects are closely linked in relation to FGM: to be a part of the community, women must marry and have children to perpetuate the community, and in some ethnic groups it is traditionally required that they undergo FGM in order to marry.

COMMUNITY/SOCIAL ACCEPTANCE

It is clear from both the literature and anecdotal evidence that the tradition of FGM in Nigeria continues to be reinforced from generation to generation by family and community pressures, regardless of demographic characteristics like education and wealth. Discussion groups in south-

west Nigeria during a 2011 study (Alo and Babatunde, 2011) demonstrate this. Participants made statements such as 'I am circumcised so do my parents and grand parents, so why would I not circumcise my daughters. [*sic*] This is our custom . . .', and, 'This is our tradition and nothing can change it'.

Again, it is men and women in the older age-groups who cite community/social acceptance as a benefit of FGM in the DHS 2008 (pp.306-7).

These types of expectations and pressures mean that even some parents who are well-educated and/or wealthy, and who disagree with the practice, will have their daughters undergo FGM. In a survey carried out in 2015 of over 1,500 men and 500 women, nine out of ten respondents of both sexes disagreed with statements in favour of the continuation of FGM and other harmful practices against women (Voices 4 Change, 2016, p.28); still, the practice continues.

At the launch of a special response programme implemented by the Nigerian Federal Government in collaboration with the UNJP, Her Excellency Aisha Buhari, the First Lady of Nigeria urged the wives of state governors to be vocal about the need to stop FGM in Nigeria. She said, 'We are mothers and women and have the primary role to use our privileged positions to make lives better for Nigerians, especially women and girls' (Ogundipe, 2016a).

CLEANLINESS/HYGIENE

In some ethnic groups FGM is part of a rite of passage or linked to the practice of body modification to enhance beauty (Nsentip, 2006, p.4). FGM may also be incorrectly perceived to have benefits to reproductive health, such as genital cleanliness and the prevention of diseases and complications during childbirth (Ayenigbara, Aina and Famakin, 2013, p.9). In some parts of Nigeria, uncut women are considered unclean, or unhygienic, and it is believed that FGM will prevent bad odours (Otiye-Igbuzor, 2014, p.52).

In a 2010 study (Alo and Babatunde, 2011) conducted in six south-western states, respondents gave reasons for their approval of FGM. Among those reasons were 'The clitoris will continue to grow as a girl gets older and so it must be

removed' and 'The clitoris is dangerous; it can cause the death of an infant during delivery.' Another study (Otive-Igbuzor, 2014, p.52) reported a belief in certain areas of southern Nigeria that '[t]he clitoris is an aggressive organ and that should a baby's head touch it during delivery, such baby will either die or develop a hydrocephalic head'.

In the DHS 2008 (pp.306-7), 6.4% of women and 4.4% of men who have heard of FGM cite cleanliness/hygiene as a benefit of it.

RELIGIOUS REQUIREMENT

The DHS 2008 (pp.306-7) asked respondents who had heard of FGM whether they perceived 'religious approval' to be a benefit of FGM; the responses were not broken down by religion. 1.9% of women and 2.7% of men named it as a benefit.

The DHS 2013 (pp.359-60) asked respondents aged 15 to 49 who have heard of FGM whether they believe their religion *requires* FGM, and this time the responses were broken down by background characteristics: age, religion, education, ethnic group, wealth quintile and residence. 68.2% of women and 57% of men believe the practice is not required by their religion. Traditionalist practitioners are more likely than other religious groups to believe it is required. Across all religions, more men (23.6%) than women (15%) believe it is required by their religion; however, of women who have been cut, 23% believe it is required. Respondents with 'no education', women in the lowest wealth quintile, respondents in the Hausa ethnic group and respondents living in rural areas or in North West Zone are more likely to believe FGM is required by their religion.

The relationship between religious beliefs and FGM is discussed further on page 42.

ECONOMIC MOTIVES

Traditional FGM practitioners often have elevated standing in communities where FGM prevalence is high and it is considered an important tradition. For these practitioners, FGM is their livelihood (often a substantial one), and its continuance is therefore important to them and promoted at every opportunity (Ayenigbara, Aina and Famakin, 2013, p.9).



Fig. 35: Opinions on whether FGM is a religious requirement varies across religions and between men and women in Nigeria (Photographer: Rosemary Lodge)

LAWS RELATING TO FGM

INTERNATIONAL & REGIONAL TREATIES

For information on international and African regional laws relating to FGM please refer to the [law factsheet](#) on our website.

Many of the international human rights conventions and treaties related to the practice of FGM have been signed and ratified by Nigeria. The ratification of these conventions places a legal obligation on the Nigerian Government to ensure that FGM, as an international human-rights violation, is eradicated by putting certain provisions in place.

Nigeria has ratified or signed up to the following conventions and treaties:

- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 (ratified in 2001);
- International Covenant on Civil and Political Rights, 1966 (ratified in 1993);
- International Covenant on Economic, Social and Cultural Rights, 1966 (ratified 1993);

- Convention on the Elimination of all Forms of Discrimination Against Women, 1979 (ratified 1984); and
- Convention on the Rights of the Child, 1990 (ratified 1991).

Nigeria has also signed up to the following regional charters which, like the international treaties, require certain provisions to be put in place to enact them:

- African Charter on Human and Peoples' Rights (the Banjul Charter), 1981 (ratified 1983);
- African Charter on the Rights and Welfare of the Child, 1990 (calls upon all states to take appropriate measures to eliminate harmful social and cultural practices [Art. 22]) (ratified 1983); and
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), 2003 (calls upon states to take measures to eliminate FGM and other traditional practices that are harmful [Art. 2(2)]) (ratified 2004).

NATIONAL LAWS

THE CONSTITUTION

The Constitution of the Federal Republic of Nigeria, 1999 does not specifically refer to FGM, but Section 34(1) provides that every individual is entitled to respect for the dignity of his person and, accordingly, no-one 'shall be subject to torture, inhuman or degrading treatment'.

Nigeria is a federal republic, and each state has the authority to draft its own legislation. However, any law that is contradictory to federal law or the Constitution can be challenged in a federal court. Furthermore, Nigeria's 'combination of federation and a tripartite system of civil, customary and religious law makes it difficult to harmonise legislation and remove discriminatory measures' (SIGI, 2016). Islamic (Sharia) law exists in certain states in the north (see page 41), although it is not exclusively adhered to and all parties must consent to using a Sharia court (US Department of State, 2014).

NATIONAL LAWS AGAINST FGM

The first state to ban FGM in Nigeria was Edo State in October 1999. The penalty upon conviction was a 1,000 Naira (approximately US\$5) fine and a minimum of 6 months' imprisonment, or both. Several other states followed suit (US Department of State, undated and 2001; Ifijeh, 2015). Appendix II of this report, produced by WRAPA, sets out the current legislation related to FGM in each of Nigeria's 36 states.

In 1994, Nigeria attended the 47th World Health Assembly to resolve to eliminate FGM, and since then its Government has taken several steps, including forming a Technical Working Group on Harmful Traditional Practices, carrying out several studies and drawing up a National Policy and a National Plan of Action for the elimination of FGM in Nigeria. The Policy was passed in 2002; then, in 2013, the Policy and Plan of Action were reviewed to cover five years (2013-2017) and adopted at the National Council on Health (Kandala, Nwakeze and Kandala, 2009; Office of UN Human Rights Council, 2014). The Policy 'provides that FGM can be eradicated with the help of all the levels of government in collaboration with traditional rulers, women leaders, community and religious leaders, traditional birth attendants and NGOs working on the subject' (The Federal Ministry of Women Affairs, 2004).

The VAPP (see also page 53), which was passed in May 2015, is the first federal act that commits to the criminalisation of FGM in the entire country (Goldberg, 2015). Section 6(1) of the VAPP states, 'The circumcision or genital mutilation of the girl child or woman is hereby prohibited.' The VAPP also outlaws other types of violence, including rape (but not spousal rape), incest, domestic violence, stalking and HTPs (Onyemelukwe, 2015).

AGE OF SUFFRAGE, CONSENT AND MARRIAGE

Age of Suffrage:

The age of suffrage in Nigeria is 18 years (INEC, 2016).

Age of Consent:

The Criminal Code Act, Chapter 77 (1990), which applies in the southern states, stipulates that

'unlawful carnal knowledge of a girl under the age of thirteen years' is a criminal act. The Penal Code, which applies in the northern states, at Section 282(1)(e) defines rape as including sexual intercourse, with or without consent, with a woman under the age of 14.

The Sexual Offences Bill, 2013 was heavily criticised for its lack of a clear definition, and possible reduction, of the age of consent (see for example Ezeamalu, 2015). Section 7 (Defilement of children) states:

- (1) A person who commits an act which causes penetration with a child is guilty of an offence called defilement.
- (2) A person who commits an offence of defilement with a child aged eleven years or less shall upon conviction be sentenced to imprisonment for life.
- (3) A person who commits an offence of defilement with a child between the age of twelve and fifteen years is liable upon conviction to imprisonment for life.
- (4) A person who commits an offence of defilement with a child between the age of sixteen and eighteen years old is liable upon conviction to imprisonment for life.

The arguably ambiguous wording of the Bill gives the impression that the age of consent is 11. The original Bill stated a minimum age of 18; however, the Senate Committee on Judiciary and Legal Matters amended that figure to 11 (Femi Falana cited in Ezeamalu, 2015).

Age of Marriage:

The laws regarding marriage further contribute to the confusion over the age of consent.

The Marriage Act, Chapter 218, 1914, at Sections 18 and 19, refers to marriage under the Constitution. Section 18 states only that parental/guardian consent must be obtained if either party to an intended marriage is under the age of 21. No minimum age is stipulated, meaning that marriage involving children/young adults may take place with a parent's/guardian's consent.



Fig. 36: The introduction of a law against FGM in Nigeria is a positive step towards protecting young girls from the practice (Photographer: Mike Blyth)

The Child Rights Act, 2003 at Section 21 states, 'No person under the age of 18 years is capable of contracting a valid marriage, and accordingly, a marriage so contracted is null and void and of no effect whatsoever.' However, only 24 of the 36 states have adopted the Child Act, which means that in some regions girls as young as 12 are married (Ajumobi, 2016; Girls Not Brides, 2013).

LEGAL SYSTEM AND LAW ENFORCEMENT

The decision to bring the VAPP into place is a dramatic step forward, but many have noted that this is only one of the necessary steps towards abolishing the practice of FGM (Topping, 2015; Ijfeh, 2015). Three critical challenges remain:

- *Enforcement of the law across all 36 states of Nigeria.* The VAPP is a federal law and is therefore only effective in the FCT of Abuja. The remaining states have the authority to pass mirroring legislation; some have already done so but in the majority of states FGM is still not criminalised (see Appendix II).
- *Creating an effective enforcement authority.* The US Department of State (2014, p.32) reports that police often refused to protect women when 'the level of alleged abuse did not exceed customary norms in the areas'. More

encouragingly, the police have formed a Gender Unit to help bring justice for victims of gender-based crimes, ensure the inclusion of gender training in the Nigerian police curriculum and enhance already existing collaborations with other stakeholders in the area of gender equality (SIGI, 2016).

- *Breaking cultural ties to FGM.* Rosamund O'Donnell (2015) notes, 'The practice of FGM is rooted in longstanding social norms – beliefs, attitudes and behaviours – shared by a community. The norms that endorse female circumcision are often founded on tradition as well as cultural and religious misconceptions, all believed to be in the interests of girls and their communities.' It is therefore unsurprising that studies have demonstrated that using a proactive approach to prevent FGM, rather than simply reactively punishing offenders, produces more successful outcomes (O'Donnell, 2015; Ifijeh, 2015).

VIOLENCE AGAINST PERSONS PROHIBITION ACT (VAPP)

Section 6 of the VAPP, which relates to FGM, states in full:

- (1) *The circumcision or genital mutilation of the girl or woman is hereby prohibited.*
- (2) *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 N200,000.00 or both.*
- (3) *A person who attempts to commit the offence provided for in subsection (2) of this section commits an offence and is liable on conviction to a term of imprisonment not exceeding 2 years or to a fine not exceeding N100,000.00 or both.*
- (4) *A person who incites, aids, abets, or counsels another person to commit the offence provided for in subsection (2) of this section commits an offence and is liable on conviction to a term of imprisonment not exceeding 2 years or to a fine not exceeding N100,000.00 or both.*

STRATEGIES TO END FGM

AND ORGANISATIONAL PROFILES

BACKGROUND

The campaign to end FGM in Nigeria must work at every level of society, from affecting and educating the hearts and minds of community members, to engaging the support of local and religious leaders, to influencing the makers of state and federal government policies and procedures.

Although Nigeria has signed up to CEDAW, the Convention Against Torture, and Rights of the Child, as well as the Maputo Protocol in 2003, which calls on African states to eliminate FGM, it was only in 2015 that a federal law, the VAPP, was passed, specifically criminalising FGM across the whole country. As a result, until now there has been no national institutional framework for coordinating resources and actions and, even with this Act in place, each of Nigeria's 36 states is required to put in place a mirror law, if there is not one in existence already.

Since 1999 only 13 states have put in place laws banning FGM. These laws may be hard to enforce in rural areas where there is limited police activity, and where girls and women may be unable to leave their villages to seek help and escape FGM, due to lack of transport or restrictions placed on their movements by male relatives.

Corruption is also a barrier to effective law enforcement and inhibits the flow of money to education, public health and other development issues that would help tackle FGM. It also affects the views of donors and suppliers of ongoing aid.

GOVERNMENT POLICY AND SUPPORT

Following the passing of the VAPP, in February 2016, a national programme was launched by Her Excellency Aisha Buhari, the First Lady of Nigeria. The programme is a collaboration between the Federal and State Governments and is supported by the UNJP. This is an opportunity to establish a national platform on which the campaign to end FGM can take hold across the country.

Nigeria is also a signatory to the SDGs, and the inclusion of a specific target to eliminate FGM by 2030 in those Goals provides a focus for Federal and State Governments when putting in place policies and allocating resources, and an encouragement to take action in support of the work of the many NGOs who have been advocating the end of FGM for the past couple of decades.

ANTI-FGM INITIATIVES NETWORKS

Although there are many NGOs active in particular areas of Nigeria to eliminate FGM through the education of traditional and religious leaders, working with health professionals, and talking to women and girls about the dangers of FGM, 28 Too Many has been unable to find a national or state-level network that brings these organisations together. The setting up of such a network at a federal level, with state-level subsidiaries, would help facilitate exchanges of information and ideas as to what works most effectively to achieve abandonment of the practice.

‘WE HAVE STOPPED CUTTING WOMEN AND GIRLS’

During a two-day workshop on the harmful effects of FGM organised by UNICEF in Osogbo, traditional cutters talked about how they decided to abandon the practice. Chief Isaiah Fayomi, who has been practising for nearly 70 years, said he has stopped cutting girls because he doesn’t want to go against the law of the land. ‘I stopped female circumcision in the last seven years No-one circumcises females in Ile Ife or in Osun State anymore,’ he said.

His wife, Mrs Christianah Fayomi, who has been a practitioner for nearly 29 years, charging between N500 and N1,000 to circumcise an infant or child, or N5,000 for an adult woman, is also a convert: ‘I saw the diagrammatic representation of the female genitalia and was tutored about the ills of the practice and I am now promoting its abandonment.’

(Ogundipe, 2016b)

OVERVIEW OF STRATEGIES TO END FGM

A broad range of interventions and strategies have been used by different types of organisations to eradicate FGM in Nigeria. More information can be found in [Overview of Strategies to end FGM Factsheet](#). Often a combination of the interventions and strategies below are used:

TYPE OF STRATEGY	ABBREVIATION
Alternative Rites of Passage	ARP
Human Rights/Community Dialogue Programmes	HR/ CDP
Promotion of Girls' Education to Oppose FGM	E
Educating Traditional Excisors and Offering Alternative Income	EX
Addressing Health Complications of FGM	H
Health Risk/ Harmful Traditional Practice	HTP
Legal	L
Media Influence	M
Working with Men and Boys	MB
Religious-Oriented	R
Supporting Girls Escaping from FGM/Child Marriage	SG

Table 7: Strategies used by organisations to promote the abandonment of FGM

INTERNATIONAL ORGANISATIONS

GIRL EFFECT NIGERIA

Strategies: HR / HTP / CDP / H / E / M / R / SG
www.girleffect.org

Launched in 2009 at the World Economic Forum in Davos, Girl Effect has undertaken to put girls at the centre of the development agenda, and Nigeria is a key focus country for their work. To meet the essential social, health and economic needs of Nigerian girls, particularly in the north, Girl Effect undertakes a ‘safe spaces’ programme in partnership with the Population Council (West Africa), known as CSAGE (Community Spaces for

Adolescent Girls Empowerment). It also works with faith leaders to increase their understanding and engage their support in promoting girls' health and education in their communities. The NGO also networks with and advises key leaders and influencers in the private sector to support girls as a means to improving the local and national economies.

Girl Effect Nigeria utilises media tools to highlight issues that girls face and opportunities to empower them. In June 2014, for instance, it produced a handbook following two years of research and interviews with girls in northern Nigeria. Entitled *Meet the Arewa Girl*, the handbook is intended to equip and motivate individuals and organisations to invest in girls in the region. There is also work being done to develop and pilot a national curriculum in Nigeria that will include all aspects of girls' rights, including addressing HTPs such as FGM (see the Education section of this report for further details).

(Girl Effect, undated & 2016)



Fig. 37: Members of the Youth Dialogue network brought together by the Girl Generation (© The Girl Generation)

THE GIRL GENERATION

Strategies: HR/ HTP / H / E / M / MB

www.thegirlgeneration.org

The Girl Generation is an African-led initiative, backed by the UK's DFID, that supports grassroots organisations in advocating an end to FGM. Work in Nigeria includes building networks and developing communications and advocacy campaigns through training, events and media

partnerships. The Girl Generation has developed a Monitoring and Evaluation Strategy to track progress being made in Nigeria and monitor performance moving forward. It also identifies potential ambassadors in-country to promote its values and messages.

(The Girl Generation, undated & 2016b)

INTER-AFRICAN COMMITTEE ON TRADITIONAL PRACTICES (IAC)

Strategies: HTP / CDP / R / EX / L / H / M / MB

www.iac-ciaf.net

The IAC is an umbrella body with national chapters in 29 African countries. It has been working on policy programmes to stop FGM for the last 28 years, collaborating with a number of international organisations, including UNFPA, the WHO and UNICEF. The headquarters of the IAC is in Addis Ababa, Ethiopia and it has a liaison office in Geneva. 28 Too Many is the IAC's Affiliate Member in the UK.

The IAC in Nigeria was inaugurated in 1985 and since then has operated in communities across the country, in partnership with local governments, to address HTPs and inform the public about the harmful consequences of FGM. Key target groups include TBAs and young people as peer educators. IAC activities have included:

- advocating and lobbying for legislation to be introduced (Ondo State);
- conducting information and sensitisation campaigns aimed at community and religious leaders (Ondo State);
- capacity-building and training public health workers, nurses and midwives (Ondo State);
- targeting TBAs through seminars and workshops (Idanre and Akoko in the North East);
- running youth outreach programmes to sensitise young people to reproductive-health issues, women's and girls' rights and the harms of HTPs (Akure in the South and areas of Ondo State); and
- using television and radio for sensitisation campaigns, and distributing information and education materials (handbills, posters, etc.)

(IAC, 2009 & 2016; Orchid Project, 2014)

UNICEF/UNFPA

Strategies: HR / CDP / H / E / HTP / M

www.unicef.org

www.unfpa.org

Since 2008, across 17 countries including Nigeria, UNICEF and the UNFPA have been leading the UNJP to end FGM within a generation.

In 2015 a study with local partners in the high prevalence states of Ebonyi, Ekiti, Imo, Osun, Oyo and Lagos collected information on local beliefs, knowledge and practices of FGM. It highlighted the need for continued communication with communities and close collaboration with the media to promote the changes needed for abandonment.

This study complements the ongoing work of the UN in Nigeria, which has included research, capacity-building with partners and working with the media on information, education and communication campaigns. UNICEF and the UNFPA also undertake advocacy work, partnering with different government departments in Nigeria, the National Human Rights Commission, the Nigeria Law Reform Commission, the Nigeria Police Force and the Legal Aid Council.

(UNICEF, undated[b]; Voice of Nigeria, 2016)



Fig. 38: UNICEF/UNFPA with local partners discussing FGM with the Association of Circumcisers in Osun State as part of the UN Joint Programme (© AHI)

NATIONAL AND LOCAL ORGANISATIONS

ACTION HEALTH INCORPORATED (AHI)

Strategies: HR/CDP / H / HTP / M / SG

www.actionhealthinc.org

AHI is an NGO established in 1989 to promote young people's health and development in Nigeria. It is currently an implementing partner in the UNJP, taking part in activities in Osun and Lagos States and continuing its involvement as these are extended in 2016 to Oyo and Ekiti States. The approach taken in these activities is one of behavioural change, involving both men and women in community discussions and targeting traditional and religious leaders and circumcisers. This work is supplemented by the use of media (including phone-in radio programmes to discuss FGM) and engagement of community members to become advocates for stopping the practice. AHI has also been involved in high-level meetings with Government, international agencies and other key stakeholders about girls' rights and their access to education and social services.

(Action Health Incorporated, 2015 & 2016)

CENTRE FOR HEALTHCARE AND ECONOMIC EMPOWERMENT FOR WOMEN AND YOUTH (CHCEEWY)

Strategies: HR/ HTP / M / E / MB /SG / L EX

The NGO CHCEEWY was developed in response to the challenges faced by women and girls in accessing sexual- and reproductive-health services and economic justice in the Plateau State of Nigeria. Now additionally working in Benue and Enugu States, CHCEEWY undertakes a number of activities around human rights and GBV, geared towards women and young people, and also involving men with political, religious and cultural influence.

The approaches being used by CHCEEWY to tackle these issues, including FGM, are as follows:

- community mobilisation – mobilising and sensitising members of communities on the harms of FGM, and working alongside other healthcare personnel to support girls who have had FGM;

- involvement of men – seen as key participants in the work to address FGM in communities;
- community theatre – allowing members of a community, including local and religious leaders, to explore the issues around the sexual- and reproductive-health rights of women and girls, and discuss why FGM is not healthy for their development;
- media – through radio programmes and text messages or ‘jingles’ in different languages;
- schools – through teacher training, to include health issues such as FGM in the school curriculum and the development of clubs in schools to address the issues around GBV, including FGM; and
- advocacy – for example, for the successful implementation of the Gender and Equal Opportunity Law in Plateau State.

(CHCEEWY, 2016)



Fig. 39: CHCEEWY uses a variety of approaches to educate and mobilise different members of the community to advocate against FGM (© CHCEEWY)

CENTER FOR SOCIAL VALUE AND EARLY CHILDHOOD DEVELOPMENT (CESVED)

Strategies: HR / HTP / CDP / H / E / M / EX / MB

The community-based NGO CESVED is run by Abu and Gift Augustine, a married couple who travel throughout Cross River State and beyond carrying out awareness campaigns to educate all members of practising communities, including local and

religious leaders, about the dangers of FGM and why it must stop. CESVED also addresses issues such as child marriage and breast ironing.

CESVED’s work is successful as it has built up trust and respect. It seeks to engage everyone in communities who needs to understand and ultimately speak out about these issues, by:

- encouraging FGM survivors to share their stories and experiences (this was a successful approach during the first national FGM conference in February 2016);
- appreciating local culture and engaging community and religious leaders to find alternatives to cutting and its celebration;
- training young girls and other community volunteers to take a lead in the public campaign against FGM;
- involving men in discussions;
- taking the campaign into schools and running workshops for head-teachers;
- caring for and supporting children who have been orphaned as a result of FGM;
- using sports that bring people together, such as community football games, to raise awareness;
- using media; and
- working in partnership with *The Guardian’s* campaign to identify activists and equip them to use different media; for example, developing children’s songs, posters and other printed information.

A further important part of CESVED’s work is finding alternative forms of livelihood for the traditional practitioners. Sensitisation programmes that have targeted this group in Cross River State and beyond have highlighted the need for the practitioners to find alternative sources of income before they will consider stopping the practice. CESVED therefore teaches new skills such as agricultural and fish farming, and bead and basket making.

(The Guardian, 2016a; Augustine, 2016)

CHILD ADOLESCENT AND FAMILY SURVIVAL ORGANIZATION – WOMEN’S RIGHTS ACTION GROUP (CAFSO-WRAG)

Strategies: HR/ CDP / HTP / M / EX
www.cafsowrag4development.org

CAFSO-WRAG was established in Ibadan, Nigeria in 1994 and focuses on gender rights, sexual and reproductive health, women’s empowerment and micro-credit schemes. In particular, it campaigns against HTPs, including FGM, through seminars with key stakeholders at which it secures commitments to end the practice.

Relevant projects have included work with Amnesty International in 2003 to raise awareness and campaign against FGM through radio and television programmes, and efforts to sensitise communities (including government representatives and circumcisers) across six states in the south-west. This work contributed to the bill on FGM passed by the Osun State House of Assembly.

(CAFSO-WRAG, 2014 & 2016)

CHILD HEALTH ADVOCACY INITIATIVE (CHAI)

Strategies: HR/ HTP / M / R / MB / EX

CHAI is a USAID initiative based in Lagos that works in collaboration with other NGOs, including UNICEF and the UNFPA, to promote women’s and girls’ rights and bring about an end to FGM in the high-prevalence areas of south-west Nigeria (including Lagos, Osun, Ekiti and Ogun States).

Targeting a range of individuals and groups (including women and girls, men and boys, students, community and religious leaders, Government, the media and circumcisers), CHAI undertakes a number of activities including lobbying and engaging parliamentarians, sensitising of and awareness-raising among traditional and religious leaders in Lagos State, raising awareness through media campaigns and taking part in public events and rallies (for example, 16 Days of Activism).

(CHAI, 2016)

INITIATIVE FOR FOOD ENVIRONMENT AND HEALTH SOCIETY (IFEHS)

Strategies: HR/ HTP / H / CDP / MB
www.ifehs.org

The IFEHS is an NGO working primarily across nine states in Nigeria’s North, six states in South South and five states in South East. As part of its work to promote the rights and health of the poorest and most vulnerable and to bring about sustainable development, the IFEHS conducts community sensitisation programmes that educate women, men and local leaders on the negative effects of FGM. Work has been done in partnership with the International Fund for Agricultural Development, for instance, to implement discussions with community and religious groups on FGM. In correspondence with 28 Too Many, it has stated that a major challenge is trying to teach young mothers who have no education.

(IFEHS, 2015 & 2016)



Fig. 40: Providing health advice to women in local communities (© IFEHS)

MEDICAL WOMEN’S ASSOCIATION OF NIGERIA

Strategies: HR/ HTP / H / CDP / L / M
www.mwanrivers.org

The River States arm of the Medical Women’s Association of Nigeria was set up in 1985 to undertake the promotion of women’s rights and health, cancer awareness and health talks for the media and schools. In partnership with organisations such as the Federation of Women Lawyers and the National Council on Women Societies, it undertakes educational activities in

communities and the media on the negative effects of FGM, and advocates for the passing of a law to prohibit FGM in the River State.

(Medical Women's Association of Nigeria, 2016)



Fig. 41: One of DFID/The Girl Generation's campaigner cards featuring Safehaven's Executive Director, Margaret Onah (© DFID/The Girl Generation)

SAFEHAVEN DEVELOPMENT INITIATIVE

Strategies: HR / HTP / CDP / H / E / M / R / ARP

Safehaven Development Initiative, based in the Cross River State of Nigeria, was established in 2004 with a mission to enhance human rights and the wellbeing of vulnerable members of society. Education and awareness programmes (including support and advice for women and girls at risk) are run in rural communities to address the issues of human rights, sexual and reproductive health, HIV/AIDS and GBV, as well as provide job training and business skills to improve economic stability.

This work has empowered women to take up the issue of FGM and campaign in their communities for an end to the practice. Key to this success has been community dialogue and education, with particular attention to addressing the misguided belief that FGM is a religious obligation. Safehaven has studied religious texts alongside women and girls so that they understand they are not disrespecting their religion by refusing FGM. With this knowledge and understanding, these women go on to become advocates against the practice in their communities, gradually encouraging others to abandon it. This activity has been complemented by raising awareness of the existence of the laws prohibiting early child marriage and FGM in Cross River State (which many people are not aware of), running media campaigns and introducing the concept of an alternative rite of passage without FGM.

(Safehaven International, 2016; Institute for Women's Empowerment, undated)

SOCIETY FOR THE IMPROVEMENT OF RURAL PEOPLE (SIRP)

Strategies: HR / HTP / CDP / H / E / M / MB
www.sirpnigeria.org

SIRP is an NGO founded in 1988 that aims to support vulnerable people in rural areas of Nigeria through poverty alleviation and rights advocacy, with a key focus on sensitisation programmes to end FGM in the communities where it is still practised. It has worked on the Targeted Education, Communication and FGM Training Programme in the south-eastern states of Enugu and Ebonyi (with funding from RAINBO UK). This has involved advocacy and sensitisation visits to five communities, the use of discussion groups, radio programmes and poster campaigns, and the distribution of information and education materials, followed up with evaluation to understand what impact the work has had. (Further information can be found in the Foreword to this report.) Following on from the success of this project, SIRP hopes to extend its work into other communities in the south-east of Nigeria.

(SIRP, 1988-2016 & 2016)

SIRP INTRODUCES NAMING CEREMONY WITHOUT FGM IN ENUGU



Fig. 42: SIRP naming ceremony without FGM (© SIRP)

In Enugu State, FGM 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. The naming and cutting are linked. SIRP found that poor mothers could not openly resist their girls undergoing FGM because it would also mean there would be no naming celebration.

SIRP introduced the sponsorship of naming ceremonies for children whose mothers showed a commitment not to cut their infant daughters. These women went on to become SIRP's FGM Abolition Champions and Peer Educators in their communities, working hard and often facing social persecution.

'It is their resilience and ownership of the campaign by these women which has contributed to the sustainability of our work to end FGM in Enugu,' said Chris Ugwu, Director of SIRP.

(SIRP, 2016)



Fig. 43: Young girls and infants are most at risk of undergoing FGM in Nigeria (Photographer: Mike Blyth)

STAR OF HOPE TRANSFORMATION CENTRE

Strategies: HR/ HTP / H / CDP / M

The Star of Hope Transformation Centre was founded in 2009 as a rights-based NGO working to prevent child sexual abuse and GBV and support communities through education and empowerment. Its founder, Olutosin Oladosu Adebowale, has explored the topic of FGM in Nigeria in partnership with the Wole Soyinka Centre for Investigative Journalism, and produced a number of articles and a documentary. She has visited communities in ten states (primarily in the west, south and east of the country) to understand the reasons for cutting and has met very strong opposition to the campaign to end FGM. For instance, in Ondo State, some TBAs believe that the campaign is against God and vow to continue their work according to the Bible. In Cross River, too, access was denied to a community where it is known that only pregnant women are cut. The community members believe that if any woman should die, it is an indication that the gods are angry with her and she should not be mourned.

(Star of Hope Transformation Centre, 2016; Crunch Base, undated)

CHALLENGES FACED BY ANTI-FGM

INITIATIVES

Challenges fall into two categories: firstly, strategic issues, which are embedded in the structure of Nigerian society, representing tradition and social norms; and secondly, practical aspects of how to encourage individuals and communities to change their behaviour and deliver the kind of support needed by those who go against the social norms.

Strategic challenges can be divided into three types:

- the pervasiveness of cultural and social norms that support the continuation of FGM;
- the systemic failure of authorities to enforce the law in a way that curbs the practice and prevents it being driven underground; and
- poor physical infrastructure (lack of roads, electricity, telecoms, schools and properly equipped clinics), which makes it difficult to outreach and work effectively in many rural communities.

FGM remains a deeply-entrenched tradition in Nigeria that continues to be reinforced from generation to generation by family and community pressures. The main benefit of FGM cited by women (11.2%) and men (17.3%) is 'preservation of virginity/prevention of pre-marital sex' (DHS 2008, pp.306-7). Social acceptance and improved marriage prospects are also closely linked to the continuation of the practice, and in some communities it is traditionally required in order to marry. Therefore, without a holistic approach that includes all members of the community, myths and misunderstandings around FGM will continue. For example, a gender specialist with UNFPA (cited in Onehi & Leonard-Okafor, 2016) stated, 'What we discovered in Ebonyi is that men don't want FGM, but women are doing it because they think men want it. They do not talk to each other. So, we have to foster inter gender dialogue so men can say "we don't want this. It's unnecessary. This is the impact."'

As has been shown by NGOs such as SIRP and CESVED, initiatives at community level, working

with traditional and religious leaders, and supporting and training peer educators, can raise awareness of the harmful effects of FGM and encourage abandonment. Advocacy by NGOs can also influence legislators (for example, CHCEEWY's role in achieving implementation of the Gender and Equal Opportunity Law in Plateau State).

CUTTERS DESCENDANTS ASSOCIATION OF NIGERIA



Fig. 44: International Summit on Female Genital Mutilation/Cutting in Ibadan (© Premium Times)

In May 2016 an International Summit on Female Genital Mutilation/Cutting was held in Ibadan, organised by the Cutters Descendants Association of Nigeria (CDAN). The Chair of CDAN called on members to collaborate with other organisations to bring about an end to the practice. But he also called on the Government to 'consider the need for support to this family whose source of livelihood is being taken from them' and 'provide sources of income to alleviate the possible economic effect that may likely affect their families. As this is the case of demand and supply, it is definite that the refusal of the supplier will bring an end to the demand' (cited in Ezeamalu, 2016a).

He was supported in this demand by anti-FGM campaigner Gift Abu (cited in Ezeamalu, 2016a), who said, 'They do it for money, it's their livelihood. . . . It's like a profession to them.'

Also attending the Summit were several wives of state governors, who called on their counterparts in other states in South West to champion campaigns to end FGM.

(Ezeamalu, 2016a; Premium Times, 2016)

One of the main challenges, however, is to persuade the traditional practitioners of FGM to give up a practice that continues to be an important part of their livelihood and status in Nigerian communities. As NGO CAFSO-WRAG (2016) reported to us: '[W]e often face challenges from the practitioners since they see FGM as part of their profession and age long tradition that cannot just be relinquished easily.' Consequently, some traditional practitioners may flout the law.

13 of Nigeria's 36 states have put in place laws against FGM over the past couple of decades, but it was only in May 2015 that a federal law was passed – the VAPP. This, however, only covers the FCT, and similar legislation needs to be passed in those states that are still without an act criminalising FGM and other HTPs.

Practical challenges to anti-FGM initiatives include:

- *Providing continued support to communities that have started the abandonment process, and extending successful activities into new areas.* Many NGOs, such as the IAC and CAFSO-WRAG, have pointed out to 28 Too Many that a lack of funding is a constant challenge to the achievement of their aims; for example, funding is needed to transport volunteers and activists to communities, and cover the cost of printed materials and the running of workshops. CHCEEWY (2016) has also stated, 'Many Donors seem not to be interested in . . . project[s] that are specifically addressing FGM'; instead, 'we have project[s] on human right[s] that plug-in issues of FG[M] . . . and that is the reason why we do not have networks on FGM but [on] Human Right[s].'
- *Maintaining funding for the re-training of traditional practitioners who are reluctant to give up the practice of FGM.* Some NGOs provide education and skills training, and introduce alternative livelihood options, and this requires funding support, from the initial training and set-up costs, through to ongoing monitoring to ensure the practitioner does not return to FGM as their source of income. For example, CESVED report that they have had problems funding the provision of training materials and seeds in the rural communities where they work (Augustine, 2016).



Fig. 45: CESVED working with circumcisers and women of Agwagune community (© CESVED)

- *Identifying key religious and traditional leaders in communities, and engaging them for long-term programmes.* As experienced by Star of Hope Transformation Centre, anti-FGM campaigners may risk strong opposition and exclusion from communities.
- *Continuing and increasing enforcement of the law, and making protection available to those women and men who want to save their daughters from being cut.* Speaking at a recent meeting on violence against women organised by New Initiative for Development, its Executive Director, Abiodun Oyeleye, said, 'There is a general apathy on the issue of violence against women on the part of the police institution.' He was supported in this view by Wale Adebajo of the British High Commission, who said that the challenge of the domestic violence law (the VAPP) is that it is not yet known to the people. '[C]itizens have no access to the law including the justice sector stakeholders which makes it very difficult to enforce,' he said (Oyeleye and Adebajo cited in Ezeamalu, 2016b).
- *Providing care to women who have already undergone FGM and have limited access to healthcare to deal with the problems that have arisen as a result.*

- *The need for further surveys gathering data on FGM prevalence and levels of abandonment, which take into account the illegality of the procedure and the effect this might have on accurate reporting.* The number of cases of FGM may be under-reported as awareness of the criminalisation of FGM in Nigeria spreads and is implemented further at state and regional levels. 28 Too Many has previously reported that this challenge exists in other countries where FGM laws have been introduced.
- *The security situation across many areas of Nigeria.* This ongoing insecurity impacts upon the ability of those working in both education and healthcare services to secure the welfare of women and girls in many regions, including the north and south-east of the country.
- *Putting in place transparent procedures and policies to counteract corruption.* NGOs are vulnerable to the impacts of corruption, and need to have good management, clear policies and the capacity to closely monitor and show how funds are spent if they are to continue receiving donor support.
- *Freedom and safety of the press.* There is an opportunity for the new Government to establish a greater freedom of the press and work to ensure the safety of journalists, where possible, so that the anti-FGM message may be more widely spread.
- *The increase of social and physical mobility in Nigeria creates both challenges and opportunities for young women.* Improved access to education, which is usually available in urban areas, offers an opportunity to spread understanding and discussions about the harmful effects of FGM; similarly, social media is a mechanism of growing importance for spreading information in Nigeria. As more people move to urban areas, there is therefore the potential to step up education and advocacy to end FGM. On the other hand, there remains the challenge that deeply embedded social norms may mean that girls residing in urban areas will still be taken back to their rural, familial homes to undergo the practice.

CONCLUSIONS

[E]ngaging parents, especially mothers and health workers in continuous empowerment programmes and constant work and talk with the religious institutions in order to change their mindsets about this issue are some of the genuine measures of ending female genital mutilation. Female genital cut can only end in Nigeria if there is a mindset shift from parochial belief about gender inequality.

~Olutosin Adebowale
(Olutosin, 2015)

The information available during the research for this report suggests that women aged 15 to 49 who have experienced FGM in Nigeria are likely to be wealthier, more highly educated and living in urban areas (DHS 2013, p.350). However, it is this same group of women who are most likely to state that they have *not* had their daughters cut, which suggests that girls who may be most vulnerable to undergoing FGM in Nigeria in the future are those whose mothers are poorer, less educated and living in rural areas (DHS 2013, pp.354-5). This observation is reinforced by anecdotal evidence provided by NGOs working in the country.

Based on a comparison of the available data on the number of women cut to the number of daughters being cut, there would appear to be a decline in the practice across generations. Conversely, there may be an element of under-reporting due to the illegality of the procedure in some states where a law against it already exists. There may be increased under-reporting in the future if the VAPP is taken up and adopted in the remaining states. This is evidenced in other countries when laws banning FGM have been introduced.

NGOs have been working in Nigeria for the past three decades to eliminate FGM, supported by the media putting out anti-FGM messages and information about its harmful effects. These efforts have led to some communities and practitioners publicly condemning and pledging to abandon the practice.



Fig. 46: Girls and young women face a number of challenges and opportunities in Nigeria today (Photographer: Joachim Huber)

While NGOs have been able to work openly on anti-FGM programmes and have had the support of the former and current Governments, there is a continuing need for them to avoid the challenges presented by corruption. NGOs need to have robust management practices, and transparency in their policies and procedures, particularly those surrounding the use of funding.

28 Too Many recognises that each country where FGM exists requires an individualised plan of action for elimination to be successful. Drawing on the successes described in this report, we propose the following general ways forward, many of which are applicable within the wider scope of international policy and regulation, and some that are specific to Nigeria.

ADOPTING CULTURALLY RELEVANT PROGRAMMES

Communities in which FGM is found often have different customs surrounding the practice and express different reasons for performing FGM. Those designing programmes to tackle FGM need to be aware of these differences, deploying strategies to address the issues within each community, and building local support to stop FGM.

LONG-TERM FUNDING

Programmes and research studies concerned with the elimination of FGM require long-term funding to be effective. Continued publicity of current FGM practices at a global level, particularly through the UN and WHO, is crucial for ensuring that NGOs and charities are given the support and resources

they require in the long term. Obtaining charitable aid and grant funding is inherently challenging, as programmes for ending FGM tend to be given less attention than those related to broader health and poverty issues. This is one area where support from the media and the generation of discussions on social media platforms is important.

FGM AND THE SDGs

The push for change gathered momentum with the UN's global ban on FGM in December 2012 and the UN Commission on the Status of Women 57th Session, at which 28 Too Many was present and which focused on violence against women and girls, including FGM. This momentum can continue within the framework of the SDGs, which have global support.

The inclusion in the SDGs of a specific target to eliminate FGM associates the practice with the eradication of extreme poverty and hunger, the promotion of universal primary education and gender equality, the reduction of child mortality, the improvement of maternal health and the fight against HIV/AIDS. It is important therefore to highlight FGM in the context of these when creating policies and grant proposals and communicating anti-FGM initiatives to a wider audience.

FGM AND EDUCATION

Education is a central issue in the elimination of FGM. Lack of basic education is a root cause of the perpetuation of social norms and stigmas that surround FGM as it relates to health, sexuality and women's rights. The health impacts of FGM, and the discrimination against women and girls caused by the practice, can also hinder girls' ability to access basic education. In turn, this prevents them from pursuing higher education and employment opportunities. Lack of education also directly correlates with issues surrounding child marriage and GBV.

28 Too Many recommends that government organisations, international agencies and NGOs continue to provide education programmes for boys and girls about FGM and other HTPs and their negative impacts on health and economic development, such as the curriculum currently

under development by Girl Effect Nigeria (see 'Education'). We also recommend that the Federal and State Governments continue efforts to comprehensively and accurately report on education conditions and the factors that hinder universal education.

July 2016: Her Excellency Aisha Buhari, the First Lady of Nigeria has said that, in recognition of education being 'the key to liberation and empowerment of the girl child', the Federal Government is considering introducing a law to make it compulsory for every girl child to attain at least secondary-school education through the free education policy (Eboh, 2016).

FGM, MEDICAL CARE AND HEALTH EDUCATION

More resources and education are required across the health system in Nigeria at federal, state and district levels. Nigeria's expenditure on health in 2015 was only 5.5% of the national budget, compared with the 15% proposed in the African Union's Abuja Declaration of 2001. In particular, there needs to be better access to health care in rural areas.

Health professionals need to be better trained to deal with complications resulting from FGM, and the recent announcement of the introduction of a module on FGM into the curricula for doctors and nurses is to be applauded. The WHO recently introduced guidelines for designing professional training curricula for doctors, nurses, midwives and public health workers, which should be used to provide healthcare professionals with the knowledge to support girls and women who have undergone FGM, in order to address both their physical and psychological trauma.

FGM, ADVOCACY AND LOBBYING

Advocacy and lobbying at national and state level is essential to ensuring that current and future governments continue to support anti-FGM programmes and initiatives. An example of this is the collaboration between the Nigerian Federal Government, State Governments and the UNJP recently launched by Her Excellency Aisha Buhari, the First Lady of Nigeria. Particular areas for lobbying include the introduction and implementation of the VAPP across the country,

and the development of national and state action plans aimed at eliminating FGM.

Support is also required from international partners and donors for the continued development of Nigeria's health and education sectors, as well as for local initiatives that tackle FGM. It is particularly important for time, money and other resources to be invested in health and education services and NGOs working in rural areas that are harder to reach with media messages, and where more girls are likely to be cut in the future. This will make a significant contribution to achieving a decline in the incidence of FGM across the whole of Nigeria.

The VAPP and related legislation in individual states must be enforced and upheld. Education and training is needed for all those responsible for upholding and enforcing the law. Consideration should also be given to providing full protection – safe spaces – for girls who are at risk of FGM and women seeking to protect their daughters from it.



Fig. 47: Sensitisation programme run by CHAI highlighting the dangers of FGM to mothers in the community (© CHAI)

FGM IN THE MEDIA

All forms of media, but particularly social media, are proving useful tools in the campaign against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with the mass media on eliminating FGM and encourages these projects to continue, particularly projects to take the message to rural communities, where many have limited access to media.

Furthermore, the media is an effective means of raising awareness of the issue and thereby financial and social support for campaigns.

28 Too Many also recommends the development of projects that more generally promote women's access to the media, including greater engagement of women in the media industry. The use of diverse forms of media, and radio in particular, together with film screenings and interactive theatre, have proved to be successful tools, for many of Nigeria's anti-FGM NGOs.

FGM AND FAITH-BASED ORGANISATIONS

Religious narratives are essential for personal understanding, family and society. FBOs are major agents of change, and their international, national and regional configurations offer platforms for teaching, education support and health provision.

In Nigeria, given the trusted position that religious leaders have in society, it is essential that they are engaged in anti-FGM programmes, and are encouraged to speak out against the practice and support its abandonment. Several NGOs (for example, SIRP and CHCEEWY) are working closely with local traditional and religious leaders, alongside community partners, to achieve this.

FGM AND MEN

Several NGOs (including the IAC) and international agency programmes (such as Voices 4 Change) have highlighted how important it is to engage with boys and men as well as girls and women when conveying the negative impacts of FGM. V4C has produced a report in which more than nine out of ten men and boys said they did not agree with the continuation of FGM and other harmful traditional practices (Voices 4 Change, 2016, p.28). NGOs, for example AHI and CHCEEWY, see men as key participants in their work with communities to end FGM.

COMMUNICATION AND COLLABORATION

There are a number of successful anti-FGM programmes currently operating in Nigeria, with the majority of the progress beginning at grassroots level, where attitudes and behaviour are changing as a result.

28 Too Many recommends that successful projects and strategies be communicated more widely and publicly, to encourage collaboration. The fight against FGM will be strengthened by networks of

organisations working against it (and, more broadly, for women's and girls' rights), integrating anti-FGM messages into other development programmes; sharing best practice, success stories, operations research, training manuals, support materials and advocacy tools; and providing links and referrals to other organisations. Federal-wide and cross-state networks facilitated by the Government, possibly as part of the Accelerating Change programme in collaboration with UNFPA and UNICEF, would further strengthen the work against FGM by providing a framework for coordinating resources and action.

FURTHER RESEARCH

There is a need for continued research and data collection to inform anti-FGM programmes and analyse trends and practices across Nigeria. Consistency in the questions asked and the age cohorts of subjects will allow for more accurate analysis. The challenge of also collecting reliable data on an illegal practice needs addressing at both a national and global level.



Fig. 48: A programme organised by CHAI for Children's Day in May 2016. Raising awareness and knowledge among children and young people in communities where FGM prevalence is high is essential for Nigeria. (© CHAI)

APPENDIX I – LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO WOMEN’S AND CHILDREN’S RIGHTS IN NIGERIA

Action Aid Nigeria	Medical Women’s Association of Nigeria (MWAN) Rivers State
Action Health Incorporated (AHI)	National Association of Nigeria Nurses and Midwives
Adolescent Health and Information Projects (AHIP)	Nigeria Association of Women Journalists (NAWOJ)
Alliances for Africa	OneLife Initiative for Human Development
AmplifyChange	Oxfam
Child Adolescent and Family Survival Organization – Women’s Rights Action Group (CAFSSO-WRAG)	Planned Parenthood Federation of Nigeria
Campaign Against Female Genital Mutilation (CAGeM)	Population Council
Centre for Development and Population Activities (CEDPA)	Safehaven Development Initiative
Centre for Health Care and Economic Empowerment for Women and Youth, Nigeria (CHCEEWY)	Save the Children
Center for Social Value and Early Childhood Development (CESVED)	Society for the Improvement of Rural People (SIRP)
Child Health Advocacy Initiative (CHAI)	SOS Children’s Villages
Civil Resource Development and Documentation Centre (CIRDDOC) Nigeria	Soteria Trust
Community Health and Research Initiative (CHR)	Star of Hope Transformation Centre
Community Health Information Education Forum (CHIEF)	The Calvary Foundation
Defence for Children International (DCI)	The Girl Generation
Department for International Development (DFID)	<i>The Guardian</i> End FGM Global Media Campaign (GGMC)
Forum for African Women Educationalists (FAWE)	United Nations Children’s Fund (UNICEF)
Foundation for Women’s Health, Research and Development (FORWARD)	United Nations Development Programme (UNDP)
Gender Equality and the Girl Child Development Foundation	United Nations Population Fund (UNFPA)
Girl Effect Nigeria	UN Women
Girls’ Power Initiative (GPI) Nigeria	USAID
Grassroots Health Organisation of Nigeria (GHON)	Wole Soyinka Foundation
Initiative for Food, Environment and Health Society (IFEHS)	Women Aid Collective (WACOL)
Inter-African Committee on Traditional Practices (IAC) Nigeria	Women’s Health and Action Research Centre (WHARC)
International Centre for Reproductive Health and Sexual Rights (INCREASE)	Women’s Health and Economic Development Association (WHEDA)
International Center for Research on Women	Women’s Rights Advancement and Protection Alternative (WRAPA) Nigeria
	World Health Organization (WHO)
	Young Men’s Network Against Gender Based Violence
	Young Women’s Christian Association of Nigeria
	Youth, Adolescent Reflection and Action Centre (YARAC)

Please note that this is not a comprehensive list of all INGOs and NGOs working in Nigeria; it is a selection.

APPENDIX II – PROFILE OF GENDER & GBV-RELATED LAWS/

BILLS ACROSS STATES IN NIGERIA

This Women's Rights Advancement and Protection Alternative (WRAPA) annex of mapping of laws related to FGM in states was originally published in 'Guidelines on Gender based Violence and Young Persons in Nigeria' (2014), produced by Women Arise for Change Initiative and WRAPA.

	STATE	TITLE OF LAW/BILL	STATUS
1	Abia	Child's Rights Law, 2004	Operational
2	Adamawa	Child's Rights Law, 2004	Operational
3	Akwa Ibom	a) Interpretation Law, Cap. 64, Laws of Akwa Ibom 2000, as in the Federal Act, provides that words importing the masculine gender shall include the feminine b) Personal Income Tax Act 1993, No. 104, Cap. P8, Vol. 13, Laws of the Federation of Nigeria, 2004 – A Federal legislation applicable in Akwa Ibom State c) Customary Marriages (Special Provisions) Law, Cap. 8, Laws of Akwa Ibom State, 2003 d) Child's Rights Law, 2004	Operational Operational Operational Operational
4	Anambra	The Prohibition of Infringement of a Widow's and Widowers Fundamental Rights – 2000	
5	Benue	Child's Rights Law, 2004	Operational
6	Bauchi	a) Married Women's Property Law; Laws of Bauchi State, 1985 b) Withdrawal of Girls from School for Marriage (Prohibition) Law, No. 17 of 1985; Laws of Bauchi State, 1985 c) Neglect of Children's Law, Part VII (No.33), Laws of Bauchi State d) Hawking by Children (Prohibition) Laws of Bauchi State, 1985, (CAP 58) e) Children and Young Persons Law, 1959, Laws of Bauchi State, 1985	Operational Operational Still operational? Operational Operational
7	Borno	N/A	
8	Bayelsa	Child's Rights Law, 2004	Operational
9	Cross River State	a) The Girl-Child Marriages and Female Circumcision (Prohibition) Law, 2000 b) Domestic Violence and Maltreatment of Widows (Prohibition) Law, 2004 c) The Cross River State Female Person's Inheritance of Property Law, 2007	Operational Operational Operational

		d) Child's Rights Law, 2004	Operational
10	Delta	Child's Rights Law, 2004	Operational
11	Ebonyi	a) Ebonyi State Law Abolishing Harmful Traditional Practices Against Women and Children – 2001 b) Banning Hawking for School-Age Children Law, Ebonyi State, 2000 c) Child's Rights Law, 2004	Operational Operational Operational
12	Edo	a) Prohibition of Female Genital Mutilation law b) Inhuman Treatment of Widows (Prohibition Law) of 12 Nov. 2001, Laws of Edo State c) Child's Rights Law, 2004	Operational Operational Operational
13	Enugu	a) Prohibition of Infringement of Widow and Widower Fundamental Right law, 2001	Operational
14	Ekiti	a) Gender-Based Violence (Prohibition) Law, 2011 b) Child's Rights Law, 2004	Operational Operational
15	Gombe	Child's Rights Law, 2004.	Operational
16	Imo	a) Violence Against Persons Prohibition Bill b) Gender Equal Opportunity Bill c) Child's Rights Law, 2004	Both have been passed but yet to be signed by Governor Operational
18	Kogi	a) Violence Against Persons Prohibition Bill b) Gender Equal Opportunity Bill c) Child's Rights Law, 2004	Both have been passed but yet to be signed by Governor Operational
19	Kwara	Child's Rights Law, 2004	Operational
20	Katsina	N/A	
21	Kaduna	a) Infants Law, Laws of Kaduna State, 1991 b) Legitimacy Law, Cap 79, Laws of Kaduna State, 1991 ¹ c) Married Women Property Law, Kaduna, 1991	Still Operational? Still Operational? Still Operational?
22	Kano	Marriage (Customary Practices) Control Law, Cap. 91, Laws of Kano State, 1991	Still Operational?
23	Kebbi	N/A	
24	Lagos	a) Protection Against Domestic Violence Law, 2007. b) Child's Rights Law, 2004	Operational Operational

¹ Laws promulgated in some states which affect the legitimacy of children born out of wedlock under Christian doctrine, by legitimizing such children. Examples of such laws can be found in the South East and North West Zones, i.e. Legitimacy Law of Eastern Nigeria and Legitimacy Laws of each of Kaduna, Sokoto, Kano and Zamfara States.

25	Niger	N/A	
26	Nassarawa	Child's Rights Law, 2004	Operational
27	Oyo	a) Married Women's Property Law, Cap 83 Laws of Oyo State, 1990 b) Married Women's Property Law, 2000 c) A Bill on Protecting the Inheritance Rights of Widows, Prohibition, Harmful Traditional Practices Against Widows & Other Related Matters, Oyo State d) Child's Rights Law, 2004	Operational Operational Has it been passed? Operational
28	Osun	Child's Rights Law, 2004	Operational
29	Ondo	a) A Bill on Harmful Traditional Practices Affecting the Health of Women and Children and Other Matters Incidental Thereto and Connected Therewith, Ondo State. b) Child's Rights Law, 2004	Has it been passed? Operational
30	Ogun	Child's Rights Law, 2004	Operational
31	Plateau	Child's Rights Law, 2004	Operational
32	Rivers	a) Female Circumcision Law, No. 2 of 2001, Laws of Rivers State b) Child's Rights Law, 2004	Operational Operational
33	Sokoto	a) Married Women's Property Law Cap 91, Laws of Sokoto, 1996 currently applicable in Zamfara State ² b) Infants Laws, Cap. 68, Sokoto State Laws, 1996, also currently applicable in Zamfara State	Operational Operational
34	Taraba	Child's Rights Law, 2004	Operational
35	Yobe	N/A	
36	Zamfara	Married Women's Property Law Cap 91, Laws of Sokoto, 1996 currently applicable in Zamfara State	Operational

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- (i) A compilation of the Constitution, National and State Statutes and Regulations, Local Government Bye-Laws, Customary Laws And Religious Laws, Policies and Practices, and court decisions relating to the Statuses of women and children, applicable in Nigeria by National Centre for Women Development, Abuja, Nigeria, July 2005.
- (ii) Women's Rights Advancement and Protection Alternative & Legislative Advocacy for Violence Against Women – Raising Her Voice (RHV) Report, 2012.

² Only married women are allowed to acquire, hold and dispose of any immovable property or interest in them.

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