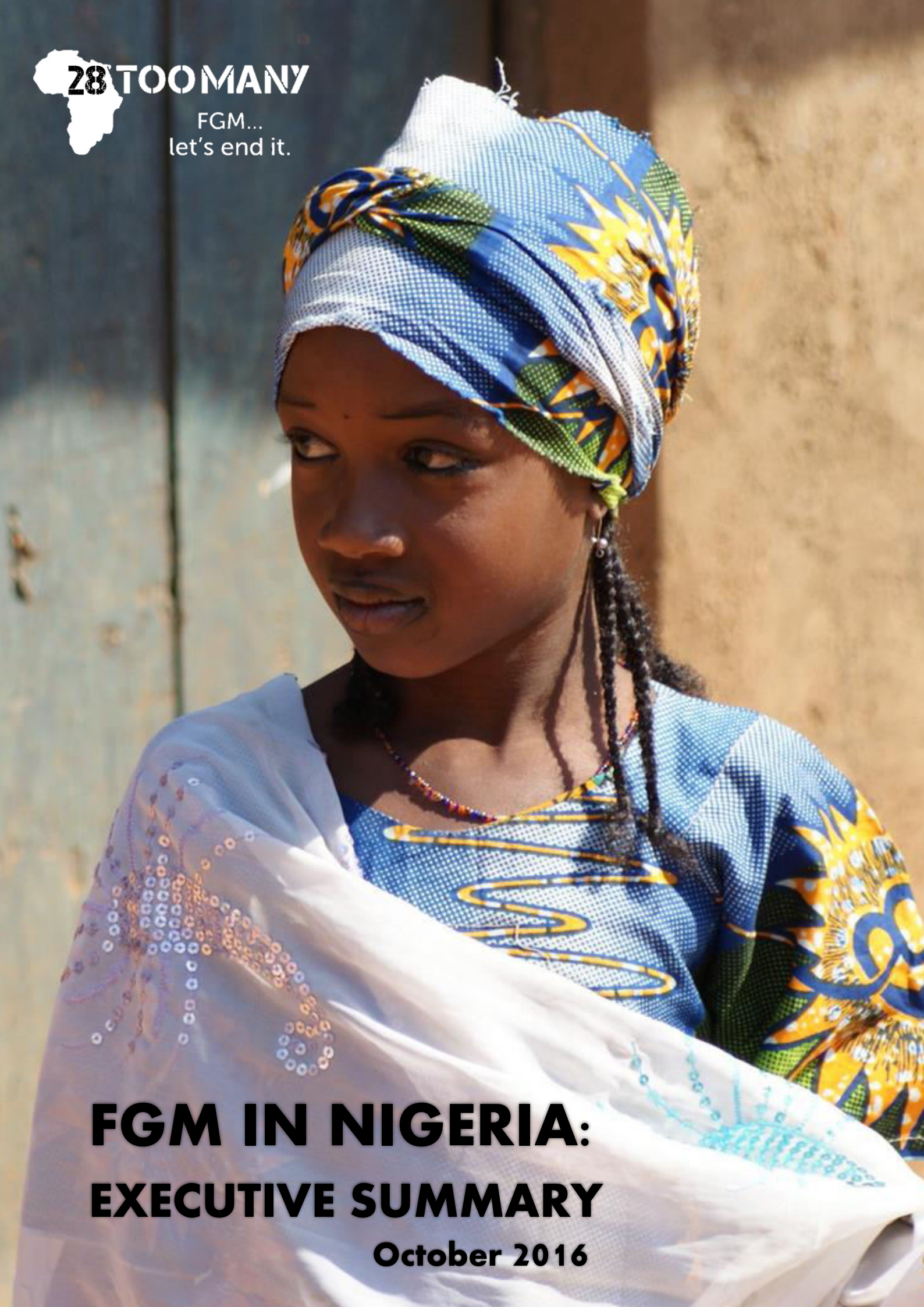

FGM IN NIGERIA:
EXECUTIVE SUMMARY

October 2016

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FGM...
let's end it.

COUNTRY PROFILE: FGM IN NIGERIA EXECUTIVE SUMMARY

October 2016

20 million girls and women are estimated to have undergone FGM in Nigeria. This represents 10% of the global total.
(UNICEF, 2013; 2016)

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

In Nigeria the estimated prevalence of FGM among women aged 15 to 49[i] is 24.8% (DHS 2013, p.348). This figure has not changed significantly in recent years. In the DHS 2008 (p.300) it was 29.6%, which meant Nigeria was classified as a 'moderately low prevalence' country by UNICEF (2013, pp.26-7). This 4.8% reduction has now moved it into UNICEF's 'low prevalence countries' classification.

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

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

This variation broadly corresponds to the spread of Nigeria's ethnic groups. The Hausa-Fulani, largely based in North East and North West, have an average prevalence of 16.3%, while the

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

Yoruba, mainly based in the South West, have a prevalence of 54.5%, and the Igbo, mainly based in the South East, have a prevalence of 45.2% (p.349). However, social and physical mobility means the lines between ethnic groups and their locations are becoming increasingly blurred in modern Nigeria.

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

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

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

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

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

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

Most instances of FGM are carried out by traditional practitioners; the remainder are carried out by medically trained personnel (or by unknown parties) (p.357). The slight increase in the use of traditional practitioners that is evidenced through the DHS data may be indicative of the

laws against FGM put in place in some states, as doctors and nurses become more reluctant to take part in the practice.

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

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

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

Although freedom of press in Nigeria is limited, social media is taking a strong hold across the country and has been used effectively to draw the attention of Federal and State Governments to violence against women and girls. Her Excellency Aisha Buhari, the First Lady of Nigeria has been active in encouraging female leaders and the wives of state governors to take up the issue of FGM, and introduce and implement the laws against FGM and child marriage in their states. *The Guardian*'s End FGM Global Media Campaign (GGMC) has, alongside other projects that target influencers, recently run a successful Media Training Academy for activists, journalists and religious broadcasters, training them on effective ways to use the media in activism against FGM. Immediately after this, a number of new projects were begun by graduates.

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

We propose the following measures:

- *Adopt culturally relevant programmes.* There is a strong national message against FGM, but this needs to be reinforced at state and district levels, to ensure changes in behaviours and attitudes towards FGM take hold within communities.

- *Provide long-term funding*. Funding is a common problem across the development sector. Organisations working against FGM need sustained and committed support from government programmes, particularly given the conflict in parts of the country, which increases the vulnerability of girls and women. They also need to continue reaching out for partnership and networking opportunities among themselves, across states, and with other national and international organisations.

- *Consider FGM in response to the SDGs*. The SDGs contain a specific target for the elimination of FGM by 2030. This will be an incentive to countries to take more positive action against the practice.

- *Improve access to education*. Facilitating education and supporting girls through secondary and further education is vital, as current figures indicate that better-educated mothers are less likely to have their daughters cut.

- *Increase health resources, improve access to healthcare and provide healthcare professionals training and guidance on managing health complications related to FGM.*

- *Introduce and increase enforcement of relevant laws at state level, and ensure those responsible for FGM are prosecuted.*

- *Foster effective and diverse media campaigns*. Effective campaigns reach out to various regions and sections of society, especially women, and/or take advantage of the recent social media boom.

- *Encourage faith leaders and faith-based organisations* to act as agents of change, challenge misconceptions that FGM is a religious requirement and be proactive in ending FGM.

- *Engage with men and boys when conveying the anti-FGM message.*

- *Government facilitation of a federal-wide and cross-state network of organisations working towards the elimination of FGM.* This may be done in collaboration with UNFPA and UNICEF, as part of the UNJP, and would encourage learning and provide a framework for coordinating resources and action.

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

References:

Alo, O. A. and Babatunde, G. (2011) 'Intergenerational attitude change regarding Female Genital Cutting in Yoruba speaking ethnic group of Southwest Nigeria: A qualitative and quantitative enquiry', *Electronic Journal of Human Sexuality*, 14(8). Available at http://www.ejhs.org/volume14/FGC.htm [accessed September 2016].

Chatora, A. (2016) 'Nigeria: Medical and nursing councils to offer course in female genital mutilation to fight the practice', *This Is Africa*, 19 February. Available at http://thisisafrica.me/16782-2/ (accessed September 2016).

DHS 1999, DHS 2003, DHS 2008 and DHS 2013, respectively (all accessed August 2016):

National Population Commission [Nigeria] (2000) *Nigeria Demographic and Health Survey 1999*. Calverton, Maryland: National Population Commission and ORC Macro. Available at http://dhsprogram.com/pubs/pdf/FR115/FR115.pdf.

National Population Commission [Nigeria] and ORC Macro (2004) *Nigeria Demographic and Health Survey 2003*. Calverton, Maryland: National Population Commission and ORC Macro. Available at http://www.dhsprogram.com/pubs/pdf/FR148/FR148.pdf.

National Population Commission [Nigeria] and ICF Macro (2009) *Nigeria Demographic and Health Survey 2008.* Abuja: National Population Commission and ICF Macro. Available at http://www.unicef.org/nigeria/ng_publications_Nigeria_DHS_2008_Final_Report.pdf.

National Population Commission [Nigeria] and ICF International (2014) *Nigeria Demographic and Health Survey 2013*. Abuja and Rockville, Maryland: NPC and ICF International. Available at https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf.

The Guardian (2016) *Nigeria: UNFPA Partners FG to End FGM/C in 40 Communities*, 9 February. Available at http://allafrica.com/stories/201602100147.html [accessed May 2016].

UNICEF – UNITED NATIONS CHILDREN'S FUND (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. Available at http://www.unicef.org/publications/index_69875.html [accessed September 2016].

Photograph on front cover:

Lodge, Rosemary (2009) *Girl in Selby, Gashaka Gumti National Park, Nigeria* [cropped]. Available at https://flic.kr/p/a2PnDG [accessed August 2016].

Please note the use of this photograph does not imply that the girl pictured has, nor has not, undergone FGM.

Registered Charity: No. 1150379
Limited Company: No: 08122211
E-mail: **info@28toomany.org**

v2 November 2017