



# FEMALE GENITAL MUTILATION IN NIGERIA

SITUATION ANALYSIS

UNFPA 2021



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## FOREWORD

It is my honor and privilege to write the Foreword to this important document that should significantly enhance the lives of women and girls in Nigeria.

Based on a joint statement issued by the WHO, UNFPA and UNICEF 2007 against the practice of FGM and calling for its elimination, the 2008 World Health Assembly (WHA) resolution on the elimination of FGM highlighted the need for member countries to develop and implement policies and plans backed by adequate resources and indicators to track progress, coordination, and impact. The UN General Assembly in 2012 also passed a resolution calling for the elimination of FGM and urging countries to create awareness, allocate resources and enforce legislation to end the practice. In addition, the United Nations Human Right Council, during its 44th session, passed a resolution calling upon all governments to adopt comprehensive, multisectoral and rights-based measures to prevent and eliminate FGM. Subsequently, there have been concerted global and national efforts to facilitate the abandonment of FGM. These efforts have been backed by charters, international conventions, legal and policy frameworks and advocacy.

Female genital mutilation (FGM) is defined by the World Health Organization (WHO) as all procedures which involve partial or total removal of the external female genitalia and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons. In Nigeria, subjection of girls and women to obscure "traditional" practices abounds. FGM is an unhealthy practice inflicted on girls and women, shrouded in secrecy and controversy, as an initiation ceremony of girls into womanhood, or misguidedly to ensure modesty and chastity.

FGM is thought to be still widespread in Nigeria, with certain sociocultural determinants identified as supporting the practice. Critical decision makers can, in fact, be grandmothers, mothers, opinion leaders, and elders, who closely associate it with girls' eligibility to be married. FGM was traditionally the specialization of traditional healers, birth attendants or members of the community guild for the practice. There is, nowadays, the "medicalization", introduced by trained health practitioners and community health workers. The WHO is advocates against this "medicalization" and has advised that FGM must neither be institutionalized nor performed by health professional in any setting, including hospitals or in the home setting.

With improvement in educational and social status of women and increased awareness of the complications of FGM, most women who underwent FGM disapprove of the practice and hardly any is prepared to subject their daughters to the harmful procedure.

The educated, informed, and socially and economically upward mobile women appreciate and understand the hazards of the practices, as an unnecessary procedure.

This situation analysis provides a comprehensive review of the FGM situation in Nigeria, in exploring reliable data that describe the context of the current policy and programmatic response to FGM. It describes milestones achieved in policy response, identifies unmet needs for FGM intervention and highlights context-specific enablers and barriers to elimination of FGM in Nigeria. This review also triangulates data from available surveys and program reports to document what is known of gaps and opportunities to achieved set targets.

The development of this situation analysis involved consultations with organizations implementing the Female Genital Mutilation Action Plan (both public and private services providers) in Nigeria, individual health experts, numerous Civil Society Organizations and Development Partners.

The Federal Ministry of Health is committed to the implementation of the Identified opportunities in the situation analysis for better FGM programming and response in Nigeria.

A handwritten signature in red ink, appearing to read 'Osagie E. Ehanire', is written over the printed name below.

Dr. Osagie E. Ehanire MD, FWACS

Honourable Minister of Health

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## LIST OF ACRONYMS

<b>BAFROW</b>	Foundation for Research on Women's Health, Productivity, and the Environment
<b>CDAN</b>	Circumcision Descendants Association of Nigeria
<b>CEDAW</b>	Convention on the Elimination of Discrimination Against Women
<b>CFRN</b>	Constitution of the Federal republic of Nigeria
<b>CRA</b>	Child Rights Act
<b>CSO</b>	Civil Society Organization
<b>FGM</b>	Female Genital Mutilation
<b>FIGO</b>	Federation of International Obstetrics and Gynaecology
<b>FMoH</b>	Federal Ministry of Health
<b>HTP</b>	Harmful Traditional Practices
<b>IAC</b>	Inter-African Committee
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>NDHS</b>	Nigeria Demographic and Health Survey
<b>NGO</b>	Non-Governmental Organization
<b>NHMIS</b>	National Health Management Information System
<b>NHSDP</b>	National Health Strategic Development Plan
<b>NOA</b>	National Orientation Agency
<b>NPPAEFN</b>	National Policy and Plan of Action for the Elimination of FGM/C in Nigeria
<b>SMoH</b>	State Ministry of Health
<b>SOGON</b>	Society of Gynaecology and Obstetrics of Nigeria
<b>SUBEB</b>	State Universal Basic Education Board
<b>UNESCO</b>	The United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UNJP</b>	United Nations Joint Programme
<b>VAPPA</b>	Violence Against Persons Prohibition Act
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization

## EXECUTIVE SUMMARY

Female Genital Mutilation (FGM) constitutes a violation of the human rights of girls and women internationally and it reflects inequalities that drives an extreme form of discrimination. The practice is enshrined in cultural and traditional beliefs within a frame of sexual, moral, and religious factors that are preserved, perpetrated, and sustained through community mechanisms. The drivers of FGM are rooted in cultural practices and norms underlying unequal power relations that govern sexual behavior. This practice has profound negative implications for physical, mental, and sexual wellbeing as well as maternal and child health. There are no health benefits of FGM; rather, health complications include immediate complications such as bleeding, infection, pain, trauma to the urogenital system and death as well as long term sequelae such as obstetric, genitourinary, sexual, and psychological complications. Globally, it is estimated that over 200 million women and girls alive have undergone FGM. Approximately two thirds of females who have been cut are from four African countries: Sudan, Egypt, Ethiopia, Nigeria. The estimates for Egypt, Ethiopia, and Nigeria are 27 million, 24 million, and 20 million respectively making them the countries with the highest absolute numbers of women and girls living with FGM in Africa. In addition, it is estimated that about 68 million girls are at risk of FGM from 2015 to 2030 if the current trend continues (UNFPA 2018).

In 2007, a joint statement was issued by the WHO, UNFPA, and UNICEF against the practice of FGM, calling for its elimination. In 2008, the World Health Assembly (WHA) resolution on the elimination of FGM highlighted the need for member countries to develop and implement policies and plans backed by adequate resources with indicators to track progress, coordination, and impact. The UN General Assembly in 2012 also passed a resolution calling for the elimination of FGM and urging countries to create awareness, allocate resources and enforce legislation to end the practice. In addition, the United Nations Human Right Council, during its 44<sup>th</sup> session passed a resolution, calling upon all governments to adopt comprehensive, multisectoral and rights-based measures to prevent and eliminate FGM. Subsequently, there have been concerted global and national efforts to facilitate the abandonment of FGM. These efforts have been backed by charters, international conventions, legal and policy frameworks and advocacy.

In Nigeria, prior to the passage of the Violence Against Persons Prohibition Act (VAPP), the 1999 Constitution of the Federal Republic of Nigeria (CFRN) and the Child Rights Act (CRA) were used to advocate against FGM as these laws stipulate that the act of

subjecting a person or child to inhumane or degrading treatment is a punishable offence. State laws were also adopted for addressing FGM prior to the enactment of the VAPP act such as the Law Abolishing Harmful Traditional Practices Against Women and Children (2001) by Ebonyi state and the FGM (Prohibition) Law (2004) in Cross River state. In 2015, the VAPP act was passed into law and this law explicitly states that FGM is a criminal and punishable offense in Nigeria; over 20 states have domesticated the act. The VAPP act also makes provisions for the protection of the rights of women and girls at individual, household, and community level. The act has however, not been domesticated in all the states thus limiting its application. Unfortunately, a federal law is not enforceable at state level unless it is domesticated in that state; this implies that the act cannot be actively enforced in states where it has not been domesticated.

This review explores the FGM situation in Nigeria, the FGM response as well as gaps and opportunities that need to be considered to improve future response and programming for FGM in Nigeria. Findings from the MICS and NDHS using the state-of-the-art synthesis approach suggest an overall long-term steady decline in the prevalence of FGM among women. This may be linked to weakening of community structures and beliefs that continue to yield to an integrated abandonment strategy that incorporates advocacy, awareness, education, and legal frameworks that drive support for abandonment. Although significant progress has been made in supporting interventions and policies for the elimination of FGM, findings suggest that the impact is fragmented across the country possibly due to lack of sustained policy change, medicalization, and other emerging issues. The findings also suggest an increase in prevalence among girls reflecting continuation of the practice. The increase in prevalence among girls is however driven by an increase in the burden across the Northern region of the country compared to the Southern region. The Southern region of Nigeria has experienced a concentration of intervention programs focused on abandonment of FGM. Despite the decline, the overall prevalence continues to be higher in the Southern region of Nigeria suggesting the need for interventions to continue to facilitate further decline.

Regional disparities in the emergence of new hotspots reflect the need for country wide interventions that address FGM to ensure that milestones achieved in abandonment are sustained. The emergence of new hotspots in Northern Nigeria reflects the need for country wide interventions that address FGM, to ensure that milestones achieved in abandonment are sustained. The reduction in the practice of medicalization is a positive development, however, there is the need to continue to drive awareness and intervention programs among traditional circumcisers and birth attendants who continue to sustain the practice.

Findings from the UNJP states show that the prevalence of FGM has declined across the states due to focused interventions over the past decade. Imo state, however, still has the highest burden for women (age 15-49) in Nigeria and the third highest burden for girls (age 10-14) after Jigawa and Kaduna states as reported by the NHDS. MICS however, reports Osun state as having the highest prevalence in the country. The support for FGM among women has largely declined in Osun, Oyo, Ebonyi, and Imo states indicating a positive development in weakening of the practice. Despite the efforts towards abandonment, the burden of FGM is still very substantial, and it is important more than ever to intensify efforts to further reduce and eventually abandon the practice.

# 1.0 INTRODUCTION

## 1.1 Global overview of FGM

The World Health Organization (WHO) defines FGM as all procedures that involve the partial or total removal of the external female genitalia and/or injury to the female genital organs, either for cultural or any other non-therapeutic reasons (WHO, 2008). FGM constitutes a violation of human rights of girls and women internationally and it reflects inequalities that drives an extreme form of discrimination against women and girls (UN General Assembly, 2012; Azuonwu & Ezekiel, 2020). Globally, it is estimated that over 200 million girls and women have undergone Female Genital Mutilation and cutting (FGM) (UNICEF, 2016). The number of girls estimated to be at risk of FGM will increase from 4.1 million girls in 2019 to 4.6 million in 2030 if current levels of risk prevail (UNFPA 2018). There are global calls for the elimination of FGM following the 2012 United Nations (UN) resolution (67/146) banning FGM in recognition of the devastating and irreversible consequences on health and human rights (UN General Assembly, 2012). The Sustainable Development Goals also incorporate a target to eliminate harmful traditional practices such as FGM by 2030 under Goal (5).

FGM is classified by the WHO into 4 types (WHO, 2008):

- Type I also known as clitoridectomy is partial or total removal of the clitoris and/or the prepuce (the skin fold surrounding the clitoris).
- Type II also known as excision is the partial or total removal of the clitoris and the labia minora with or without the removal of the labia majora.
- Type III also known as known as infibulation is the narrowing of the vagina orifice and the creation of a covering seal by cutting and repositioning the labia minora and/or labia majora. This may or may not involve the excision of the clitoris.
- Type IV includes all other harmful practices carried out on the female genitalia such as pricking, scraping, incising, piercing, and cauterizing the genital area).

FGM has no health benefits. The practice of FGM is associated with health consequences with the risks increasing with the severity of the procedure (R. Berg et al., 2014). FGM has profound negative implications for sexual wellbeing, mental health as well as maternal

and child health (Behrendt, A., 2005; R. Berg et al., 2014; Kizilhan, 2011). FGM is practiced for a wide range of reasons such as controlling sexuality in females, upholding cultural norms, avoiding community level stigma, improving the prospects of marriage and facilitating a rite of passage into adulthood (Adebola, 2020; Bodunrin, 1999; Briggs, 1998).

FGM is a global health issue; the type of FGM practiced varies widely across countries as well as the prevalence. There is a disproportionate distribution of the practice with majority of those affected (or at risk) living in Africa, Middle East and Asia (UNICEF, 2016a). The practice of FGM is also common among women migrating from African and Asian countries to Western countries (Azunwu & Ezekiel, 2020; Odo et al., 2020). African countries with the highest prevalence of FGM (above 80%) include, Sudan and Egypt in North Africa; Mali, Guinea Bissau and Sierra Leone in West Africa; Somalia, Eritrea and Djibouti in East Africa. Ethiopia, Mauritania, Liberia, and Burkina Faso have prevalence rates between 51 and 80%. Approximately two thirds of females who have been cut are from four African countries: Sudan, Egypt, Ethiopia, Nigeria (UNICEF, 2016a).

## 1.2 Overview of FGM in Nigeria

Nigeria is the most populous country in Africa with a population of 199 million and an annual growth rate of 3.1% based on 2019 population estimates from National Bureau of Statistics (National Bureau of Statistics, 2019). Nigeria has 36 states and the Federal Capital Territory (FCT) grouped within six geopolitical zones: North Central (NC), North East (NE), North West (NW), South East (SE), South West (SW) and South-South (SS). The 36 states are divided into 774 Local Government Areas (LGAs). Rural-urban ratio in Nigeria is approximately 1:1 with an urbanisation rate is 3.7% per annum (The United Nations Statistics Division, 2017). Males constitute about 51% of the population while females constitute 49% (National Bureau of Statistics, 2019).

The country has a predominant youth population; about 20% are between 15-24 years, 43% are less than 15 years and the median age of the population is 18.3 years (National Bureau of Statistics, 2017; Index Mundi, 2017). There are more than 250 ethnic groups, the largest ethnic groups are: Hausa in the North, Yoruba in the West, and Igbo in the East (National Bureau of Statistics, 2016). Osun, Ebonyi, Ekiti, Imo and Oyo states are among the states with the highest prevalence of FGM Nigeria (NPC and ICF., 2019). Osun, Ekiti and Oyo are states located in the South Western region of Nigeria, while Imo and Ebonyi are in the South Eastern region.

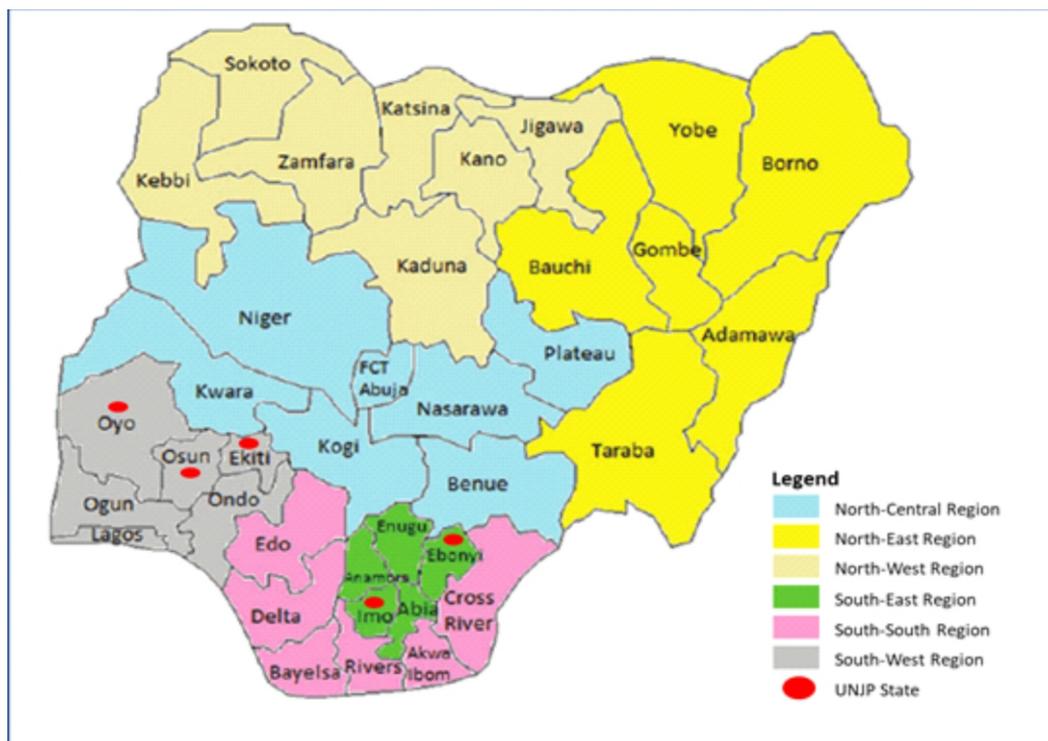


Figure 1: Map of Nigeria Showing Geographic Regions and UNJP Focal States

Findings from the National Demographic and Health Survey (NDHS) show that Nigeria has experienced a decline in the prevalence of FGM from 30% in 2008 to 20% in 2018 among women aged 15–49 years (NPC and ICF., 2019). A comparison of the FGM prevalence data among women within ages 15–49 years from the NDHS between 2003 - 2018 and Multiple Indicator Cluster Survey – [MICS] between 2007 – 2017 shows an increase followed by a decline in recent years. With an estimate of 19.9 million women and girls cut between 2004–2015, Nigeria constitutes the Country with the third highest burden for FGM globally after Ethiopia (23.8 million) and Egypt (27.2 million) (UNICEF, 2016a). There are wide variations in the practice of FGM across communities in Nigeria either openly or in secret regardless of the constitutional provision against torture and human degradation (Azuonwu & Ezekiel, 2020; Odo et al., 2020). All the six largest ethnic groups (Yoruba, Hausa, Fulani, Ibo, Ijaw and Kanuri) practice FGM, the prevalence is however lowest among the Kanuris (5.6%) (NPC and ICF., 2019). Findings from the NDHS reflects a reduction in prevalence in four regions (North West, 20.7% - 20.2%; South-South, 25.8% - 17.7%, South West, 47.5% - 30%; South East, 49% - 35%), an increase in in the North East, 2.9% - 6.1% and unchanged in the North Central at 9.9% as shown in Figure 2 (NPC and ICF., 2014, 2019). The South East currently has the highest prevalence while the North East has the lowest.

In Nigeria, traditional healers, traditional circumcisers, traditional birth attendants and community members (usually women) are known to perform FGM and this is similar to other African countries. Through the process of medicalization, modern health practitioners and community health workers also practice FGM. (Ilesanmi & Ilesanmi,

2018). The most common types of FGM practised in Nigeria are Type I (clitoridectomy) and Type II (excision) and to a lesser extent Type III (infibulation) and Type IV (unclassified) (Azuoanwu & Ezekiel, 2020; Ilesanmi & Ilesanmi, 2018). About 10% of women undergo Type I, 41% undergo type II, 6% undergo Type III procedure and Type IV is unclassified; 40% of women who had been circumcised had Angurya (scraping of the vagina orifice) performed, 13% had gishiri (cutting of the vagina) cuts and 7% experienced use of corrosive substances (NPC and ICF., 2019).

The practise of FGM in Nigeria is driven by cultural beliefs, community values and norms, concerns about hygiene and as a measure to curb promiscuity (Nwankwo, 2020; Odo et al., 2020). On the 2016 International Day of Zero Tolerance for FGM, the Office of the First Lady in Abuja launched the National Response Plan to FGM in partnership with the UNFPA-UNICEF Joint Programme (UNJP) on the Elimination of Female Genital Mutilation and relevant Nigerian ministries. The launch was a collective call for everyone to join the campaign to end FGM. This approach was replicated by wives of governors of the five target states with high prevalence of FGM: Osun, Ebonyi, Ekiti, Imo, and Oyo in collaboration with other key stakeholders.

### 1.3 Overview of the FGM: Situation Analysis

#### 1.3.1 Overall Aim

The aim of this situation analysis is to provide a comprehensive review of the FGM situation in Nigeria by exploring reliable data that describe the context of the current policy and programmatic response to FGM. The situation analysis will describe milestones achieved in the policy response, identify unmet needs for FGM intervention and highlight context specific enablers and barriers for the elimination of FGM in Nigeria. This review will triangulate data from available surveys and program reports to document what is known about the gaps and opportunities in achieving set targets for FGM elimination in Nigeria.

#### 1.3.2 Specific Objectives

- a. Summary analysis of women and girls using NDHS, MICS and other available data sources.
- b. Summary analysis of the UNFPA-UNICEF joint programme on the elimination of FGM data for women and girls.
- c. A desk review/secondary analysis of key data sources for better understanding of the situation, vulnerability and response to Female Genital Mutilation programme in Nigeria.
- d. Development of Female Genital Mutilation situation report for Nigeria.

### **1.3.3 Methods and Approach to the Situation Analysis**

This situation analysis entailed the mapping of evidence based on the objectives from a broad range of data sources such as national surveys (NDHS, MICS), reports (FGM program reports, UNJP on elimination of FGM), peer reviewed publications and other documents (obtained from conference proceedings, FGM Organisations' websites) to triangulate insights and provide a better understanding of the FGM situation in Nigeria.

# PHOTO GALLERY



# PHOTO GALLERY





## | 2.0 SYNOPSIS OF FCM AND FGM PROGRAMMING IN NIGERIA

### 2.1 History of Abandonment Approaches in Africa

Many African countries and by extension their communities considered the early efforts to ban FGM as an attempt to consolidate colonial imperialism. For this reason, there was widespread resistance to the efforts and a somewhat rise in the practice in some African communities. These early efforts were led by Christian missionaries in the twentieth century who emphasized the adverse health effects and termed the practice as 'uncivilized, unacceptable to their faith (Shell-Duncan & Hernlund, 2000).

In the 1960s and 1970s, the attempts by European and American Feminists to persuade Africans to abandon the FGM practice failed because they were perceived as controlling, imposing and very strange to the African culture. There were gaps in the cultural sensitivity of the messaging and campaigns which called for "eradication" of a "pathological" practice. The language used was considered too insensitive to provide room for dialogue for abandonment of FGM against the backdrop of social norms in Africa (GTZ, 2001).

In 1994, many African leaders participated in the ICPD conference and began to recognize FGM as a health and human rights issue. Also, because of African leaders' participation in the Fourth World Conference on Women in Beijing in 1995 and several other international forums, Governments, international agencies, and nongovernmental organizations (NGOs) began to support international declarations on abandonment of the practice.

Given the diversity of stakeholders and factors that influence the continuation of FGM practice, several approaches have been instituted to respond programmatically in the African Continent (R. C. Berg & Denison, 2012). Some of these are:

- Human rights approach
- Legal approach
- Health risk approach
- Training health workers as change agents

- Training and converting circumcisers
- Alternative rites approach
- Positive deviance approach
- Comprehensive social development approach

A typical example of the human rights approach is Tostan's model of community education which focused on increasing participants' awareness of human rights and women's health to reduce violence against women—including the practice of FGM (Diop et al., 2004). The program which combined social mobilization approach has been implemented in Senegal, Guinea and Burkina Faso to successfully lower the levels of domestic violence, lower approval of FGM and lower reported levels of FGM among girls.

Most African countries also embraced the legal approach by legislating against or criminalizing the practice. For example, Egypt has decrees that makes FGM unlawful and punishable under their penal code while Nigeria, has national laws domesticated at state level, for offenders. Similarly, the health risk approach engages authoritative individuals such as doctors, nurses, midwives, and educators to deliver messages on the long and short-term medical complications of FGM. In Mali, PRIME II, a USAID-funded project (Newman & Nelson, 2003) developed and tested a national FGM curriculum, which was used to train 120 reproductive health care providers in Bamako Commune and in Bougouni and Koulikoro districts. The project demonstrated that the proportion of clients intending to have their daughters cut reduced significantly.

Across Africa, significant efforts have been made to educate and train circumcisers about the risk of FGM practice and provide them alternative sources of income. For example, in Ghana, circumcisers were trained to become traditional birth attendants. In Ethiopia, circumcisers were provided instruction in sandal-making and bread-baking (Armstrong, 1991). An assessment of this approach shows that although the income-earning activities addressed economic benefits of performing FGM, they did not address issues with the community recognition that accompanied the work of circumcisers. A study in Mali (Diop et al., 1998) particularly revealed that circumcisers who stopped performing FGM did so for two reasons; they were retiring due to old age and associated illness, replacing with their daughters or they had a promise of income from alternative activities. As conversion efforts for circumcisers do not influence demand for FGM practice, it is important that they are accompanied by extensive community-based awareness campaigns so community consensus can be reached to abandon the practice.

The alternate rites approach offers rites of passage into womanhood in line with tradition and culture, without cutting or FGM. Traditionally, the rites include introducing girls to their responsibilities, educating them on their roles as potential wives and mothers, and teaching them about sexuality. The alternate healthy initiation

celebrations, also called “circumcision without cutting” have been used as strategies in Kenya, Uganda and Gambia. In Kenya, none of the 5,000 girls who participated in the alternative rites was excised (Folsom, 2003). In Gambia, Foundation for Research on Women's Health, Productivity, and the Environment (BAFROW), through a project, developed alternative rites of passage for girls in 1996 which emphasized girl's health, rights as individuals, community responsibilities and religious education. Results showed that in the Niamina District, the number girls cut reduced from 92 girls in 1996 to 12 girls in 1997 during their initiation ceremonies. Also, the proportion of women who favored abolishment of the practice increased from 30% in 1996 to 78% in 1997, indicating an attitude change (ICRW & CEPDA, 1999). There is thus, substantial evidence (World Bank, 2004) that this approach is a good option when FGM is practiced as part of an initiation. However, it may not be effective in countries like Somalia where FGM is not seen as a rite of passage.

The positive deviance approach involves identifying individuals who have deviated from societal expectations of FGM by abandoning the practice. It then leverages these individuals to publicly declare their opposition to the practice, acting as strong advocates and role models. Between 1998 and 2001, Centre for Development and Population Activities (CEDPA) implemented some positive deviance programs in collaboration with local NGOs in Cairo, Egypt. During the programs, role models through their visit to parents of girls at the risk of being cut, persuaded at least 70% who declared they would not have their daughters cut (McCloud et al., 2003).

The comprehensive social development approach utilizes a guided process that involves learning and consensus-building to birth social change. This approach is heavily invested in stakeholders owning the process of challenging norms and co-creating change by raising concerns, promoting dialogue and learning. It is based on public discussion, dialogue, and the principle (Figuroa et al., 2002) of “people coming together to decide who they are, what they want, and how they will obtain what they want”. The Tostan International Program in Senegal has used this model. The program implemented a non-formal, participatory education program, which provided learners the skills and knowledge to be confident, resourceful actors and game changers in social transformation of their communities. It integrated FGM into the learning modules alongside other such as health, human rights and women's empowerment. Since inception in 1997, the Tostan program has enabled more than 1,500 communities in Senegal to make public declarations to abandon FGM, translating to 32% of the 5,000 communities that practice FGM in the Country (Diop et al., 2004).

## **2.2 Efforts to Eliminate FGM in Nigeria**

In Nigeria, a multi-disciplinary approach has been used to address the practice of FGM. This has been done through formation of legislative frameworks banning the practice, research, medical intervention (treatment of complications) for cut girls and women, sensitization (preventive messaging), mass mobilization and community action. In 1994, Nigeria joined other members at the 47<sup>th</sup> World Health Assembly to resolve to end FGM.

The Nigerian government established a multi-sectorial technical working group on Harmful Practices (HPs). To consolidate this, several studies, and national surveys on HP have been conducted. Other steps taken to respond to FGM in Nigeria include the launching of a regional plan of action, formulation of a National Policy and Plan of Action for the elimination of FGM in Nigeria which was approved by the Federal Executive Council for the elimination of FGM in Nigeria. The first policy in 2008 was not fully implemented and was replaced by a revised version spanning the years 2013-2017 and adopted by the National Council on Health. The revised version outlines response from government and civil society organisations to include; National Baseline Survey on Beneficial and Harmful Traditional Practices (1998), Best Practices on Elimination of FGM; The Nigerian Experience (2004), Community level education on the need to eliminate FGM, capacity building of stakeholders to sensitize on negative impact of the practice, Advocacy for legislation and treatment of FGM complications, intersectoral collaboration and integration of anti-FGM programs in relevant sectors, anti-FGM legislation at state levels.

In 2018, the policy version spanning 2013-2017 was revised (WHO, 2019). The new policy, which spans 2021-2025, has mapped roles for health workers, health regulatory bodies, professional health associations (like SOGON), CSOs and other stakeholders working to end FGM in Nigeria. The new policy also highlights specific strategies which include sensitization and awareness creation, capacity building of health workers and set up of surveillance system to detect medicalization of the practice (WHO, 2019). The Violence Against Persons Prohibition (VAPP) law already prescribes sanctions for persons implicated in FGM and its medicalization.

#### **Other Key events in the Movement to end FGM Nigeria:**

- 1993 - Nigeria ratifies the Convention on the Elimination of Discrimination Against Women-CEDAW.
- 1994 - resolution to end FGM at the 47th World Health Assembly. The Federal Government responded by establishing Multi Sectorial technical working group on harmful traditional practices (HTP), commissioned studies and national surveys.
- 1995 - Fourth World Conference on Women in Beijing (International Event). FGM is seen as a human rights issue.
- 1998 - Federal Government launches the National Baseline survey on the Benefits and Harm of Traditional Practices.
- 2002 - Federal Ministry of Health (in the absence of a federal law) approves and launches the National Plan of Action on Elimination of Female Genital Mutilation in Nigeria and Launch of the National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria.
- 2004 - Nigeria ratifies the Protocol to the African Charter on Human and Peoples' Rights (Rights of Women in Africa) popularly referred to as the Maputo Protocol

- 2011 - The Violence Against Persons Prohibition (VAPP) Bill is introduced to the National Assembly.
- 2012 - The 69th Session of the United Nations General Assembly unanimously pass the anti FGM Resolution [A/RES/67/146] calling on member states to intensify global efforts to eliminate FGM. The entire Africa Group (including Nigeria) sponsored the resolution.
- 2013 - Nigeria National Demographic and Health Survey (NDHS) provides updated information about the prevalence of FGM. Launch of the National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria.
- 2015 - Federal Government signs into law the Violence Against Persons (Prohibition) Act. Among other issues, the law bans FGM in Nigeria at a higher level.

The UNFPA-UNICEF Joint Programme for the elimination of FGM with UNFPA as the global lead, co-ordinates the largest interventions on FGM in Nigeria. Nigeria became part of the UNJP in 2014, partnering with Federal ministries and state-level departments in Ebonyi, Ekiti, Imo, Lagos, Osun and Oyo. The UNJP is a consortium programme of UNFPA and UNICEF committed to achieving abandonment of FGM. The UNJP is intended to be strategic and catalytic; holistic; based on a theoretical understanding of FGM as a social norm; human rights-based and culturally sensitive—preserving positive cultural values whilst working to eliminate harmful practices. The design of the programme acknowledges that ending FGM is a long-term objective. For this reason, the program was unveiled in phases. The program, which was developed in 2007, had its Phase I operationalized between 2008-2013 while phase II was operationalized between 2014-2017. A critical achievement of the phase II in Nigeria is the signing of the VAPP act into law which bans FGM practice. Nigeria is currently implementing phase III of the program.

### **The Phase III Vision**

The vision for Phase III of the Joint Programme is to contribute to the SDG target of eliminating FGM by 2030. The goal of the Joint Programme is to accelerate efforts towards the reduction of FGM, fulfilling the rights of girls and women by realizing social and gender norms transformation by 2021.

### **Theory of Change**

The Joint Programme's hypothesis is that; If policies and legislation are in place and appropriately resourced for the elimination of FGM, and women and girls at risk of and affected by FGM access comprehensive services, and individuals, families and communities accept the norm of keeping girls intact (i.e., not subjected to FGM), then there will be elimination of FGM at the household, community, and society levels by 2030 (UNICEF & UNFPA, 2017).

The joint program is providing crosscutting interventions to enhance effectiveness in many ways as follows.

- Strengthen the enabling environment by holding governments accountable for the development of policies and legislation, and for ensuring adequate resources to end FGM.
- Scale up the amplification of social norms change interventions that support expanding collective knowledge and strengthening champions for the elimination of FGM using a broad range of interpersonal and innovative mass/social media communications strategies.
- Address gender norms in support of gender equality and girls' and women's rights.
- Expand youth engagement to harness the strengths and advantages of demographic growth and empower them to drive the end of FGM in their communities and countries.
- Address the trend of medicalization by galvanizing health professionals to champion the end of FGM as a human rights violation; and

Establish a global knowledge hub for the measurement and dissemination of social norms and good practices captured by the Joint Programme for policymaking and improved programming.

# PHOTO GALLERY



# PHOTO GALLERY



## 3.0 EPIDEMIOLOGICAL ANALYSIS OF FGM IN NIGERIA

### 3.1 Brief description of available data on FGM in Nigeria

To develop effective and synchronized interventions for the abandonment of FGM in Nigeria, accurate and timely data is needed. The availability of nationally representative data is critical to understanding the FGM situation and designing effective interventions in Nigeria. Two national surveys provide prevalence data on FGM in Nigeria: the NDHS and the MICS. Female Genital Mutilation was an important issue in international discourse prior to the publication of the first data national data in Nigeria in 1999. Prior to the 1999 NDHS, (i.e., the second national demographic and health survey for the country after the premier survey of 1990), there was dearth of data on the prevalence of FGM in Nigeria.

The NDHS collected data from all women participating in the 1999 survey about their circumcision status (age at circumcision, type of circumcision, person who performed the circumcision, circumcision status of their daughters, perception about continuation of the practice). This survey has continued to collect repeated cross sectional FGM data thus contributing to critical decision making around interventions, policy, and practice. There are, however, nuances in the structure of data collection for NDHS, for example the 1999 NDHS obtained circumcision data from married women and inadvertently excluded women who reported that they never had sexual intercourse at the time of survey. Women who had daughters were asked the same series of questions about their eldest daughter. In subsequent survey years of 2003, 2008, 2013 and 2018, the scope was expanded to cover topics including knowledge, prevalence, and types of FGM conducted on women and girls; age at circumcision; person who performed the circumcision; perceived benefits of circumcision and attitudes towards the practice.

Apart from NDHS, the Multiple Indicators Cluster Survey [MICS] also collects FGM data. The first MICS Nigeria data was published in 1995, but only focused on health issues relating to maternal mortality, child health, breast feeding, prevalence, and treatment of illnesses such as malaria, diarrhoea, etc. Since 2007, MICS has continued to report information on the practice at the national level in Nigeria till date (2016 -17). The NDHS and MICS datasets have remained the most accessible and available datasets over the years on prevalence of the practice at the national level, geopolitical zones and across the states in Nigeria. This situation analysis examines available NDHS and MICS data from 1999 -2018 for ages 0-14 and 15- 49 years. FGM data on women aged 15-49 years

was from self-report and FGM information about girls aged 0-14 years was obtained from their mothers (NBS & UNICEF, 2017; NPC and ICF., 2019).

### 3.2 FGM prevalence by demographic indices and patterns across states and zones

The prevalence and practice of FGM varies significantly across states, political regions, and ethnic groups in Nigeria (National Population Commission, 2019). This is mostly because the Nigerian context varies with respect to unique norms, culture, and beliefs. These beliefs and norms are further driven by factors such as residence, perception about religious validation of the practice, education level, religion, and age among others. In this section, data from FGM is drawn from NDHS and MICS and prevalence of the practice is expressed by different demographics including age, region, residence, education, wealth, types, and support for FGM.

#### 3.2.1 Overall prevalence of FGM

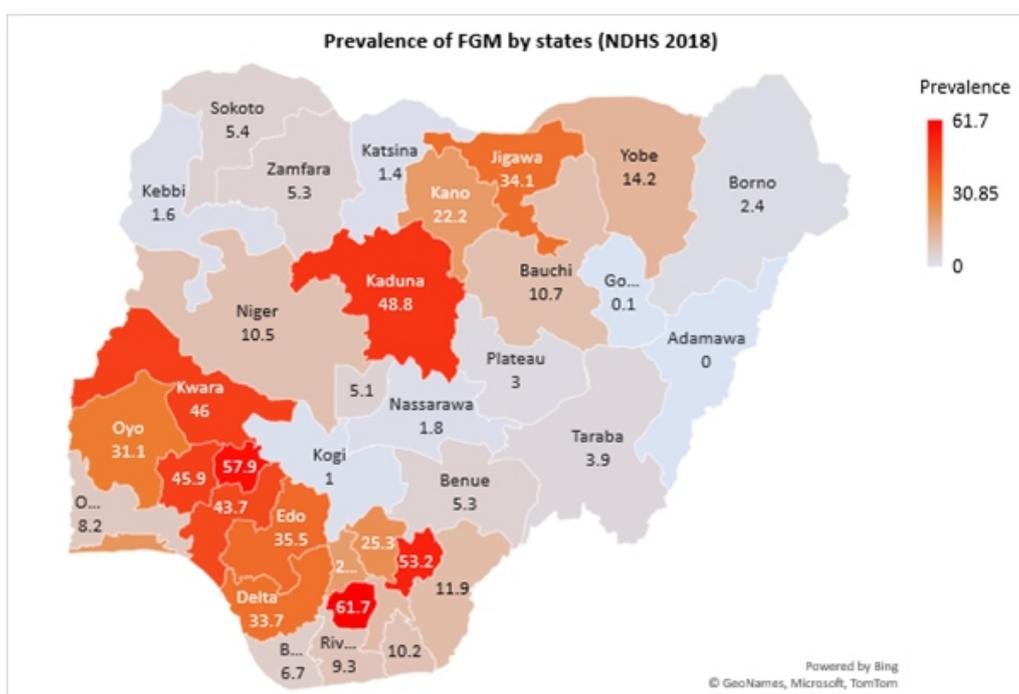


Figure 2: Map showing the state level prevalence of FGM among women in Nigeria (NDHS 2018)

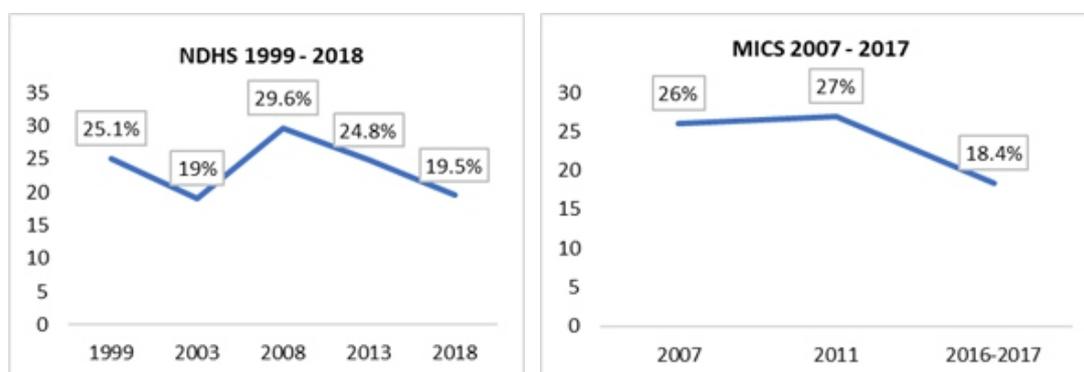


Figure 3: FGM Prevalence among women age 15 - 49 years (NDHS 1999-2018 & MICS 2007 - 2017)

The FGM prevalence among women aged 15 - 49 years is shown in Figure 3. According to the 2018 NDHS, there has been a decline in the burden of FGM from 1999 to 2018 among women aged 15-49 years. The data shows that the prevalence of the practice was highest in 2008 at 29.6% and lowest in 2003 at 19%. However, there has been a marked decrease from 29.6% in 2008 to 19.5% in 2018. This assertion is buttressed by the MICS. The MICS of 2007 -2017 also shows a decrease in the burden of FGM with the highest prevalence recorded in 2011 at 27% and lowest in 2016-17 at 18.4%. These estimates are in line with assertions that FGM is declining in Nigeria (Justice Department, 2019; Shell-Duncan et al., 2016). This could be as a result of laws and policies targeted at FGM such as the VAPP Act (2015) (28TooMany, 2018a; FGN, 2015), the National Policy and Plan of Action for the Elimination of FGM ((2014-2017), and series of social change interventions(Jensen et al., 2018)(The Girl Generation, 2018) focused on the abandonment of FGM.

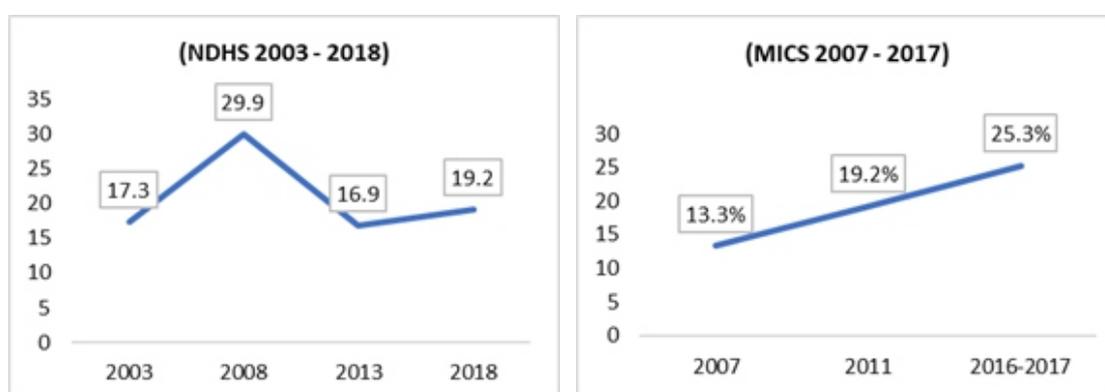


Figure 4: Prevalence among girls aged 0 - 14 (NDHS 2013-2018 & MICS 2007 - 2017)

In contrast to the trend among women aged 15 – 49 years, NDHS shows that prevalence among girls is on the increase (Figure 4). Despite a decrease from 29.9% in 2008 to 16.9% in 2013, FGM prevalence among girls has increased to 19.2% in 2018. Data from the MICS also shows the increasing burden of FGM among girls. The prevalence among girls was 13.3% in 2007 and has increased to 25.3% in 2017. Prevalence among girls reflects the most recent FGM evidence. The increase in the burden suggests the continuation of the practice despite the slow decrease in the practice among women.

### 3.2.2 Prevalence by age groups

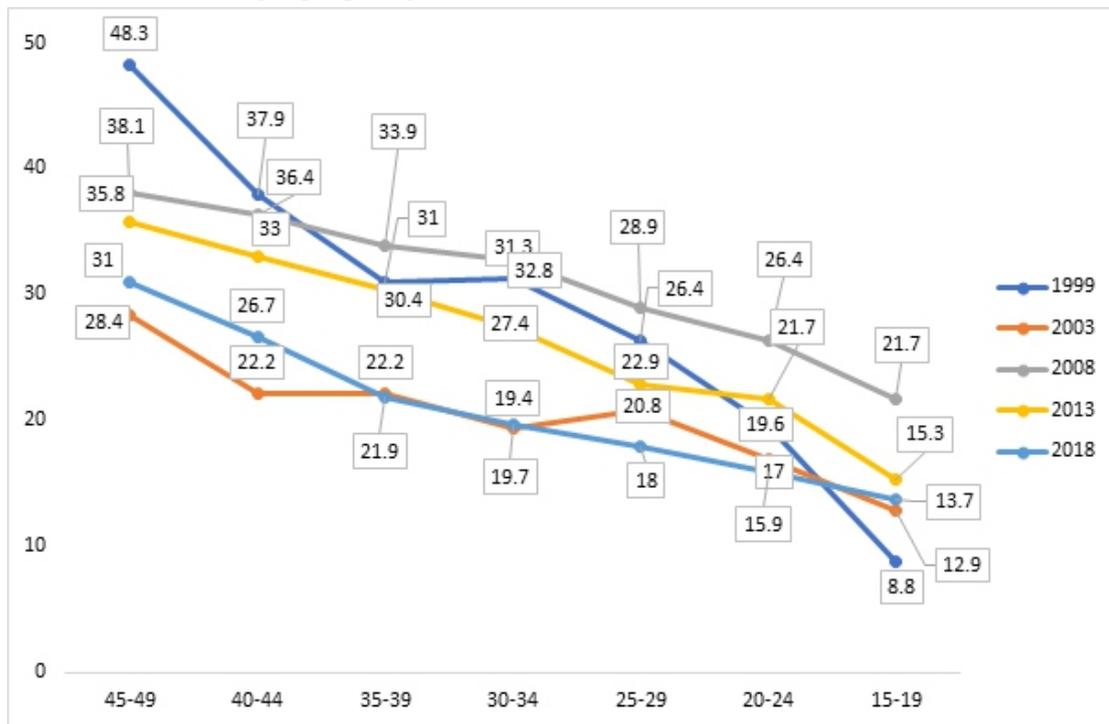


Figure 5: Prevalence of FGM among women age 15 - 49 years by age group (NDHS 1999 - 2018)

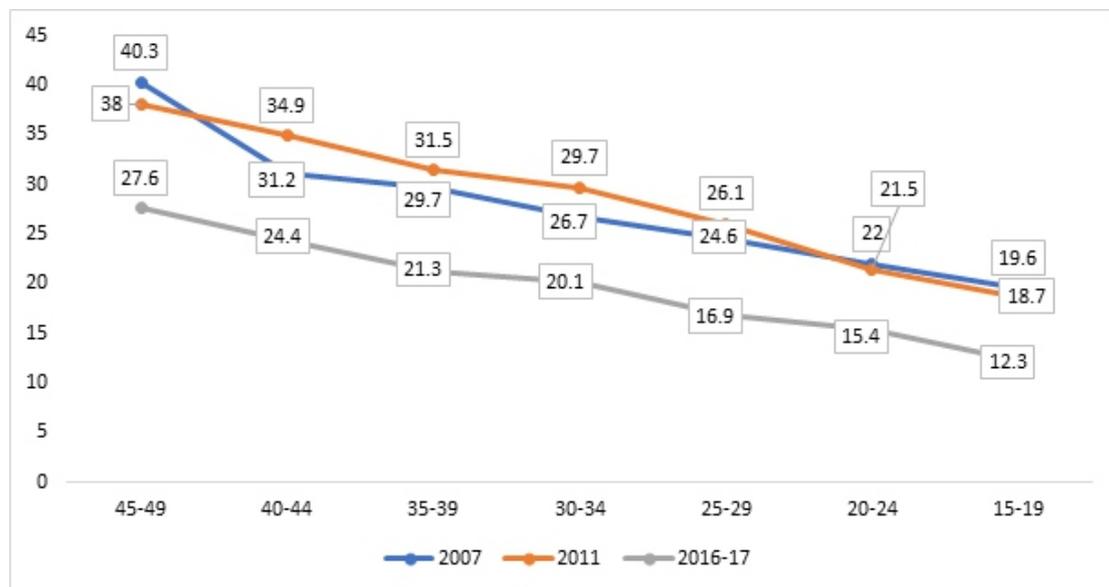


Figure 6: Prevalence of FGM among women aged 15 - 49 years by age group (MICS 2007 - 2017)

A better description of the slow decline of FGM among women in Nigeria can be achieved using the method suggested by Shell-Duncan et al. (2016) in the state-of-the-art synthesis on FGM. This approach compares differences between the youngest (15-19) and oldest (45-49) age cohorts, as this gives a clearer indication of recent changes that have occurred among the younger cohort. The comparison between both age cohorts using the NDHS shows that the FGM prevalence was highest among women aged 45 – 49 years. For this age group, the highest proportion was recorded in 1999 (48.3%) and lowest in 2003 (28.4%) as shown in Figure 5. It has continued to drop from 2008 (38.1%) to 2018 (31%). The 15-19 years cohort shows an increase between 1999 (8.8%) and 2008 (21.7%) and has dropped since then to 13.7% in 2018. Prevalence in 2018 among 15-19 years (13.7%) is considerably lower than that of the 45-49 years cohort (31%) by 17.3%. The MICS shows a similar trend for women age 45 – 49 years. There has been a steady decrease from 2007 (40.3%) to 2017 (27.6%). The downward trend is in line with the decrease in overall prevalence across the years. Over the years, women exit the age group and since prevalence is already dropping, it affects the proportion of women entering the group. The practice was rampant during their timing of the age group 45-49 years and interventions have since driven the practice down. This also agrees with the argument of Shell-Duncan et al. that Nigeria has witnessed a steady long-term decline in FGM prevalence (Shell-Duncan et al., 2016).

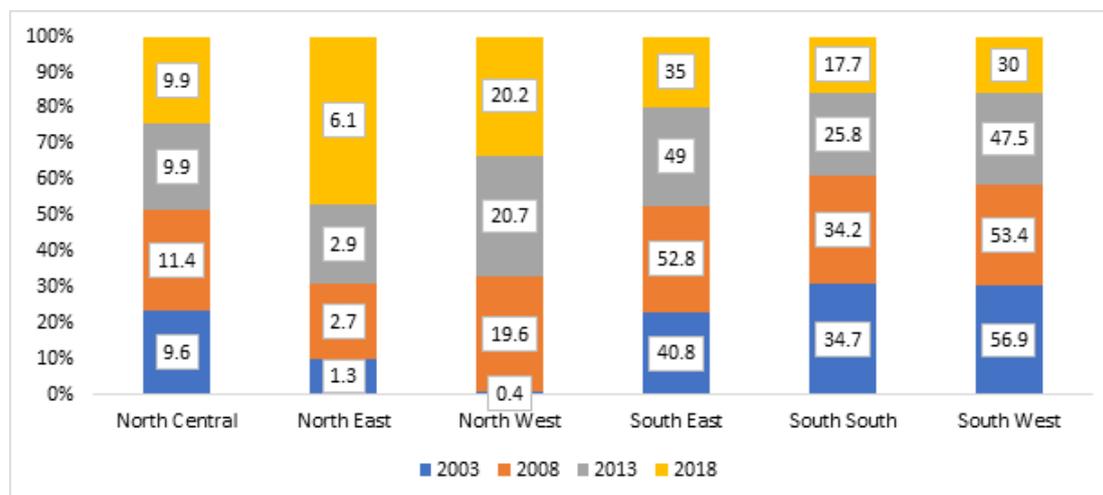
### 3.2.3 Rural-urban Spread



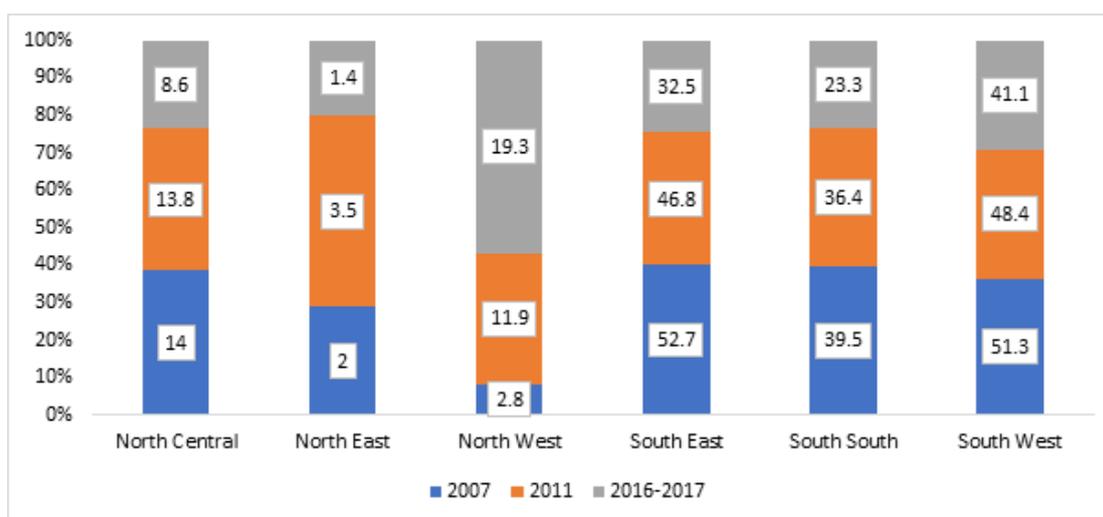
Figure 7: FGM Prevalence among women aged 15-49 years by residence (NDHS 1999 - 2018 & MICS 2007 - 2017)

Prevalence was categorized by residence and presented in Figure 7. Data from NDHS and MICS showed that women who have been cut are domiciled more in urban areas of the country compared to rural areas. It has been suggested that this spread is a result of massive rural-urban drift taking place in most parts of the country (Epundu UU et al., 2018). However, the prevalence by residence does not necessarily indicate where FGM was carried out. It is possible that migration occurred after FGM was conducted due to factors such as marriage, conflict or work (Justice Department, 2019).

### 3.2.4 Prevalence by region



**Figure 8: FGM Prevalence by region (NDHS 2003 - 2018)**

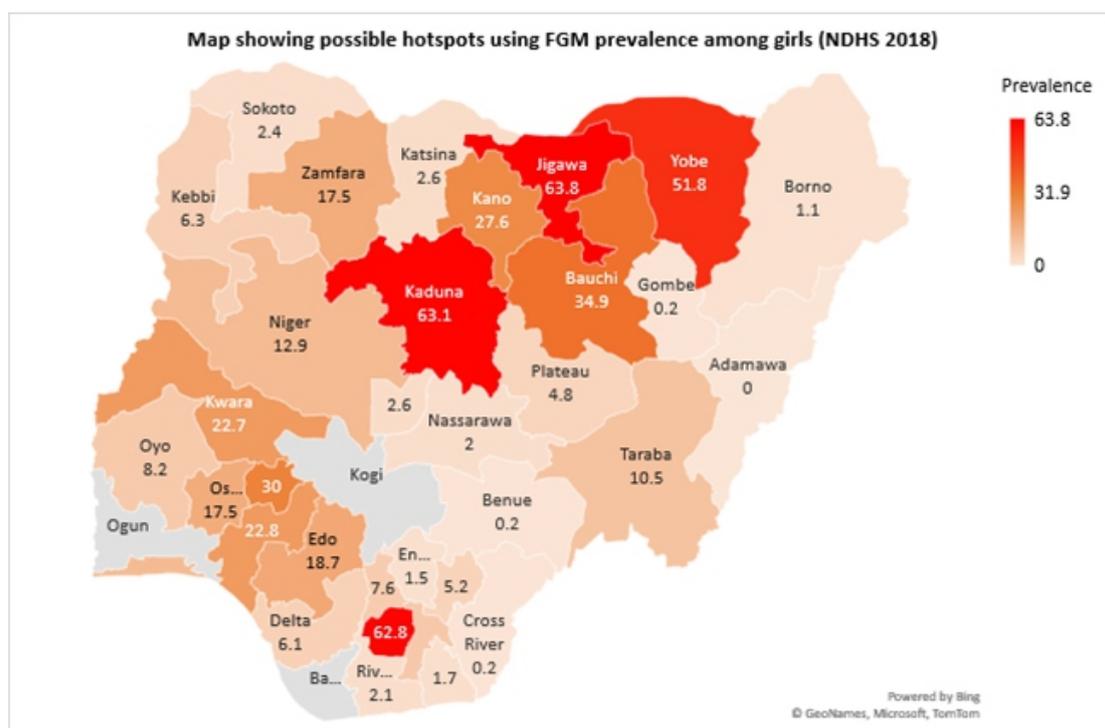


**Figure 9: FGM Prevalence by region (MICS 2007 - 2017)**

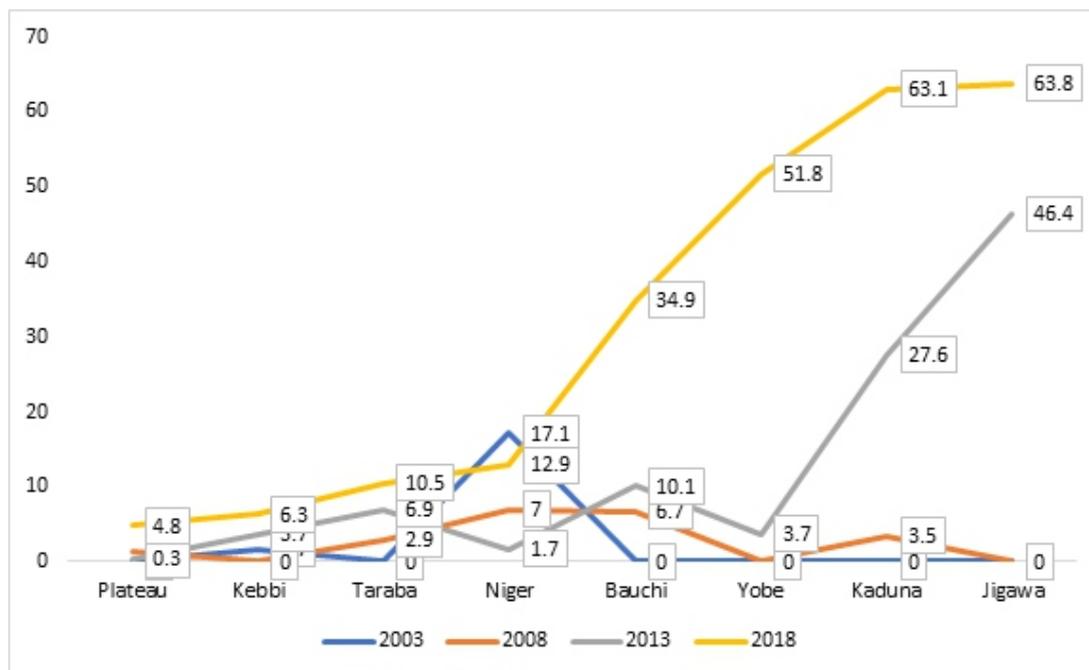
According to NDHS, the prevalence of FGM distributed by region show the decline of the practice over the years in the southern region of the country. For example, the South Eastern region remains the region with the highest burden of FGM at 35% in 2018. However, there was a decline from 52.8% in 2008. NDHS data shows that the prevalence of FGM in the South Western region has reduced from 56.9% in 2003 to 30% in 2018. Similarly, for the South-South region, prevalence reduced from 34.7% in 2003 to 17.7% in 2018. In the Northern Region of the country, the burden of FGM has either remained the same or increased slightly. The prevalence of FGM in the North West increased from 0.4% in 2003 to 20.7% in 2013 before dropping minimally to 20.2% in 2018 as shown in Figure 8. For the North-Eastern region, the prevalence has increased steadily from 1.3% in 2003 to 6.1% in 2018. Finally, the prevalence in the North Central region of the country has remained at 9.9% in 2018.

The data from the MICS shows the same pattern for the Southern region of the country where data there has been a marked decline. However, unlike NDHS that puts the South East as the most prevalent region at 35%, the MICS show that the South West has the highest FGM prevalence at 41.1%. For the Northern region, the MICS also differs from the NDHS. For example, the MICS shows a sharp increase in prevalence from 11.9% in 2011 to 19.3% in 2017 for the North Western Region while there was a decrease for the North Eastern and North Central regions.

### 3.2.5 Possible hotspots



**Figure 10: New hotspots of FGM shown with data from FGM prevalence among girls by region (NDHS 2018)**

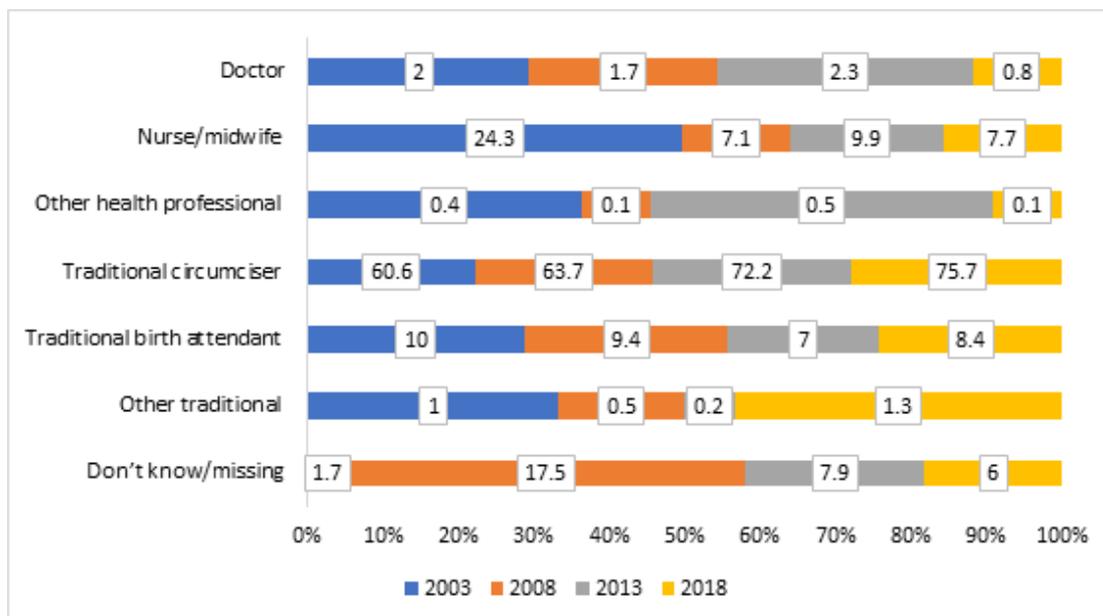


**Figure 11: Possible new hotspots for FGM (NDHS 2013 - 2018)**

A closer look at data from NDHS (2013-2018) on FGM among girls reveals a significant increase in states such as Bauchi (10.1% in 2013 to 34.9% in 2018), Yobe (3.7% in 2013 to 51.8% in 2018), Kaduna (27.6% in 2013 to 63.1% in 2018), and Jigawa (46.4% in 2013 to 63.8% in 2018). Additionally, the map in Figure 10 portrays this shift from a slight burden of FGM in the Southern region to the heavy burden in the Northern region.

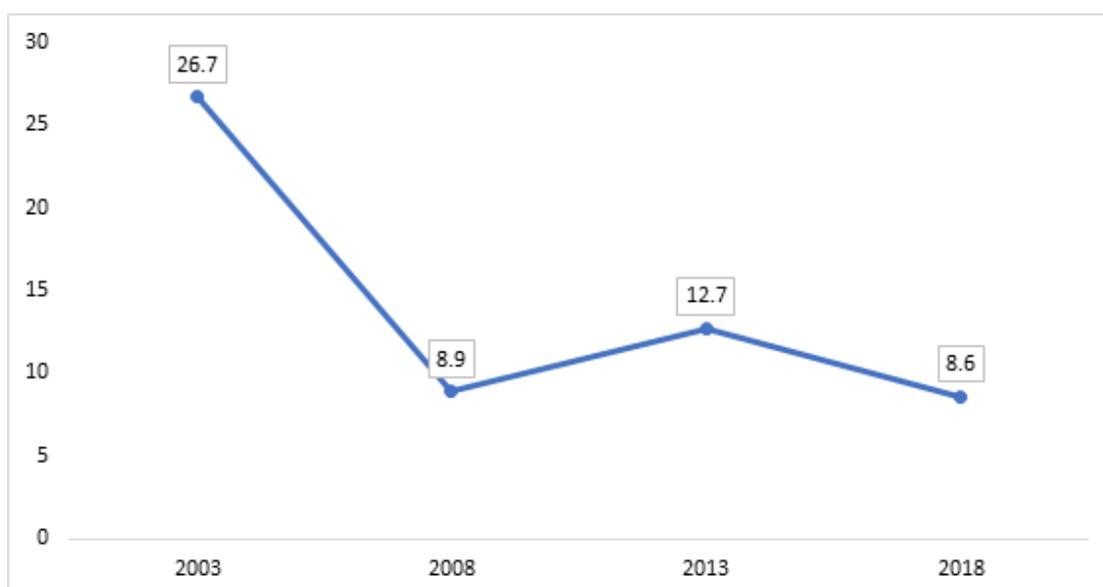
The disparity in findings across regions could be a result of the varying levels of interventions over the past decade. For example, the UN Joint Programme on FGM has largely focused intervention efforts on selected prevalent states in the Southern Region of Nigeria. Similarly, other efforts such as The Girl Generation movement led by Options UK and government campaigns have focused more on the Southern region and may have contributed to the steady decline in that region. In contrast, the surveys show that the North-Western region of the country might be a new hotspot for the practice. The data reveals a steady increase across the years for this region compared to others. This argument is in agreement with the findings of Ngianga-Bakwin et al. (2020) that showed declines in FGM in the Southern Region and a significant increase in the Northern part of the country especially the North Western Region (Kandala, Chibuzor, et al., 2020). The increase in the North could also be because of better data collection methods during recent surveys compared to previous years or the lack of interventions to address the practice in this region.

### 3.2.6 Persons who performed the cutting



**Figure 12: Person who performed the cutting (NDHS 2003 - 2018)**

The major providers of FGM services continue to be traditional circumcisers. The chart in Figure 12 shows a continued increase in the proportion of FGM done by traditional circumcisers from 2003 (60.6%) to 2018 (75.7%). The proportion of FGM done by traditional birth attendants reduced from 10% in 2003 to 7% in 2013. This has since increased to 8.4% in 2018. In contrast, the proportion of FGM performed by trained health workers also known as medicalization continues to reduce compared to traditional methods.

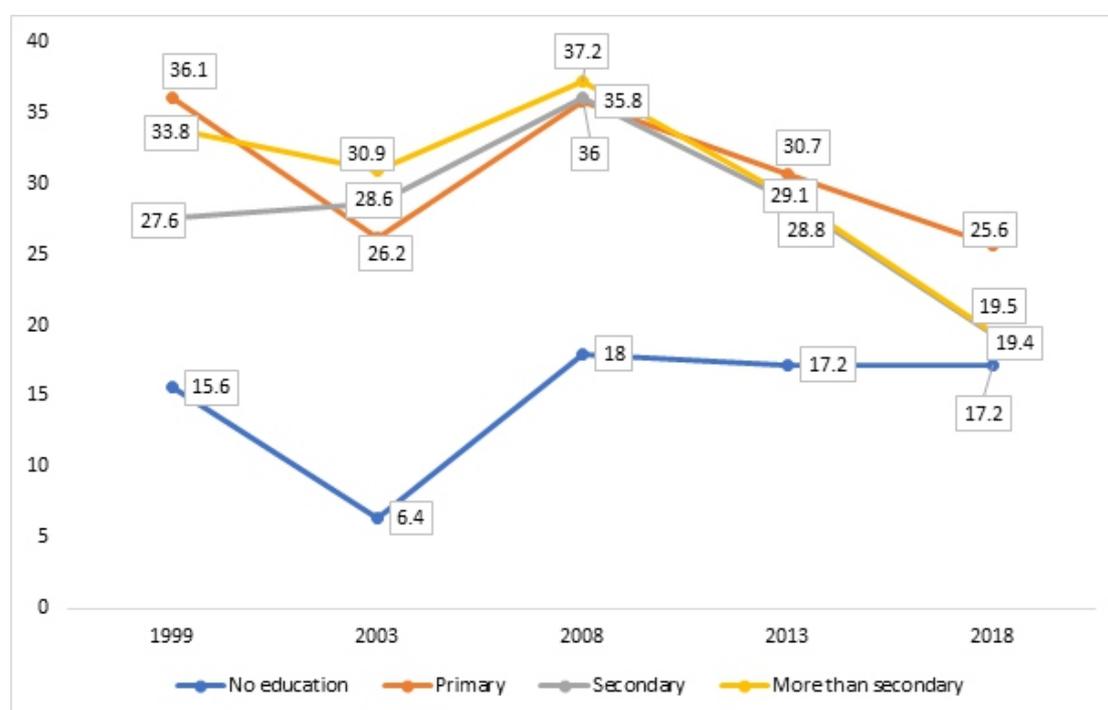


**Figure 13: Medicalization of FGM (NDHS 2003 - 2018)**

Medicalization is defined by the World Health Organization as a “situation in which FGM is practised by any category of health-care provider, whether in a public or private clinic, at home, or elsewhere” (WHO, 2010). In Nigeria, although the overall contribution is reducing, the proportion of medicalization continues to be substantial. Though the proportion of FGM performed by Nurses/Midwives has reduced from 24.3% in 2003 to 7.7% in 2018, they continue to contribute the highest proportion to medicalization. Medicalization overall, has also reduced from 26.7% in 2003 to 8.6% in 2018 and this includes a 4.1% reduction between 2013 to 2018 as shown in Figure 13. It could be argued that the decrease in the medicalization of FGM has seen women take up traditional means of cutting as evidenced by the increased proportion of FGM performed by Traditional Circumcisers. Performance of FGM by health workers was mostly because they shared the same beliefs as their community members, on its supposed benefits and perceived approval (or lack of disapproval) by their professional peers (Obianwu et al., 2018). A study among health workers found that the reasons why HCWs practiced FGM were: were cultural (83.3%), financial gain (50%), and preventing patients from going to traditional cutters (25%) (Onuh et al., 2006).

Reduction in medicalization could be because of improved awareness of laws and policies on FGM among health workers, health system-related interventions, value clarifications among health professional organizations and documented opposition to medicalization of FGM and training of health workers on FGM prevention by SOGON in 2015 (SOGON, 2015).

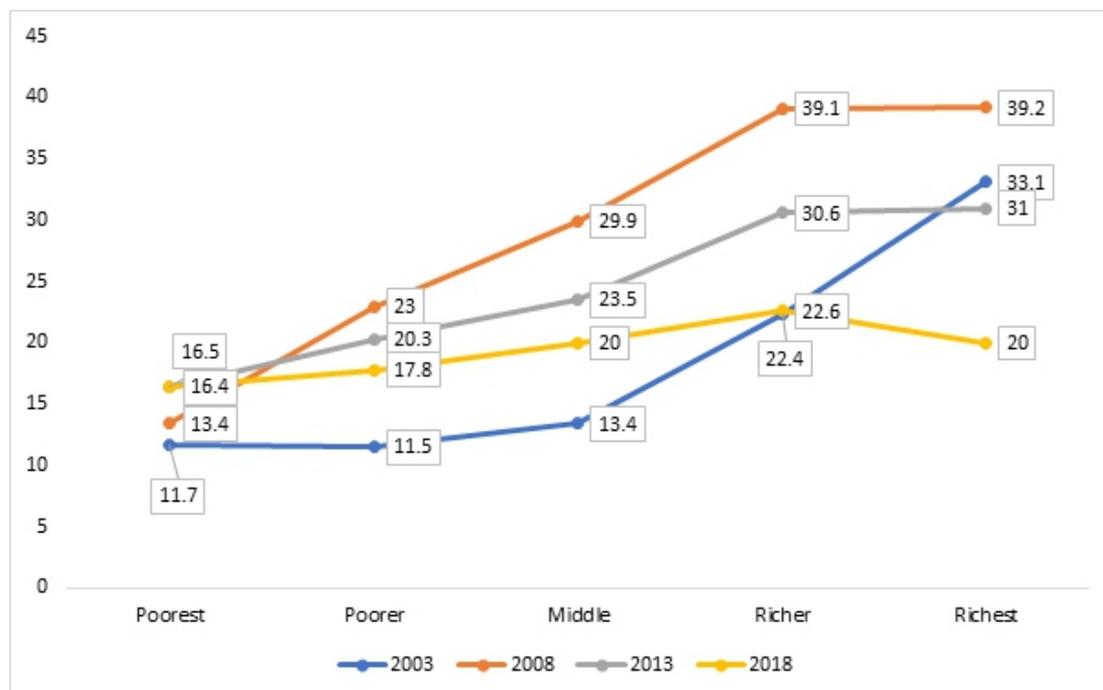
### 3.2.7 Prevalence by education



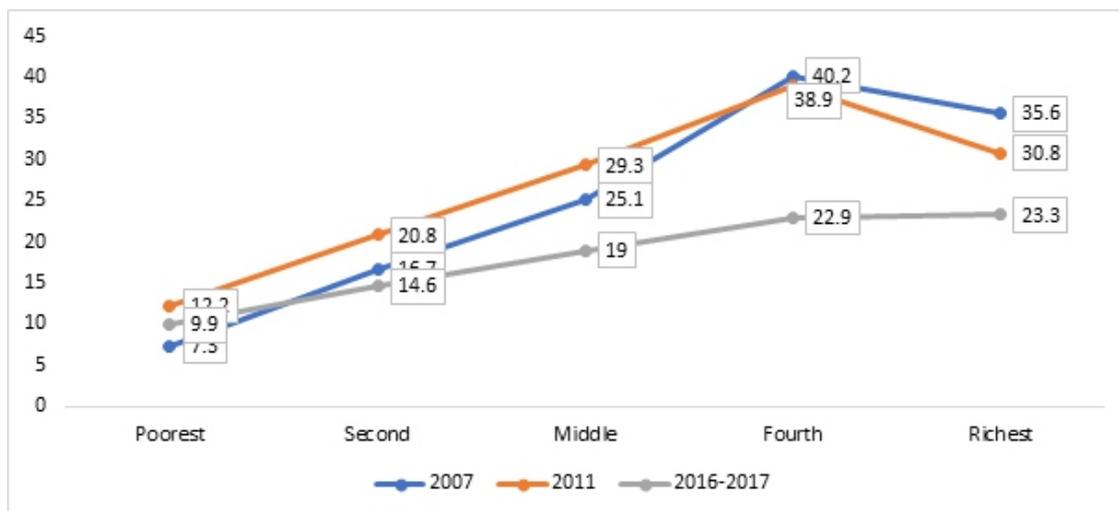
**Figure 14: Prevalence of FGM among Women by level of education (NDHS 1999 - 2018)**

The NDHS revealed the prevalence of FGM among women by level of education. Overall, there has been a steady decline in prevalence among women with primary, secondary, and higher education from 2008 to 2018. Despite the decline, the burden is more among women with secondary education (37.2%) compared to others. In contrast to other categories, the prevalence among women with no education has remained the same at 27.2% between 2013 and 2018. Studies have suggested that high levels of education could be responsible for reducing the burden of FGM (Kandala, Chibuzor, et al., 2020; Rawat, 2017). This is not surprising as education improves the socio-economic status of women over time (Jackson, 2009), independence and ability to make informed decisions over their wellbeing and that of their family (World Bank, 2020; Zwane, 2017). It is therefore expected that more educated women will make use of anti-FGM information provided during interventions and in the process abandon the practice.

### 3.2.8 Prevalence of FGM by Wealth Status

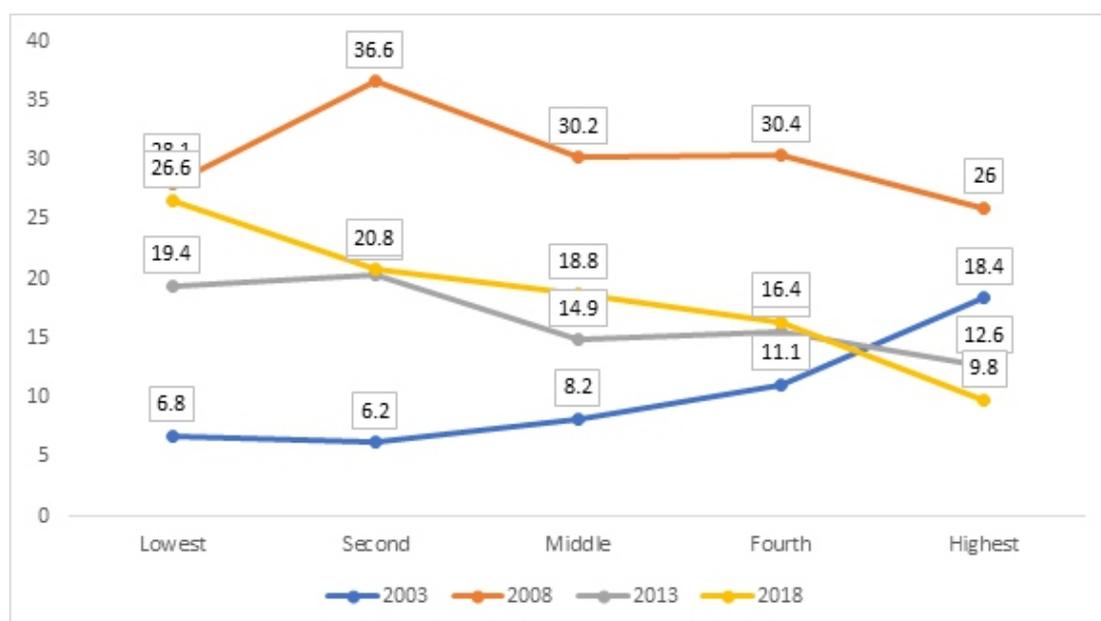


**Figure 15: Prevalence of FGM among Women by Wealth (NDHS 2003 - 2018)**



**Figure 16: Prevalence of FGM among Women by Wealth (MICS 2007 - 2017)**

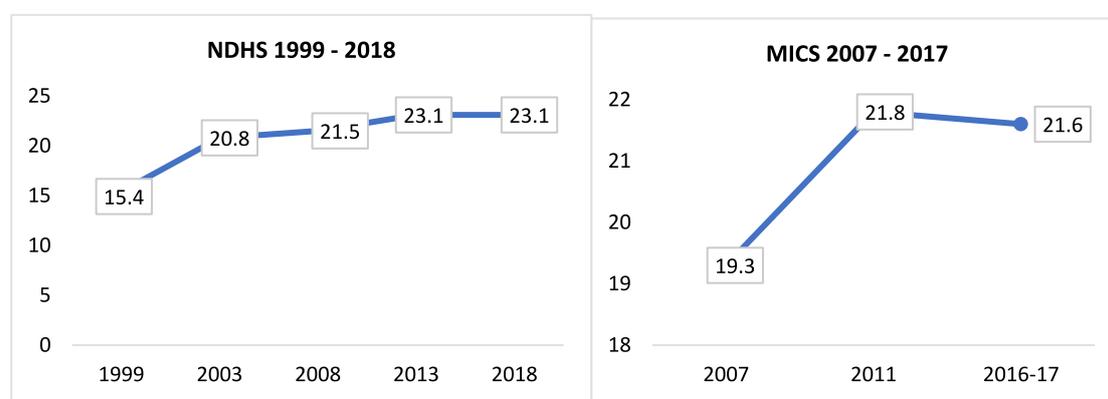
The data from NDHS and MICS from 2003 to 2018 shows FGM prevalence is higher among those with higher wealth status. For example, the NDHS shows that 42.6% of the prevalence of FGM in 2018 was among the aforementioned categories compared to the 23.2% recorded among women who were considered poorer and poorest. The decline in the FGM prevalence among women is also reflected in the trend as it relates to wealth across the reporting years. According to the NDHS, the prevalence of FGM has reduced from 2008 (39.2%) to 2018 among those with higher wealth status (20%). This was similar for data sourced from the MICS where 35.6% was reported among the richest in 2007 and 23.3% in 2017.



**Figure 17: Prevalence of FGM among girls by mother's wealth status (NDHS 2003 - 2018)**

For FGM prevalence among girls, data from NDHS shows a contrasting picture compared to the prevalence among mothers. Higher FGM prevalence was found among girls whose mothers were poor (lowest and second categories) from 2003 to 2018 as shown in Figure 17. This means women who are poor are more likely to cut their daughters. This is supported by a recent study on socio-economic and demographic determinants of female genital mutilation in sub-Saharan Africa where the authors found that women with the richest wealth quintile and their daughters less likely to undergo FGM compared to those with the poorest wealth quintile (Ahinkorah et al., 2020). This also agrees with what has been documented in literature that wealth is associated with a decreased risk of FGM (Andro & Lesclingand, 2016).

### 3.2.9 Support for FGM



**Figure 18: Opinion of women on whether FGM should continue (NDHS & MICS)**

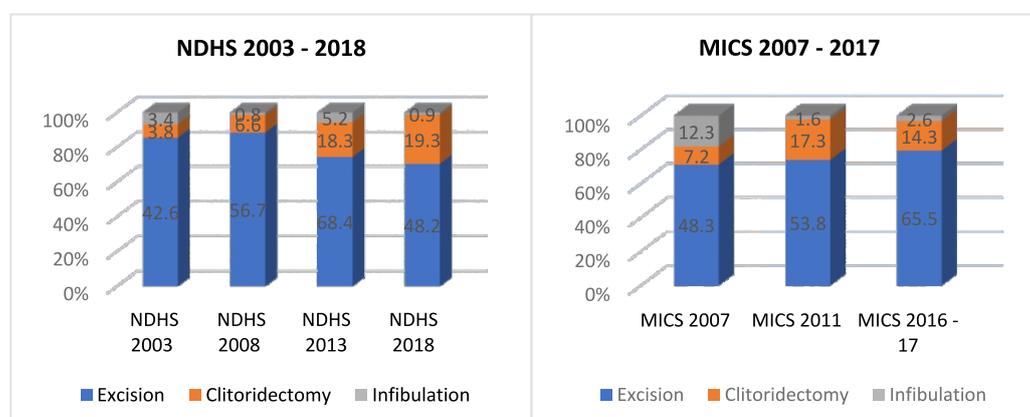
Figure 18 presents the trends in the opinion of women on whether FGM should continue. The NDHS shows a steady increase in the proportion of women who think that FGM should continue. This proportion increases steadily from 15.4% in 1999 to 23.1% in 2013 and stayed the same. This is similar to findings from MICS. The MICS shows that 19.3% of women believed the practice should continue, and this has grown minimally to 21.6% in 2017. Table 1 shows a marginal increase in support for the discontinuation of FGM.

**Table 1: Levels and Trends in the Opinion of Women ages 15 -49 years regarding the Continuation or Discontinuation of FGM in Nigeria (2003–2018)**

	NDHS				MICS		
	2003	2008	2013	2018	2007	2011	2016-17
<b>Circumcision reduces premarital sex</b>							
No	58.2	81.7	-	-	-	-	-
Yes	16	18.3	-	-	-	-	-
Don't Know	25.8	-	-	-	-	-	-
<b>Female circumcision required by religion</b>							
No	59.9	56.9	67.5	77.9	-	-	-
Yes	26.9	27.2	21.5	17.4	-	-	-
No religion	-	-	5.2	4.7	-	-	-
Don't know	13.1	15.9	5.9	-	-	-	-
<b>Female circumcision should continue or stop</b>							
Continued	45.1	39.5	38.9	22.1	17.2	20.2	20.9
Stopped/Discontinued	43.7	45.5	52.9	69.2	64	67.3	69.1
Depends	4.8	7.1	6.1	7.4	8.1	8.2	6.7
Don't know	6.4	8	2.1	1.4	10.6	4.3	3.3

While substantial support for the practice in recent surveys is alarming, it is not unusual to see this proportion of women holding on to the practice despite the growing interventions to accelerate the abandonment of FGM. This could be because of the insufficient scale of FGM interventions in the country that makes it difficult to address social norms that continue to drive the practice. This is a gap to calls for continued interventions and scaling up of current efforts particularly to other hotspots of FGM. Substantial support for FGM reveals possible tendencies of women to cut their daughters (Kandala, Chibuzor, et al., 2020).

### 3.2.10 Patterns and types of FGM



**Figure 19: Trends and Patterns in the Types of FGM Practices in Nigeria (NDHS & MICS)**

Trends in the pattern of FGM practice in Nigeria shows that excision is the most common practice in Nigeria as shown by the findings from the NDHS and MICS surveys. The proportion of women and girls who have excisions done increased from 48.3% in 2007 (MICS dataset) and 42.6% in 2003 (NDHS dataset) to 65.5% in 2016-17 (MICS) and 68.4 in 2013 (NDHS). From the 2018 NDHS survey, about 48.2% of women reported they had this procedure performed on them.

Another common type of FGM performed on women/girls in Nigeria is “Clitoridectomy” which involves the nicking of the genital area without removing the flesh. The practice was not common as observed from the data in previous surveys (NDHS 2003 - only 3.8% had the procedure performed on them and MICS 2007 - 7.2%), but data from the recent surveys shows that it is becoming more popular. From the 2016 - 17 MICS survey, the clitoridectomy method of FGM was performed on about 14.3% of women, double the 2007 rate of 7.2% (i.e., approximately within a space of 10 years). While the NDHS data shows that, about 19.3% of women reported that they went through the clitoridectomy procedure which was found to be 5 times more than the rate of 3.8% who had the same experience in 2003.

The upward surge for clitoridectomy could mean a shift in the practice from the more severe type of excision to clitoridectomy. This shift suggests possible uptake of FGM information around the health impact of more severe forms of the practice and has seen communities start to lean towards a less invasive form. This phenomenon which has also been documented in Sudan (Bedri et al., 2019) is not necessarily a win as FGM of any form still has severe implications for women and girls. It also remains a contravention of their rights. It is important to further understand if this shift is moving towards abandonment or stabilising the FGM practice in the country.

### 3.2.11 Opinion on whether FGM is a religious requirement

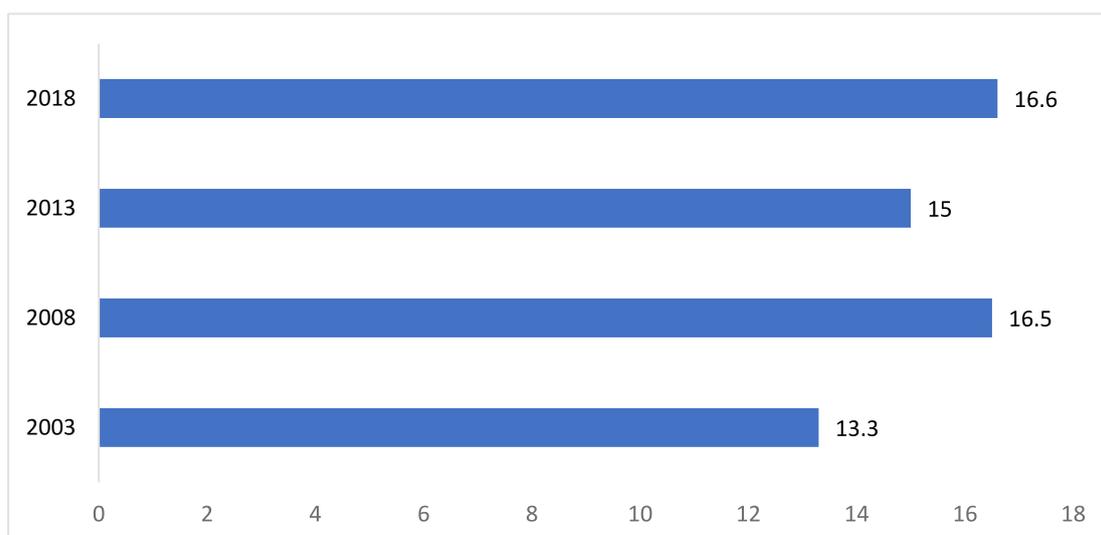


Figure 20: Whether FGM is a requirement for religion (NDHS 2003 - 2007)

Data from NDHS shows that 16.6% of women believe FGM is required by religion. This is a slight increase from 15% in 2013. This increase despite the gains earlier made (reduction from 16.5% in 2008 to 15% in 2013) may be a source of concern. This is because of the potential of this opinion to validate the practice. There is no known religious requirement for FGM (Althaus, 1997; Kandala, Komba, et al., 2020). For example, A 2019 study documented that religious leaders disagreed that Islam requires, encourages, permits, or discourages the practice. Additionally, the religious leaders generally agreed that most of the Islamic religious scripts about FGM are weak, and no clear and strong hadiths that encourage FGM (Ahmed et al., 2019). Ngianga-Bakwin et al. (2020) in their analyses of household data on FGM in Nigeria found religion to be significantly associated with FGM. They showed that apart from the results of the 2003 MICS, findings in subsequent surveys show that daughters of Muslim women are more likely to be cut than daughters of Christian women (Kandala, Komba, et al., 2020). An explanation for religion as a predictor for FGM in Nigeria could be because of the relationship that exists between religion and ethnicity. This claim is further buttressed by the assertion of Hayford and Trinitapoli (2011) who reported in their study on religious differences in female genital cutting that in countries such as Kenya and Nigeria, religious affiliation is closely linked to ethnic identity (Hayford & Trinitapoli, 2011).

### **3.3 The situation of FGM in the UN Joint Program on elimination of FGM implementing states**

#### **3.3.1 Summary**

This section shows selected analyses on the UN Joint Program on FGM implementing states. Generally, the prevalence of FGM has declined across the states owing to intense interventions from the UN and other FGM actors in Nigeria. NDHS data especially affirms this but also shows variations in the rates of decline. For example, the prevalence in Oyo state dropped by 34.6% between 2013 and 2018 while it only dropped by 6.3% in Imo state. This is also similar to the prevalence among girls that represents more recent data compared to the prevalence among women. The prevalence of FGM among girls dropped by 30.2% in Oyo State and has increased by 30.5% in Imo state between 2013 to 2018. This makes Imo state the state with the third-highest burden of FGM among girls behind the new hotspots: Jigawa and Kaduna. To further confirm this development, an estimated decline between the oldest age group of 45 – 49 years and the youngest age group of 15-19 years reveal more decline in Oyo state and least decline in Imo state. On attitude towards FGM, almost half of the women shared the belief that FGM should continue in Ekiti as of 2018 and almost the same proportion viewed FGM as a religious requirement in Ekiti state. A detailed explanation is provided below:

### 3.3.2 Prevalence of FGM among women (15-49) in the UNJP states (NDHS)

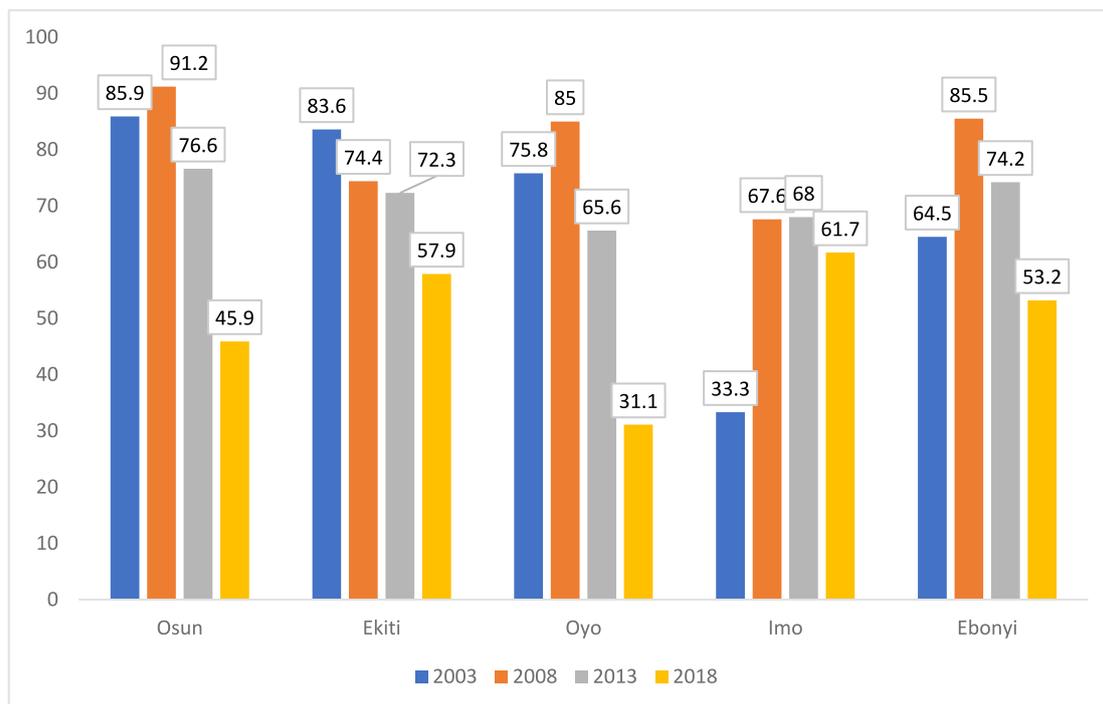


Figure 21: Prevalence of FGM among women in the UNJP States (NDHS 2003 - 2018)

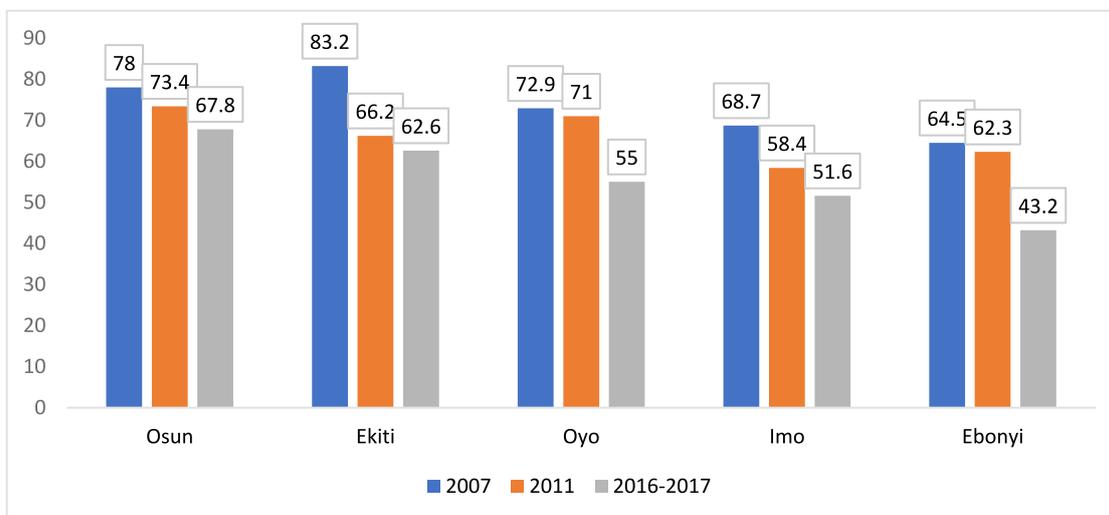
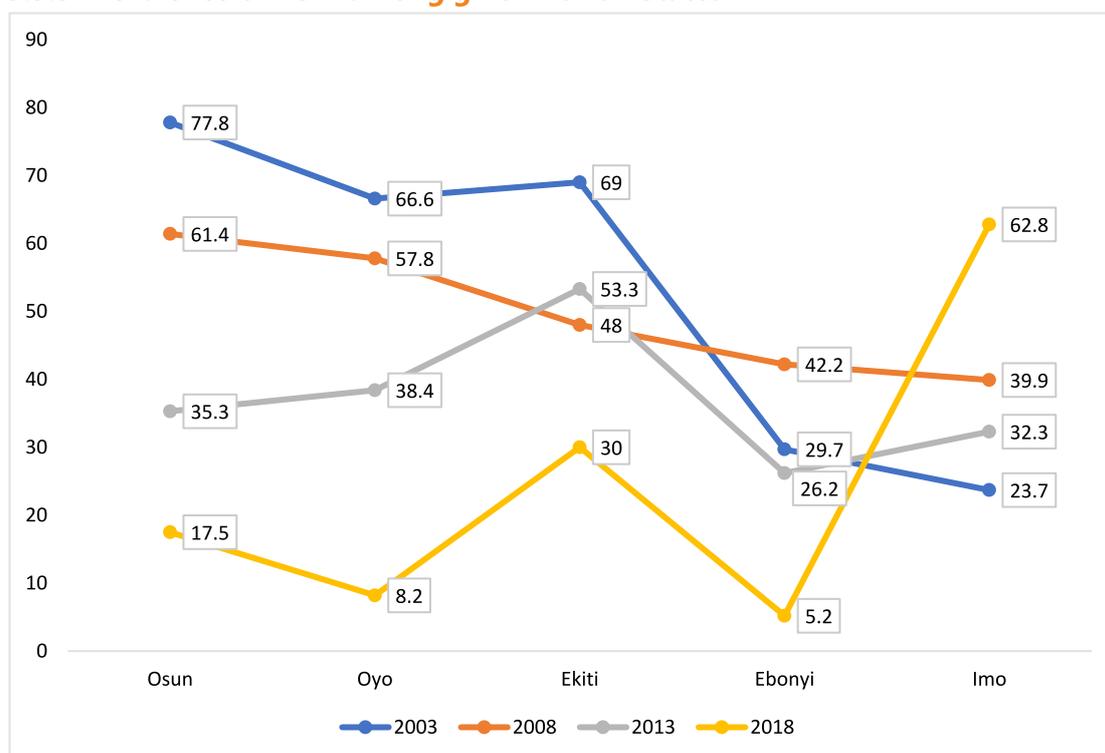


Figure 22: Prevalence of FGM among women in the UNJP States (MICS 2007 - 2017)

Figures 21 and 22 show the prevalence of women in UNJP states with data from the NDHS and MICS. Similar to the overall prevalence across the country, data from the NDHS shows a decrease across the 5 UN Joint Programme implementing states. Additionally, Oyo state performed better than the other states as prevalence dropped by up to 34.5%. In contrast, the prevalence in Imo state dropped by only 6.3%. Imo state currently has the highest FGM prevalence in the country at 61.7%. Reduction across the five states was also reflected in the MICS. In contrast to the NDHS however, Osun state currently has the highest prevalence at 67.8% having dropped by only 5.8% from the 2011 estimates. Prevalence among women in Ebonyi state on the other hand dropped sharply by 19.1% between 2011 and 2017. Intervention efforts have intensified in these states over the last couple of years with UNJP been the chief actor driving the various processes (UNJP, 2018). This could explain the reason why there was a major decrease in prevalence across the states. Despite these efforts, the burden of FGM is still very substantial and it is important more than ever to intensify efforts to further reduce and eventually abandon the practice.

### 3.3.3 Prevalence of FGM among girls in UNJP States



**Figure 23: Prevalence of FGM among girls in UNJP States (NDHS 2003 - 2018)**

Data from NDHS shows the prevalence among girls has dropped considerably in Osun, Oyo, Ekiti, and Ebonyi States. NDHS 2018 shows that prevalence is least in Ebonyi state at 5.2% and highest in Imo state at 62.8%. The data alludes to the fact that FGM prevalence among girls increased from 23.7% in 2003 to 39.9% in 2008. The prevalence dropped to 32.3% in 2013 and almost doubled to 62.8%. The prevalence among girls further reinforces the current situation in Imo State. As established previously, NDHS data showed that Imo State currently has the highest prevalence of FGM in the country

despite a slight decrease from 2013. In the same vein, Imo state currently has the third-highest prevalence of FGM among girls after Jigawa (63.8%) and Kaduna (63.1%). This affirms the fact that FGM is still going on in the state and at a very significant scale.

### 3.3.4 Prevalence by age group in UNJP states

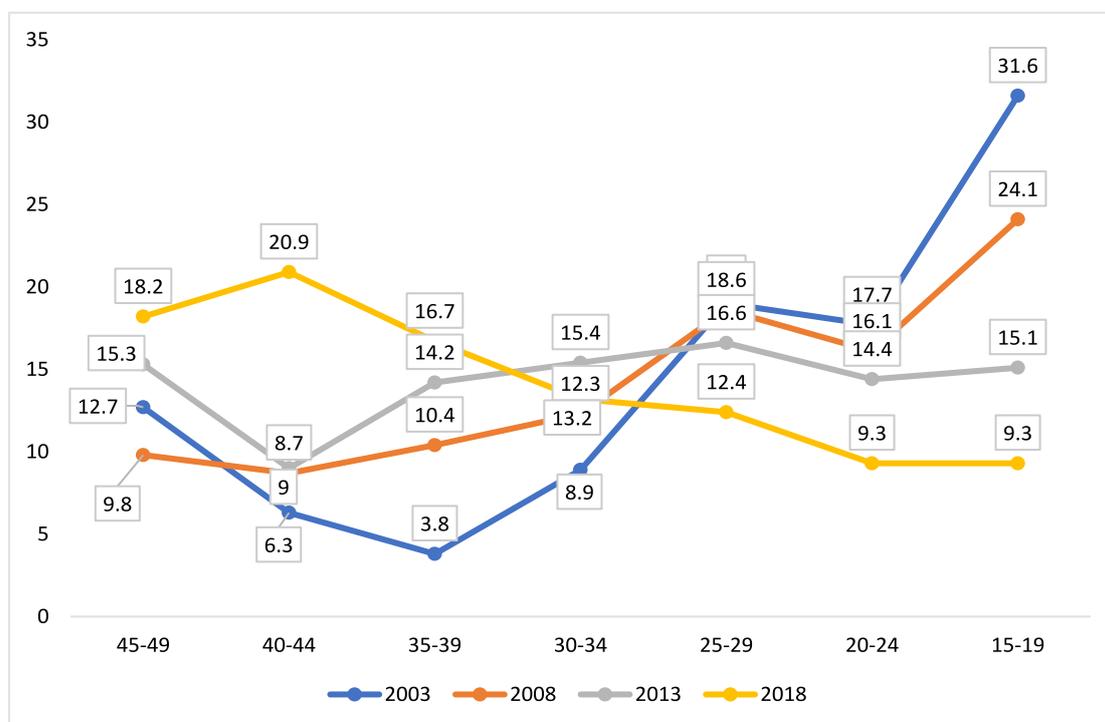


Figure 24: Prevalence of FGM among women in Osun State by age groups (NDHS 2003 - 2018)

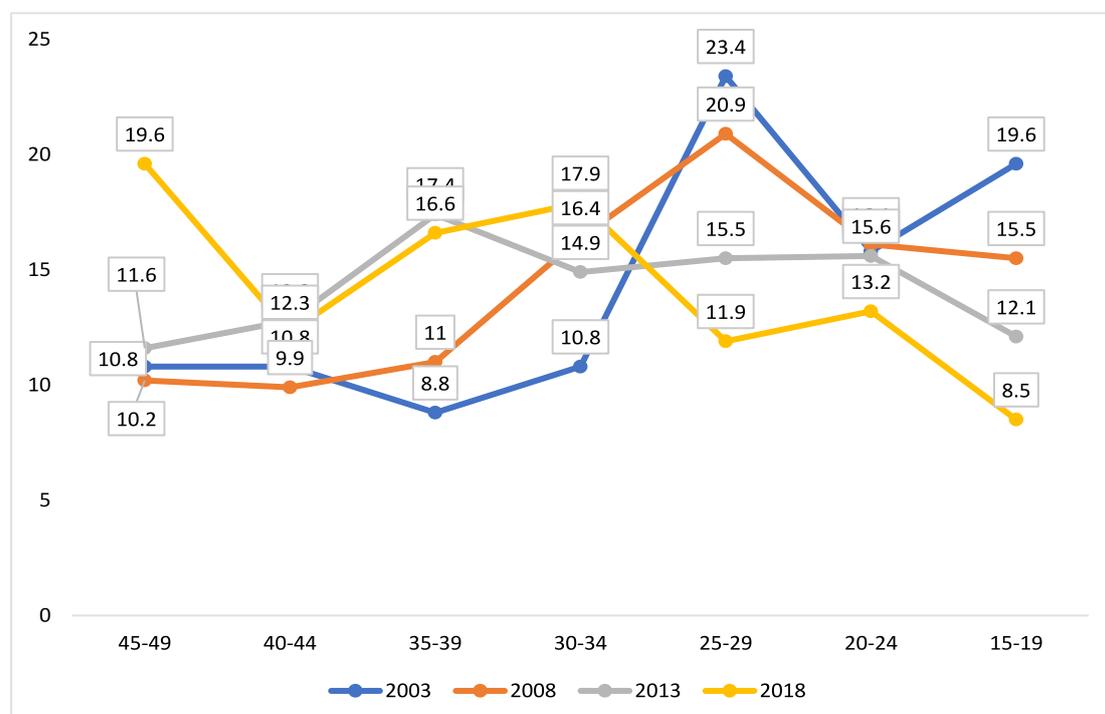
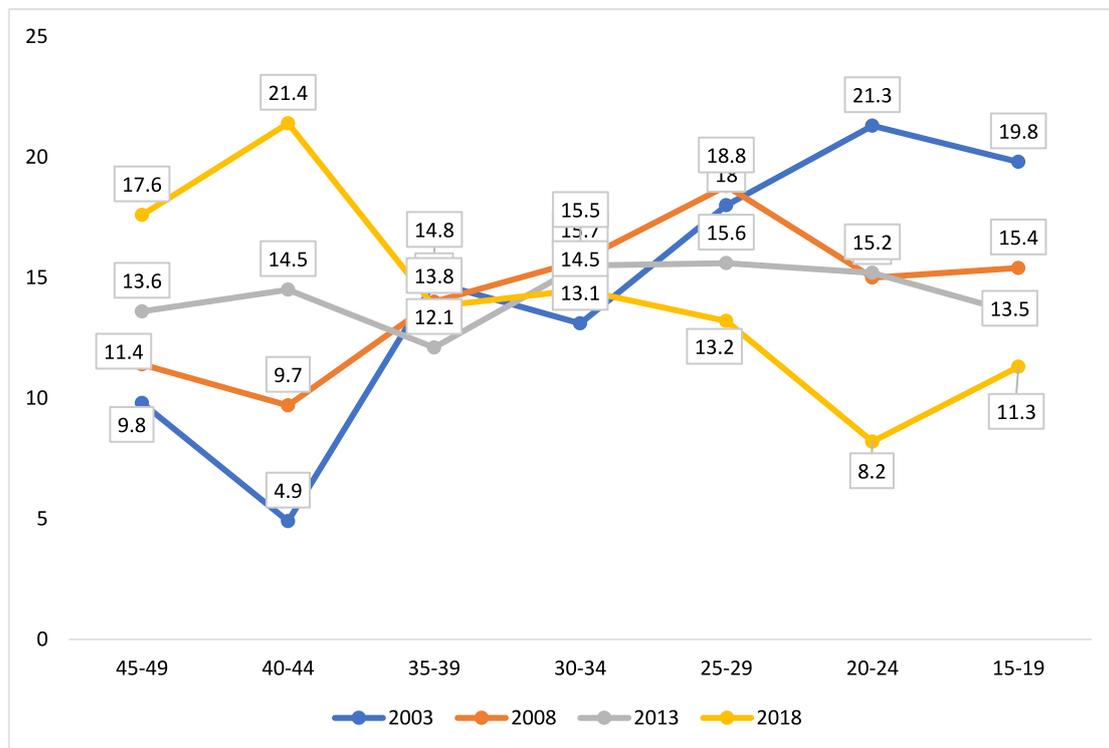
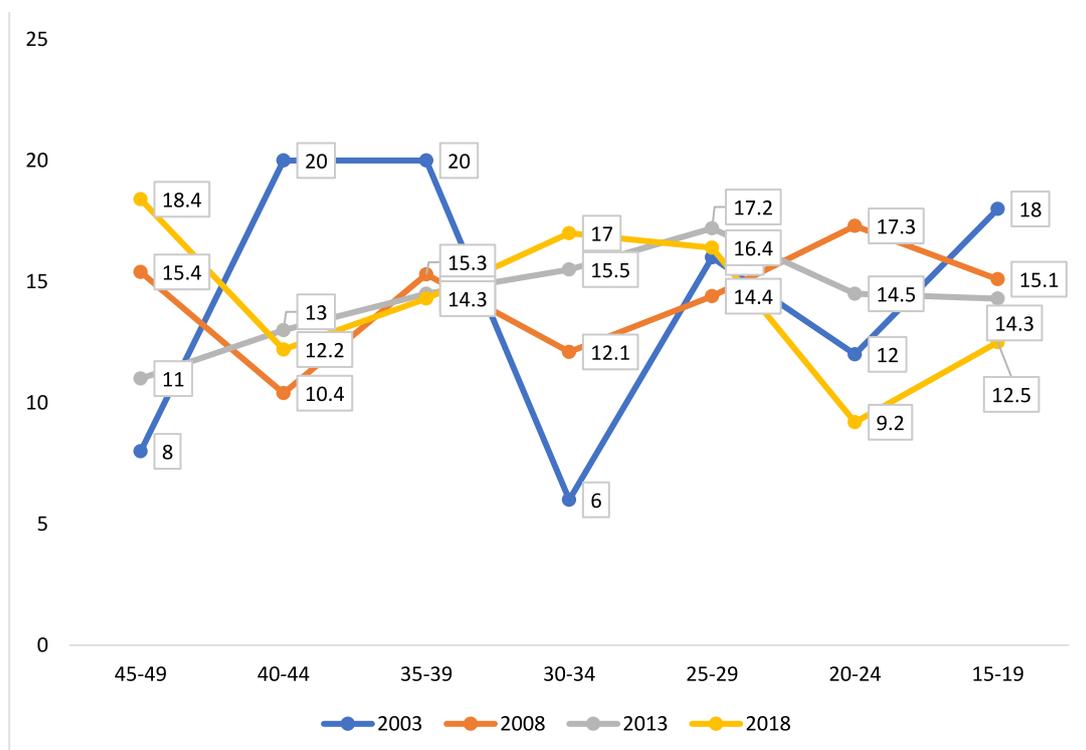


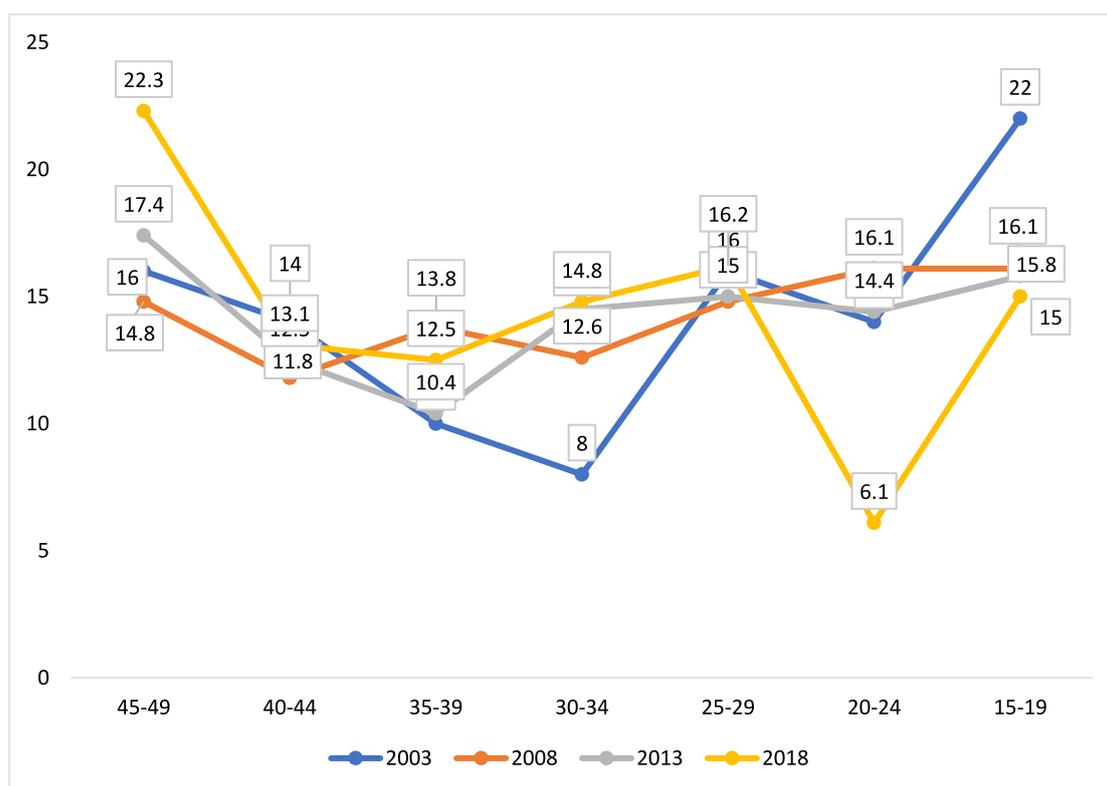
Figure 25: Prevalence of FGM among women in Oyo State by age groups (NDHS 2003 - 2018)



**Figure 26: Prevalence of FGM among women in Ekiti State by age groups (NDHS 2003 - 2018)**



**Figure 27: Prevalence of FGM among women in Imo State by age groups (NDHS 2003 - 2018)**



**Figure 28: Prevalence of FGM among women in Ebonyi State by age groups (NDHS 2003 - 2018)**

Figures 24 - 28 shows the prevalence of FGM among women by age group in the 5 UNJP states. In Osun State, prevalence among the 15 - 19 age group was highest in 2003 and has declined to 9.3% in 2018 while among the 45 - 49 years age group, prevalence has grown from 9.8% in 2008 to 18.2% in 2018. Similarly, in Oyo State, prevalence among the 15-19 years age group decreased from 19.6% in 2003 to 8.5% in 2018 while among the 45-49 years age group, prevalence has grown from 10.8% in 2003 to 19.6% in 2018.

In Ekiti State, prevalence among the 15-19 years age group has declined from 19.8% in 2003 to 11.3% in 2018 while among the 45-49 years age group, prevalence has grown from 9.8% in 2008 to 17.6% in 2018. Similarly, in Imo State, prevalence among the 15-19 years age group decreased from 18% in 2003 to 12.5% in 2018 while among the 45-49 years age group, prevalence has grown from 8% in 2003 to 18.4% in 2018. In Ebonyi state, the NDHS shows that prevalence among the 15-19 years age group decreased from 22% in 2003 to 15% in 2018 while among the 45-49 years age group, prevalence has grown from 14.8% in 2008 to 22.3% in 2018.

The method suggested by Shell-Duncan et al. (2016) in the State-of-the-art synthesis on FGM (Shell-Duncan et al., 2016) is used to understand how the decline of FGM has happened in the 5 UNJP states. In doing this, a comparison is made between the youngest (15 - 19) and oldest (45 - 49) age cohorts. This method shows that the current prevalence in Oyo state with a difference of 11.1% between the 45-49 years cohort (19.6%) and 15-19 years cohort (8.5%) declined more than the other states with Imo state.

### 3.3.5 Type of FGM performed in UNJP States

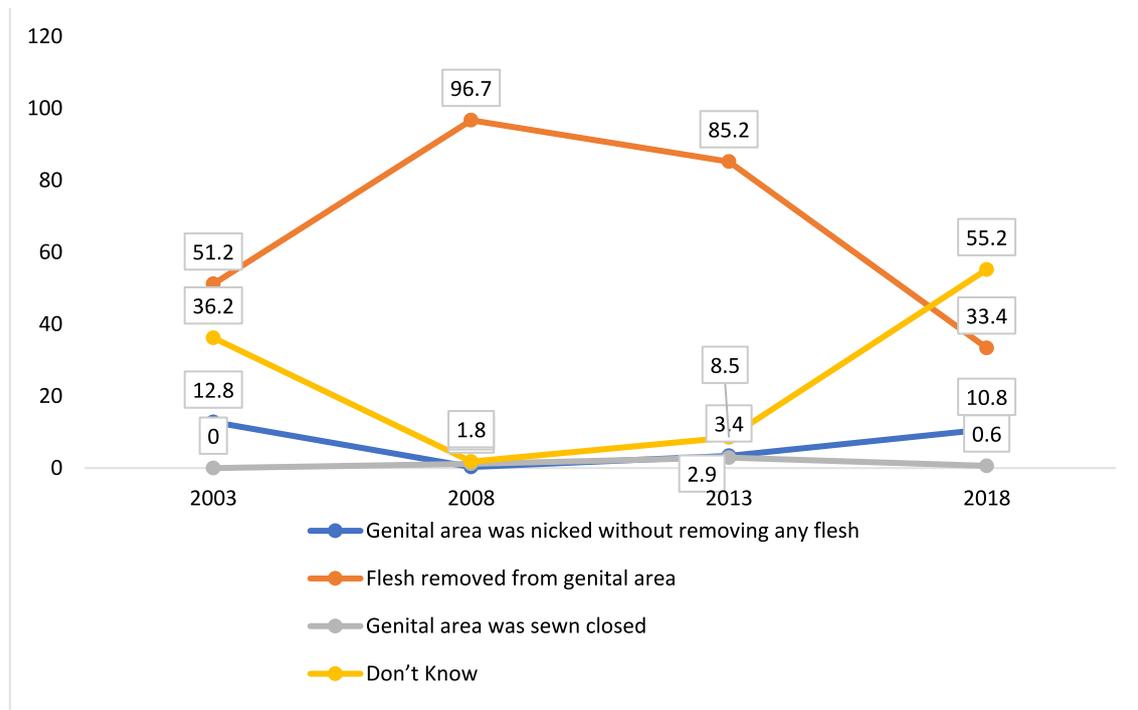


Figure 29: FGM types in Osun State (NDHS 2003 - 2018)

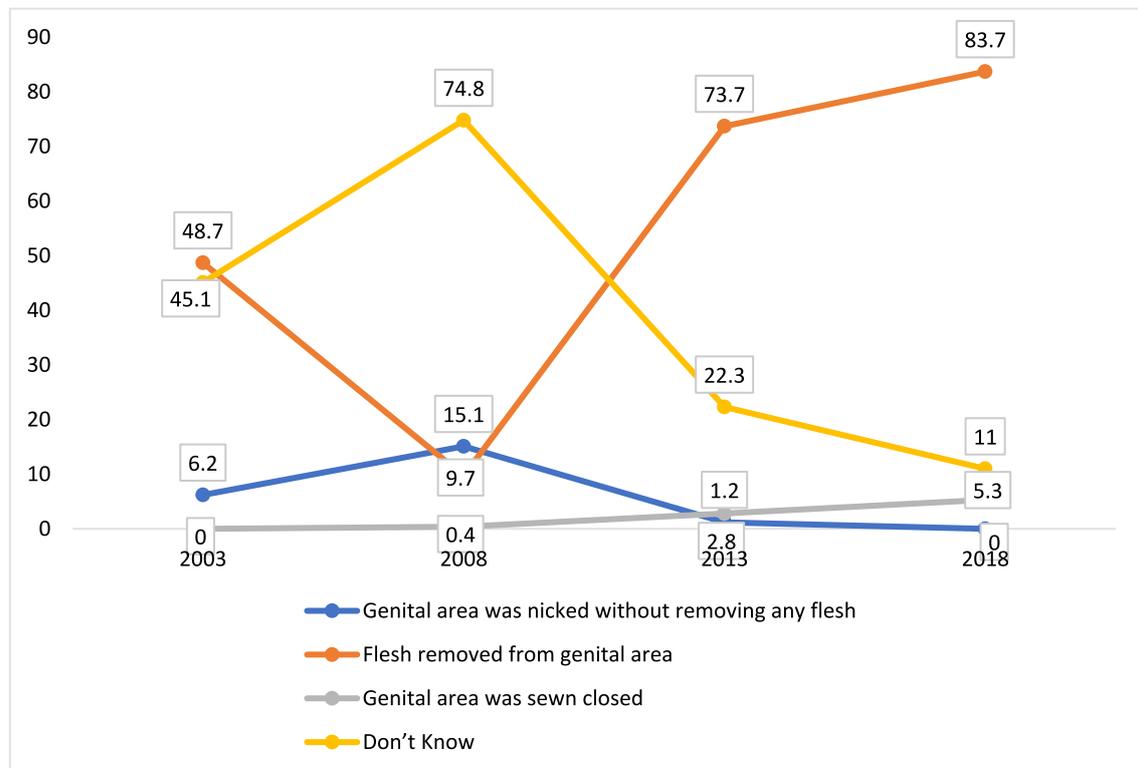


Figure 30: FGM types in Oyo State (NDHS 2003 - 2018)

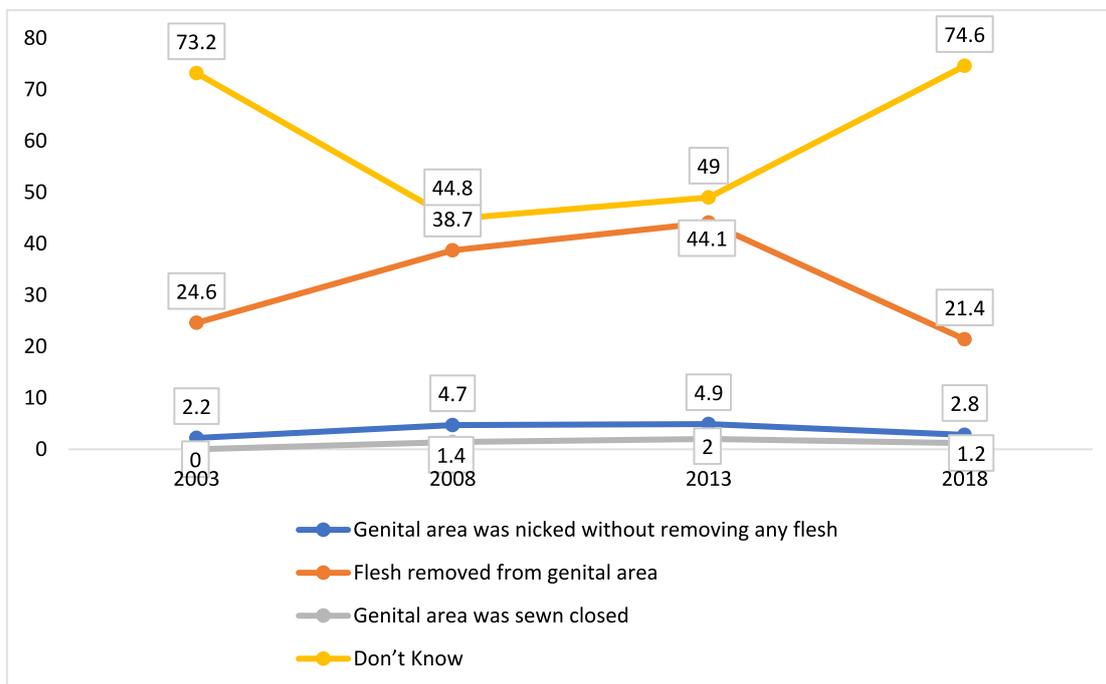


Figure 31: FGM types in Ekiti State (NDHS 2003 - 2018)

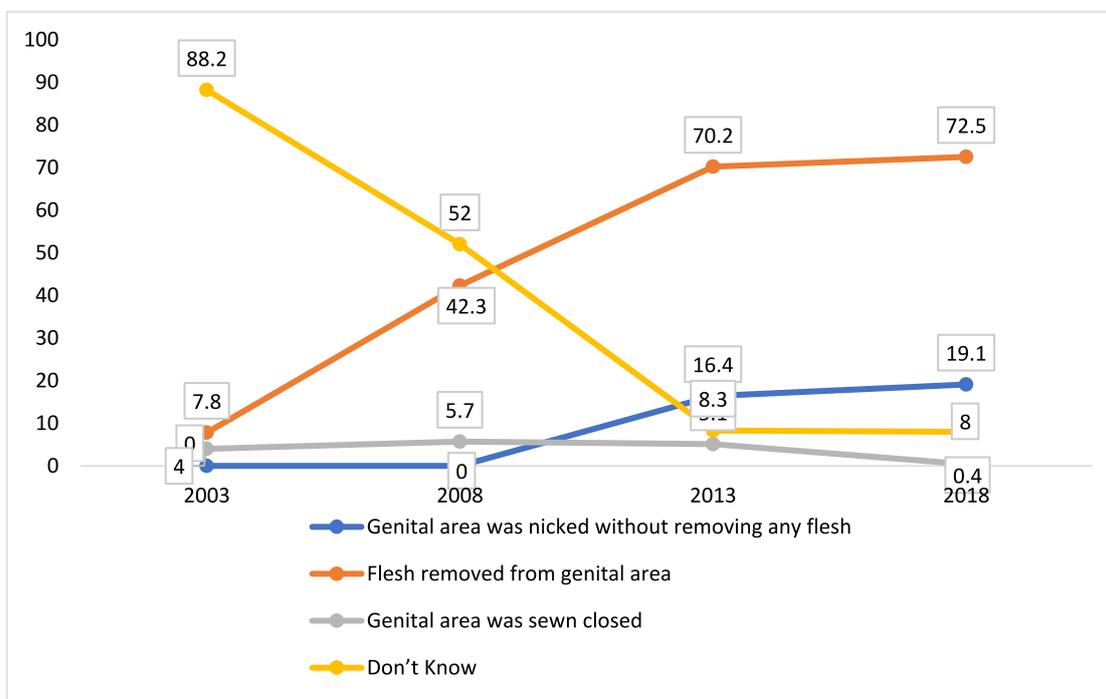
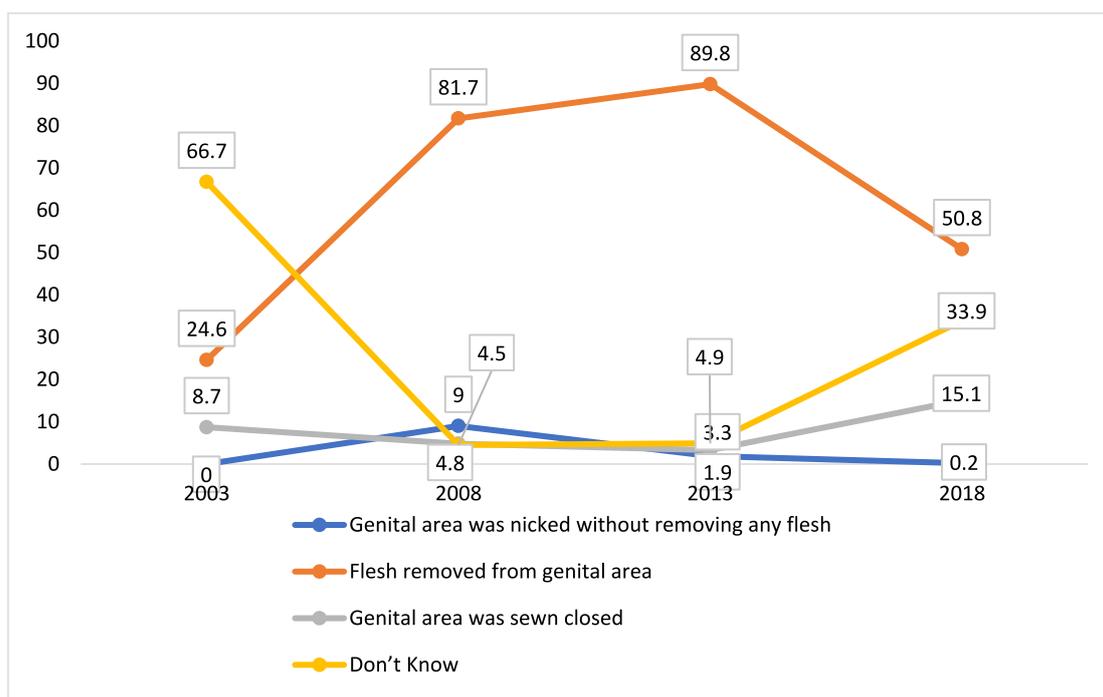


Figure 32: FGM types in Imo State (NDHS 2003 - 2018)



**Figure 33: FGM types in Ebonyi State (NDHS 2003 - 2018)**

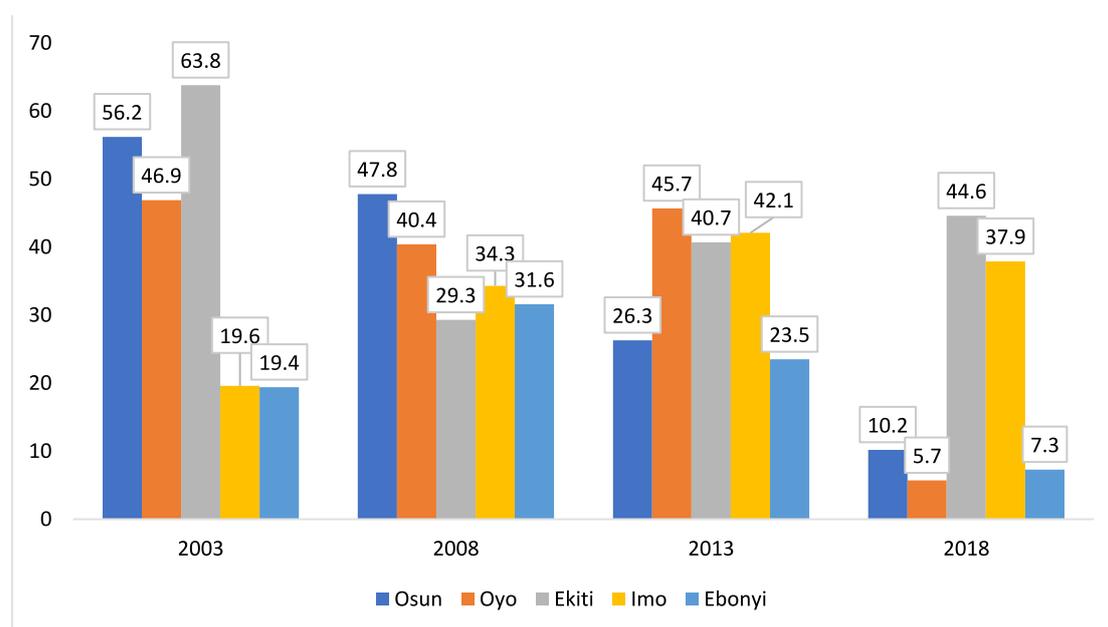
Overall, the predominant FGM type across all UNJP states remain Type 2 FGM or Excision. In Osun state, NDHS shows a huge decrease in Type 2 FGM from 85.2% in 2013 to 10.8% in 2018. More than half (55.2%) did not know what type of FGM was performed and this proportion increased from 8.5% in 2013. Additionally, Type 1 FGM (clitoridectomy) has increased from 2.9% in 2013 to 10.8% in 2018. At 83.7%, Type 2 FGM remains the form of FGM being practised in Oyo state. This is an increase from 73.7% in 2013 and 9.75 in 2008. There has been a steady increase from 2008 (0.4%) to 2018 (5.3%) in the practice of Type 3 FGM (infibulation) in the state.

As at 2018, 74.6% of FGM performed was undetermined in Ekiti State while Type 2 FGM was still substantial at 21.4% but had dropped from 44.1% in 2013. In Imo State, 72.5% of the FGM performed was Type 2 FGM in 2018. This has been an increase from 0% in 2003. Also, Type 1 FGM has increased from 0% in 2008 to 19.1% in 2018. While Type 2 FGM remains the main form of practice in Ebonyi state, the proportion of women with this form has decreased from 89.85 in 2013 to 50.8% in 2018. Additionally, infibulation has increased from 3.3% in 2013 to 15.1% in 2018 while undetermined forms of the practice have increased from 4.9 to 33.9%

In Osun and Ebonyi, unknown forms of the practice currently make up half or just over half of the FGM types available. Additionally, there has been an increase of clitoridectomy in Osun and Imo state while there was an increase in infibulation in Oyo and Ebonyi states. An increase in clitoridectomy, which is a less severe form of FGM, compared to excision and unknown forms of FGM could signal reactions to

interventions such as the awareness of the health complications of the practice. This could mean communities are starting to adopt forms that they believe would lessen the perceived harm associated with more severe FGM types. This shift may make it difficult for the abandonment of the practice to occur if not addressed quickly. An increase in infibulation is a great source of worry as it is a more severe form of practice. With data showing that more people are turning to infibulation in Oyo and Ebonyi states, it means the norms driving the practice are still very strong and stronger approaches are needed to address this challenge.

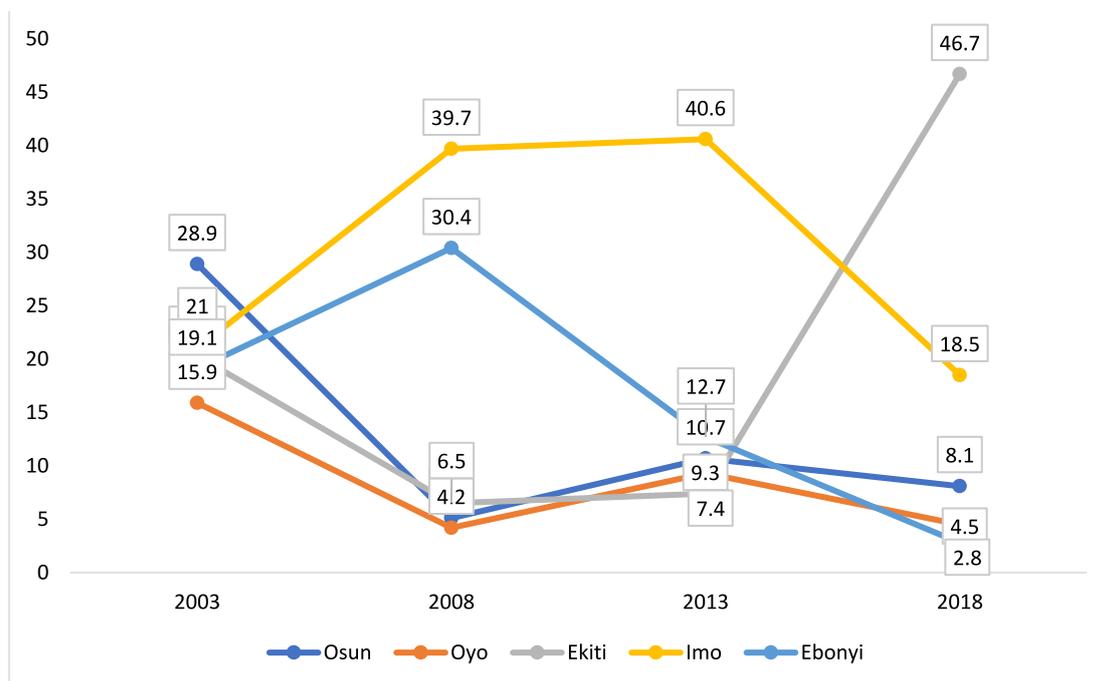
### 3.3.6 The opinion of women about whether FGM should continue



**Figure 34: Support for FGM in UNJP States (NDHS 2003 - 2018)**

The support for FGM among women has largely declined in Osun, Oyo, Ebonyi, and Imo states. The largest decline was in Oyo state where the proportion of women who shared the opinion that FGM should continue dropped by 40% between 2013 (45.7) to 2018 (5.7%). Despite the decrease recorded in the four states, data show a steady increase in Ekiti state from 2008 (29.3%) to 2018 (44.6%). The high level of support in Ekiti could be because women are still holding on to beliefs driving FGM in the face of anti-FGM interventions as a result of socio-cultural norms. The connection between continued support for FGM and social norms has been documented in literature (Alo & Gbadebo, 2011; Sipsma et al., 2012). This in turn necessitates the need for more holistic interventions that will address social norms and erroneous beliefs driving FGM.

### 3.3.7 Opinions of women about whether FGM is required by religion



**Figure 35: Opinion of women about whether FGM is required by religion (NDHS 2003 - 2018)**

On FGM as a requirement for religion, the proportion of women who share this belief have steadily declined in Osun, Oyo, Imo, and Ebonyi. The biggest decline was in Imo state where the proportion of women who believed FGM is required by religion declined reduced by 22.1% from 2013 to 2018. In contrast, this proportion of women who shared the belief in Ekiti state increased 6 folds between 2013 (7.4%) and 2018 (46.7%). This contravenes the position that FGM does not have any religious basis (Ahmed et al., 2019; Althaus, 1997; Kandala, Komba, et al., 2020). Additionally, this is a significant challenge that will continue to drive and validate the practice and, in the process, undo the gains that have been made in controlling the prevalence of FGM in the state. The sharp increase in prevalence could be a result of inadequate interventions to directly address and separate religiosity from the practice.

### 3.3.8 Prevalence by education level in the UNJP implementing states

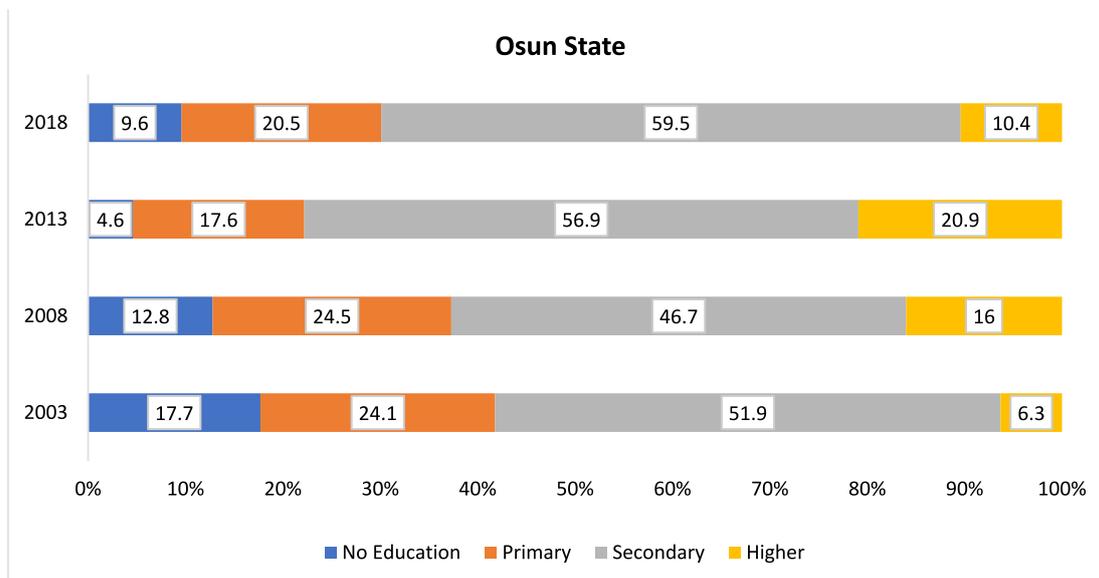


Figure 36: Prevalence of FGM by level of education in Osun State (NDHS 2003 - 2018)

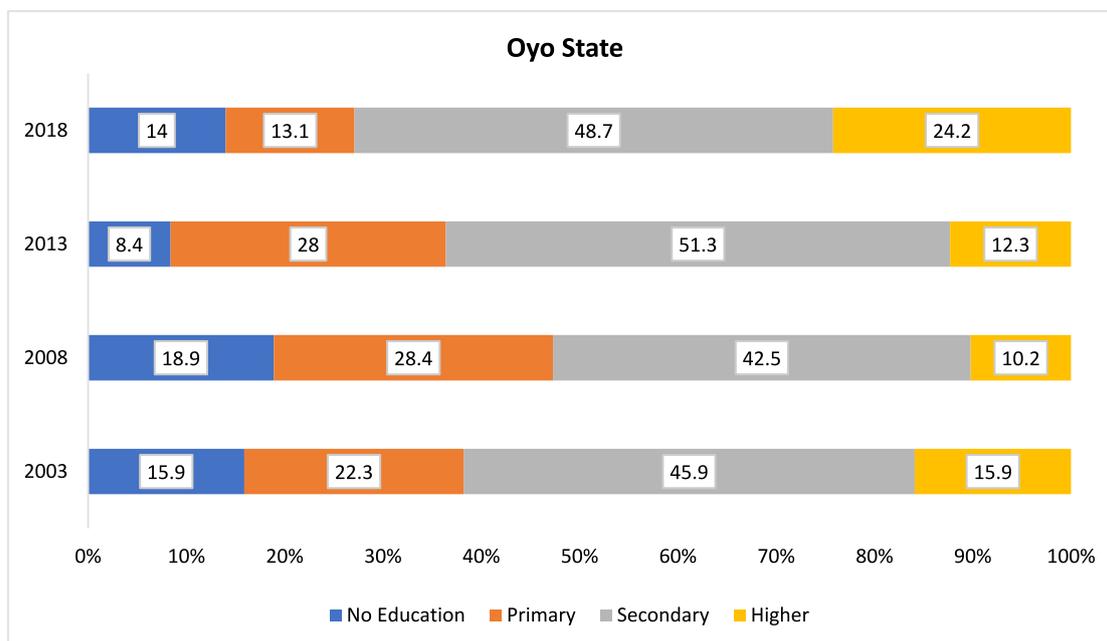


Figure 37: Prevalence of FGM by level of education in Oyo State (NDHS 2003 - 2018)

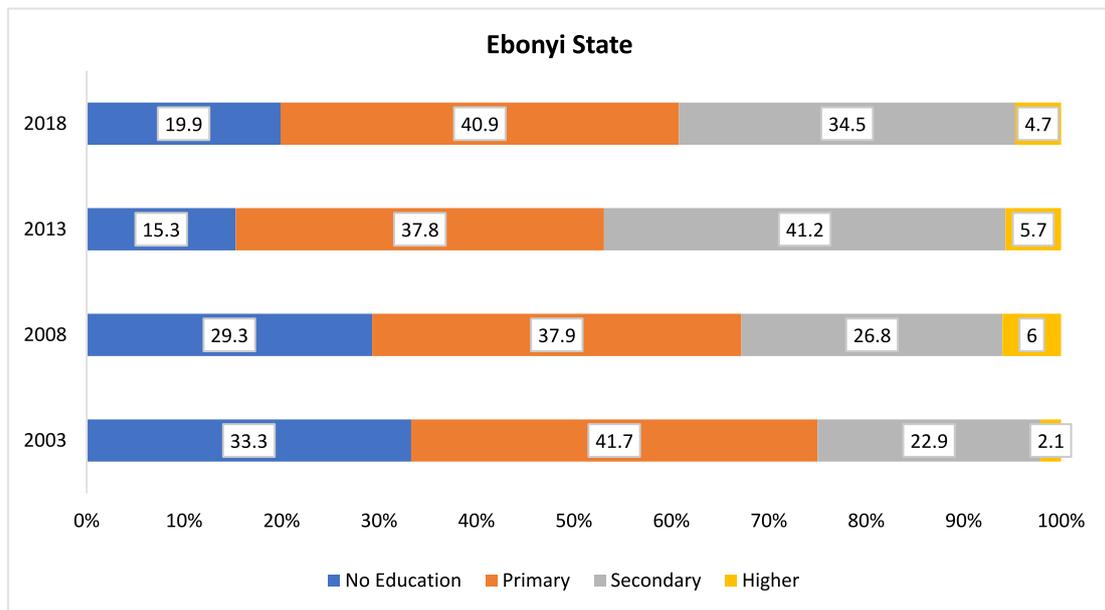


Figure 38: Prevalence of Female Genital Mutilation by level of education in Ebonyi State (NDHS 2003 - 2018)

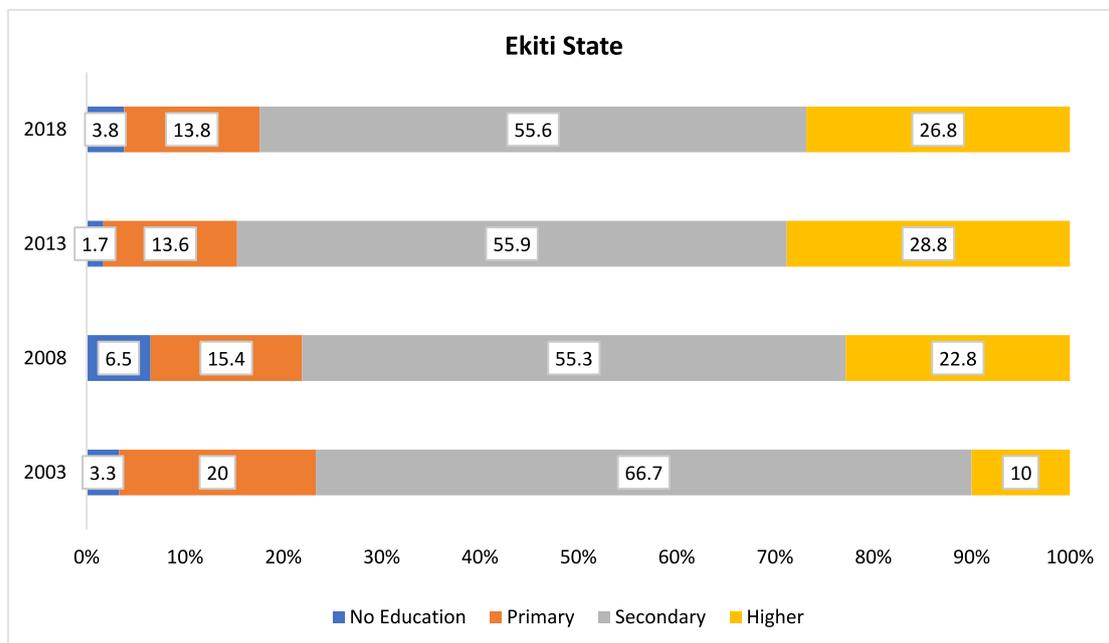
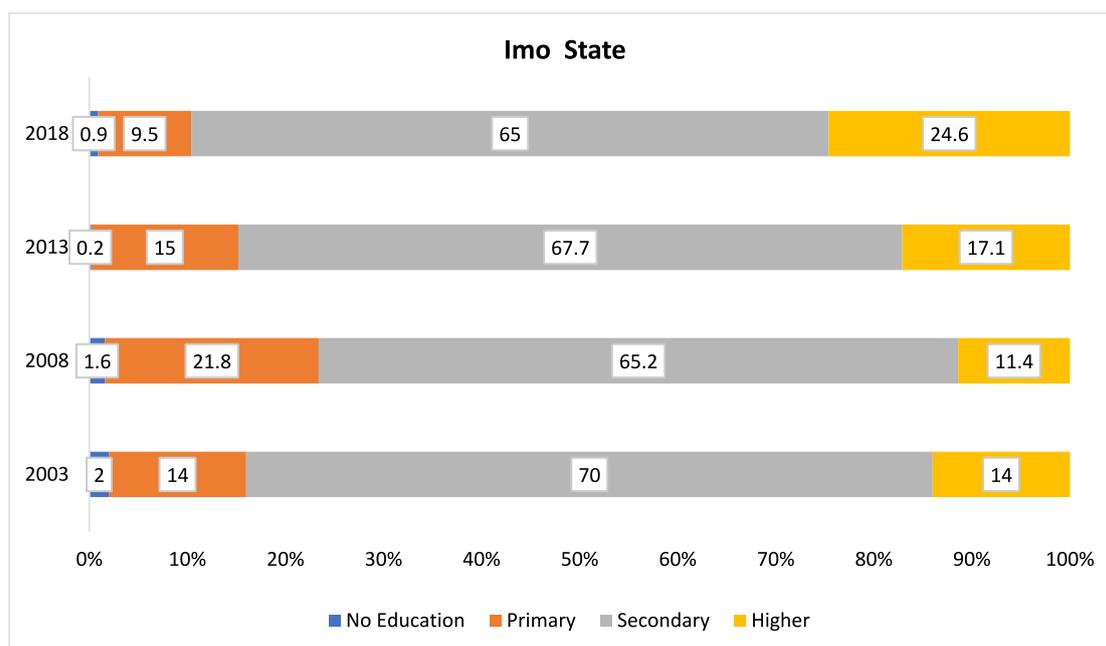


Figure 39: Prevalence of Female Genital Mutilation by level of education in Ekiti State (NDHS 2003 - 2018)



**Figure 40: Prevalence of Female Genital Mutilation by Education Attainments in Imo State (NDHS 2003 - 2018)**

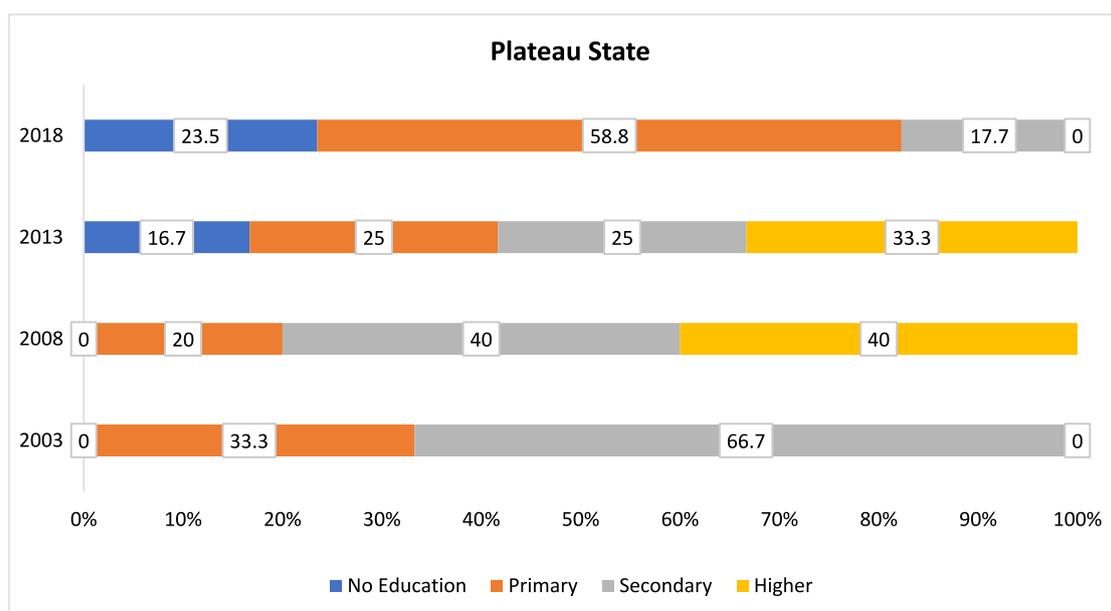
Further observation shows an increment in prevalence from 2003 to 2018 among women with secondary education in Osun State (51.9% to 59.5%). In other states (Oyo, Ebonyi, Ekiti, and Imo), it was observed that there was an increment in FGM prevalence among women from 2003 to 2013 after which a decline was noticed in 2018. The prevalence of FGM by educational attainments of women across the five UNJP implementing states is shown in Figure 36 - 40. An explanation for this could be the social norms that encourage FGM despite the education attainment of mothers. It is also possible that girls who joined the 15 -49 years age bracket just before the survey accounted for the surge, since the predominant age of cutting in Nigeria is below five years. It was reported in the 2018 NDHS that 86% of the women who had undergone FGM were cut before their fifth birthday (NPC and ICF., 2019). This category of women would have been cut at least 10-15 years before the survey. This therefore does not highlight new experience of FGM.

It should be noted, however, that educational attainment does not always translate into a reduced burden of FGM. A study has shown that no evidence links an increase in the education level of mothers to the likelihood of supporting the practice or their daughters undergoing the practice (Batyra et al., 2020; De Cao & La Mattina, 2019). This is reflected in the UNJP implementing states. While there was a decline over the years across some educational levels, others showed an increase. Findings from the data show that the prevalence of FGM was higher among women with secondary and primary education than any level of educational attainment across the five states.

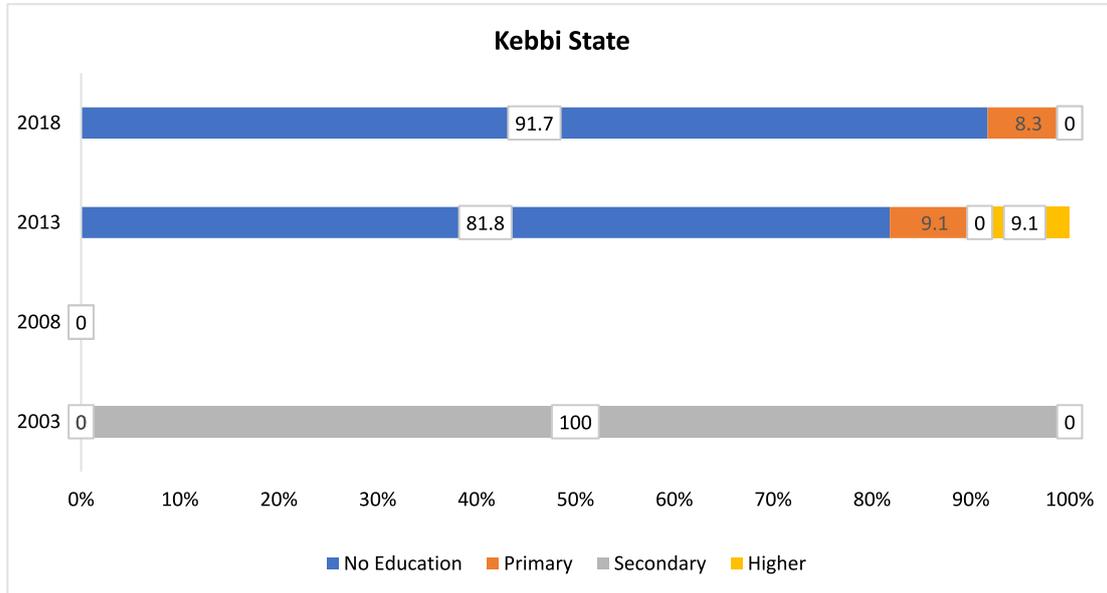
### 3.3.8.1 Comparison of FGM prevalence by level of education in UNJP States and possible hotspots

For newly identified hotspots of FGM such as Jigawa, Kaduna, Yobe, Bauchi, Niger, Taraba, and Kebbi states, the prevalence was more among women with no education between 2013 and 2018. An increase in prevalence among women with no education was documented from 2013 to 2018 in Kebbi, Taraba, Niger, and Bauchi states. In contrast to the other identified hotspots states, Plateau has seen more FGM among women who have primary and secondary level education since 2003 with a steady increase among those with primary education from 2008 to 2018.

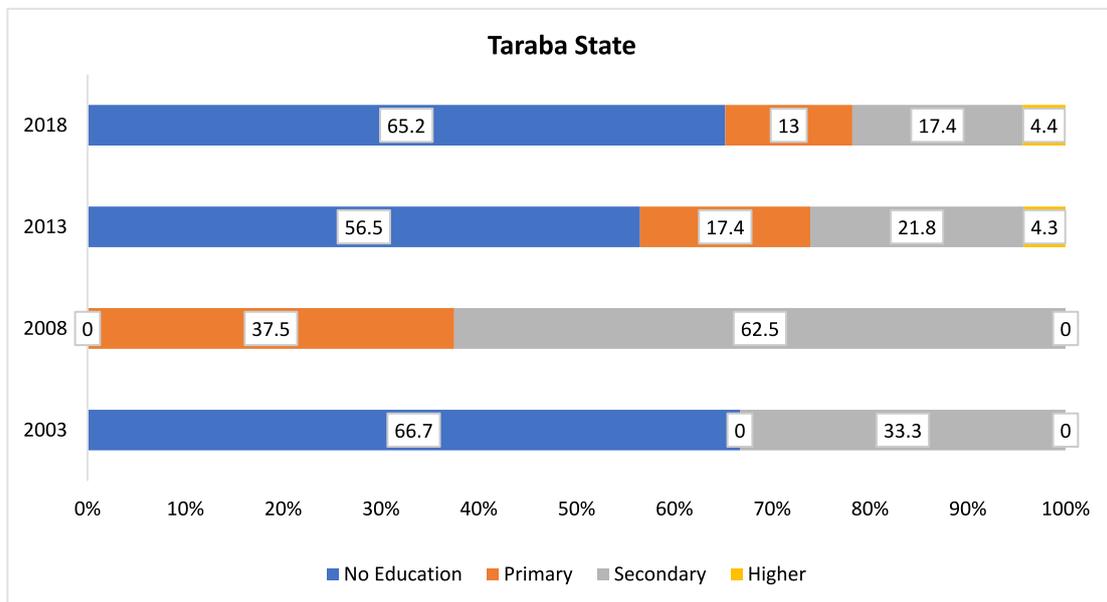
The observation in the hotspots states shows a disparity when compared to the UNJP States where there was a substantial increase in prevalence among women with a higher level of education across survey years and predominantly, cut women had secondary education. These observations could be because of the education gap between the Northern Region where most of the new hotspots are located and the Southern Region



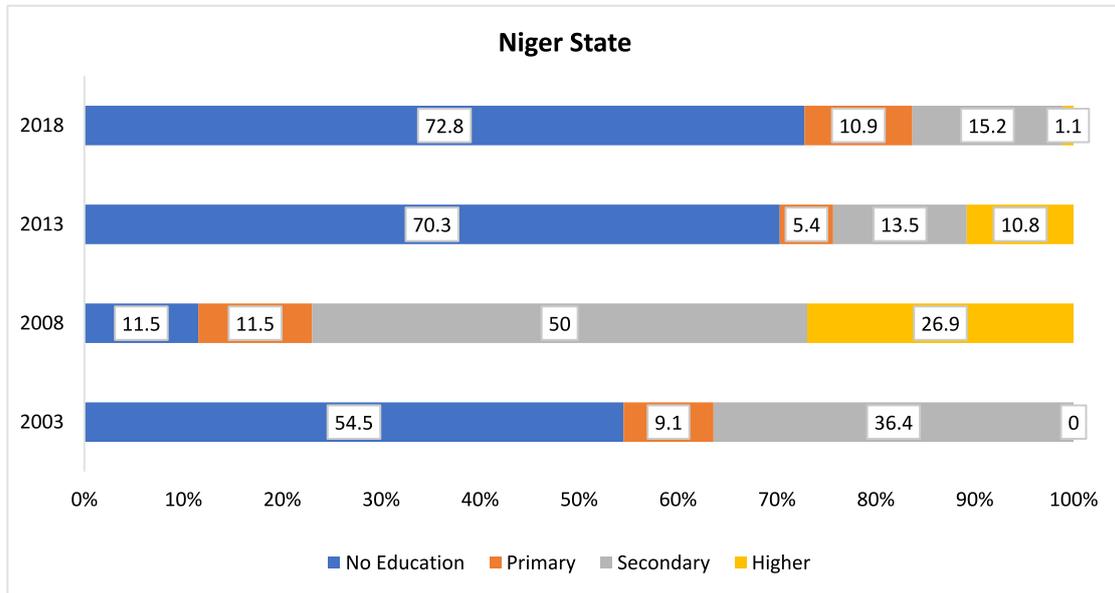
**Figure 41: Prevalence of Female Genital Mutilation by level of education in Plateau State (NDHS 2003 - 2018)**



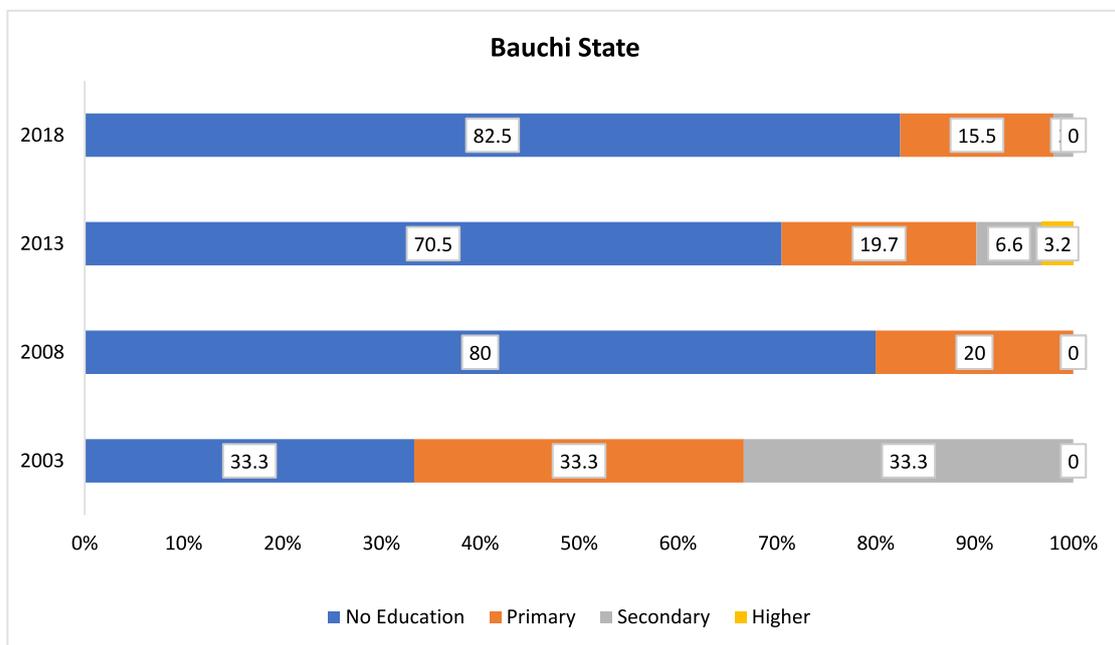
**Figure 42: Prevalence of Female Genital Mutilation by level of education in Kebbi state (NDHS 2003 - 2018)**



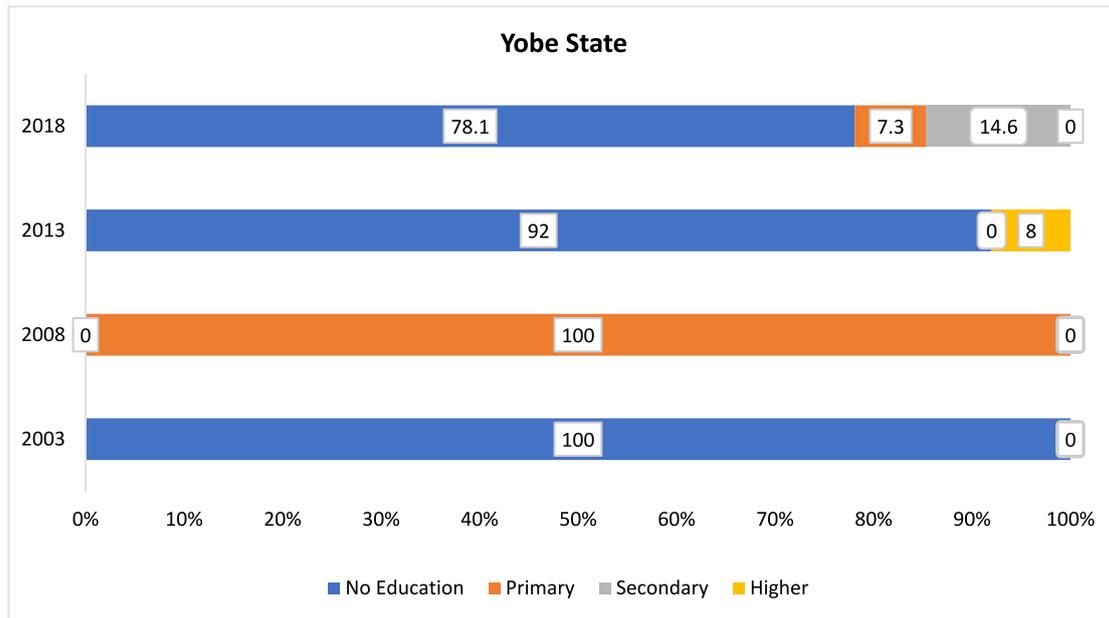
**Figure 43: Prevalence of Female Genital Mutilation by level of education in Taraba State (NDHS 2003 - 2018)**



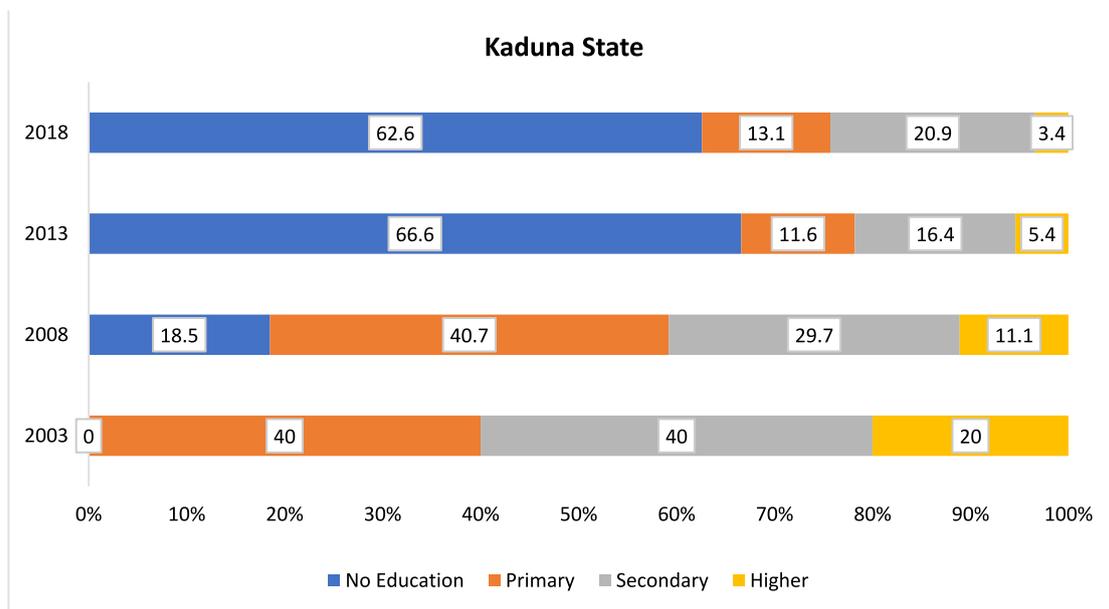
**Figure 44: Prevalence of Female Genital Mutilation by level of education in Niger State (NDHS 2003 - 2018)**



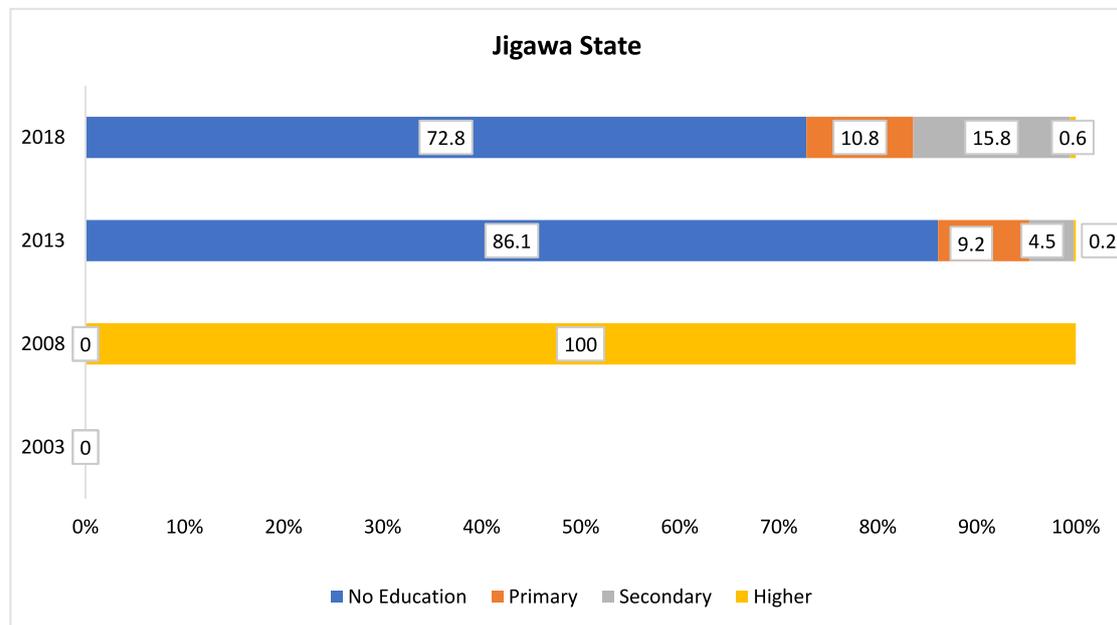
**Figure 45: Prevalence of Female Genital Mutilation by level of education in Bauchi State (NDHS 2003 - 2018)**



**Figure 46: Prevalence of Female Genital Mutilation by level of education in Yobe State (NDHS 2003 - 2018)**



**Figure 47: Prevalence of Female Genital Mutilation by level of education in Kaduna State (NDHS 2003 - 2018)**



**Figure 48: Prevalence of Female Genital Mutilation by level of education in Jigawa State (NDHS 2003 - 2018)**

# PHOTO GALLERY



# PHOTO GALLERY



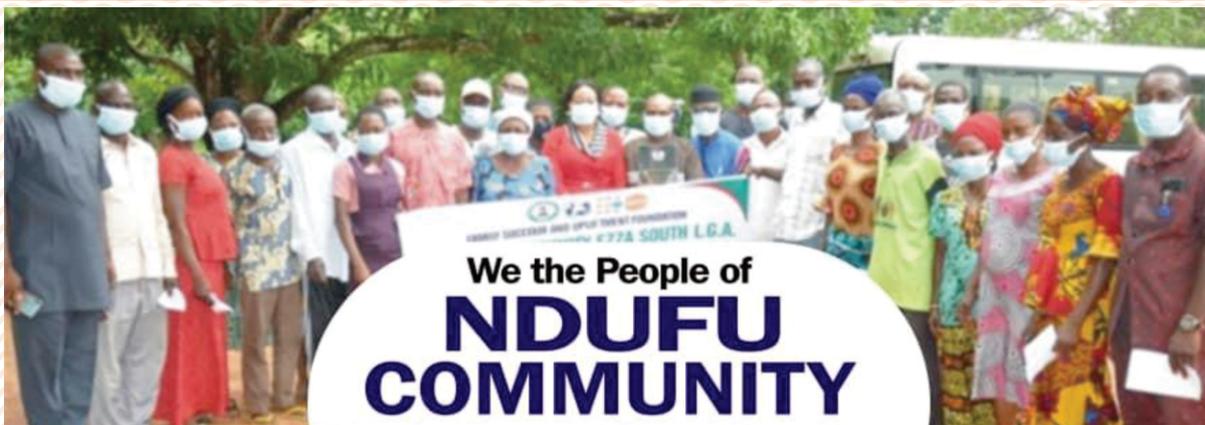
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## 4.0 KEY SOCIAL AND BEHAVIORAL DRIVERS OF FGM

Culture shapes the social patterns and identity unique to a group; learned beliefs, values, and shared codes of behaviour drive community preferences. There is a consensus that FGM is deeply rooted in complex cultural perspectives about women and these have been preserved carefully and passed down over generations making them difficult to change (Okeke et al., 2012; Orji & Babalola, 2006; UNICEF, 2001). The practice of FGM is enshrined in cultural and traditional beliefs within a frame of sexual, moral, and religious factors that are sustained through community mechanisms (Odo et al., 2020). 'Mental maps' guide individuals and communities to define their worldview and interaction (WHO, 1999). The mental maps within communities are similar although they may be influenced by level of education, association, exposure, and personal experiences. In communities where FGM is practiced, people share a similar mental map that advances the persuasive need to remove the clitoris and external genitalia. (Mohamud, 1992). The drivers of FGM can be explained by exploring the core motivations for the practice:

- Spiritual and religious reasons
- Sociological reasons
- Hygienic and aesthetic reasons

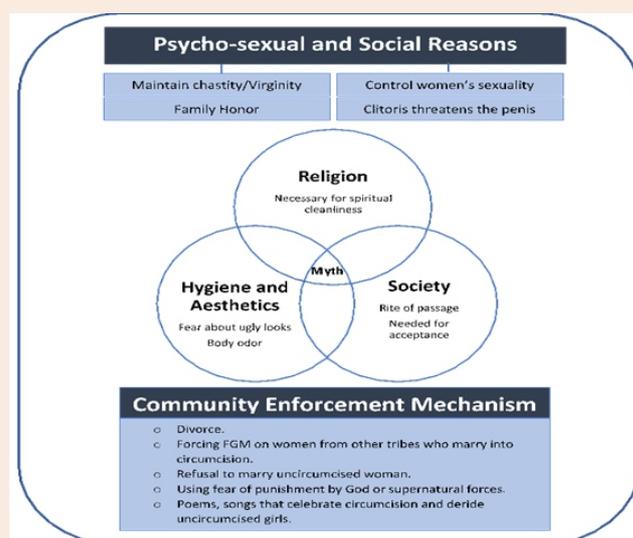


Figure 49: Mental Map for FGM

Although these drivers provide a justification for the conduct of FGM by explaining that the external genitalia is unsightly, dirty and makes women spiritually unclean; they do not address the overarching arguments about sexuality (Orji & Babalola, 2006; WHO, 1999). Underlying the core motivations for the practice is the need to control a women's sexuality to prevent her from becoming 'loose', 'exposed' and consequently disgracing her family, unfit for marriage, losing her virginity and risking social exclusion. Furthermore, it is perceived that FGM increases the sexual pleasure of husbands, fertility and marriageability of women (B. Uchenna, 2017). They reinforce myths that are used to propagate FGM by postulating that women who do not perform FGM will suffer consequences such as neonatal death or abnormality, death of husbands, death of the unexcised women and other unfortunate family events (WHO, 1999). These consequences validate the need to ostracize unexcised women as a community preservation strategy. Central to this strategy are strong enforcement mechanisms that punish unexcised women through divorce, public shaming and forced excisions before marriage. Women who have undergone excision are accorded respect for preserving family honor, rewarded, and included in social activities within the community (B. Uchenna, 2017). FGM is also viewed as a rite of passage into womanhood in communities where it is practiced and it fosters social inclusion for women who are cut and thus, they get rewarded for the initiation into chastity (M & Öztürk, 2014).

#### **4.1 Sociocultural Factors**

Contextualizing the mental map is key to exploring focused interventions for addressing FGM. Despite the growing evidence on the devastating consequences, the continuance of FGM in sub-Saharan Africa reflects the prevailing cultural context. Sociocultural practices that are rooted in culture and traditional values may be resistant to policy instruments (Sanni & Bishwajit, 2018). While a legal framework for addressing FGM is an important step in the right direction, understanding and addressing the social norms that perpetuate the practice is critical to fostering lasting behaviour modification that is needed to sustain change (UNICEF, 2016b).

##### **4.1.1. Social norms and beliefs**

Across cultures and countries, there are nuances in the motivation for the practice and consequences for not conforming to the FGM code of conduct. A hybrid of norms and beliefs that are seen in other countries and cultures are also seen in different regions in Nigeria (Orji & Babalola, 2006). For example, in some cultures in South West Nigeria, it is believed that the clitoris poses a health risk for babies, and that if the head of a baby comes in contact with the clitoris, the baby will die (Refugee Legal Aid Information, 2018). In other cultures, it is believed that the practice of FGM prevents mother and child from dying during childbirth (Ilesanmi & Ilesanmi, 2018). In some communities it is considered a taboo for an unexcised young girl or woman to be married and this could lead to her being disowned by her family (Chidera, 2018). FGM also confers inheritance rights and is performed as part of the process of social integration (Odoi, 2005).

In communities where it is practised, FGM is associated with social significance for females as women can only achieve recognition and economic security through marriage and childbearing. Unfortunately, these cannot be achieved without the rite of passage into womanhood which occurs when a woman is cut. Most women, therefore force their daughters to undergo FGM to protect them from being ostracized, shamed or beaten (Ilesanmi & Ilesanmi, 2018; Olajumoke Ereola et al., 2020). Some other beliefs that perpetrate FGM include the narrative that women who have not been cut are promiscuous, unclean, unattractive, and will be unable to find a husband. Hence, studies have shown that FGM is perceived to promote hygiene, improve female attractiveness, enhance fertility and male sexual pleasure (Olajumoke Ereola et al., 2020; O. V. J. Uchenna et al., 2019). Even after marriage, it is widely believed that uncut girls have the tendency to be unfaithful to their husbands. The acceptance of FGM by women may reflect the powerful influence of tradition and normalisation of the practise as a necessary and even a natural part of life (Olajumoke Ereola et al., 2020). In South-East Nigeria, the practice of FGM is linked with respect; women who have undergone FGM are accorded respect and it is done to satisfy the community norms around respect (Odo et al., 2020).

A study of 500 women attending family planning clinics in South West Nigeria selected consecutively showed that 85% of them had undergone FGM; about 95% of them were cut in childhood and majority had type 1 (Orji & Babalola, 2006). When asked about the reasons for circumcision, 95% reported that culture was the main reason for FGM, about 49% reported prevention of promiscuity as a reason, 18% reported prevention of newborn death, 9% reported family pressure and 6% reported religion (Orji & Babalola, 2006). These findings resonate with findings from other studies in the South East Nigeria that have listed culture and reduction of promiscuity as key reasons for FGM (R. Berg & Denison, 2013).

FGM is considered a “social convention which is ensured through non-written system of rewards and punishments”, any attempt to discontinue the practice is met with societal pressure and risk of isolation (Kolawole & Anke, 2010). The culture of FGM is preserved by family and community structures that monitor and enforce the practise. Older women such as mothers, grandmothers, mothers-in law, play a key role perpetrating the practice by ensuring that girls within families are cut (Akosile, 2016; Edukugbo, 2015). These women were also cut and view it as their duty to enforce FGM as an obligation to preserve culture and tradition. Some of these women who act as enforcers do this to protect the family from shame. As part of the enforcement process, girls are manipulated to accept the value of FGM and their helplessness in the decision-making process; rewards and sanctions are advanced for conformance and non-conformance respectively (B. Uchenna, 2017). A study conducted in three LGAs of Ekiti State which attempted answering whether poverty was a stronger driver of FGM than culture and tradition reported that the practice, was mainly driven by culture. Most respondents reported that circumcisers were not doing it for money but because of their cultural belief and tradition which they desired to uphold at all cost. (Rufus & Matthew, 2019).

There are no clear recommendations from the Bible or Koran about the cutting of woman (B. Uchenna, 2017). Although the practice of FGM is not known to be associated with any religious scripts that prescribe it, practitioners believe the practice has religious support. There are divergent views among religious leaders about the value of FGM, while some promote it, others consider it irrelevant to religion and support its elimination woman (Ilesanmi & Ilesanmi, 2018; O. V. J. Uchenna et al., 2019). Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice. In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups and sometimes it starts as part of a wider religious or traditional revival movement (WHO, 2018).

FGM is practiced both in Christian dominated parts of Nigeria (Southern zone) and in Muslim communities (Northern zone). FGM is also linked to the religious obligation to preserve a girl's virginity before marriage (Refugee Legal Aid Information, 2018).

#### **4.1.2. Medicalization of FGM**

Although FGM is mainly performed by traditional birth attendants and cutters in Nigeria, there are indications about a transition to medicalisation of the practice (NPC and ICF., 2014; Onuh et al., 2006; Umar & Oche, 2014). FGM medicalisation as defined by WHO is 'situations in which FGM is practiced by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere; including the procedure of re-infibulation at any point in time in a woman's life'. Medicalisation emerged as an unintended consequence of early messages which focused on using health risks to discourage FGM practice. It is thought that by doing this, parents will eschew from the practice. However, this further created a market for parents who held on to the practice but shifted to the clinics for safety and harm reduction; health personnel rode on this to attempt to legitimize the practice (WHO, 2010). Some health workers also encourage FGM practice due to their personal beliefs and in some cases for economic gains.

Parents are inclined to patronize these health workers trusting their ability to perform the procedure on their female children without complications. Unfortunately, despite the assumptions about medicalisation being safer with minimal complications, it does not legitimise FGM and does not address the issues with violation of human rights and perpetuation of emotional and physical torture as well as degrading inhuman treatment (Obianwu et al., 2018). The same study by Obianwu et al, 2018 demonstrated that legislations against FGM as well as training of nurses on health implications of FGM increased their knowledge and awareness; they were however, more likely to only nick the clitoris causing bleeding and satisfying the parents that the procedure had been done, without removing much tissue (Obianwu et al., 2018). Findings from the NDHS 2018 showed that 7% of girls aged 0-14 years and medical professionals circumcised 9% of women aged 15-49 years. This indicates a reduction in medicalization compared to 2013 NDHS which reported 12% of girls and 13% of women were circumcised by medical practitioner.

Medicalization rates, defined as the percentage of FGM performed by medical professional, are highest in five countries namely Sudan (67%), Egypt (38%), Guinea (15%), Kenya (15%) and Nigeria (13%) (Shell-Duncan et al., 2017). The rate has been on the increase in all the listed countries except Nigeria. Although the medicalization rate in Nigeria is reducing, more work needs to be done in re-orienting and educating health workers who perform this act. The 2018 NDHS reports that nurses and midwives play an important role in medicalization (7% for girls, 8% for women), attention should be focused on this cadre of health workers. Also, the economic gains from medicalisation can threaten the abandonment of FGM in Nigeria. Medicalization has been strongly criticized by the WHO as the involvement of medical personnel may be perceived to justify the practice whereas it violates human rights and medical ethics (WHO, 2010).

#### 4.1.3 Gendered issues/inequalities

FGM is an extreme form of discrimination against women and girls (Azuonwu & Ezekiel, 2020). FGM is a gendered harmful practice that reflects the imbalance of power between men and women and perpetuates inequalities and control over women and girls. Achieving gender equality is at the core of the 2015 Sustainable Development Goals (SDGs) Goal 5 and the elimination of FGM is critical to this goal. There have been concerns about the rejection of the Gender and Equal Opportunities Bill 2010 by the Senate of the Federal Republic of Nigeria. The bill was rejected because it was perceived by the senate as not aligning with the religious and cultural landscape of Nigeria and lacked merit to be passed into law (Makinde et al., 2017).

The imbalance in gender roles which limits women and girls, leading to a “male-centric society” has led to the denial of women's' rights as reflected in the practice of FGM (Olanrewaju, 2020) and other harmful practices such as child, early and forced marriage, inheritance rights among others. A study in South West Nigeria showed that more men than women supported the perpetuation of FGM reflecting the patriarchal nature and the limited agency women have in taking a stand against it (Adeyinka et al., 2009). The strong gendered dimension of FGM is also perpetuated by the fact that women are unable to speak out and openly communicate their views. Such discussions are considered taboos; women and girls are bound by the culture of silence. The ability to control a woman's sexuality is one of the significant reasons why FGM still exist in the society (Adebola, 2020; Odo et al., 2020). The expectations from the girl child are so high that the family or clan's honour is dependent on her. As a traditional superstitious belief, FGM is used to promote community ideals about modesty/fidelity, socio-sexual attitudes (countering the failure of a woman to attain orgasm), to increase sexual pleasure of the husband, and increase matrimonial opportunities (Adebola, 2020; Ilesanmi & Ilesanmi, 2018). The gendered dimension of FGM is reflected in the linkage with preservation of virginity, marriageability and female chastity (Kolawole & Anke, 2010). This is similar to findings from an FGM study in Imo State (Ibebuike et al., 2018).

Women suffer negative experiences associated with FGM practice such as shame from not being cut, anxiety in anticipation of the procedure, regret, sadness and anger when

complications arise (Omigbodun et al., 2020). In addition, the woman is denied an opportunity to participate in the decision-making process because FGM is mainly practiced at birth or childhood (O. V. J. Uchenna et al., 2019).

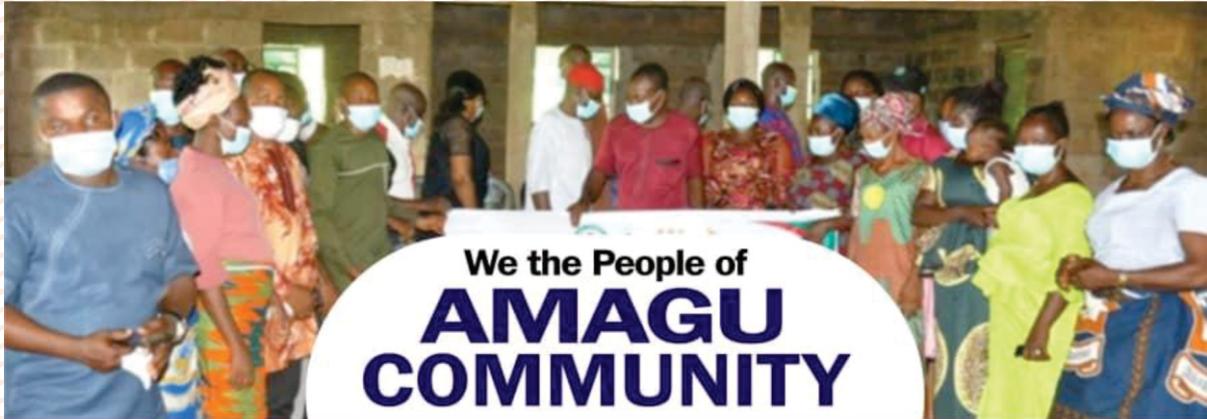
#### 4.2 Socio-economic factors

Socio-economic factors such as income, education, employment and social support play a significant role in the perpetration of FGM. Cultural and ethnic practices that are potentially harmful for health are usually more common among communities with lower socioeconomic status where people are least likely to be empowered by appropriate health education and behaviour change programs. Beliefs and practices are also likely to vary according to an individual's sociodemographic background, educational experience, and financial capacity to access the resources of health and adopt healthy behaviour (Sanni & Bishwajit, 2018). Socioeconomic standing is a strong marker of health beliefs, self-efficacy, and sensitivity to social pressure (Sanni & Bishwajit, 2018).

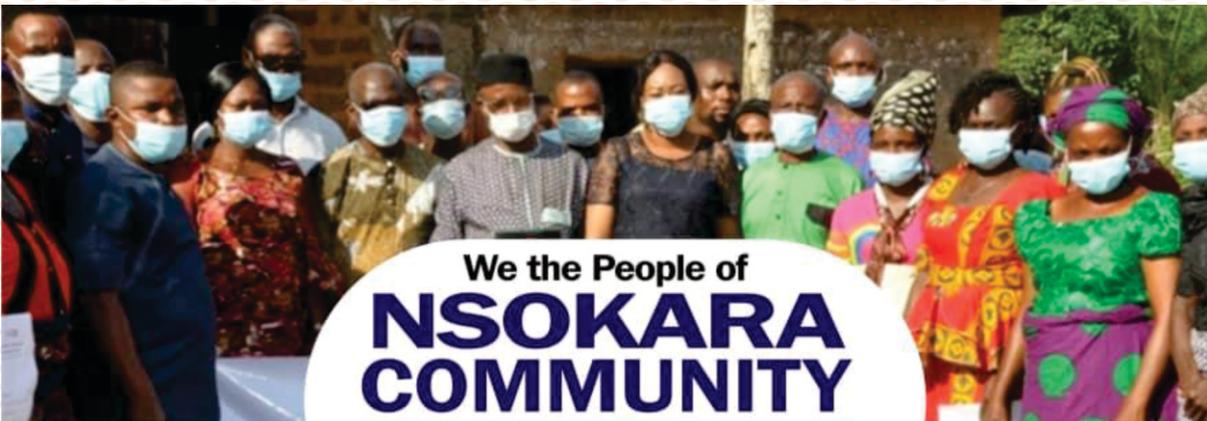
In some communities, the practice of FGM was perceived to have some form of economic advantages. In some culture, girls who went through this ritual were showered with gifts from community members and this motivates girls from poor families to subject them to the procedure (Olajumoke Ereola et al., 2020). Some health care workers perform FGM for financial gains due to poor remuneration and lack of strict code of conduct within the healthcare systems (Hinsliff-Smith et al., 2020). In addition, it serves as a means of livelihood for traditional excisors who practise FGM as a profession. These economic benefits which are viewed as a lifeline for sustaining their families may limit their motivation to support abandonment of the practice. Medicalisation is presumed to provide an alternative source of income for retired midwives; this implies that underlying the need to propagate the practice through this avenue are economic considerations among others (Kolawole & Anke, 2010).

South West Nigeria, plays host to several communities with very high prevalence of FGM and economic factors are critical drivers. Underlying the motivation for preserving the practice in some communities is the need to generate income for practitioners under the guise of preserving and continuing values and rituals (Kolawole & Anke, 2010). Eliminating the practice invariably would mean stopping the means of livelihood for the circumcisers, the Circumcision Descendants Association of Nigeria (CDAN), in their declaration for abandonment of FGM canvassed for the provision of alternative livelihoods for their members as a means of curbing FGM in South West Nigeria (B. Uchenna, 2017).

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## 5.0 RESPONSE ANALYSIS OF FGM IN NIGERIA

The primary responsibility of any government is to protect lives and property of its people through enactment of laws, and policy frameworks as well as programmes that address social problems. There is a consensus on the need for a multisectoral response to addressing FGM by incorporating education, health, community, legislation, as well as women and social services (WHO, 2008).

### 5.1 Policy Analysis: The Institutional and Policy Framework for FGM response

In 1994, Nigeria joined other members of the 47th World Health Assembly (WHA) in a resolution to eliminate and abandon FGM (Okeke et al., 2012). In 2008, the WHA resolution on the elimination of FGM highlighted the need for member countries to develop as well as implement policies and plans backed by adequate resources with indicators to track progress, coordination, and impact (WHA, 2008). The UN General Assembly in 2012 also passed a resolution calling on the elimination of FGM and urging countries to create awareness, allocate resources and enforce legislation to end the practice (UN General Assembly, 2012). As a response to these resolutions, the Nigerian government through various ministries developed health and legal frameworks for addressing FGM. The National Gender Policy, National Health Policy, National Health Strategic Development Plan (NHSDP) as well as other legal frameworks were reviewed to understand the existing policy framework, policy enablers and the alignment of state to national level response strategies for addressing FGM.

#### 5.1.1 Legal Framework for FGM response in Nigeria

Prior to the passage of the Violence Against Persons Prohibition Act (VAPP), the 1999 Constitution of the Federal Republic of Nigeria (CFRN) and the Child Rights Act (CRA) were used by organisations to campaign against FGM as these laws stipulate that the act of subjecting a person or child to inhumane or degrading treatment is a punishable offence. Although the Nigerian Constitution does not make specific reference to violence against women and girls, harmful traditional practices, or FGM, it prohibits discrimination and upholds equality and dignity. Article 34(1) of the 1999 CFRN provides that every individual is entitled to respect for the dignity of their person and, accordingly, no one 'shall be subject to torture, or to inhuman or degrading treatment.' Prior to the

enactment of VAPP Act, some states had enacted laws to address issues on violence against women and girls as well as criminalising FGM, the laws include:

- Ebonyi State -- Law Abolishing Harmful Traditional Practices Against Women and Children (2001)
- Bayelsa state -- FGM (Prohibition) Law (2004)
- Cross River State – The Girl-Child Marriages and Female Circumcision (Prohibition) Law (2000)
- Edo State – Prohibition of Female Genital Mutilation Law (1999)
- Enugu – FGM (Prohibition) Law (2004)
- Rivers State – Child Rights Act (2009) (28TooMany, 2018a).

In 2015, the VAPP act was passed into law and this law explicitly states that FGM is a criminal and punishable offense in Nigeria. The VAPP act also makes provisions for the protection of the rights of women and girls at individual, household, and community level. In summary, the law stipulates the following:

- Prohibition of mutilation or circumcision of the girl child or women.
- A person who performs or engages another person to carry out the offence is liable to imprisonment not exceeding 4years or a fine not exceeding N200, 000 (\$540.7) or both.
- A person who attempts to commit the offence is liable to imprisonment not exceeding 2 years or to a fine not exceeding N100, 000 or both.
- A person who incites, abets, counsels another person to commit the offence is liable to imprisonment not exceeding 2years or to a fine not N100, 000 (\$270.3) or both.

Figure 50 shows states that have adopted the VAPP act. Some states have their own prohibition laws against FGM (Olajumoke Ereola et al., 2020)



**Table 2: FGM Legal Framework in Nigeria (Adapted)**

S/N	Components of Laws Relevant to FGM prevention and management	VAPP Act (2015)	CFRN (1999)	Criminal Code
1	Clear definition of FGM	Nil	Nil	Nil
2	Criminalisation of the practices of FGM and associated penalties.	<b>Yes</b> Imprisonment not exceeding 4 years or to a fine not exceeding N200, 000 (as of June 25th, 2019) or both.	Nil	Nil
3	Criminalisation of the attempted practice of FGM and associated penalties.	<b>Yes</b> Imprisonment not exceeding 2 years or to a fine not exceeding N100, 000 or both.	Nil	Nil
4	Criminalisation of aiding, abetting and/or inciting the practice of FGM.	<b>Yes</b> Imprisonment not exceeding 2 years or to a fine not exceeding N100, 000 or both.	Nil	Nil
5	Provision forbidding FGM in consenting adults and the penalty	Implied	Nil	Nil
6	Provision prohibiting the use of consent as a defence.	Nil	Nil	Nil
7	Provision criminalizing assault, disability, discrimination due to refusal to undergo FGM and penalty	Nil	Nil	Nil
8	Provision for out of jurisdiction practice of FGM and penalty (extraterritorial clause)	Nil	Nil	Nil
9	Provision forbidding medicalization of FGM and penalty.	Implied	Nil	Nil
10	Provision mandating reporting of the offence and penalty.	Nil	Nil	Nil
11	Provision mandating a duty to avert and penalty.	Nil	Nil	Nil

### 5.1.2 Policies, Guidelines, and Strategic Frameworks for FGM response in Nigeria

The government has enacted several FGM related policies and sought to implement them. These are the National Gender Policy 2006, National Policy on the Health and Development of Adolescents and Young People 2007, National Policy and Plan of Action for the Elimination of FGM in Nigeria (NPPAEFN) 2013-2017 and National Reproductive Health Policy 2017 (Kimani and Obianwu, 2020). Of all the policies, guidelines, and strategic framework, the NPPAEFN is the only FGM related document that defines and classifies FGM using WHO standards.

The NPPAEFN (2013-2017), and National Reproductive Health Policy explicitly provided the situational analysis and policy context for FGM while others did not. The NPPAEFN outlines a robust national response to FGM in Nigeria, guiding principles, policy goals and objectives, strategies for implementation multi-sectoral roles and responsibilities, research, monitoring and evaluation, resource mobilisation and action plan from 2013-2017.

Table 3: Health sector response to prevention and management of FGM in Nigerian policies (Adapted from Kimani and Obianwu, 2020)

S/N	Components related to prevention and management of FGM	National Gender Policy 2006	National Policy on the Health and Development of Adolescents and Young People 2007	National Policy and Plan of Action for the Elimination of FGM in Nigeria 2013-2017	National Reproductive Health Policy 2017
1	Contains guiding principles relevant to addressing FGM	Yes	Yes	Yes	Yes
2	Highlights policy context/environment concerning FGM	Implied	Implied	Yes	Yes
3	Provides situation analysis of FGM	Nil	Nil	Yes	Yes
4	Priority areas and actions related to FGM addressed by the policy	<ul style="list-style-type: none"> <li>• Culture, family, and socialization</li> <li>• Gender-based violence</li> <li>• Health and reproductive services</li> </ul>	Sexual reproductive health and rights		Achieving gender equality and elimination of all forms of discrimination.
5	FGM related roles and responsibilities of health sector actors	The gender policy does not explicitly state the health sector's roles and responsibilities in policy	The policy recognizes that a multi-sectoral response is necessary for its successful	The policy outlines the roles and responsibilities for the different FGM	Reproductive health programme delivery rests on the pillar of inter-sectoral partnership with

		implementation	implementation and it describes the roles and responsibilities of the relevant sectors including the health sector, which it describes as having an important lead role in ensuring that there is an enabling environment for policy implementation.	response coordinating mechanisms (FGM advisory committee and FGM technical committee) at federal, state, and local government area/ community level	detailed roles and responsibilities for different sectors, including health sector actors namely the FMOH, SMOH, the local government, health professional associations, health professional regulatory bodies, and lay health workers
<b>6</b>	<b>Coordination mechanism for managing/implementing policy</b>	The structures and institutions involved in institutionalizing gender issues are coordinated by the Federal Ministry of Women Affairs, which has a seat at the Federal Executive Council.	The FMOH provides overall strategic support for the implementation of the policy	Implementation of the policy is driven by two major committees, the FGM Advisory Committee, and the FGM Technical Committee at Federal, State, and Local Government Levels	The National Reproductive Health Technical Working Group, a multidisciplinary and multi-sectoral technical advisory group coordinates policy implementation
<b>7</b>	<b>Monitoring and evaluation</b>	Yes	Yes	Yes	Yes
<b>8</b>	<b>Documentation of FGM related data or cases</b>	Nil	Nil	Yes	Nil

### 5.1.3 The Policy Environment: Enablers and gaps

The VAPP Act is not void of gaps as the implementation level is in its infancy as a few states are yet to domesticate the Act. Inconsistencies or absence of FGM definition in the Nigerian laws can create institutional loopholes on the accurate interpretation of what constitutes FGM, thereby perpetuating the practice, giving opportunities for people to evade sanctions, as well as weaken the effectiveness of these laws in protecting the rights and lives of women and girls (Kimani & Obianwu, 2020). In addition, FGM definition and classification does not incorporate type IV which consequently means it is silent about practices like pricking and cauterising which do not involve cutting. The VAPP Act does not directly criminalise cross-border FGM practice – in other words, it does not criminalise FGM carried out by Nigerians in other countries (28TooMany, 2018a). Additionally, the knowledge of the law and enforcement is weak, and no successful prosecutions have been made to date (28TooMany, 2018a).

#### Alignment of state with national level strategies for FGM response

The national level strategies have been included in the National Policy document which has the main goal of eliminating the practice of FGM in Nigeria in order to improve the health and quality of life of girls and women (Kimani & Obianwu, 2020). The plan of action targets the time period from 2013 – 2017 and they include:

- Plan of action for the reduction of incidence and prevalence of FGM in Nigeria
- Plan of action for the promotion of behaviour change initiatives towards the elimination of FGM in Nigeria
- Plan of action for strengthening the legal framework for the elimination of FGM at national and state levels
- Plan of action for the strengthening of systems for research, monitoring, and evaluation towards the elimination of FGM in Nigeria

It has been recorded that implementation of this legislative framework remains low across the states in Nigeria (WHO).

### 5.1.4 COVID-19 pandemic and impact on FGM Programming

There is a consensus among FGM stakeholders that the COVID-19 pandemic has disrupted the plans for FGM elimination and increased the risk of FGM in Africa due to the gendered impact of the pandemic on women and girls (ORCHID, 2020; UNFPA, 2020). FGM programming slowed down or in some instances was halted during the pandemic because interventions which typically occur in group settings at community level were not feasible; other programs were redirected to achieving pandemic control (UNFPA, 2020). There were reports that former cutters in Nigeria had returned to cutting due to loss of alternative sources of income (Thomas Reuters Foundation, 2021). Due to protracted school closures and increased economic pressures on households because of limited income, girls were more vulnerable to FGM as families explored the option of

marrying them off in exchange for dowry (Thomas Reuters Foundation, 2021). The conduct of FGM was easier due to associated restrictions in movement during the lockdown that made detection more difficult; unfortunately access to essential health and support services for FGM was also more difficult (ORCHID, 2020). The integration of FGM interventions into crisis response and classification of GBV/SRHR as essential services are key strategies that can improve FGM response in pandemics (ORCHID, 2020).

## 5.2 Health systems (Education, prevention, and response)

The health system is pivotal in providing a platform for prevention, management of complications and abandonment of FGM in Nigeria. Key components of the health system's role in the prevention of FGM should include discouraging the practice of medicalisation, raising awareness about the health and psychological consequences of FGM and facilitating abandonment by families and communities (Dirisu et al., 2020). Health complications of FGM include immediate complications such as bleeding, infection, pain, trauma to the urogenital system and death (R. Berg et al., 2014). Long term sequelae include obstetric complications (difficult and/or prolonged labour, perineal tears, postpartum haemorrhage, still birth), genitourinary complications (urinary tract obstruction, urinary incontinence, scarring and vaginosis), sexual complications (sexual dysfunction, dyspareunia, lack of libido) and psychological complications (depression, anxiety, post-traumatic stress disorder) (R. Berg et al., 2010; R. Berg & Denison, 2012; WHO, 2006). Policy, practice, and clinical guidelines for the management of FGM detail the role of the health sector in integrating prevention and provision of care for the management of complications (WHO, 2001c, 2001b, 2001a). Although several countries have established policies and protocols for addressing FGM, the level of engagement of the health sector is poorly understood (Johansen et al., 2018). A review of the health sector response in 30 countries showed that most countries forbade health care providers from conducting FGM on girls and women but re-infibulation was not consistently disallowed (Johansen et al., 2018). FGM related medical records were, however, limited or completely lacking in most countries (Johansen et al., 2018). Additionally, the area of responsibility of the health system is to support policy implementation for the abandonment of FGM in the society, including medicalisation. A health system's study reviewed the National Policy and Plan of Action for the Elimination of FGM in Nigeria and highlighted targets and strategies for relevant agencies, particularly health system, in responding to FGM (Dirisu et al., 2020). These targets are provided below:

- Increasing the number of healthcare facilities that provide care, counselling, and support to FGM survivors.
- Eradicating medicalisation of FGM
- Identifying appropriate indicators and developing relevant data-collection tools on FGM elimination for integration into the National Health Management Information Systems

- Mainstreaming FGM issues into the national agenda through incorporation into the National Strategic Health Development Plan.

Although, there are policy documents and guidelines detailing the roles of the health sector in integrating prevention and provision of care for the management of complications, there are limited policy documents and guidelines on the prevention and management of FGM in Nigeria (Dirisu et al., 2020).

### 5.2.1 Health System structures for prevention and management of complications

In Nigeria, the health system is structured to provide services through primary, secondary, and tertiary health facilities by both public and private sectors (FMOH, 2016). The 2016 National Health Acts and 1999 constitution failed to clearly give direction and leadership on the roles and responsibilities of the tiers of government in health systems management and delivery (FMOH, 2016; Dirisu et al., 2020). To fill this existing gap, Nigeria has several policies and plans, including National Reproductive Health Policy 2017, the Health Financing policy, and the National Health Promotion Policy. These policies are nested within the highest level of leadership of National Council on Health and other coordination platforms. However, poor harmonization and coordination of these platforms have led to duplication of functions and wastage of scarce resources (FMOH, 2016). The health system's response to FGM in Nigeria can be better understood using the WHO health system's framework under the following thematic areas; Leadership and governance; finance, service readiness, health workforce, Health Information Systems, and availability of medicines

- **Leadership and governance**

In Nigeria the NPPAEFN (2013-2017), is the most comprehensive FGM specific plan in Nigeria. The policy emphasizes the health system's response through the provision of care to FGM survivors and its significant role in prevention (FMOH, 2013). The health focused interventions include conducting training for health care providers, integrating FGM into sexual and reproductive health and HIV services, advocacy for the integration of FGM module into the training curricula of health institutions, sensitizing regulatory bodies and health professional associations on medicalisation and penalties for the practice, supporting regulatory authorities to monitor FGM practises in the health sector by developing and including FGM indicators in routine data collection tools at health facilities as part of National Health Management Information System (NHMIS). Additionally, the policy provides structures for coordinating FGM response at national, state, and local government levels. Despite the existence of these policies, the health system lacks comprehensive guidelines to manage FGM complications in line with WHO standards. The absence of adequate guidelines could limit the health system's response and efforts to improve the lives of women and girls who have undergone FGM (Kimani & Obianwu, 2020). In 2017, as a response to the gap, the Federal Ministry of Health developed "Standards and Guidelines for the Medical Management of Victims of Violence". Although the guideline is not FGM specific, it provides a structure for the management of complications experience by victims of violence in Nigeria. Also, it is

used as a working tool for the management of FGM complications and provides guidance to all categories of service providers across relevant agencies on FGM-related issues (FMOH, 2016). There is also a validated National Protocol for the management of FGM complications.

Findings from a health system study on FGM suggests that stakeholders were not aware of the FGM specific policy and the plan of action (Dirisu et al., 2020). Poor policy awareness among stakeholders would negatively impact on the stakeholders' ability to implement strategies as well as impede stakeholder's ownership of policy implementation strategies at state and local level. Additionally, poor domestication of VAPP Act in states and the fact that VAPP Act does not criminalise and penalize failure to report FGM by health care workers is a major challenge limiting health system's response.

- **Financing**

Paucity of funds to drive health activities across all tiers of government is a key barrier to the FGM health system response. A study indicates that expenditure from all tiers of government amounts to less than 6% of total government expenditure (Ichoku & C.I., 2015). This reflects poor political will from all tiers of government and explains over reliance on donor funds for projects.

- **Service Delivery**

There are pockets of interventions that are focused on trainings, awareness, and sensitisation which have increased knowledge about the practice in communities. In some states, FGM topics have been integrated into Antenatal Clinics (ANC) at PHCs. Also, FGM topics have been included in the curriculum of Health Training Institutions but this was however limited to a segment of health care workers and this reflects a knowledge gap in the prevention and management of FGM in Nigeria. Also, lack of FGM specific training would mean that healthcare workers depend on their judgement to manage complications resulting in inconsistencies in responding to the needs of survivors. In 2018, UNFPA supported the development of a FGM module for nurses and midwives as part of a series of modules available for them to take as part of their mandatory continuous education program.

- **Health workforce**

It is essential for healthcare workers to have a clear understanding of what services to provide when they encounter FGM survivors. The National Protocol for the management of complications of FGM addresses the gaps in capacity relating to management of FGM as well as referral pathways. Aside capacity gap, the health system in Nigeria is plagued by inadequate health workforce. It has been estimated that the ratio of health workforce to population is 1.95 per 1000 (Abimbola et al., 2017; WHO, 2016; Gyuse et al., 2018). This speaks volume about the health system levels of preparedness in terms of access to care. Inadequate workforce has series of implications, the limited health workforce is

stretched and this may pressure the health system to engage poorly qualified professionals (Willis-Shattuck et al., 2008). UNFPA as part of the UNJP is building capacity of health workforce in the five intervention states to manage the complications of FGM and to sensitise the workforce against the practice of medicalisation.

- **Health Information System**

One of the crucial strategies highlighted in the policy is the health system's role in monitoring FGM in the health sector by developing and including FGM indicators in routine data collection tools at health facilities as part of National Health Management Information System (NHMIS). A health system study in Imo state found that FGM cases were not captured at the health facility, hence FGM specific data was non-existent (Dirisu et al., 2020). The National Strategic Health Development Plan 2009 -2015 indicated that failure to capture data makes it difficult to have successful interventions (Federal Ministry of Health (FMOH), 2010). FGM indicators to assess services for prevention and care were recently included in the NHMIS and it is expected that this will improve FGM monitoring in the health sector. It is expected that health workers will facilitate the collection of FGM data across health facilities in Nigeria. In addition to training health workers to consistently collect accurate data on FGM, it is also important to ensure that they are equipped to use the data to improve decision making for FGM prevention and programming at facility, local government and state level.

- **Availability of Medicines, Equipment and Supplies**

Funding is a major determinant of availability or unavailability of essential commodities. The issue of inadequate commodities relating to FGM services mirrors the state of the health system in the country. Studies have documented a poorly equipped health system in Nigeria and limited capacity for quality health service delivery (Uneke et al., 2007; Efe, 2013).

### 5.3 Community Systems

#### 5.3.1 Community mechanisms for FGM response

In Nigeria, there are community level programmes targeted at protecting girls from FGM. A broad range of interventions and strategies have been undertaken by international and local NGOs to eliminate FGM. NGOs adopt variety of strategies in their work against FGM, including community dialogue approaches targeting traditional and religious leaders. These strategies are aimed at addressing health complications of FGM; promoting girls' education and awareness against FGM; equipping traditional excisors with alternative income sources; using media to enhance messages on FGM; and working with boys, men and religious leaders to become change agents. Some examples of Government, local and international NGO work to facilitate abandonment include:

- In the year 2000, the Federal Ministry of Women Affairs undertook a zonal advocacy and sensitization programme to traditional rulers, religious and policy makers to increase awareness on harmful traditional practices and advocate for

its abandonment resulting in the reduction of these practices (Anzaku et al., 2018). In 2019, WHO in collaboration with UNICEF and UNESCO launched a global “de-medicalization campaign” strategy which was aimed at coordinating the efforts of policy makers, community leaders and other stake holders in the fight against medical FGM (Epundu et al., 2018).

- In 2016, there was a five-point communique by the traditional leaders in Ebonyi state which included total condemnation of the practice of FGM and advocacy for state laws and sanctions against those that practice FGM. Furthermore, these rulers made commitments to lead in the sensitisation against the practice of FGM in their communities and also to introduce traditional laws to sanction defaulters (Epundu et al., 2018). In addition, the Circumcision Descendants Association of Nigeria (CDAN)—a group whose members perform FGM in Nigeria, advocated to end the practice in 2016 by creating new programs and economic opportunities for those who perform female genital mutilation (Omotola, 2016). Other community level campaigns have involved massive community level awareness focusing on men to take the lead to end FGM; this campaign has been implemented in Osun state (Education as a Vaccine, 2016).
- Girls Effect's effort for the inclusion of Harmful Traditional Practices (HTPs) in school curricula and teacher training (28TooMany, 2018a); and the Girl Generation initiative supporting grassroots organisations to strengthen their social change communications strategy to end FGM.
- The Inter-African Committee (IAC) on Traditional Practices' work on advocacy and sensitization through videos, booklets, and mass media as well as Alternative Employment Opportunity (AEO).
- UNJP: Since 2014, the UNFPA - UNICEF Joint Programmes have been crucial to FGM abandonment interventions, campaigns, and strategies in Nigeria. The UNJP has worked through a human-right based approach to address social and cultural norms driving the practice in states with high burden including Ebonyi, Ekiti, Imo, Oyo, and Osun states in Nigeria. It is currently in phase 3 with the goal of achieving the global commitment to end the practice by 2030, as called for in the Sustainable Development Goals (UNICEF & UNFPA, 2017). The UNJP utilises an integrated approach using legal and policy instruments at federal level as well as provision of services and community approaches to addressing norms and taboos surrounding the practice. Some community specific achievements include:
  - Capacity strengthening for health workers to manage FGM complications.
  - Increase awareness and information among women on FGM
  - Community education to drive social change among young people on abandonment.

- Engagement of community and religious leaders to reach consensus on declaring FGM abandonment
- Social media campaign through video production, website hub, twitter chats, website hub, Facebook conferences and blogs, and radio announcements.

A wide range of local NGOs and community-based organisations have worked closely with traditional and religious leaders to support the abandonment of FGM. The broad range community of mechanisms they utilise include community discussions targeting circumcisers, traditional and religious leaders; media engagement on FGM (for example, 16 days of activism), community mobilisation on the health effect of FGM and empowerment support for girls and women (Awolola & Ilupeju, 2019; Ilesanmi & Ilesanmi, 2018).

The scope of the coordinated FGM response by the Nigerian government includes awareness campaigns, and attitude interventions which comprise changing the attitudes of health care professionals, individuals, families, and communities as well as practice interventions that seek to give rise to behavior change (Uchenna Mberu & Mberu, 2017). Interventions have been associated with state wide sensitizations, outreaches and programs directed at raising awareness of the practice by targeting women's group, platforms like 'August Meetings' and also utilizing local influencers such as FGM champions and traditional leaders to advocate for total abandonment in Imo state (Dirisu et al., 2020).

In the past 20 years, several international organisations including, UNICEF, UNDP UNFPA and WHO have partnered with the Federal Ministries of Women's Affairs and Health to fund awareness programs on FGM. Across the nation, there have been several efforts on ending FGM and these include the involvement of "FGM Champions", sponsored media programs as well as partnerships between the wives of state governors in the UNJP states to facilitate social mobilization to end FGM (Awolola & Ilupeju, 2019; Ilesanmi & Ilesanmi, 2018). The provision of alternative sources of income for circumcisers has also been used as a strategy to end FGM, unfortunately, this has not yielded the expected result in some communities where it was practised (Awolola & Ilupeju, 2019; Ilesanmi & Ilesanmi, 2018).

### **5.3.2 Community level barriers and enablers of the response**

The most common reasons for the practice of FGM are related to tradition and religion; (Amusan & Asekun-Olarinmoye, 2008) this explains the reluctance to stop the practice by some because they believe that the practice is associated with benefits (Odo et al., 2020). According to (Wogu et al., 2019), mothers who were circumcised gave up their own female children for circumcision. Some who do not believe in the benefit of FGM still give their daughters to be cut because of cultural orientation, societal pressure/norms or fear of punishments like being excommunicated or mocked by members of the community or even maltreated by family members (Odo et al., 2020). Parents are aware of the immediate physical health consequences of FGM such as pain

and bleeding which some don't see as enough reason to stop the practice, this could be due to the cultural perception of the practice. In a recent study carried out, only a few participants could fully identify all the health implications of FGM, this could be the main reason the practice is still going on in the communities (Odo et al., 2020).

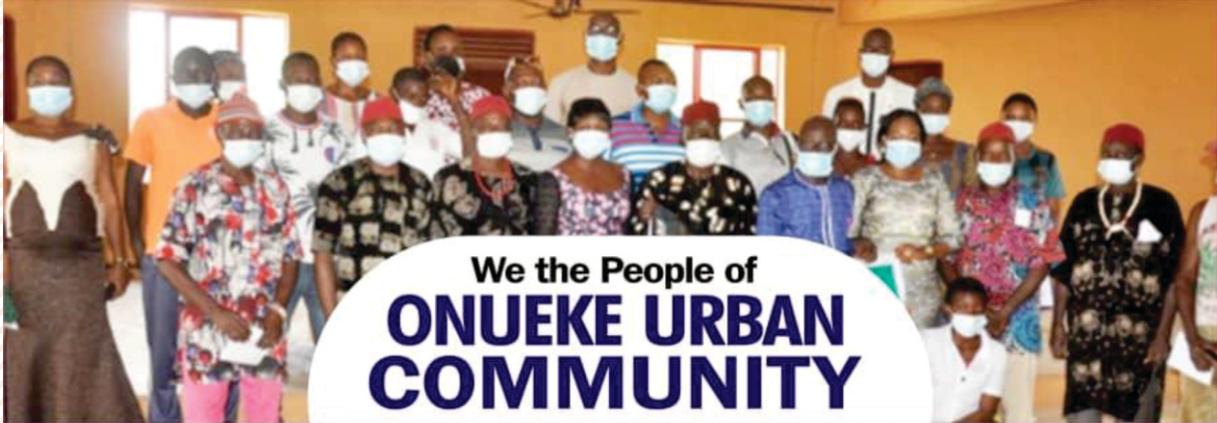
One of the strategies employed by UNJP was to encourage community and religious leaders who are key influencers to openly declare the abandonment of FGM in communities and religious centres. For example, in 2017, community and religious leaders with good media coverage openly declared complete abandonment of FGM in communities such as Ekoinde, Ede, Iwo, and Apomu in Osun states, a UNJP state (Okeke et al., 2012). The introduction of FGM Champions by UNFPA in some communities to sensitize community members on associated harmful effects and legal implications of the practice has also been effective (Uchenna Mberu & Mberu, 2017). Another community response enabler involve awareness campaigns about the medical, social, and psychosocial complications of FGM, as increased education empowers vulnerable people to take informed decisions about their lives. A mother with accurate knowledge of FGM is less likely to cut her daughter (Uchenna Mberu & Mberu, 2017). Studies have shown that programs designed to be participatory at community level are more successful in protecting girls from FGM and invariably help the drive towards elimination (UNICEF, 2008). Community members and families are equipped with knowledge of their human rights and responsibilities, encouraging them to sensitize other members of their families and communities (UNICEF, 2008).

A key barrier to FGM practice is the pervasiveness of cultural and social norms that support the continuation of the practice (28TooMany, 2018a). Studies have indicated that one of the commonest justifications for FGM practice is religious and cultural orientations (Amusan & Asekun-Olarinmoye, 2008). Hence, the refusal to abandon the practice because they believed that the practice is beneficial (Odo et al., 2020). Other factors limiting the FGM abandonment include resistance from circumcisers who believed that alternative source of income should be

provided as a form of replacement for cutting. Additionally, reports have revealed that some babies are being secretly cut in some communities where abandonment resolutions were made (UNFPA, 2016). Additional barriers at community level include mothers, aunts, grandmothers who view themselves as key enforcers in most communities and push the narrative that girls who refuse to be cut will be forced to undergo the procedure against their own will (Uchenna Mberu & Mberu, 2017). According to (Wogu et al., 2019), mothers who were circumcised gave up their own female children for circumcision.

The absence of coordinated Federal level network of organizations or groups working to eliminate FGM has been identified as a gap in the efforts towards eliminating FGM. Although there are a number of organizations in different regions of the country working to eliminate FGM, there is a limit to what can be done if they don't synergize in terms of exchanges of ideas of information, as concerted efforts may get the job done faster (28TooMany, 2016). Some studies also have shown that programs designed to be participatory at community level are more successful in protecting girls from FGM and invariably help the drive towards elimination. Community members and families are equipped with knowledge of their human rights and responsibilities, encouraging them to sensitize other members of their families and communities.

PHOTO GALLERY

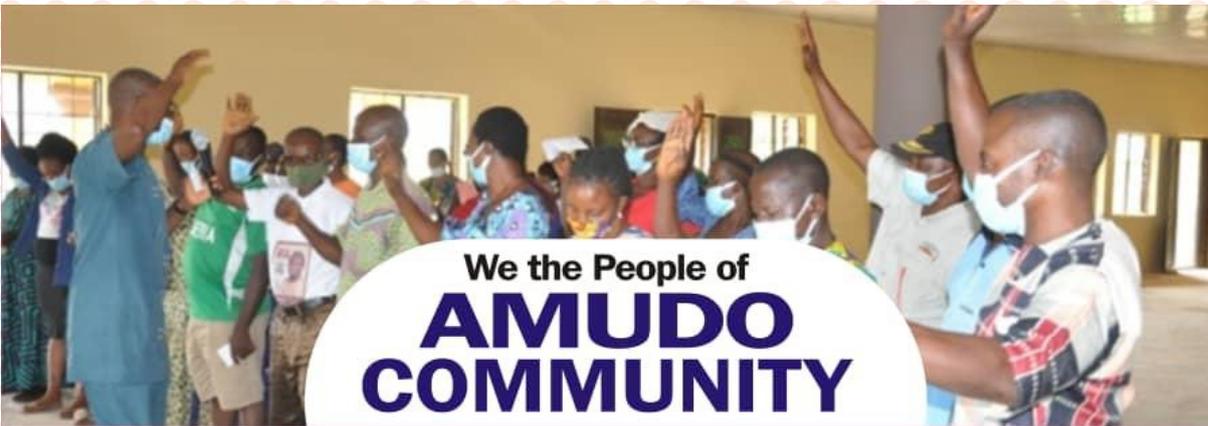


**COLLECTIVELY AGREED PUBLICLY  
DECLARE THE ABANDONMENT OF FEMALE  
GENITAL MUTILATION ON THIS DAY 14TH SEPTEMBER, 2021**



**COLLECTIVELY AGREED PUBLICLY  
DECLARE THE ABANDONMENT OF FEMALE  
GENITAL MUTILATION ON THIS DAY 15TH SEPTEMBER, 2021**

## PHOTO GALLERY



**COLLECTIVELY AGREED PUBLICLY  
DECLARE THE ABANDONMENT OF FEMALE  
GENITAL MUTILATION ON THIS DAY 15TH SEPTEMBER, 2021**



## PHOTO GALLERY



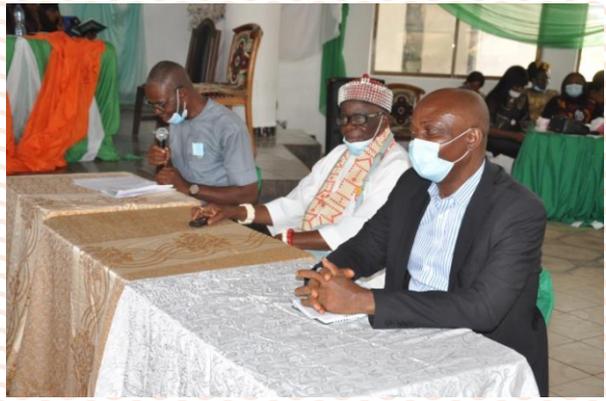
**COLLECTIVELY AGREED PUBLICLY  
DECLARE THE ABANDONMENT OF FEMALE  
GENITAL MUTILATION ON THIS DAY 16TH SEPTEMBER, 2021**



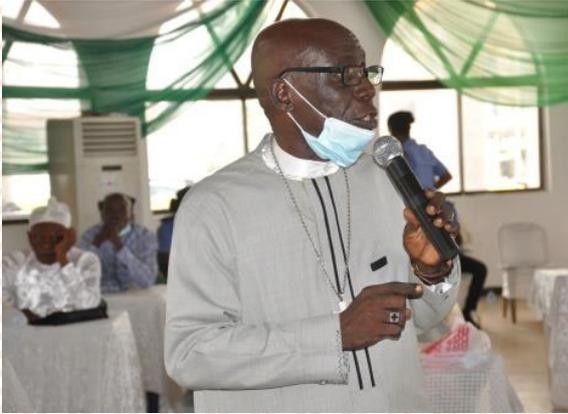
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## 6.0 CONCLUSION AND RECOMMENDATION

### 6.1 Summary of Findings

This review explored the FGM situation in Nigeria, the response as well as enablers and barriers in achieving set targets. Although significant progress has been made in supporting interventions and policies for the elimination of FGM, findings suggest that the impact is fragmented across the country possibly due to lack of sustained policy change, medicalization, and other emerging issues. Findings from the MICS and NDHS using the state-of-the-art synthesis approach suggests an overall long-term steady decline in the prevalence of FGM among women (Shell-Duncan et al., 2016). This may be linked to weakening of community structures and beliefs that continue to yield to an integrated abandonment strategy that incorporates advocacy, awareness, education, and legal frameworks that drive support for abandonment.

The findings also suggest an increase in prevalence among girls reflecting continuation of the practice. The increase in prevalence among girls is, however, driven by an increase in the burden across the Northern region of the country compared to the Southern region. The Southern region of Nigeria has experienced a concentration of intervention programs focused on abandonment of FGM. The impact of these programs maybe closely linked to the decline in the Southern Nigeria (Kandala, Chibuzor, et al., 2020). Despite this decline, the overall prevalence continues to be higher in the Southern region of Nigeria suggesting the need for interventions to continue to facilitate further decline. Regional disparities in the emergence of new hotspots reflect the need for country wide interventions that address FGM to ensure that milestones achieved in abandonment are sustained.

Despite the overall decline in FGM, the proportion of women who support the continuation of FGM has remained stable across the surveys for the NDHS and MICS. With over 20% of women supporting the continuation of FGM, the need to sustain awareness and behavior change in favor of abandonment at community level cannot be overemphasized. Support for FGM even in areas that have experienced a decline may lead to the re-emergence of those areas as new hotspots in the future as this is a reflection of women's willingness to cut their daughters (Kandala, Chibuzor, et al., 2020).

Findings reflect a reduction in the practice of medicalization possibly due to improved awareness of laws and policies on FGM among health workers, health system-related interventions, and the strict stance taken by professional associations such as SOGON (SOGON, 2015). Despite the decline, medicalization continues to occur. Nigeria, however, still has one of the highest medicalization rates globally possibly because of the integration of FGM into the bouquet of services provided by health workers at birth such as ear piercing and new-born care (Obianwu et al., 2018). There is the need to continue to drive awareness and intervention programs among birth attendants who continue to sustain the practice.

Different types of FGM persist across the country, findings in this review show that although excision is still the most common form of FGM, clitoridectomy is increasing. This represents a trend towards less severe forms of the practice possibly due to increasing awareness of the health risks of FGM (Obianwu et al., 2018). The increase in the proportion of people who view FGM as a religious requirement may not only validate the practice but reinforce community norms around chastity and fidelity (Ilesanmi & Ilesanmi, 2018; O. V. J. Uchenna et al., 2019). The most common reason for the practice of FGM relate to traditions which is intricately linked to ethnicity and religion (Amusan & Asekun-Olarinmoye, 2008). This explains the resistance to change because of the strong linkages with norms and religion (Odo et al., 2020). Ending FGM requires close and sustained engagement with religious leaders, community leaders, custodians of culture that include mothers, grandmothers, heads of households that work to preserve the practices through generations. When women, girls, community members and families are equipped with knowledge of their human rights and responsibilities in a participatory manner, they are encouraged to sensitize other members of their families and communities (UNICEF, 2008).

Findings from the UNJP states show that the prevalence of FGM has declined across the states due to focused interventions over the past decade. Imo state, however, still has the highest burden for women (age 15-49) in Nigeria and the third highest burden for girls (age 10-14) after Jigawa and Kaduna states as reported by the NHDS. MICS however, reports Osun state as having the highest prevalence in the country. The support for FGM among women has largely declined in Osun, Oyo, Ebonyi, and Imo states indicating a positive development in weakening of the practice. The reverse is, however, the situation in Ekiti state possibly due to sustenance of norms that support the practice (Alo & Gbadebo, 2011; Sipsma et al., 2012). Despite the efforts towards abandonment, the burden of FGM is still very substantial, and it is important more than ever to intensify efforts to further reduce and eventually abandon the practice.

## **6.2 Identified gaps in what is known about FGM programming and response in Nigeria**

The linkages between FGM policy and practice interventions with the decline in FGM is poorly understood. There has been no rigorous evaluation of FGM interventions in Nigeria making it difficult to clearly attribute the decline in FGM prevalence to the direct

impact of these programs. Lack of a clear understanding of what works limits the replicability of strategies in new hotspots coupled with the complex contextual situations that exist in different regions of Nigeria. The transitions in the practice of FGM across cultures may be related to the ways community norms and beliefs have evolved but it unclear how this has occurred (Uchenna Mberu & Mberu, 2017). This is strongly reflected in the perceptions that facilitated a shift towards medicalization that were still situated in the community norms that perpetuate FGM.

Although FGM interventions in Northern Nigeria have been limited, the drivers of the recent increase in prevalence are poorly understood especially against the backdrop of sustained awareness about policy change in favor of abandonment in Nigeria. There is need for further research to understand the new trends in Northern Nigeria and the culturally appropriate response to adapt. Evidence based interventions will be more effective in creating sustained reduction in FGM and facilitate replication in other settings. In addition, although it is presumed that rural-urban migration may account for the higher prevalence in urban areas, there may be other explanations for this finding that may have implications for the FGM response in Nigeria.

### **6.3 Identified opportunities for better FGM programming and response in Nigeria**

1. **Government Legal Framework:** The enactment of the VAPP act in 2015 is considered a landmark development in the elimination of FGM in Nigeria because it specifically prohibited FGM as well as other forms of violence against women and girls. Programs that support the domestication of The act across all states in Nigeria will increase opportunities for institutionalizing the legal framework for the elimination of FGM in Nigeria.
2. **Advocacy:** Sensitization and advocacy are key to ensuring that the act is understood, adopted, domesticated, and operationalized using participatory approach to foster abandonment. While a legal framework for addressing FGM is an important step, understanding and addressing the social norms within the framework is critical for sustainable change.
3. **Prevention:** The health system response has been a critical component of the programs for prevention and management of complications of FGM. As the medicalization rate in Nigeria continue to reduce, health workers can become advocates in re-orientation and education within the health system and across communities.
4. **FGM Program Coordination:** The absence of coordinated Federal level network of organizations or groups working to eliminate FGM has been identified as a gap in the fight towards eliminating FGM. Although there are several organizations in different regions of the country working to eliminate FGM, there is a limit to what can be achieved given the poor synergy in interventions (28TooMany, 2018a). Future opportunities for the response should include the integration of approaches and synergy across FGM implementing organisations.

This will also address current gaps to effective implementation of current FGM strategies which may not be the best approach to abandonment (Awolola & Ilupeju, 2019).

#### **6.4 Limitations of this situation analysis**

Findings and interpretations in this situation analysis may be limited due to limitations in the data collection methods for the national surveys utilized in exploring the epidemiological situation for FGM in Nigeria so of which have been described in the review. There may be possible cofounders that were not accounted in the prevalence, patterns and trends in the practice of FGM. The absence of rigorous evidence on the evaluation of the FGM response in Nigeria implies that some of the inferences are suggestive of the potential impact described.

#### **6.5 Conclusion**

This review explored the FGM situation in Nigeria, the response as well as enablers and barriers in achieving set targets. Findings reflect significant progress towards the decline in the prevalence of FGM among women. An integrated abandonment strategy has garnered high level support globally may be linked to the milestones achieved in abandonment. The milestones achieved with weakening of community structures and norms that promote FGM are linked to the strong advocacy and awareness creation for FGM based on legal, human rights and moral grounds. The emergence of new hotspots in Northern Nigeria reflects the need for country wide interventions that address FGM to ensure that milestones achieved in abandonment are sustained. The reduction in the practice of medicalization is a positive development, however, there is the need to continue to drive awareness and intervention programs among birth attendants who continue to sustain the practice.

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