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Female genital mutilation/cutting in Nigeria: A scoping review

Blessing U. Mberu

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FEMALE GENITAL MUTILATION/CUTTING IN NIGERIA: A SCOPING REVIEW

May 2017

FEMALE GENITAL MUTILATION/CUTTING IN NIGERIA: A SCOPING REVIEW

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AFRICAN POPULATION AND HEALTH RESEARCH CENTRE

MAY 2017

The Evidence to End FGM/C: Research to Help Girls and Women Thrive generates evidence to inform and influence investments, policies, and programmes for ending female genital mutilation/cutting in different contexts. Evidence to End FGM/C is led by the Population Council, Nairobi in partnership with the Africa Coordinating Centre for the Abandonment of Female Genital Mutilation/Cutting (ACCAF), Kenya; the Gender and Reproductive Health & Rights Resource Center (GRACE), Sudan; the Global Research and Advocacy Group (GRAG), Senegal; Population Council, Nigeria; Population Council, Egypt; Population Council, Ethiopia; MannionDaniels, Ltd. (MD); Population Reference Bureau (PRB); University of California, San Diego (Dr. Gerry Mackie); and University of Washington, Seattle (Prof. Bettina Shell-Duncan).



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LIST OF ACRONYMS

AU	African Union
AJRH	African Journal of Reproductive Health
CDAN	Circumcision Descendants Association of Nigeria
CSO	Civil Society Organisation
CWSI	Centre for Women Studies and Intervention
DFID	Department for International Development
ECA	Economic Commission for Africa
FGM/C	Female Genital Mutilation/Cutting
FIGO	Federation of International Obstetrics and Gynecology
HTP	Harmful Traditional Practice
IAC	Inter-African Committee of Nigeria on Harmful Traditional Practices Affecting the Health of Women and Children
IEC	Information, Education and Communication
LGA	Local Government Area
MDCN	Medical and Dental Council of Nigeria
NAPTIP	National Agency for the Prohibition of Trafficking in Persons
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organisation
NOA	National Orientation Agency
NCN	Nursing Council of Nigeria
NOKC	Norwegian Knowledge Centre for the Health Services
NPC	Nigeria Population Commission
PRB	Population Reference Bureau
TBA	Traditional Birth Attendant
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAPP	Violence Against Persons (Prohibition) ACT, 2015
WACOL	Women Aid Collective
WHARC	Women's Health and Action Research Centre
WHO	World Health Organisation
WOPED	Women's Centre for Peace and Development

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EXECUTIVE SUMMARY

This report's overarching objective is the examination of key trends in the evidence base of female genital mutilation and cutting (FGM/C) and gaps in knowledge for Nigeria, building on a scoping review of peer-reviewed and 'grey' literature along with quantitative analysis of relevant data. What is clear from prevalence levels identified over the last 15 years is how widespread different types of FGM/C are, in Nigeria's different ethno-geographical zones, and the little change that has taken place over time, despite increased international, and renewed national, political commitment to eradicate the practice. FGM/C remains a recognised and accepted practice in many Nigerian cultures, performed any time from a few days after birth until after death, considered important for women's socialisation, curbing their sexual appetites and preparing them for marriage (NPC and ICF 2014). In each survey year (1999, 2003, 2008, 2013), the highest prevalence of FGM/C was found in the South West and South East geopolitical zones, among the Yoruba and Igbo ethnic groups, respectively. Similarly, for 2008 and 2013, where data are available, the three states with the highest prevalence rates were Ebonyi (83%), Osun (83%), and Oyo (84%), in 2008, and Ebonyi (74%), Ekiti (72.3%), and Osun (77%) in 2013. Although few women in the North have been circumcised, Type IV forms of FGM/C, which constitutes 30 percent of national FGM/C prevalence, are more prevalent in the region, vis-à-vis the greater prevalence of Type I, II, and III in the South. For instance, 76 percent of women who underwent scraping of tissues surrounding the vaginal orifice (*angurya* cuts) (Type IV) were in three Northern States: Jigawa, Kano, and Kaduna, with 48 percent of the cuts in Kano alone. Among women who underwent vaginal cutting (*gishiri* cuts), the state of highest prevalence is Kaduna (25%).

Beyond the perspective that cultural and customary beliefs supporting FGM/C remain strong, the justifications of the proponents of the practice and factors supporting its persistence have continued to wane and unable to withstand moral, legal, or ethical scrutiny, following the global and local push to end the practice. Education is an important empowerment tool with a positive intergenerational effect on FGM/C, with mothers with higher levels of education less likely to have their daughters circumcised (NPC Nigeria and ICF International 2014). There is also an almost monotonical decrease in prevalence levels from older women to girls and women of younger age cohorts, showing changes over time. These changes are slow and not sufficient for the practice's eradication, which demands policy and programme interventions supported by robust evidence. This scoping review is a critical step in filling the FGM/C evidence gap in Nigeria by triangulating available data from multiple sources.

Beyond identifying FGM/C prevalence across Nigeria by geographic and socio-economic characteristics, the review identified beliefs, attitudes and social norms; community enforcement mechanisms, as well as social and economic factors that sustain FGM/C practices among different groups. Social and cultural beliefs and norms are the leading factors pushing families to have their daughters circumcised, as FGM/C represents a symbol for the formation of an ethnic identity for the girl in the society in which she lives, and a reflection of her transition from teenager to womanhood. Other specific beliefs and social norms that fuel the practice include protection of the young women from extramarital relationships; uncircumcised vulva viewed as unclean, to avoid death of newborn infant, social influence of circumcision for marriage, and religious reasons.

The community enforcement mechanisms identified in this review include utilising FGM/C as an instrument of social conformity, an integral part of community festival activities and community identity. Enforcers are mostly women, primarily mothers (especially those who were cut) and aunts, as well as highly respected women in the communities, including traditional birth attendants (TBAs), local barbers, medical doctors, and health workers. In some communities enforcement mechanisms include promises of rewards; emotional manipulation and outright misinformation,

such as preventing promiscuity, making a girl a good wife and girls not being able to deliver babies without being cut. Several identified socio-economic and demographic determinants include lack of full awareness of the magnitude of the FGM/C problem and the consequent negative physical and emotional health outcomes. Making money from the practice was particularly a factor in the South West of the country. Level of educational attainment is found in several studies to be associated with FGM/C, with more educated women less likely to circumcise their daughters. A group of studies identified women who were cut (and living in a community where most women were cut); women with no or low education, older women, and those in the poorest households as more likely to favor FGM/C and cutting of their daughters. Other identified determinants include weak law enforcement, a culture of silence, and a lack of open communication on the practice.

Efforts for the abandonment of the FGM/C in Nigeria were strengthened by the Violence Against Persons (Prohibition) Act 2015, which criminalises female circumcision or genital mutilation, as well as other forms of gender-based violence (GBV). This marked the first time that the entire country has committed to stopping FGM/C through an Act of the National Assembly. The Act does not only ensure that the violators are brought to justice, but also that victims are adequately compensated, re-integrated into society, and given the necessary support and protection. Nevertheless, legal enforcement has been acknowledged as necessary but not sufficient to eradicate FGM/C. The law has been described as only the first step in a sequence of strategies needed for reducing the practice's prevalence. Consequently, beyond sensitisation activities across the country to educate citizens on the new law and accompanying legal sanctions, the review identified several types of FGM/C interventions in the last 15 years and beyond and the implementing organisations in the country over time.

The key types of interventions were awareness and training campaigns, circumciser conversion outreaches, and legal and human rights as well as health and behaviour change interventions. The review identified a coalition of international agencies, the diplomatic community, national and state government agencies and officials, non-governmental organisations (NGOs), civil and traditional societies, and the media that have been important voices in campaigns and interventions to eliminate the challenge of FGM/C in Nigeria over the years. Fundamentally, the review shows that Nigeria has not been and is not currently lacking willing and able organisations to tackle the FGMC challenge at all levels and in all its ramifications. Notwithstanding there is no visible focus on economic empowerment and promotion of alternative livelihood initiatives for practitioners of FGM/C. Further, besides expressions of intentions by relevant officials, there is no evidence of legal challenges to the practice anywhere in the country, especially following the passing of enabling laws. While there is much focus on Types I through III forms in the literature, Type IV, which includes severe forms and constitutes up to 30 percent of overall national FGM/C prevalence, are often not highlighted. Similarly, while most groups and their activities are visibly located in the country's South West, South East, and South South geopolitical zones, there are generally few or no activities reported in the northern parts of the country, where there is the predominance of various forms of Type IV of FGM/C.

There is a general dearth of intervention studies on FGM/C in Nigeria and equally little evaluation of their effectiveness. For the few evaluation studies undertaken, the weaknesses of the methodologies employed in the studies, were underscored. Consequently, the ability to adequately conclude on the effectiveness of FGM/C abandonment interventions in Nigeria and how contextual factors related to FGM/C help explain the effectiveness of interventions was hampered by a general lack of information. The findings show that much work remains to be conducted on the evaluation of FGM/C abandonment efforts, particularly the need for methodologically rigorous intervention evaluations.

This review reveals that we need to collect data to understand FGM/C prevalence over time and identify contributing factors among regional cultures that will be necessary to inform specific future policy and programme interventions. The need for strengthening monitoring and evaluation (M&E) of interventions to establish what works and what does not work, together with investments in methodologically robust data collection and analysis will be important parts of the process for generating credible evidence to inform FGM/C policy and action.

CHAPTER 1: INTRODUCTION

Background to the review: Definition and global overview

Female genital mutilation and cutting (FGM/C), also known as female circumcision, is defined by the World Health Organisation (WHO) as all procedures that involve partial or total removal of the external female genitalia or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons. WHO (2010) classifies FGM/C into four major types:

Type I (Clitoridectomy) is partial or total removal of the clitoris (the small, sensitive, erectile part of the female genitals) and, in very rare cases, only the prepuce, i.e. the fold of skin surrounding the clitoris.

Type II (Excision) involves partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (the labia are the "lips" surrounding the vagina).

Type III (Infibulation), the most severe form of FGM/C, narrows the vaginal opening through a covering seal formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris. The wound edges are repositioned by stitching or holding the cut areas together for a period of time (for example, girls' legs are bound together), to create the covering seal; a small opening is left for urine and menstrual blood to escape (Ahmadi 2013, Okeke et al 2012).

Type IV includes all other harmful procedures to female genitalia for non-medical purposes, including pricking, piercing or incising the clitoris or labia; stretching the clitoris or labia; cauterization by burning the clitoris and surrounding tissue; scraping tissue surrounding the vaginal orifice or cutting the vagina; introducing corrosive substances or herbs into the vagina, to cause bleeding for tightening or narrowing it.

Despite global concerns, awareness, and campaigns, FGM/C's prevalence remains high in many countries. While exact numbers remain unknown, recent estimates by the United Nations Children's Fund (UNICEF) suggest that at least 200 million girls and women in 30 countries have been subjected to the practice (UNICEF 2016a). Table 1 (following page) presents estimates of prevalence of FGM/C in different countries, from multiple sources published between 2013 and 2016. These data show prevalence levels varying from as high as 98 percent of girls and women ages 15 to 49 in Somalia to one percent in Cameroon. These prevalence figures translate to 27.2 million girls and women in Egypt to 0.9 million in Uganda, Togo, Djibouti, and Guinea-Bissau. In half of the countries, most girls were cut before age five, and in the rest of the countries most cutting occurs between five and 14 years of age (UNICEF 2013a).

Table 1. Prevalence of FGM/C, by country

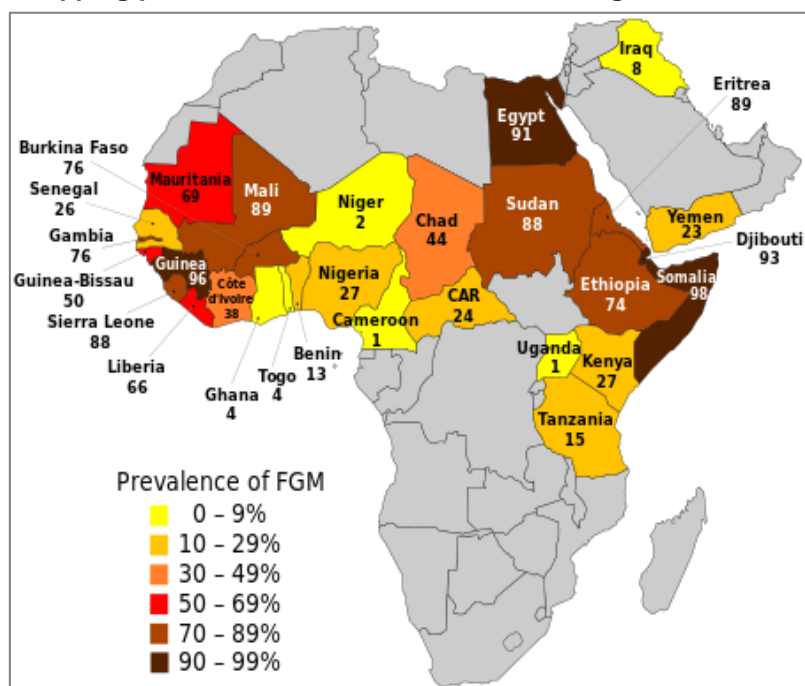
Country	Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, 2004–2015 ¹	Number of girls and women who have undergone FGM/C ²
Somalia	98	6.5 million
Guinea	97	6.5 million
Djibouti	93	0.9 million
Sierra Leone	90	3.5 million
Mali	89	7.9 million
Egypt	87	27.2 million
Sudan	87	12.1 million
Eritrea	83	3.5 million
Burkina Faso	76	9.3 million
Gambia	75	1.3 million
Ethiopia	74	23.8 million
Mauritania	69	3.4 million
Liberia	50	2.7 million
Guinea-Bissau	45	0.9 million
Chad	44	3.8 million
Côte d'Ivoire	38	5.0 million
Nigeria	25	19.9 million
Senegal	25	3.4 million
Central African Republic	24	1.3 million
Kenya	21	9.3 million
Yemen	19	5.0 million
United Republic of Tanzania Benin	15	7.9 million
Iraq	9	2.7 million
Togo	8	3.8 million
Ghana	5	0.9 million
Niger	4	1.3 million
Uganda	2	3.4 million
Cameroon	1	0.9 million
	1	2.7million

Sources ¹UNICEF (2016a); ²UNICEF (2013a)

With a focus on Africa, Figure 1 shows the concentration of the practice in from the Atlantic Coast to the Horn of Africa in the northeast, with wide variations in percentages of girls and women cut, both within and across countries (UNICEF 2013a).

According to UNICEF (2016a), FGM/C is a human rights issue that affects girls and women worldwide. As such, its elimination is a global concern. In 2012, the United Nations General Assembly (UNGA) adopted a milestone resolution calling on the international community to intensify efforts to end the harmful practice. More recently, in September 2015, the global community agreed to a new set of development goals—the Sustainable Development Goals (SDGs)—which include a target under Goal 5 to eliminate all harmful practices such as child, early and forced marriage as well as FGM/C, by the year 2030. Both the 2012 UNGA resolution and the 2015 SDG framework signify the political will of the international community and national partners to work together to accelerate action towards a total, and final, end to FGM/C in all continents (UNICEF 2016a).

Figure 1. Mapping prevalence of FGM/C across of the high concentration countries



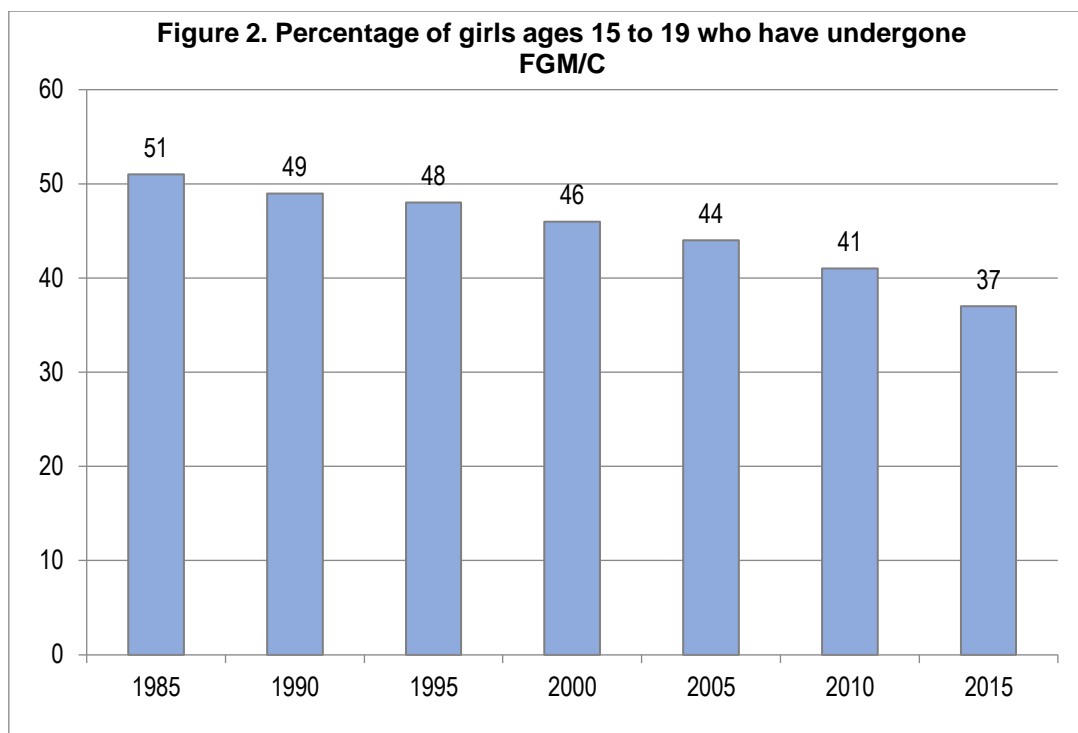
Source UNICEF (2013a)

In the African continent in particular, political voices in support of eliminating the practice are not lacking. At its second summit of July 2003, the African Union adopted the Maputo Protocol promoting women’s rights and calling for an end to FGM/C. The agreement came into force in November 2005, and by December 2008 25 member countries had ratified the protocol (US Department of State 2001).

As of 2013, according to a UNICEF report, 24 African countries have legislations or decrees against FGM/C: Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Mauritania, Niger, Nigeria (since 2015) (Topping 2015, D’Urso 2015), Senegal, Somalia, Sudan (some states), Tanzania, Togo, Uganda, Zambia, and South Africa (UNICEF 2013a). In 2015, Gambia’s former president Yahya Jammeh banned FGM/C (Lyons 2015), and in 2014 The Girl Generation, an Africa-led campaign to oppose FGM/C worldwide, was launched (Topping 2014).

Figure 2 shows an overall but slow decline, over the last three decades, in prevalence among girls ages 15 to 19, with an adolescent girl today about one third less likely to be cut than 30 years ago (UNICEF 2016ab). Available data support reports that in most countries where FGM/C is practiced the majority of girls and women think it should end.

Current progress is, however, insufficient to keep up with increasing population growth, and if current trends continue, the number of girls and women undergoing FGM/C will rise significantly over the next 15 years (UNICEF 2016a). In fact, without far more intensive and sustained action now, from all parts of society, hundreds of millions more girls will suffer profound, permanent, and utterly unnecessary harm. If rates of decline seen in the past three decades are sustained, the impact of population growth means that up to 63 million more girls could be cut by 2050 (UNICEF 2016b).



Source: UNICEF, 2016a

Nigeria and FGM/C: an introduction

Nigeria has the world's third highest FGM/C prevalence. It is estimated that 25 percent or 19.9 million Nigerian girls and women 15 to 49 years old underwent FGM/C between 2004 and 2015. These absolute numbers are only a third of Egypt's 27.2 million victims and Ethiopia's, 23.8 million (UNICEF 2016a). The Nigerian estimate is consistent with prevalence rates derived from the analysis of the 2013 Nigeria Demographic and Health Survey (NDHS) data (NPC Nigeria and ICF International 2014). According to the US Department of State (2001) report, Type I (commonly referred to as clitoridectomy), Type II (commonly referred to as excision), and Type III (commonly referred to as infibulation) are historically the most common forms of FGM/C in Nigeria. Type IV is practiced to a much lesser extent (US Department of State 2001, Mandara 2004). It is important to note, however, that analysis of current data shows a high level of prevalence of Type IV across Nigeria, with a total national prevalence of up to 30 percent (see Table 5), a level unusually high for Sub-Saharan Africa, and not often emphasized by practitioners and campaigners in the country.

FGM/C is widely practiced in many Nigerian cultures and is considered important for women's socialisation, curbing their sexual appetites and preparing them for marriage (NPC Nigeria and ICF International 2014). In a study of circumcised women's attitudes towards female circumcision in a Nigerian community where the practice is accepted, Briggs (1998) showed that 62 percent of the 100 interview subjects, from all social strata, favored the practice as an instrument for controlling female sexuality and cultural pride. According to Bodunrin (1999), FGM/C is identified simply as a cultural obligation and cleansing rite, with people describing it as female circumcision, believing it an equivalent of male circumcision. Mockery, loss of respect, and reduced marriage offers are social sanctions against non-circumcised females in Nigerian cultures where FGM/C is practiced (Bodunrin 1999).

Despite the cultural justifications for the practice, as in many other countries, evidence in Nigeria of declining levels of FGM/C is supported by almost monotonic decrease in the proportion of women circumcised, from oldest to youngest age cohorts. The proportion of circumcised women

decreased from 35.8 percent among women ages 45 to 49 to 15.3 percent (NPC Nigeria and ICF International 2014). Despite decreasing support for the practice, however, millions of girls remain in considerable danger of being circumcised. The UNICEF report reveals that a majority of people in most countries where the practice is concentrated oppose it, yet about 30 million girls are still at risk of being cut in the next decade (UNICEF 2013a).

FGM/C has drawn considerable criticism, particularly because of its potential short- and long term medical complications, harm to victims' reproductive health, and infringement on women's rights (Toubia 1995). Despite the medical implications of FGM/C, it persists, as it is deeply rooted in culture (Yerima and Atidoga 2014), and its eradication by government and other stakeholders is challenging. A 1985-1986 national study by the National Association of Nigerian Nurses and Midwives found FGM/C practiced in all states, and in five states at least 90 percent of women had been cut. FGM/C prevalence from 1999 to 2013 remained relatively constant, around 25 percent, or one out every four women of reproductive age (NPC Nigeria and ORC Macro 2000, NPC Nigeria and ICF International 2014). Several FGM/C eradication efforts in the last two decades have emphasized the health and psychological consequences suffered by women, although Babalola and Adebajo (1996) found that FGM/C in Nigeria is a cultural practice persisting despite its social and health detriments.

The United Nations (UN) banned FGM/C worldwide in 2012. The Nigerian states of Bayelsa, Cross River, Edo, Ekiti, Enugu, Imo, Ogun, Osun, and Rivers each banned the practice, beginning in 1999. Although no federal law banned FGM/C in Nigeria until 2015, opponents of the practice relied on Section 34(1)(a) of the 1999 Constitution, "No person shall be subjected to torture or inhuman or degrading treatment," as the basis for campaigning for its ban nationwide (US Department of State 2001). In 2015, however, Nigeria's federal government passed a law criminalising FGM/C in the Violence Against Persons (Prohibition) Act 2015, making female circumcision or genital mutilation illegal, with several other forms of violence including forceful ejection from homes and harmful widowhood practices. This marks the first time that the entire country committed to stopping FGM/C through an Act of the National Assembly. Under Nigeria's federal system, acts of the National Assembly such as the VAPP 2015 need to be ratified by each of the 36 state's House of Assembly to apply in those respective states.

Despite all this progress, FGM/C is still actively practiced in six states (Nkwopara 2015), and prevalence rates have remained relatively stable over time. In states such as Edo, where the practice was banned in October 1999, opponents applauded the ban as a step in the right direction but criticised the small fine and lack of enforcement. In fact, persons convicted under the national Act are subject to a paltry 1,000 Naira (US\$10) fine and six months imprisonment. A gap in comprehensive knowledge of FGM/C in Nigeria remains, even after the recent developments (Nigeria's 2015 VAPP Act and the new UNFPA/UNICEF global target and call to eliminate FGM/C by 2030), with no rigorous review of the most recent literature and interventions in the country. No study or report has comprehensively examined the types, and effectiveness, of abandonment interventions in the country. This scoping review, therefore, provides a unique opportunity for generating such vital information and providing evidence of the state of research on FGM/C practices in all regions of Nigeria. This review profiles past and present interventions implemented in the country and the indicators of their effectiveness, or otherwise. This review principally aims to inform FGM/C research and intervention strategies in Nigeria.

Objectives of this review

In pursuit of the overarching objective of understanding key trends within the evidence base of FGM/C in Nigeria, along with gaps in knowledge, this review specifically seeks to answer:

1. What is known about FGM/C in Nigeria—prevalence rates and trends, where practiced and by which groups, policies and legal situation over the last 15 years leading to the federal law criminalising FGM/C in 2015?
2. What are the drivers of FGM/C among different groups in Nigeria—Belief systems and attitudes, social norms, community enforcement mechanisms in various communities of Nigeria?
3. What types of interventions have been implemented in Nigeria, and by what organisations—Awareness raising, circumciser training and conversion, human rights, bodily integrity, behaviour change, and organisation type, e.g. federal or state governments, communities, NGOs, CSOs?
4. What evidence exists to assess the effect of various interventions designed to reduce the prevalence of FGM/C in Nigeria—Types of evaluation and measures of success?
5. What is known about the contextual factors that may help explain the effectiveness, or lack thereof, of such interventions—Social norms, community enforcement mechanisms, religious beliefs, witchcraft, secret societies, patriarchy?
6. How do factors related to the continuance and discontinuance of FGM/C help explain the effectiveness of interventions designed to reduce FGM/C prevalence—Type of intervention, supporting organisation, resourcing, political environment?

Data and Methods

Scoping reviews “aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as stand-alone projects in their own right, especially where an area is complex or has not been reviewed comprehensively before” (Mays et al 2001). Arksey and O'Malley (2005) emphasize that, unlike systematic reviews which typically focus on a well-defined question where appropriate study designs can be identified and aim to provide answers to questions from a relatively narrow range of quality assessed studies, a scoping study tends to address broader topics where many different study designs might be applicable and are less likely to address very specific research questions nor, consequently, to assess the quality of included studies.

In practical terms, a scoping review has six steps: 1) Identify the research questions: What domain needs to be explored? 2) Find relevant studies, through usual means: electronic databases, reference lists (ancestor searching), organization web sites, conference proceedings, others, 3) Select the studies relevant to the question(s), 4) Chart the data, information on and from the relevant studies, 5) Collate, summarise, and report results, and 6) (Optional) Consult stakeholders (clinicians, patients and families, policymakers, or appropriate groups) for more references and insights on what the literature fails to highlight, others (*ibid*).

Consequently, a scoping review is not a linear process (as typically dictated by the protocol for a systematic review) but a back-and-forth between early findings and new insights, and changes in the search terms and even the questions and culminates into a narrative integration of relevant evidence.

Guided by these principles, this scoping review searched various databases, with particular focus on: 1) Published literature (PubMed, Web of Science, Scopus, Cochrane library, Google Scholar, Google searches), 2) ‘Grey’ literature and relevant publication databases of international organisations and groups addressing FGM/C (UNICEF, WHO, UNFPA, Population Council, among others, in acknowledgment of the important roles of such organisations), along with 3) Groups or alliances addressing FGM/C globally and in Nigeria (National Orientation Agency,

National Population Commission), 4) Individual organisations and FGM/C scholars, in and outside sub-Saharan Africa (scientific experts, community groups, others), and 5) Other grey literature in electronic and print media, expert opinions, and interviews. Related references in the reference lists of reviewed publications were also scrutinised.

To make the search as sensitive as possible, a wide range of key words were included ‘female genital mutilation in Nigeria’, ‘female circumcision in Nigeria’, ‘historical and cultural practices of FGM/C’, ‘interventions to end FGM/C in Nigeria’, ‘banning FGM/C in Nigeria’, etc. Initially the search was consciously limited to the last 15 years, yet substantial numbers of peer-reviewed publications pre-date 2002, and many were included to inform the much-needed historical background, as well as filling gaps because of the dearth of more recent studies. These searches yielded an extensive collection of published and grey literature, and intensity sampling helped select those best clarifying the nature of the topic and representativeness (Teddlie and Yu 2007). Reputational case selection also allowed expert or key informant recommendations for secondary data sources relevant for FGM/C trends and shaping ideas for programme and policy priorities (Gleshne and Peshkin 1992, Teddlie and Yu 2007, Ishak and AbuBakar 2014). These searches principally occurred in September and October 2016, with additional searches during peer review of the draft report, from September 2016 until April 2017. These search efforts led to the selection and review of a combined of 90 peer-reviewed articles, books, and grey publications dealing partially or wholly with FGM/C issues and interventions in Nigeria.

After retrieval, a cursory assessment of the publications allowed determination of their relevance in terms of cultural sensitivity, transparency, appropriateness, and internal and external validity, utilising guidelines for assessing evidence strength generally used in systematic reviews (DfID 2014). While most peer-reviewed journal articles were cross-sectional, rankings of the journals in which they were published were difficult to establish or non-existent. The near absence of research studies appropriately designed to address interventions’ effects, or to evaluate them, is an obvious gap in the literature. In fact, a previous evaluation of FGM/C evidence in Nigeria found only one appropriate study, and the general evidence was judged weak (Berg and Denison 2013). The general lack of rigorous and relevant studies, especially since 2015, after enactment of the VAPP Act, is another clear gap. Thus, this scoping review relies mostly on grey literature for the 2015 to 2017 period.

Table 2. Types and Sources of publications used in the review

Type/Source of Publication	Year of publication			Total
	Pre-2002	2002-2014	2015-2016	
Peer-Reviewed Articles	9	24	-	33
Grey Literature (government and inter-governmental agencies including UNFPA, UNCEF, WHO, US State Dept)	7	11	4	22
NGOs/CSO Publications	1	9	2	12
Private and Public Print and Electronic Media		4	16	20
Published Books and Book Chapters	2	1	-	3
Total	19	49	22	90

To understand specific FGM/C topics not covered by previous studies, and for which data are available, secondary quantitative data were analysed. For insight into FGM/C prevalence by type and by Nigerian state, data from the 2013 Nigeria Demographic and Health Survey (NDHS) for 5,281 women (ages 15 to 49) who had been cut were analysed, using appropriate descriptive statistical tools. Triangulation of data from all these sources and the collation of results derived from them culminate into a narrative integration of all the relevant evidence into the report presented in this volume.

Structure of the Review Report

This report is presented in six chapters. After the introductory chapter, *Chapter Two* presents the state of knowledge of FGM/C in Nigeria with focus on the prevalence rates and trends across the country, where FGM/C is practiced and by which groups, the change and continuities in relation to policies and legal frameworks that have regulated FGM/C over the last 15 years, and the historical federal law, the Violence Against Persons (Prohibition) ACT 2015, which prohibits female circumcision or genital mutilation, and other related violence. *Chapter Three* discusses the drivers of FGM/C practices among different groups in Nigeria, covering beliefs, attitudes, and social norms supporting FGM/C, community enforcement mechanisms and the socio-economic and demographic determinants of FGM/C practices across the country.

Chapter Four presents the types of FGM/C interventions, covering awareness raising, training and converting circumcisers, human rights, bodily integrity, and behaviour change interventions. The chapter presents the organisations involved in implementing these interventions and their roles and strategies, including federal and state governments, as well as community, NGOs, and CSOs. *Chapter Five* examines the different evaluations designed to understanding the effects of various FGM/C interventions in Nigeria, highlighting their achievements. The chapter identifies different types of evaluation and their respective measures of success, the contextual factors that explain the effectiveness, or lack thereof of interventions and how factors related to the continuance and discontinuance of FGM/C help explain the effectiveness of interventions designed to reduce the prevalence of FGM/C. The final chapter provides a summary and conclusions of this review, outlining key policy and programme issues.

CHAPTER 2: STATE OF KNOWLEDGE OF FGM/C IN NIGERIA

Introduction

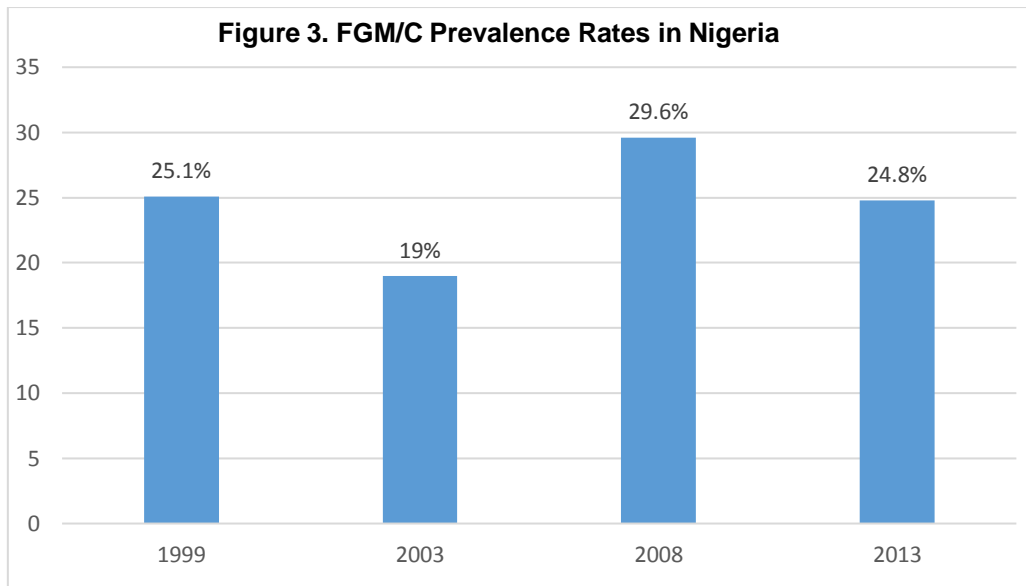
Nigeria is home to millions of FGM/C survivors in addition to girls at risk, yet has received little international or national attention, with comprehensive knowledge of FGM/C in Nigeria lacking, including no rigorous reviews of the most recent literature. This chapter begins to address these gaps by seeking in-depth answers to what is known about FGM/C in Nigeria, for prevalence rates and trends, where FGM/C is practiced, and by which groups. This chapter further explores policies and legal frameworks regulating FGM/C in the country for the last 15 years. In response to the UNFPA/UNICEF global target and call to eliminate FGM/C by 2030, an understanding of prevalence, trends, and legal frameworks in Nigeria is a critical first step in designing policy and programme interventions.

Prevalence rates and trends

In 2016, UNICEF estimated that at least 200 million women and girls in 30 countries have been subjected to FGM/C (UNICEF 2016a). The prevalence or proportion of all females ages 15 to 49 who report having been cut varies widely across countries with nationally representative data. While less than five percent of women in Cameroon, Uganda, Niger, and Ghana have undergone FGM/C, the practice is nearly universal in Djibouti, Egypt, Guinea, Sierra Leone, and Somalia. Nigeria is among four countries where two thirds of all women who have undergone FGM/C live; the other three countries are Egypt, Ethiopia, and Sudan. Most recent estimates show that nearly 70 million girls 14 years old and younger around the world have been cut or may be at risk of being cut, with more than half of these girls living in Egypt, Ethiopia, Indonesia, and Nigeria (Shell-Duncan et al 2016).

While earlier focus in Nigeria has generally been on three major types of FGM/C practiced—Type I, Type II, and Type III—recent evidence shows that different forms of Type IV are as prevalent as the other types, especially in the northern regions, where little attention has been paid over the years. The particular form of FGM/C practiced varies by ethnic group and geographic location throughout the country. FGM/C crosses numerous population groups and is a part of the many cultures, traditions, and customs in Nigeria. It transverses various religious groups, found among Christians, Muslims, and Animists alike (US State Department 2001). The procedures for FGM/C can take place anytime from a few days after a child's birth to a few days after a woman's death. In Edo state, for example, the procedure is performed within a few days after birth, while in very traditional communities, if a deceased woman is discovered to have never had the procedure, it may be performed on her before burial (*ibid*).

Although FGM/C is known to be widespread in Nigeria and is an important issue in international discourse, nationally representative data on its prevalence in Nigeria is comparatively rare. An earlier large, national study by the Center for Gender and Social Policy Studies of Obafemi Awolowo University in Ile-Ife in 1997 was not sustained, but the 1999 Nigeria Demographic and Health Survey (NDHS) continued data collection on FGM/C across the country, with all participating women asked if they were circumcised, at what age, with the type of circumcision and who performed it. Women with daughters were asked the same series of questions about their eldest daughter, and their opinions of whether the practice should be continued, or otherwise. Besides the 1999 survey, NDHS was repeated in 2003, 2008, and 2013, collecting nationally representative, repeated cross-sectional data relevant for understanding FGM/C practices. Using the data from these surveys, Figure 3 summarises the prevalence rates of FGM/C in Nigeria in the 1999, 2003, 2008, and 2013 survey years.



Data Sources: Nigeria Demographic and Health Surveys 1999, 2003, 2008, 2013

The data suggest no dramatic change in FGM/C prevalence levels across the survey years. It is important to exercise caution, however, in directly comparing these rates across the survey years because of sampling, data collection, and measurement issues. In 1999, for instance, NDHS collected data on female circumcision only from currently married women. An error in the questionnaire was later detected (and acknowledged), due to the fact women who had never had sexual intercourse were not asked questions on female circumcision (National Population Commission 2000). The prevalence of the practice was potentially underestimated as a result, and since those excluded women were more likely younger, it likely affect the analysis of age patterns of FGM/C prevalence.

The 2008 NDHS shows a higher prevalence of FGM/C than reported in the 2003 NDHS (30% vs 19%). According to the 2008 NDHS report, however, this is unlikely given the decreasing prevalence of female circumcision among sequentially younger age groups in both surveys (NPC Nigeria and ICF Macro 2009). An investigation of the 2008 survey's methodology showed that this increase was actually due to variations in FGM/C's definition used in the two surveys. In the 2008 NDHS, some survey teams included then unclassified *angurya* and *gishiri*¹ cuts, while others did not. This was not the case in the 2003 NDHS, which explicitly followed WHO's definition and included *angurya* and *gishiri* cuts (NPC Nigeria and ICF International 2014).

Consequently, any comparisons of FGM/C data from the most recent 2013 survey with data from the earlier surveys require caution, demonstrating the need to address these observed measurement limitations. Consensus on the definition of FGM/C needs to be achieved, in addition to promoting further research to ascertain more accurate prevalence rates, utilising WHO's definition, as was done in the 2013 NDHS. Despite these measurement issues, it is clear from the prevalence levels identified over the last 15 years that there has been little change in the practice. This observation is consistent with the earlier conclusion of Yoder and Khan (2008) that, despite the increased international and little national attention, the prevalence of FGM/C in Nigeria has declined little.

¹ *Angurya* cuts involves scraping of tissue surrounding the vaginal orifice and *Gishiri* cuts, involves cutting of the vagina mostly done in the North West than other zones of Nigeria. Both are Type IV forms of FGM/C.

Where FGM/C is practiced, and by which groups

This sub-section presents information on where FGM/C is practiced, and by which groups, utilising data from NDHS 1999, 2003, 2008, and 2013. Table 3 summarises the prevalence of FGM/C for each survey year for key demographic, geographic, and socio-cultural characteristics of interviewed women. In each survey year, FGM/C prevalence generally decreases, almost monotonically, with age. The consistent prevalence differentials by age indicate that the practice has gradually become less common. In 2008 women ages 45 to 49 were nearly twice as likely as women ages 15 to 19 to have been circumcised (38% vs 22%). In 2013 the differential between the two groups is enhanced (36% vs 15.3%).

Data consistently show highest prevalence of FGM/C among the Yoruba and Igbo, in all survey years. The data show evidence of a slow but consistent decrease in the prevalence of the practice in each ethnic group over the observation period. The proportion of circumcised women at the time of each survey was greatest in the southwest and southeast, the traditionally home regions of the Yoruba and Igbo ethnic groups, respectively. Similarly, for 2008 and 2013, where data are disaggregated, the three states with the highest prevalence rates were in the southeast and southwest: Ebonyi (83%), Osun (83%), and Oyo (84%) in 2008, and Ebonyi (74%), Ekiti (72.3%), and Osun (77%) in 2013. Table 3 presents the prevalence data by urban and rural residence, and education. In all survey years, a consistent differential by urban and rural residence is observed, with a larger proportion of urban than rural women circumcised.

Table 3. Prevalence of FGM/C in Nigeria 1999-2013

Characteristics	1999	2003	2008	2013
Age				
15-19	8.8	12.9	21.7	15.3
20-24	19.6	17.0	26.4	21.7
25-29	26.4	20.8	28.9	22.9
30-34	31.3	19.4	32.8	27.4
35-39	31.0	22.2	33.9	30.4
40-44	37.9	22.2	36.4	33.0
45-49	48.3	28.4	38.1	35.8
Major Ethnic Groups				
Hausa	-	0.4	20.3	19.4
Fulani	-	0.6	8.5	13.2
Igbo	-	45.1	51.4	45.2
Yoruba	-	60.7	58.4	54.5
Geopolitical Zones				
North Central	16.4	9.6	11.4	9.9
North East	1.9	1.3	2.7	2.9
North West	2.6	0.4	19.6	20.7
South East	36.5	40.8	52.8	49.0
South South	-	34.7	34.2	25.8
South West	48.4	56.9	53.4	47.5

Characteristics	1999	2003	2008	2013
High Rate States				
Kwara	-	-	67.4	53.3
Kano	-	-	74.0	40.9
Ebonyi	-	-	82.6	74.2
Imo	-	-	63.5	68.0
Delta	-	-	56.5	40.3
Edo	-	-	51.2	41.6
Ekiti	-	-	63.2	72.3
Ondo	-	-	53.4	45.0
Osun	-	-	82.8	76.6
Oyo	-	-	83.9	65.6
Place of Residence				
Urban	30.0	28.3	36.8	32.3
Rural	22.9	14.0	25.6	19.3
Educational Attainment				
No education	15.6	-	18.0	17.2
Primary education	36.1	-	35.8	30.7
Secondary education	27.6	-	36.0	28.8
Higher education	33.8	-	37.2	29.1
Total Percentage	25.1	19.0	29.6	24.8
No of women	8,206	7,620	38,948	38,948

Data Sources: NDHS 1999, 2003, 2008, 2013

FGM/C is more common among better educated women in each survey year, which seems counter-intuitive but reflects the fact that the Yoruba and Igbo, who traditionally reside in the southwest and southeast, are more urbanised and thus include more educated women in their populations than residing in the northern regions. The dominance of FGM/C in the southwest, south, and southeast, the most educated regions in the country, continues to fuel the notion that cultural and customary beliefs in support of FGM/C remain strong and that education has been unable to reduce its prevalence. Higher education's lack of huge direct effects on women's circumcision (Table 3), may be due to the fact that, in most parts of Nigeria, FGM/C is carried out at a very young age (minors), earlier before the education of the victim (Okeke et al 2012). An overwhelming majority (82%) of circumcised women were cut before their fifth birthday, while about 10 percent were cut between the ages of five and 14 (NPC and ICF Macro 2014).

While educational attainment does not have a huge direct effect on women's circumcision, the 2013 NDHS shows that education remains an important empowerment tool, with a positive intergenerational effect. Mothers with higher levels of education are less likely to have their daughters circumcised (NPC Nigeria and ICF International 2014). Data on the types of FGM/C practiced in each state were collected in an earlier study, in 1997, that covered 148,000 women and girls nationwide from 31 community samples, and is summarised in Table 4. While the data are dated, and latest prevalence estimates suggest minor reductions, it confirms that, as far back as 20 years ago, all four forms of FGM/C were prevalent throughout the country, with Types I, II, and III more predominant in the south, and Type IV of higher incidence in the northern states. Five states (Kwara, Ondo, Oyo, Osun, Delta) with the highest prevalence rates in 1997 remained among the 10 with highest prevalence rates in 2008 and 2013, respectively (Table 3).

During the last 20 years, the southwest region has had a continual higher prevalence, with three states (Ondo, Osun, Oyo) with highest prevalence rates in 2013, suggesting that little has actually changed. Although few women in the north have been cut, paradoxically Type IV is more prevalent there, with greater prevalence of Types I, II, and III in the south (UNICEF 2001, Adegoke 2005,

NPC Nigeria and ICF International 2014). *Angurya* cuts scrape tissue surrounding the vaginal orifice, mostly common among the Islamic community (54%), the Fulani and Hausa ethnic groups (87% each), northwest residents (84%), and in Kano, Jigawa, and Kaduna states. Women with no education (70%) and those in the lowest wealth quintile (76%) are most likely to have *angurya* cuts (NPC Nigeria and ICF International 2014).

Table 4. Prevalence FGM/C by types in States across the country in 1997

State	Type	Prevalence (%)
Abia	No study	No Study
Adamawa	Type IV	60-70
Akwa Ibom	Type II	45-75
Anambra	Type II	40-60
Bauchi	Type IV	50-60
Benue	Type II	90-100
Borno	Types I III and IV	10-90
Cross River	No Study	No Study
Delta	Type II	80-90
Edo	Type II	30-40
Enugu	No Study	No Study
Imo	Type II	40-50
Jigawa	Type IV	60-70
Kaduna	Type IV	50-70
Katsina	No Study	No Study
Kano	No Study	No Study
Kebbi	Type IV	90-100
Kogi	Type IV	01
Kwara	Types I and II	60-70
Lagos	Type 1	20-30
Niger	No Study	No Study
Ogun	Types I and II	35-45
Ondo	Type II	90-98
Osun	Type 1	80-90
Oyo	Type I	60-70
Plateau	Types I and IV	30-90
Rivers	Types I and II	60-70
Sokoto	No Study	No Study
Taraba	No Study	No Study
Yobe	Type IV	0-1
FCTAbuja	No Study	No Study

Source: 1997 Nationwide Study, Center for Gender and Social Policy Studies Obafemi Awolowo University in Ile-Ife

Further re-analysis of NDHS data (*ibid*), among women who had undergone FGM/C (summarised in Table 5), confirms the types of FGM/C practiced in each state, in addition to indicating where policy and action are needed.

Table 5. Prevalence of FGM/C among women ages 15 to 49 who had been cut, by Type and Nigerian state (N=5,281)

State of Residence	Removal of clitoris, partial or total excision of the labia minora (Type I and II)	Infibulation: removal of clitoris, labia minora, medial part of labia majora (Type III)	Scraping of tissue Surrounding the vaginal orifice (angurya cuts) (Type IV)	Cutting of the vagina (gishiri cuts) TYPE IV)	Ever used corrosive substances herbs into the vagina to narrow it, cause bleeding (Type IV)
Sokoto	0.08	0.00	1.80	0.00	0.00
Zamfara	0.02	0.00	0.85	0.00	0.00
Katsina	0.00	0.00	0.00	0.00	0.00
Jigawa	0.23	0.66	20.11	4.43	0.75
Yobe	0.02	0.22	1.69	1.40	2.45
Borno	0.13	0.66	0.26	0.00	0.00
Adamawa	0.06	0.00	0.37	0.00	0.94
Gombe	0.13	0.00	1.38	0.47	2.08
Bauchi	0.00	0.00	3.02	1.17	1.32
Kano	0.02	0.22	47.99	5.13	2.83
Kaduna	0.15	0.44	9.52	25.41	8.68
Kebbi	0.04	0.00	0.79	0.47	0.38
Niger	0.02	0.44	0.69	0.23	1.13
Fct-Abuja	0.44	0.22	0.16	1.40	1.32
Nasarawa	0.66	3.28	1.16	4.20	7.36
Plateau	0.09	0.22	0.00	0.00	0.00
Taraba	0.27	0.00	0.85	0.47	0.38
Benue	0.49	0.44	0.95	0.23	0.75
Kogi	0.32	0.22	0.05	0.70	0.38
Kwara	5.36	1.09	0.11	5.13	4.34
Oyo	8.69	0.44	0.11	0.47	0.75
Osun	13.71	1.09	0.00	0.23	1.32
Ekiti	6.89	0.66	0.42	0.23	0.75
Ondo	2.76	0.44	0.00	1.63	0.19
Edo	4.43	1.09	0.11	4.66	3.96
Anambra	2.50	2.18	0.21	0.23	7.17
Enugu	7.76	0.87	0.05	0.23	17.36
Ebonyi	9.20	57.0	1.59	6.16	2.26
Cross River	2.86	1.31	0.21	15.85	10.19
Akwa Ibom	1.21	0.87	0.16	2.10	1.70
Abia	4.05	6.11	0.74	3.50	8.68
Imo	8.31	3.93	0.16	1.40	1.51
Rivers	1.63	0.22	0.05	0.00	0.75
Bayelsa	2.73	10.26	1.22	7.23	4.91
Delta	5.57	3.28	2.65	0.70	2.83
Lagos	7.86	1.97	0.58	2.33	0.57
Ogun	1.31	0.22	0.00	0.23	0.00
Total	56.03	4.86	20.05	4.55	5.62

Source: Reviewer's analysis of 2013 Nigeria DHS data

Seventy-six percent of women whose tissue was scraped (*angurya* cuts, Type IV) were in three northern states, Jigawa, Kano, and Kaduna, with 48 percent in Kano alone. Among women whose vaginas were cut (*gishiri* cuts, Type IV), the highest proportion is in Kaduna state (25%).

It is important to note, however, that while Types I and II are of greater prevalence in southern states, other severe forms occur in that region: 57 percent of women who underwent infibulation (Type III) were in Ebonyi, 17 percent of those who ever inserted corrosive substances or herbs to narrow the vagina or cause bleeding (Type IV) was in Enugu, and 16 percent of women who had experienced the vaginal cutting (*gishiri* cuts, Type IV) was in Cross River.

These results reiterate that not much has changed in the last 20 years, and much work is needed to address the challenge across the country. More profound, however, is the evidence that Type IV is common in Nigeria, with a total national prevalence of as much as 30 percent (Table 5) (which is unusual in Sub-Saharan Africa) and not often emphasized by practitioners and campaigners, and thus requiring greater attention. This is particularly important, more so the northern region, as most international and national anti-FGM/C campaigns focusing on the health implications of Type III. One profound finding of this review and quantitative data analysis is the need for greater research on FGM/C Type IV and messages and interventions that could be relevant for communities practicing Type IV across Nigeria.

Nigerian policy and legal contexts for prior 15 years

The primary responsibility of government is to protect lives and property, and this responsibility is generally executed through the enactment of laws, policy frameworks, and consequent programmes to address societal challenges. This section of the review explores the policies and legal frameworks implemented over the last 15 years regulating the practice of FGM/C across Nigeria.

Background to policy and legal approaches

FGM/C is recognised worldwide as a fundamental violation of the human rights of girls and women, reflecting deep-rooted inequalities between the sexes and constituting an extreme form of discrimination against women (Okeke et al 2012). There is no lack of voices against the practice generally and particularly voices reiterating the human rights perspective. In her speech on women's right to health and wellbeing delivered on International Women's Day to The Royal College of Obstetricians and Gynaecologists, Glenys Kinnock (2014) called for combating FGM/C as an appalling crime, child abuse, and a very serious violation of the rights of girls, who are subjected to this mutilation. She restated the UN call that “we must step up our efforts—in the 21st century no woman or girl should suffer or die due to FGM/C. Addressing the persistent inequalities that negatively affect women and girl’s health and wellbeing is our unfinished business” (UNFPA 2014).

The human rights aspect, together with the adverse health consequences, have been and remain the dominant arguments against FGM/C in Nigeria. Campaigns have sought to address the practice in terms of violation of rights of children and violation of a person’s right to health, security, and physical integrity, the right to be free from torture and cruel, inhuman, or degrading treatment, and the right to life when the procedure results in death (Okeke et al 2012).

To eliminate the practice in Nigeria, a multidisciplinary approach, beyond the law and government initiatives, has been advocated over the years, especially due to the fact FGM/C is rooted in the cultural norms and values of various Nigerian communities. Consequently, stakeholders have called for; simultaneous legal recourse through legislation to prohibit the practice; health educational campaigns especially directed at parents; improvement in women's status; sex education interventions; and a collective, coordinated agreement to abandon the practice through community-led actions (UNICEF 2005, Alo and Gbadebo 2011). Improvement in education and the social status of women and increased awareness of complications of FGM/C, have been identified as crucial in breaking the cycle of FGM/C, with more educated, more informed, and more socially and economically active woman able to appreciate and understand the hazards of FGM/C and more likely to refuse to subject their daughters to such a procedure (NPC Nigeria and ICF International 2014).

Policy and programme options

The Family Health Department of the Federal Ministry of Health (FMoH) and WHO Abuja issued a position statement in December 2007, “Elimination of Female Genital Circumcision in Nigeria,” for a campaign against FGM/C, and outlined significant achievements:

1. The watershed moment was identified as 1994, when Nigeria joined other members of the 47th World Health Assembly to resolve to eliminate FGM/C;
2. Consequently, a multi-sectorial technical working group on harmful traditional practices (HTPs) was established;
3. Various studies and national surveys on HTPs were then conducted;
4. A regional plan of action was launched; and
5. A national policy and plan of action was developed, which was approved by the Federal Executive Council for the elimination of FGM/C in Nigeria.

Beyond government-led activities, FGM/C has continued to be tackled by different inter-governmental organisations, notably WHO, the United Nations International Children’s Emergency Fund (UNICEF), Federation of International Obstetrics and Gynecology (FIGO), the African Union (AU), the Economic Commission for Africa (ECA), and many other NGOs and women’s groups.

Various campaigns, primarily focused on intensifying education for the general public, have emphasised FGM/C’s dangers and undesirability (Okeke et al 2012). Typical of such campaigns is the ‘guideline’ and campaign launched by WHO and FMoH (2007) that called for grassroots mobilisation efforts for joining the crusade to say “No” to FGM/C anywhere it is practiced in Nigeria. The document called the practice crude, dangerous, wicked, and unhealthy, stating that it is not required by any religion. It further stated there is no scientific evidence that women who have been mutilated are more faithful or better wives than those who have not undergone the procedure and that it is very clear there are no benefits derived from FGM/C (WHO and Family Health Department, FMoH 2007). In the call for action to “Join the Crusade to Say No to FGM/C Anywhere It Is Practiced Among Our People,” to save future generations of women, the guideline itemized a five-point agenda:

1. Finding out about the practice in localities and giving clear information and education to other people on the negative health effects of female circumcision;
2. Working with other people to stop the practice in the area;
3. Contacting health or other influential authorities in the area to notify them about the problem;
4. Discussing with lawmakers or local representatives on making laws against FGM/C; and
5. Support families and communities in their efforts to abandon the practice and improve care for those who have undergone FGM/C.

In 1995, the Platform of Action at the Beijing Conference called for the eradication of FGM/C through the enactment and enforcement of legislation against its perpetrators (WHO 1994). There was no federal law prohibiting FGM/C in Nigeria until 2015, and this lack of legal recourse was identified as the main reason for the slow progress in decline of FGM/C prevalence in the country (Yoder and Khan 2007, Kwame-Aryee and Seffah 1999). In 2015 all that changed, when the federal government passed the law criminalising FGM/C in the Violence Against Persons (Prohibition) Act 2015 (VAPP). The law prohibits female circumcision or genital mutilation, forceful ejection from homes, as well as harmful widowhood practices. This marked the first time the nation was committed to stopping FGM/C through an act of the National Assembly.

Before the implementation of the federal law banning FGM/C, its opponents had relied on Section 34(1)(a) of the 1999 Constitution, “No person shall be subjected to torture or inhuman or degrading treatment,” as the basis for banning the practice nationwide (US Department of State 2001). Some states had passed laws against the practice as far back as 1999, including Bayelsa, Cross River, Delta, Ebonyi, Edo, Ekiti, Ogun, Ondo, and Rivers. In most cases, persons convicted under the law were liable for fines and imprisonment, but enforcement was not satisfactory, and many believe its poor enforcement was the result of low fines and short duration of imprisonment prescribed by state laws. Edo state banned FGM/C in October 1999, with perpetrators subject to a fine of approximately (US \$10) and imprisonment of six months. While opponents of the practice applauded such laws as a step in the right direction, they criticised the small fine and lack of enforcement as major impediments (*ibid*). It is important to note that while legal enforcement has been acknowledged as necessary, there is consensus it is not sufficient for FGM/C’s eradication.

Background to the federal law criminalising FGM/C

The Violence Against Persons (Prohibition) Act (VAPP) was passed in May 2015, the result of agitation for protection against different forms of violence. According to the Law Pavilion (2016), someone killing or maiming their spouse; or a scorned lover pouring acid on an ex-lover; or someone being forcefully taken away from their family and loved ones, has become a common feature across the country. It was the need to protect citizens from such violence that led to the enactment of the VAPP Act 2015. The Act is an improvement on the penal and criminal code in relation to violence; it also makes provision for compensation to victims as well as the protection of their rights. The Bill was passed by the House of Representative and the Senate in 2013 and 2015, respectively. By 8 May 2015, all legislative processes for transmission of the Bill to the Presidency were completed, and the Bill was signed into law on 28 May 2015. The Law Pavilion (2016) provided an incisive synopsis of the law highlighting its key provisions and implications as summarised.

Key provisions of the Act

The Act was passed in a bid to eliminate violence in private and public life, prohibiting all forms of violence including physical, sexual, psychological, domestic, as well as harmful traditional practices, along with prohibiting discrimination and providing maximum protection and effective remedies for victims and punishment of offenders.

The content of the Act is rich in its provisions, as it covers most of the prevalent forms of violence in the country, ranging from physical violence, psychological violence, sexual violence, harmful traditional practices, and socio-economic violence. The National Agency for the Prohibition of Trafficking in Persons (NAPTIP) is named as the service provider under Section 2 of the Act.

Under the VAPP Act, female circumcision or genital mutilation was prohibited across the country, among other forms of violence. Other punishable offences under the Act include rape, spousal battery, forceful ejection from home, forced financial dependence or economic abuse, harmful widowhood practices, child abandonment, harmful traditional practices, harmful substance attacks (such as acid baths), political violence, forced isolation and separation from family and friends, depriving persons of their liberty, incest, indecent exposure and violence by state actors (especially government security forces) among others. Some important elements of the law examined in the Law Pavilion (2016) report, particularly in relation to FGM/C and its implications, are further discussed below.

Prohibition of FGM/C

FGM/C is, by virtue of the Act, an offence regardless of the part of the country where the victim originates or resides. A person who performs FGM/C or engages another to carry out such circumcision or mutilation commits an offence and is liable on conviction to a term of imprisonment

not exceeding four years or to a fine not exceeding N200,000 (~US\$1,000), or both. Anyone who attempts the offence of FGM/C also commits an offence and is liable on conviction to a term of imprisonment not exceeding two years or to a fine not exceeding N100,000 (~US\$500), or both. A person who also incites, aids or abets, or counsels another to commit the offence commits an offence and is liable on conviction to a term of imprisonment not exceeding two years or to a fine not exceeding N100,000 (~US\$500), or both.

Compensation to Victims

A feature of the Act is its provision of compensation for victims of crimes under the Act. The Act provides that a court shall award appropriate compensation to a victim as it may deem fit in the circumstance. In addition to the rights provided under Chapter IV of the Constitution, victims and survivors of violence are entitled to comprehensive medical, psychological, social, and legal assistance by accredited service providers and government agencies or NGOs providing such assistance; information on the availability of legal, health, and social services, and other relevant assistance, and readily afforded access; and rehabilitation and re-integration.

Protection of Victims

Lawmakers, aware that victims, or potential victims, might not want to come forward to lodge complaints because of fear of further victimisation in wider society, provides that no complainant of any offence under the Act shall be expelled, disengaged, suspended, or punished in any form whatsoever by the action of compliance with the provisions of the Act.

Victims' identities are also protected by the Act, which provides for the number and categories of persons that may be in court during trial. It empowers the Court to hear proceedings in camera (secret) or to exclude any person from attending such proceedings and prohibits publication of certain information related to the trial to ensure a victim's dignity (and other parties to the trial) is protected.

The Act provides extensively for protection orders, which, according to the Act, are official documents, signed by a Judge, restraining an individual or State actors from further abusive behaviour towards a victim. This provision is laudable and curtails and mitigates, in the short term, the abuse of persons, especially in private spaces. The Act is both protective and preventive in its measures. A person who has been a victim of violence, and at risk of further violence, can apply for a protection order to be issued against violator(s).

Attempt as an offence

In the Act, attempt to commit an offence is an offence itself. The Act provides for appropriate punishment of the attempt to commit offences under the Act.

Provision for smooth operation of the law

For its judicious implementation, the Act makes it an offence for any person to defraud or conceal an offence or frustrate the investigation and prosecution of offenders under the Act, or any other act classified as a felony, liable to a term of imprisonment not exceeding three years or a fine not exceeding N200,000 (~US\$1,000), or both. Similarly, a person who willfully makes a false statement, whether oral or documentary, in any judicial proceeding under the Act, upon conviction faces a fine of N200,000 (~US\$1,000) or a term of imprisonment not exceeding 12 months.

Socio-economic violence

Abduction, abuse, harmful widowhood or other traditional practices, attack with harmful substances, date rape, damage to property in order to cause distress, deprivation of liberty, forced financial dependence or economic abuse, forced isolation or separation from family and friends, stalking, coercion, and intimidation are forms of socio-economic violence prohibited by the Act.

Superiority of the Act

When there is a conflict between any provision of the Act and any other provision for similar offences in the Criminal Code, Penal Code, or Criminal Procedure Code, the provisions of the Act supersede, consistent with Section 4(1) of the Constitution that provides that the legislative powers of the country shall be vested in the National Assembly. By virtue of Sub-Section 2, the National Assembly has powers to make laws for the peace, order, and good government of the Federation, to the exclusion of the State House of Assembly. It follows procedures as specified in Sections 58 and 59 of the 1999 Constitution, which is bicameral and made up of a Senate and House of Representatives.

Each state has its own House of Assembly with powers to legislate on any matter including FGM/C or any matter to which it is empowered to make laws in accordance with the Constitution. Section 4(5) of the Constitution prescribes that when there is inconsistency between state and federal law, the latter prevails, and the former's provisions in question become void (Lokulo-Sodipe et al 2014).

Implications of the Act

The VAPP provides a legislative and legal framework for the prevention of all forms of violence against vulnerable persons, especially women and girls, and has been in effect through three terms of the National Assembly. The law protects against violence in private and public life and brings succor and effective remedies to millions of victims who have suffered violence, in one form or the other, without recourse to justice or rehabilitative, psychological or social support for their recovery and reintegration. The Act does not only ensure that the violators are brought to justice, but also that victims are adequately compensated, re-integrated into the society and given the necessary support and protection they need. It is thus expected that States in Nigeria will take immediate and necessary action to adopt and enact similar law on Violence Against Persons.

The Act criminalising FGM/C has been described as only the first step in the sequence of strategies for reducing FGM/C prevalence. It also places FGM/C within the wider context of sexual abuse and crime, and mainstreams FGM/C as a form of gender-based sexual violence and makes it difficult for proponents to isolate it as a cultural practice. There was widespread commendation among Nigerian stakeholders of the National Assembly and the President for enacting the law, signaling that Nigerians are beginning to accept the fact that cultural and religious beliefs must be subject to universal human rights and there may be realistic hope for many who continue to live in fear across the country.

Perceived drawbacks in relation to the Act

Now the key question seems to be whether Nigeria will enforce the law (Ifijeh 2015). The major drawback in relation to the law is its limited application to the Federal Capital Territory, Abuja and only the High Court of the Federal Capital Territory Abuja empowered by an Act of Parliament has the jurisdiction to hear and grant any application brought under the Act (Law Pavilion 2016).

Duplication of laws is another major defect of the Act, as most of crimes stipulated in the VAPP are in existing criminal law, along with provisions for liberty of citizens in Sections 35, 40, and 41 of the Constitution (*ibid*).

Despite the optimism that the law will save over 40 million Nigerian women and girls from the health complications of FGM/C, whether it will be enforced nationally and if offenders will be punished for inflicting bodily harm, psychological trauma, and promoting health hazards among Nigerian women, in the name of circumcision or other traditional and cultural practices harmful to women's health, remains to be seen (Ifijeh 2015).

Of concern is that the law is not new in many states where laws were passed criminalising FGM/C several years ago, and FGM/C is still practiced openly in those states, with enforcers of the law

and even various state government officials looking the other way, as they do not want to be caught interfering cultural and religious practices. Edo state outlawed FGM/C in 1999, and other states including Rivers, Ogun, Osun, Cross River, and Bayelsa, among others, did the same between 1999 and 2002 (Center for Reproductive Rights 2009). While persons convicted under the law are supposed to be imprisoned for six months or fined the sum of N1,000 (US\$10), available information suggests that enforcing these laws in the various states has been difficult while the practice continues to gain increased acceptance (Ifijeh 2015).

Medical experts, as well as advocates of the law, have suggested that the best way to halt FGM/C in Nigeria is for the government to first embark on a massive awareness campaign on FGM/C's health implications across the country, especially in remote areas. The campaign needs to emphasise how the new law criminalises offenders, that offenders should be punished, and that such punishments should be publicised as a deterrent, so other offenders or intending offenders will know it is no longer 'business as usual' (*ibid*). Available evidence shows that part of the expert suggestions was the need for government to partner with community leaders, religious bodies, the mass media, especially television to inform the citizens that FGM/C has serious health implications (Lebimoyo 2015).

While stressing the need for government to enforce the law, since it is now a criminal offence to mutilate young women in the name of circumcision, Lebimoyo (*ibid*) warned that sporadic enforcement will not achieve the aim of reducing FGM/C.

Weak law enforcement is one reason why FGM/C persists in Nigeria. Ezeamalu (2016a) reported an interview with Abiodun Oyeleye that links the persistence of FGM/C to Nigerian police's apathy to the issue of violence against women. According to Ezeamalu, police officers do not empathise with victims and often refuse to protect their identities or guarantee their privacy (*ibid*). With the legal provisions settled, how to ensure its awareness among the citizenry, and its enforcement, remain a key challenge that need to be addressed. According to Ezeamalu, the Act will remain a law in abeyance if key stakeholders refuse to legitimize it, merely kept on the statute books. Wale Adebajo of the British High Commission stated that the law is that it is not yet known by the people and citizens have no ability to invoke or employ the law, including justice sector stakeholders, which makes it very difficult to enforce (*ibid*).

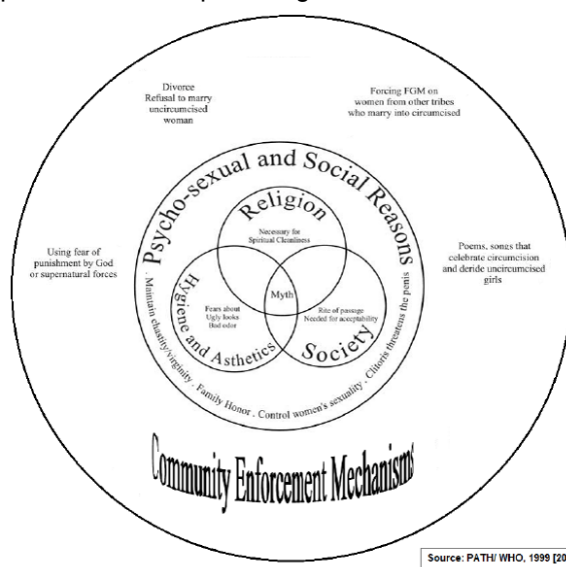
Consequently, the extent to which the law is being enforced, as well as campaign interventions to educate the people on its key provisions and the health implications of FGM/C, will remain an important focus for the FGM/C agenda in the future.

CHAPTER 3: DRIVERS OF FGM/C PRACTICES AMONG DIFFERENT GROUPS IN NIGERIA

Background and overview

The World Health Organisation (WHO) stipulated that governments and countries are confronted with complex and culturally entrenched beliefs on FGM/C, referred to as “the mental map,” incorporating myths, beliefs, values, and codes of conduct (Figure 4) that lead entire communities to view women’s external genitalia as potentially dangerous. If not eliminated, such beliefs have the power to negatively affect women who have not undergone FGM/C, along with their families and their communities (WHO 1999).

Figure 4. The Mental map shows the compounding factors for the continuation of FGM/C practice



To ensure conformity to traditional practice, strong enforcement mechanisms including the rejection of women who have not undergone FGM/C as marriage partners, immediate divorce for unexcised women, derogatory songs, public exhibitions, as well as the witnessing of complete removal before marriage or forced excisions, and the instillation of fear of the unknown through curses and evocation of ancestral wrath (*ibid*). Girls who undergo FGM/C are provided with rewards, including public recognition and celebrations, gifts, potential for marriage, respect, and the ability to participate in adult social functions (*ibid*). Building on FGM/C as an ethnic and culturally specific phenomenon, healthcare professionals and policymakers need to be aware of the diverse meanings and broad socio-cultural and religious reasons that contribute to the continuation of the practice to be able to deal with its occurrence effectively (UNICEF 2016a).

This chapter accepts the general consensus that FGM/C in Nigeria is deeply rooted in cultural beliefs and perceptions over many generations, with no easy avenue for change (Okeke et al 2012), and that the law criminalising FGM/C is only one necessary step in addressing the practice, with calls by experts for both legal and moral approaches to address the practice (Lebimoyo 2015). Ratidzai Ndhlovu, UNFPA’s Nigeria Representative, states, to end FGM/C, we must understand not only where and how it is practiced, but the social dynamics that perpetuate it, so we can use that knowledge to persuade families and practitioners to end it (UNICEF 2016c). This chapter identifies the factors of FGM/C practice among different groups in Nigeria, including supporting beliefs, attitudes and social norms, community enforcement mechanisms among different groups, as well as social and economic factors that sustain the practice across the country.

Beliefs, attitudes, and social norms supporting FGM/C in Nigeria

There remains considerable support for FGM/C in areas where it is deeply rooted in local tradition (UNICEF 2001, Abubakar et al 2004, Adeyinka et al 2009, Dare et al 2004, Odoi 2005, Orji and Babalola 2006). According to NDHS 2013, four out of five Nigerian women who were cut were cut by their fifth birthday, so it is impossible for girls to know why they are being circumcised. Social and cultural beliefs and norms are the leading factors for families to allow their children to be circumcised. These socio-cultural beliefs and norms posit FGM/C as a rite of passage into womanhood, promoting hygiene and cleanliness, as part of religious beliefs, family honour, and controlling female sexuality, in various places.

As a rite of passage, FGM/C is believed to be an important symbol for the formation of a girl's ethnic identity in the society where she lives. It is an initiation that also reflects transition from girlhood to womanhood, ensuring virginity and curbing promiscuity, and protecting female modesty and chastity (Asaad 1980, Saraçoğlu and Öztürk 2014). FGM/C is justified for family honour, female hygiene, and aesthetic reasons. The practice is believed to control female sexuality and modify socio-sexual attitudes, increase husbands' sexual pleasure, enhance fertility, and increase women's matrimonial opportunities, serving as a physical sign of a woman's marriageability (Taba 1979, Antonazzo 2003). Other beliefs and justifications include preventing mother and child deaths during childbirth, as well as legal reasons (one cannot inherit property if not circumcised) (Worseley 1938). The uncircumcised vulva is seen as dirty and ugly, with uncircumcised women also believed to be infertile (Antonazzo 2003, Orji and Babalola 2006).

While the custom of female circumcision predates both Christianity and Islam (neither the Bible nor the Koran recommend women be excised), religious requirements have been adduced, in some cases, for the practice. Muslim law (according to which, what is not forbidden is allowed) accepts the custom, "Circumcision is Sunnah for men and Makramah for women," *Makramah* means "honourable deed" (Daia 2000). There is agreement among Muslim leaders and scholars that infibulation is forbidden in Islam, but their interpretation and position on the circumcision and excision of girls remains ambiguous (Black and Debelle 1996). To help maintain cleanliness and health, uncircumcised females are considered "unclean," and if a clitoris touches a penis it is considered dangerous and ultimately fatal to the man. In some areas it is believed an infant will die if its head touches the clitoris. Taba (1979) documented the belief in FGM/C to preserve virginity and family honour and prevent immorality, with social control over a woman's sexual pleasure by clitoridectomy and over reproduction by infibulation.

While these beliefs and social norms are not specifically Nigerian, their elements are found in studies in Nigeria's different regions (Orji and Babalola 2006). A study of 500 Nigerian women found similar reasons for female circumcision: cultural and traditional reasons (95%), protection from extramarital relationships (49%), uncircumcised vulvas viewed as repellant (18%), avoidance of newborn death (11%), social influence for circumcision for marriage (9%), and religion (5%) (*ibid*). In some parts of Nigeria, cut edges of the external genitalia are smeared with secretions from a snail, with the belief that the snail, being a slow animal, will influence the circumcised girl to "go slow" with sexual activities in the future (Akpuaka 1991). Consequently, FGM/C is often routinely performed as an integral part of social conformity and in accordance with community identity (Odoi 2005).

A corpus of other studies in Nigeria listed the proportions of respondents who supported FGM/C, for various reasons (Abubakar et al 2004, Dare et al 2004, Nigeria DHS 2000, Odimegwu et al 1998, Odimegwu et al 2001, Okemgbo et al 2002, Ugboma et al 2004). The two most frequently stated reasons for favouring FGM/C among study participants in the southeast were tradition and culture (57%) and that the practice reduces female sexual desire (37%) (Berg and Denison 2013).

In their study of the Igbo-Ora community in southwest Nigeria, Adeyinka and colleagues (2009) specifically identified the patriarchal nature of society as supporting FGM/C, with more men than women supporting the practice, or opposed to its eradication.

The culture of silence further facilitates the practice's continuation. Despite falling support, millions of girls remain in considerable danger, and UNICEF (2013a) emphasises the gap between people's personal views of FGM/C and entrenched senses of social obligation fueling its continuation, exacerbated by lack of open communication on this sensitive and private issue. The sense of social obligation is consistent with the finding that gaining social acceptance is the most commonly reported benefit of FGM/C among girls and women (*ibid*). There is a lack of vocalisation on the issue, with a significant need for girls and women, and boys and men, to speak out, loudly and clearly, and announce they want it abandoned. Filling this gap in discourse by talking more and more about FGM/C is identified as crucial to breaking the taboos around the subject and helping ensure, in the future, that girls can live free from the risks it brings (Topping 2015).

Generally, there is little focus among anti-FGM/C advocates on the economic importance of FGM/C for male and female excisors. In southwestern Nigeria, where prevalence is highest, the Circumcision Descendants Association of Nigeria's (CDAN) members practice circumcision as a profession and livelihood. While 70 to 80 percent of their members have heeded the call to abandon the practice, over 20 percent remain in the trade, for economic reasons and lack of alternative means of sustaining their families. According to Ezeamalu (2016b), not addressing their concerns may have contributed to the persistence of the practice in the region, and addressing them should be part of the 2030 agenda.

Besides the fact FGM/C is a very old tradition, its persistence is supported by a combination of beliefs, attitudes, and social norms in Nigeria and beyond. There is, however, growing, undeniable consensus that its justifications, building on these beliefs, attitudes and social norms, continue to wane and are unable to withstand moral, legal or ethical scrutiny and challenges (Daia 2000, UNFPA 2014, UNICEF 2016ac). Jean Gough, UNICEF Nigeria Representative, stated categorically that not one of the myths surrounding the practice has any basis in truth, and that the only truth is that on every level it is a harmful and brutal practice with a detrimental impact on the health and the human rights of women and girls (UNICEF 2016c). This is an important line for the enlightenment campaigns that must go on across practitioners and supporters of FGM/C practice.

Community Enforcement Mechanisms in Nigeria

Despite the dearth of literature focusing on specific community enforcement mechanisms for FGM/C, this review found evidence from published and grey literature on key mechanisms through which FGM/C is enforced in communities and groups across Nigeria. These enforcement mechanisms fall under two broad categories: individual or family, and community enforcement mechanisms. Overall, both enforcement mechanisms work in concert to achieve traditional goals for womanhood and acceptability, marriageability, family honour, stigma and discrimination, and access to social and economic capital.

Individual and family enforcement mechanisms

In many Nigerian communities, FGM/C is forced upon women and girls by women, primarily mothers and 'aunties' (Akosile 2016). In an expert commentary, FGM/C in Nigeria was labelled as 'women against women' (Edukugho 2015). In the Ikom local government area (LGA), evidence supports these attributed roles. In one victim's account, a routine toilet trip resulted in four women crowding the bathroom and forcing her to lie on the floor, then tying her legs to two sticks. Two women held her hands, one sat on her chest, and the fourth woman performed the cut. Afterwards the victim was expected to go out during the festive periods, and show that she was cut

and therefore mature, but for her it was not festive, and she could not even go out (Leo and Okafor 2016).

Another respondent, who endured FGM/C in the same LGA, Ikom, stated that she did not get a chance to refuse because most girls are so young and are never given a chance for informed consent or objection. “If you refuse to be circumcised in my [community], you will be forced to be circumcised, because they say it is our tradition” (*ibid*). On the day the respondent’s cutting was planned, she went for a bath on her mother’s orders. One woman joined her, then three more, then another. Her mother brought a bench and asked her to strip and lie down. The girl refused. “If you refuse to pull your clothes, you will be forced,” she recalled her mother saying, so she obeyed, and a nurse made the deep cut, with bleeding and pain following (*ibid*).

Mothers who were themselves cut are key enforcers in many families. Cultural obligations and requirements lead young girls to be persuaded of their duty to be cut for their mother, as she was cut and all her neighbors expect that when her daughter comes of age she will be cut. Consequently, girls submit to circumcision to avoid bringing shame to their mothers. One victim stated, “I couldn’t bear the shame she would go through” (*ibid*).

Highly respected women in communities, including traditional birth attendants (TBAs), local barbers, medical doctors, and health workers, usually perform the procedure; unless performed in a medical facility, it is generally performed without anesthesia (US Department of State 2001).

Community enforcement mechanisms

As an integral part of social conformity, and in accordance with community identity (Odoi 2005), some communities dress FGM/C in cultural tradition and link it to cultural celebrations. In the Ikom LGA in Akwa Ibom state, the cut is evidence of a girl’s maturity and transition into womanhood, which must be celebrated during community festival activities (Leo and Okafor 2016).

Rewards are promised, in addition to emotional manipulation and outright false information, as enforcement mechanisms. In the preceding case, the girl was promised pampering and treatment like a baby after her cutting (*ibid*). Young women are made to feel inferior and incomplete, and that a girl who has not been cut will become promiscuous and not make a good wife.

Another study respondent was not circumcised until she was 19, when she was four months pregnant with her first child. Her Ebonyi community believed she could not have her baby unless she was cut, as an infant’s contact with its mother’s clitoris was considered a bad thing, so they cut it off (*ibid*). In reality, this was misinformation, compounding the fact that many people are not fully aware of the consequences of FGM/C. When it was time for the clitorrectomy victim to deliver, she was in labor for one day and was taken to hospital, where the midwives realised her vagina had closed due to the circumcision. She had to deliver by Caesarean section. Since then, sexual intercourse with her husband was painful (*ibid*). Experts have stated that there is no single benefit from FGM/C and have pointed out that uncircumcised women are not more prone to promiscuity, noting that about 99.9 percent of commercial sex workers have been cut (Akosile 2016).

Medicalisation of FGM/C in Nigeria: Is it the way out?

One important dimension of FGM/C in Nigeria is its medicalisation, utilising health care providers to conduct the practice, for minimising physical risks including pain, infection, and other negative health implications (Shell-Duncan 2001, WHO 2010). Data from the 2013 NDHS (NPC and ICF International 2014), summarised in Table 6, show the distribution of circumcised girls ages 14 and younger, as well as women ages 15 to 49, by person who performed their circumcisions. Traditional agents perform most female circumcisions in Nigeria: 87 percent of girls 14 and younger, and 80 percent of women ages 15 to 49 were circumcised by a traditional agent. Twelve percent of girls

and 13 percent of women were circumcised by a medical professional. Among the different types of traditional agents, 84 percent of girls 14 and younger were circumcised by a traditional circumciser, and three percent by a TBA. Similarly, 72 percent of women ages 15 to 49 were circumcised by a traditional circumciser, and seven percent by a TBA. Among medical professionals, a nurse or midwife performed most circumcisions of girls 14 and younger and women ages 15 to 49 (10% each).

Table 6. Percent distribution in Nigeria of circumcised girls ages 0 to 14 and women ages 15 to 49, by person performing the circumcision

Person who performed the circumcision	Current Age of Girls and Women	
	Girls age 0-14	Women age 15-49
Traditional agents	86.6	79.5
<i>Traditional circumciser</i>	84.0	72.2
<i>Traditional birth attendant</i>	2.5	7.0
<i>Other traditional agent</i>	0.1	0.2
Medical professional	11.9	12.7
<i>Doctor</i>	0.9	2.3
<i>Nurse/midwife</i>	10.4	9.9
<i>Other health professional</i>	0.6	0.5
Don't know/missing	1.5	7.9
Total	100%	100%
Number	6,150	9,652

Source; Nigeria DHS 2013 (NPC and ICF International 2014)

Although medicalisation is assumed to reduce the risk of FGM/C complications, it does not eliminate them nor does not change the fact FGM/C is a violation of women's and girls' rights to life, health, and bodily integrity. This has led to significant opposition by professional medical fraternities in Nigeria. Akosile (2016) reports that the National Association of Nigerian Nurses and Midwives, the Nigerian Medical Women's Association, and the Nigerian Medical Association, who were against the legitimisation of FGM/C as a medical necessity for females, actively campaigned against the practice and worked to inform all Nigerians and health practitioners about its harmful effects. FGM/C and its effects have now been introduced as part of the curricula for nurses and doctors by the Nursing Council of Nigeria (NCN) and the Medical and Dental Council of Nigeria (MDCN), including the aspects of the 2015 VAPP Act covering violence and practices against women and children. It has become a punishable offence for any medical practitioner, a nurse or doctor, to be involved in the practice (*ibid*). These efforts have curbed the push for partial or milder medicalisation.

Previous studies identified high levels of medical personnel FGM/C participation, and their opinions that some forms of FGM/C are good practice, not harmful, and their encouragement of the practice (Adekanle et al 2011, Onuh et al 2006), and it is unclear whether this new opposition signals weakening support for medicalisation and whether it translates to actual abandonment of the practice by medical practitioners in Nigeria. It is also not known whether the reported prevalence of medicalisation is evidence of entrenched support of FGM/C by medical personnel. This will require further study. It may also be helpful for study investments in whether medicalisation leads to a lessening in severity of cutting, and the extent to which medicalisation countermands abandonment. There is also little knowledge of options available to health workers for deciding whether to perform FGM/C, as well as the legal enforcement mechanisms for implementing the VAPP Act 2015 in relation to them.

Socio-economic and demographic determinants

In addition to cultural norms and values, this review identified key socio-economic and demographic factors associated with FGM/C practices across Nigeria. Besides the evidence that the country has one of the largest burdens of FGM/C, little is known about socio-economic and demographic determinants of FGM/C in Nigeria. Most studies in Nigeria are largely constrained by limited geographic coverage. Apart from an earlier, large national study in 1997 by the Center for Gender and Social Policy Studies of Obafemi Awolowo University in Ile-Ife, and the Nigeria Demographic and Health Surveys of 1999, 2003, 2008 and 2013, most of what is known of FGM/C's determinants are from small studies covering small communities, which lack national applicability. Others are constrained by focusing on a few respondents from health facilities, excluding FGM/C victims that have no contact with the health system. Piecing together this mosaic of evidence, presents the necessary first step in understanding the combination of the determinants of the persistence of FGM/C practice in the country.

One factor that runs through most of the studies and commentaries about the persistence of FGM/C in Nigeria is the lack of full awareness of the magnitude of the problem (meaning, dimensions, numbers) and its consequent negative physical and emotional health outcomes. Available evidence concludes that lack of total knowledge of both the magnitude and health implications of FGM/C, contributes to girls' continued circumcision (Adeyinka et al 2009). Five studies (Abubakar et al 2004, Nigeria DHS 2000, Odimegwu et al 1998, Odimegwu et al 2001, Okemgbo et al 2002) list proportions of respondents voicing various reasons against FGM/C. The most frequently stated opposition to FGM/C among southeast study participants was health complications (36%).

Economic factors are, of course, linked to religion, custom, and social norms that, when combined, fuel FGM/C practices. Profit from the practice is identified as a key factor in its continuation in the country's southwest, where prevalence practice is highest. This was confirmed in recent interaction with the South West Circumcision Descendants Association of Nigeria at a summit on Zero Tolerance for FGM/C in Ibadan, Oyo state's capital. According to the report by Ezeamalu (2016b), the people performing FGM/C make 'big money' and have high status.

A group of studies shows that FGM/C, in some instances, generates income for practitioners under the guise of preserving and continuing values and rituals. In an interview with *Premium Times*, Gift Abu, a nurse and activist, agrees that native customs contribute to the practice of FGM/C across the country, but she insisted that the circumcisers are the primary factors:

'For the men, they'll tell you because if they don't circumcise the girl, she becomes promiscuous. And for the women, they'll tell you we want our girls to be disciplined. And then, the monetary aspect of it. They do it for money, it's their livelihood. They'll tell you it's what keeps my family; it's what I use in training my children and feeding. So money is very important for those who don't have what to do. Some of them don't have any other thing they are doing apart from circumcision. It's like a profession to them.' (ibid)

This underscores why the Circumcision Descendants Association of Nigeria canvassed for the provision of alternative livelihoods for their members as a means of curbing FGM/C in southwest Nigeria (*ibid*).

Educational attainment, in several studies, is associated with FGM/C. In a study of 181 women randomly chosen at the family planning (FP) clinic of the Department of Community Health, College of Medicine, University of Lagos, from February through September 1984, Odujinrin and Akitoye (1989) found that more educated women were less likely to circumcise their daughters. All circumcised daughters were from circumcised mothers, except one, who circumcised her daughter in conformity with her husband's tribal practice. Aigbodion and colleagues (2007), who examined

students' attitudes towards FGM/C, found no difference between women and men, Muslim or Christian, in favorable attitudes, but students from higher educational backgrounds and with higher awareness levels held less favorable attitudes.

Four studies present results of multivariate logistic regression models identifying factors favouring FGM/C continuation and predictors of cut daughters. A comparison of factors across these regression models reveals three recurrent factors perpetuating FGM/C in Nigeria: 1) Women who themselves are cut (and living in a community where most women are cut), 2) Women with no or low education, and 3) Older women (Abubakar et al 2004, Freymeyer and Johnson 2007, Kandala et al 2009, Snow et al 2002). Similarly, in a study of 280 people over 18 years of age in the southwest Igbo Ora community, Adeyinka et al (2009) found that women with more education are less likely to practice FGM/C. Evidence from MICS data support the role of education, with girls and women with no education substantially more likely to support FGM/C. Among girls and women ages 15 to 49 who had heard of FGM/C, those supporting its continuation, by level of education were: No education, 28 percent; Primary education, 25 percent; and Secondary education, 18 percent (MICS data Nigeria 2011).

In a six week prospective study of 192 postnatal women and 95 newborns in the postnatal clinic of the Department of Obstetrics and Gynaecology of the University of Benin Teaching Hospital, in Edo state, January through April 1996, Ehigiegba et al (1998) found that more circumcised than uncircumcised baby girls had circumcised mothers, and low maternal education status was significantly related to female infant circumcision; there also was lack of antenatal counselling for most mothers. The findings of these small studies in the southwest and south are consistent with Nigeria DHS reports showing education as an important empowerment tool with a positive intergenerational effect on FGM/C. Mothers with higher levels of education are less likely to have their daughters circumcised (NPC Nigeria and ICF International 2014). Support for FGM/C is stronger among girls and women in the poorest households than those in richest households. Among girls and women ages 15 to 49 who have heard of FGM/C, 21 percent of the poorest wealth quintile and 17 percent of the richest quintile support the practice's continuation (MICS Nigeria 2011).

These studies, despite their limitations, highlight the complexity of factors determining and sustaining FGM/C in Nigeria, and the need for multi-pronged and nuanced approaches to address the challenge. Options range from enforcement of federal and state laws, economic empowerment of professional circumcisers, awareness and behaviour change campaigns among specific groups, and educational opportunities and the general empowerment of women across the country.

Medicalisation of FGM/C is assumed by a segment of the Nigerian population as a means of reducing risks of FGM/C complications, yet it does not eliminate them nor changes the fact FGM/C is a violation women's and girls' rights to life, health, and bodily integrity. Consequently, medicalisation has registered opposition from key medical fraternities, who have not only campaigned against the legitimisation of FGM/C as a medical necessity but banned participation of any medical practitioner in the practice. While these efforts have stalled momentum for partial or milder medicalisation of FGM/C in the country, much remains unclear of the status and future of medicalisation of FGM/C in Nigeria. Consequently, investments in further studies are required to understand medicalization, in the search for further gains in FGM/C abandonment. Does medicalisation lead to a lessening in the severity of cutting? Does it inhibit abandonment of the practice altogether? There is also need for knowledge of the extent of legal enforcement mechanisms for VAPP Act 2015 among medical personnel in Nigeria and whether prosecutions have resulted from the Act's enforcement.

CHAPTER 4: TYPES OF FGM/C INTERVENTIONS AND IMPLEMENTING ORGANISATIONS

The 2013 UNICEF report calls for legislation against FGM/C, which has been introduced in the vast majority of countries where it is practiced. It also calls for measures complementing this legislation and leveraging positive social dynamics for changing social norms. The UNICEF report sets out key steps for eliminating FGM/C:

- Working with local cultural traditions rather than against them, recognizing that attitudes and conformity to FGM/C vary among groups within and across national borders;
- Seeking to change individual attitudes about FGM/C, while addressing entrenched expectations surrounding the practice across wider social groups;
- Finding ways to reveal hidden attitudes favoring FGM/C abandonment so families can realise they are not alone—a crucial step for creating necessary critical mass and generating a chain reaction against FGM/C;
- Increasing exposure of groups still practicing FGM/C, to groups that do not;
- Promoting FGM/C abandonment alongside improved status and opportunities for girls, rather than advocating for milder forms of the practice, such as ‘symbolic’ circumcision;
- Continuing to gather data to inform policies and programmes, as a vital part of efforts to eliminate FGM/C.
- It also points to the role education can play in bringing further social change, noting that higher levels of education among mothers correspond to lower risk that their daughters will be cut and that while in school girls may develop ties with others who oppose FGM/C.

Nigeria heeded the call, with the 2015 VAPP Act banning female genital mutilation, along with other state laws before and after it. There is consensus among stakeholders, however, that laws alone will not end the practice, which is why a systemic cultural shift and changed attitudes are required to make sure women and girls are no longer subjected to the harmful procedure. Prior to the legal rejoinder, and afterwards, sensitisation activities were initiated across the country to address the knowledge gaps identified as hindering efforts to address FGM/C practices.

This chapter of the review outlines the types of FGM/C interventions in the country over the last 15 years and their implementing organisations. The scope of interventions include promotions, which are predominately awareness campaigns, and attitude interventions, which involve changing attitudes of professionals, individuals, and communities, along with trainings, and practice interventions that seek to engender behaviour change through, for example, health care professionals’ and excisors’ abandonment of the practice, and communities’ renouncements of it. What is clear, however, is that the interventions reported in Nigeria are not specifically focused on any one of these dimensions but generally seek changes in knowledge, attitudes, and practices at the same time. While knowledge and practice interventions can easily be identified, attitude interventions are mostly commingled in other interventions.

Knowledge and awareness interventions

Lack of full awareness of the FGM/C problem’s magnitude and its physical and emotional health consequences are factors identified in their persistence. Over time, before and after VAPP’s 2015 passage, most FGM/C interventions were “knowledge” interventions, primarily awareness campaigns on the nature and consequences of the practice and its violations of human rights.

Recent campaigns center on awareness of VAPP's provisions—with stakeholders, promoters, and enforcers—and its associated opportunities to end FGM/C.

In *Nigeria: Fighting Female Genital Mutilation on All Fronts*, Akosile (2016) records united opposition against FGM/C at a February 2016 meeting organised by UNFPA, UNICEF, and the Federal Ministry of Women's Affairs and Social Development at the Presidential Villa in Abuja. In recapitulating the beliefs supporting the practice (e.g. custom, culture or tradition, promiscuity prevention), the report reiterated how millions of Nigerian girls have passed through the FGM/C ritual, thereby denied their own bodies' rights, to the right to happiness or pleasure, and in extreme cases, the right to life itself.

The launch of the UNFPA/UNICEF joint programme on the abandonment of FGM/C in Nigeria drew participants from varied segments of society, particularly people with significant influence across the political spectrum, from traditional rulers to religious leaders, government officials to state First Ladies, from UN agencies to other donors, and from civil society to the media. United in their opposition, the programme's focus against the practice was clear. Part of the campaign was a video of two anti-FGM/C crusaders that made evident that the issue had assumed serious dimensions. Participants included high level political and civil leaders from across the country, such as the wife of the Vice President, wife of the Senate President, the Minister of Women's Affairs and Social Development, Minister of Information and Culture, Minister of State for Health, the country directors of UNFPA and UNICEF, a representative of *The Guardian*, the former Deputy Governor of Plateau state, and the wives of the governors of Ebonyi, Anambra, Imo, and Kebbi.

This high level campaign, connected to the highest authorities in the country, affirmed the federal government's commitment and efforts to combat the harmful practice and its serious health implications in the long- and short terms. The launch meeting also set an agenda to ensure that by 2030 not a single girl in Nigeria would be subjected to FGM/C. The participants called on the Executive and lawmakers to work together to end the practice and stressed the need for coordinated action and sensitisation across the nation with social awareness campaigns, including making life better for Nigerians, especially women and girls. The campaign's message labelled the practice of FGM/C as "evil and barbaric" and not suppressing promiscuity but leading to serious health consequences. Pointing to an estimated 19.9 million Nigerian women already cut, the campaign organisers made a collective call on the federal and state governments, parents, and participants to support the campaign to end the practice and champion it at federal and state levels (Akosile 2016).

Another post-VAPP awareness campaign involved a two day media dialogue on FGM/C abandonment in Osogbo, Osun state, organised by the Advocacy Unit of the Child Rights Information Bureau (CRIB) of the Federal Ministry of Information, in collaboration with UNICEF, to mark World Zero Tolerance of FGM/C (*ibid*). At the meeting, the national president of the Inter-Africa Committee on Harmful/Violence Practices Against Women and Children (FGM) observed that there is no single benefit from FGM/C. This dialogue informed its participants on regional prevalence rates in Nigeria, in particular the southwest, south, and southeast regions. The dialogue revealed that the practice is religiously required in some communities and is believed deters pre-marital sex and promiscuity. It was these entrenched beliefs that the UNFPA and other UN agencies like UNICEF declared that they are working to change. The dialogue detailed the long list of ways FGM/C affects women and young girls: infections (genital abscesses), problems with sexual intercourse (pain), depression and anxiety, painful menstrual periods, urinary problems, vesico vaginal fistula (VVF) or recto vaginal fistula (RVF), problems in childbirth (excision required for delivery and resultant trauma, often compounded by re-stitching). Finally, the dialogue challenged fears that women who were not circumcised are more prone to promiscuity than those circumcised (*ibid*).

A similar media awareness training, Reduction of Discrimination and Violence Against Women in South West Nigeria, was organized for journalists in Ado-Ekiti by the NGO New Initiative for Social Development, with the support of the British High Commission, on 21 September 2016 (Ezeamalu 2016a). In this training Oyo state was identified as having the most, almost two million, FGM/C victims, and discussed general apathy towards violence against women by the police, with examples of police officers failing to protect victims, making no effort to treat complaints with confidentiality, nor trying to conceal victims' identities or guarantee their privacy.

At this training journalists were made to see how VAPP's "tortuous journey," with 13 years in the National Assembly, itself reveals the complexity of discrimination against vulnerable women in Nigeria. This one day training was designed to create awareness for VAPP and harness contributions from all participants and stakeholders in fighting a practice now a crime under the law (*ibid*). Trainers pointed out how the objectives and approaches of the Act are robust and all-inclusive, looking beyond the courts, police, and prisons, usually the primary institutions for criminal matters, spreading a wide net of stakeholder participation, including governmental, non-governmental, faith-based, voluntary and charitable organisations, among others (*ibid*). On calling the journalists to action, the training emphasized that the success of the Act will largely depend on strong advocacy which leads to attitudinal change in the society.

In Ebonyi state, an epicentre of FGM/C in eastern Nigeria, on 25 July 2016 the state's Chief Judge stated that anyone caught practicing FGM/C will be given five years imprisonment with option of N2,000 (~US\$10)² fine (Eze 2016). The warning was given during the inauguration of a campaign against FGM/C in the state at a women's development centre, in Abakaliki, the state capital. The highlight of the event was the speech by Ebonyi's First Lady, who described FGM/C as a harmful traditional practice against womanhood that must end, insisting that the state cannot continue to live in the dark ages, to women's detriment. She noted that Ebonyi ranks second in Nigeria after Osun state for FGM/C prevalence, with 74 percent prevalence, and lamented a situation where women's reproductive organs are butchered in the name of cultural practice, stating it is no longer acceptable.

The First Lady called for a stop to the practice and waging a serious campaign against it. Her campaign against the practice is concentrated in her project, the Family Succour and Upliftment Programme. She stated that she intends to request the State House of Assembly amend the law against FGM/C. In support of the campaign, the Governor promised to retrieve a bill in the State House against FGM/C that has not been passed, and amend it for severe sanctions against violators (*ibid*). While there has been no evaluation of the impact of the First Lady's campaign, anecdotal evidence points to notable successes. She hosted and organised a high-level meeting in the state capital with support of UNFPA and the wives of governors of six states—Osun, Ebonyi, Imo, Ekiti, Oyo, Lagos—to accelerate advocacy and action for FGM/C abandonment and create awareness and engender commitment from policymakers, legislators, traditional, community and religious leaders, youth, women's groups, etc.

Governors' wives are the faces of state campaigns and key players in their resource mobilisations. This was reportedly successful in Ebonyi state, as its government committed, in principle, to providing matched funding to UNFPA activities including its FGM/C programme. These meetings offered platforms for policymakers, the legislature, and executives to make policy statements against FGM/C. The principal pronouncement was a five-point communiqué by Ebonyi state Traditional Rulers on 12 July 2016 supporting the First Lady's FGM/C campaign. The traditional rulers not only condemned the practice of FGMC in all its iterations, they also called for appropriate

² The exchange rate of the Nigerian Naira to the United States Dollar has been very volatile over time with Naira persistently losing value to the Dollar. The amounts presented reflect the prevailing values at the time the fines were stipulated. By the 20th May 2015, the spot inter-bank market saw 1 USD=199.198 NGN

state legislation against it and sanctions against defaulters, in addition to commitments to introduce traditional laws against the practice in all the autonomous communities of the state, as well as leading grassroots sensitisations against the practice in their communities³.

The Women's Health and Action Research Centre (WHARC) headquartered in Benin City, Edo's state capital, is a notable NGO with public awareness activities on FGM/C (Immigration and Refugee Board of Canada 2010). WHARC aims to improve the reproductive health (RH) and social wellbeing of women and adolescents so they can lead productive, fulfilling lives and provide their children healthy futures. Through its research, WHARC educates women, youth, community gatekeepers and policymakers about sexual and reproductive health generally. Through its *African Journal of Reproductive Health* (AJRH), an international, peer-reviewed journal, WHARC has revealed how common FGM/C is among the Edo in the south (Osifo and Evbuomwan 2009). Prior to the 2015 VAPP Act, WHARC was a notable advocate for policy change at local, state, and federal levels and legislation banning FGM/C. It also provides current and effective RH services to women and adolescent girls in Africa (WHARC 2015).

These campaigns and official communications have continued in prominence since the 2015 VAPP Act. A critique of most of these "knowledge" interventions however is their lack of clear and measurable focus. Each is rather generic, addressing many issues and themes, making them appear more interested in abstract policy. Consequently, the extent to which their messages are heard, comprehended and translated into action for the elimination of FGM/C remain to be seen, more so as the campaigns, especially since VAPP, are at infancy, with no known deliberate, systematic evaluations. Designing such interventions, in measurable formats, and monitoring their outcomes should be a point of investment for FGM/C knowledge and awareness in Nigeria.

Attitude Interventions

Interventions which involve changing attitudes of professionals, individuals and communities and training to achieve this constitute a major dimension of anti-FGM/C activities in Nigeria. One such intervention that cuts across knowledge promotion, attitude, and behaviour change was exemplified by a summit, Zero Tolerance to Female Genital Mutilation/Cutting, organised by the Circumcision Descendants Association of Nigeria (CDAN) in Ibadan, in southwest Nigeria, on 23 May 2016. In the summit, CDAN, a registered organisation of circumcisers, through its Board of Trustees Chair offered conditions for quitting the vocation. The group showed deep understanding of the challenges associated with FGM/C and the debates in the international development arena in relation to its link to women's rights and gender inequality.

To eradicate FGM/C in the southwest and penetrate other regions, CDAN proposed a lot more including increased community awareness and knowledge of the health hazards associated with FGM/C. They also advocated for the provision of alternative means of livelihood for their members, as a way of curbing the practice in their zone. The group stated that the FGM/C agenda would be difficult to achieve without the "full involvement" of their members. In an unusual reverse of roles, and to show their willingness to collaborate with NGOs and others to end FGM/C, the circumcisers stated their commitment as enshrined in their constitution to the same campaign and agenda of the UN as other NGOs and principal actors of the FGM/C campaign. They lamented, however, that their efforts have not been utilised for the successful advancement of the goal to end the practice, which necessitated the summit. Speakers in the summit underscored how CDAN had made repeated attempts to collaborate with NGOs in the past but failed due to lukewarm attitude of some of the NGOs (Ezeamalu 2016b).

³ See full communiqué attached as Appendix 1.

Part of the summit was the opportunity for scores of CDAN members across the South West (donning uniformed local attires inscribed with 'Say No to FGM') to watch video clips of the hazards of female circumcision. A statement from the group suggested that several deliberations within the rank and file of CDAN membership had resulted in a majority decision for the approval of zero tolerance to FGM/C. The declaration reads:

'We so hereby declare our resolution that 'A Total Stop to FGM/C' is now in place and we encourage the fullest cooperation of all members and to be obedient to this decision jointly agreed upon...I will however like to appeal to both government and organisations connected to this campaign worldwide to look at the other side of the profession that has been earning us economic support. To also consider the need for support to this family whose source of livelihood is being taken from them in a manner that will provide alternative sources of income to alleviate the possible economic effect that may likely affect their families...Government should also consider a programme for the circumciser's family to limit the effect on the loss of revenue.' (ibid)

While there was no follow up of this group, to examine the outcomes of their summit, the organisation exemplifies change in attitude, calling on relevant stakeholders for not only change in attitude towards the group but also on the need to assist their members to transit out of the practice through behaviour change interventions through provision of economic sustenance alternatives. This is an important point of required investments in Nigeria; examples are discussed in the Practice Intervention section.

Practice interventions

Practice interventions identified in Nigeria include training and behaviour change activities to affect FGM/C practice or prevent engagement in it altogether, such as convincing excisors to abandon it, or persuading communities to renounce FGM/C. Other behaviour change interventions identified include activities promoting human rights and enforcement of legal protections for victims and potential victims of FGM/C. An important intervention typifying the call by CDAN was a successful pilot training and circumcisers' conversion intervention sponsored by DfID among women circumcisers in the country reported by the Office of the Senior Coordinator for International Women's Issues, US Department of State in 2001. DfID worked with IAC Nigeria on the pilot project with 10 excisors, who were educated about the criminalisation of FGM/C in their state.

DfID purchased deep freezers and ice cream makers for each excisor to start her own business in her community. In each case, the excisor earned enough to replace her former FGM/C practice as her source of income. When families have brought their daughters to them to be circumcised, they refused to refer them to others who are still practicing and have even threatened to contact authorities if the families try to pursue the operation (US State Department 2001). Other practice and behaviour change interventions in Nigeria are those covering human rights and health care programmes. Beyond speeches in awareness campaigns that call for prosecution of those who practice FGM/C and enforcement of the 2015 VAPP Act, an intervention identified in the literature that speaks to the issues of human rights and bodily integrity in relation to FGM/C in the country was the reported inclusion of FGM/C in the medical curriculum in the country and the stipulation that it is now a punishable offence within the medical profession to engage in the practice.

According to Akosile (2016), negative experiences associated with FGM/C in some states led to its introduction to the curriculum for nurses and doctors by the Nursing Council of Nigerian (NCN) and the Medical and Dental Council of Nigeria (MDCN). Part of the FGM/C curriculum was the introduction of aspects of the 2015 VAPP Act covering violence and practices against women and children. Accordingly, it has become a punishable offence for any medical practitioner, a nurse or doctor, to be involved in FGM/C in the country. This has slowed the momentum for partial or milder medicalisation of FGM/C in the country.

The Child Protection Network (CPN), launched in 2010, and active in 24 out of 36 states by 2012, partnered with UNICEF Nigeria for a 16-month intervention to help prevent and respond to abuses, exploitation, and harmful practices against children in 23 states (Warren 2012). The project was to not only building on the existing strengths of CPN and communities where it works to minimize child abuse, violence, and exploitation, but to be able also to respond to reports of violations in a timely and effective manner, while always keeping the best interests of the child in mind (*ibid*). The project primarily recognises traditional practices, such as FGM/C, as causing great harm, but also recognises the many traditional practices and beliefs that are positive sources of child protection, which must be respected and bolstered (*ibid*). Further evidence before and after the passage of the 2015 VAPP Act confirms that CPN, in partnership with UNICEF, has been active across the country addressing a myriad of child rights issues and capacity building (Kayode-Adedeji 2013^{abcd}, UNICEF 2013b, Nkwopara 2015). It is important to note, however, that the overall activities CPN generally cover child right issues beyond FGM/C, especially before the passage of the 2015 VAPP Act.

In the southeast of Nigeria interventions to eliminate harmful traditional practices have been linked to the activities of independent, NGO, non-profit organisations such as the Women Aid Collective (WACOL), founded in November 1997, headquartered in Enugu with branch offices in Port Harcourt and Abuja. Its commitment is to help women and young people in need and working towards gender equality and human rights for all women and young people whose rights are threatened or denied and who are subjected to physical, mental, or sexual abuse. The increase in legal protection and fight for better choices for abused women and children, facilitate flow of information and experiences between organisations, and develop appropriate information, education and communication (IEC) materials that will be used in advocacy for human rights of women and young people.

Similarly, the Centre for Women Studies and Intervention (CWSI), headquartered in Abuja and structures in five states, has been working on women's empowerment and educational attainment since its registration in 1999. It envisions an active part to create a better world through the upholding of the dignity of women, through conscientisation and the holistic empowerment of women and the promotion of gender equity. Its activities cover good governance, reproductive rights, and economic and social rights. In pursuit of its objectives, the Centre published its research on *The Root Causes of Gender-based Violence in Nigeria, A Case Study of Delta and Ebonyi States in 2012* (Center for Women Studies and Intervention 2014).

A prospective study of 51 female children from ages 10 days to 18 years presenting with complications after FGM/C at the University of Benin Teaching Hospital, between January 2002 and December 2007, provided insight into medical intervention for the practice in a major medical facility (Osifo and Evbuomwan 2009). During the period, 29 female children were brought by their parents for mutilation, while 67 parents interviewed believed strongly in FGM/C; 47 mothers were mutilated. Religious-cultural and superstitious beliefs were the main indications and the type of mutilation ranged from excision of clitoral tip in 10 (19.6%) children to complete excision of the clitoris, labia minora, and inner layer of majora in seven (13.7%). Complications ranged from clitoral cyst formation in 21 (41.2%) to life-threatening infections (*ibid*).

Other behaviour change interventions were reported for states in eastern Nigeria. Nkwopara (2015) reported of a community awareness and behaviour change intervention launched in Imo state by UNICEF in collaboration with Imo state office of the National Orientation Agency (NOA). The sensitisation workshop was launched in Ikeduru LGA to expose the dangers of FGM/C. UNICEF and NOA brought the event to Ikeduru, because it is among the few local council areas of the state with high FGM/C prevalence. The sensitisation workshop convened participants from the communities and a coalition of resource persons drawn from reputable organisations affiliated

with UNICEF, NGO support groups, NOA, FMoH, State Universal Basic Education Board (SUBEB), CPN, Child Rights Advocacy Consultants, Ministry of Social Welfare, and the Ministry of Information and Strategy.

The workshop covered different dimensions of the FGM/C challenge, including basic definitions, the crude instruments used, the associated dangers, which include severe bleeding, shock, leakage of urine and faeces, complications at childbirth, mental failure, and other health consequences (*ibid*). The major reasons for the practice, which is rooted in culture and tradition were identified and debunked as causing more harm than good, for which reason the government and international agencies are positively engaging the stakeholders in Imo communities with a view to shifting ugly social norms. Apart from just enforcing the existing laws, UNICEF and NOA explained that the sensitisation technique is a very critical component of the crusade to eradicate the practice in Nigeria.

An important aspect of the programme was the opinion that FGM/C constitutes violence against women, building on relevant legal instruments such as the Child Rights Law of 2004, the 1999 Constitution, and the other relevant documents giving credence to the crusade against FGM/C. Royal fathers, the custodians of the people's culture and tradition, and civil society groups, faith-based organisations, youth groups, religious leaders, teachers, women's groups, town union executives, and other stakeholders, were mobilised to engender behaviour change for the FGM/C eradication. One highlight of the workshop was a resolution in favour of FGM/C's abandonment by all participants (*ibid*). Notwithstanding the solidarity exhibited, the question of whether the resolution would be carried out to the letter remains a matter for speculation but will need concrete investment to investigate and arrive at real answers.

Another important behaviour change intervention was implemented in 2006 in Enugu state also in eastern Nigeria among 957 male and female community members. The multifaceted programme involved community mobilisation, advocacy, and mass media events at three community levels: hamlet, LGA—which targeted influential decision makers—and state (Enugu). At the state level, the multimedia programme, *Ndukaku*, Igbo for "health is greater than wealth," dominated, but other activities included development of action plans to improve women's situations (Babalola et al 2006). Hamlet activities included community meetings and organised community groups, which designed action plans. LGA activities included visits with traditional leaders, religious leaders, local government officials, school authorities, women's groups, and discussions of FGM/C at tribal meetings and town forums. At the state level, newspaper columns, radio call-in shows, and public forums were organised.

The intervention activities lasted 12 months and were delivered by Women Action Research Organisation and the National Association of Women Journalists. The outcome was compared with community members in Ebonyi state (similar to the intervention state), who received no intervention. The evaluation identified changes in behaviours, beliefs, attitudes, and intentions in Enugu state compared to Ebonyi. Changes were observed in encouragement for others to not perform FGM/C, yet positive attitudes and belief in benefits to FGM/C along with personal approval persisted. There was, however, a perceived self-efficacy to resist pressure from spouses to perform FGM/C on daughters, along with the belief that most men and women in the community favour discontinuation and intend not to perform it on their daughters (*ibid*). Most interventions identified were locally relevant and largely coordinated efforts by a coalition of stakeholders.

This is consistent with the consensus from experts and stakeholders, including governmental and intergovernmental and non-governmental agencies, on the need for concerted action. However, most interventions remain at awareness and sensitisation activities. We are yet to identify activities beyond IEC workshops. Evidence of legal prosecution interventions and other empowerment activities remain largely unattended. We found no evidence of legal prosecutions or convictions.

There is also the apparent lack of research on the highly complex relationships in terms of resources, funding, cooperation, and implementation strategies of these groups of stakeholders. There is little or no evidence in relation to which intervention and approaches are more effective than others. There is little or no robust scientific evidence for judgments of what works or otherwise. Our reviews show mostly singular cross-sectional reports on interventions that generally lacked a controlled before-and-after design, or pre-post intervention questionnaires or interviews. Consequently, causal inferences are impossible, which perhaps reveals a gap in research that needs further investments.

Stakeholders in interventions in Nigeria, and their roles

A coalition of international agencies, the diplomatic community, national government, NGOs, civil and traditional societies, and the media have been listed as important arms and voices in the interventions to eliminate FGM/C in Nigeria over the years. Building our extensive review of available literature and triangulation of data from all sources, these organisations, their specific activities and reference years of their interventions are summarised in Table 7 and further discussed under the following three broad subcategories: Nigerian government agencies, inter-governmental agencies and diplomatic missions, NGOs, and CSOs.

Table 7. Stakeholders engaged in FGM/C interventions and the nature of their activities

Types and Names of Stakeholders	Types of Activities	Reference Years Intervention
1. Nigerian Government Agencies		
a) National Assembly and Presidency	<ul style="list-style-type: none"> The Violence Against Persons (Prohibition) Act prohibiting female genital mutilation, forceful ejection from home and harmful widowhood practices throughout the Federation. 	<ul style="list-style-type: none"> 2015
b) State Assemblies and Governments of Abia, Bayelsa, Cross River, Delta, Edo, Ogun, Osun and Rivers	<ul style="list-style-type: none"> Passage of State laws prohibiting FGM/C in particular States with sanctions of fine and imprisonment for offenders 	<ul style="list-style-type: none"> 1999-Onwards
c) Federal Ministry of Women Affairs and Social Development, Abuja, supported by Federal Minister of Information and Culture and Minister of State for Health	<ul style="list-style-type: none"> In collaboration with UNICEF/UNFPA launched in Abuja the Nigerian national campaign response to accelerate change and eliminate the practice of FGM/C within a generation – estimated at 20 years. 	<ul style="list-style-type: none"> 2016
d) Federal Ministry of Women's Affairs and FMOH	<ul style="list-style-type: none"> Supported knowledge generation in the study of 148,000 women and girls from 31 community samples nationwide 	<ul style="list-style-type: none"> 1997
e) Imo State office of the National Orientation Agency (NOA), in partnership with UNICEF and State Ministry of Health, State Universal Basic Education Board (SUBEB)	<ul style="list-style-type: none"> The sensitisation workshop geared towards exposing the dangers of FGM/C to stakeholders in Imo communities: royal fathers, civil society groups, faith based organisations, youth groups, religious leaders, teachers, women groups, town union executives and their mobilization towards the eradication of FGM/C 	<ul style="list-style-type: none"> 2016
f) Ebonyi State Government: Governor, First Lady, State Chief Judge	<ul style="list-style-type: none"> The inauguration of a campaign against FGM/C in Abakaliki Ebonyi State Capital, supported by The Governor, First Lady of Ebonyi and State Chief Judge 	<ul style="list-style-type: none"> 2016
2. Inter-governmental Agencies and Diplomatic Missions		
a) United Nations Population Fund (UNFPA) and United Nations International Children's Fund (UNICEF)	<ul style="list-style-type: none"> FGMC abandonment campaigns across the country; Knowledge generation on beliefs, knowledge, and practices of FGM/C in 6 high-prevalence states: Ebonyi, Ekiti, Imo, Osun, Oyo and Lagos Knowledge generation by funding a study of 148,000 women and girls from 31 community samples nationwide 	<ul style="list-style-type: none"> 2016 2015 1997
b) United Nations Development Programme (UNDP)	<ul style="list-style-type: none"> Funding knowledge generation by funding a study of 148,000 women and girls from 31 community samples nationwide 	<ul style="list-style-type: none"> 1997
c) World Health Organisation (WHO)	<ul style="list-style-type: none"> Funding knowledge generation by funding a study of 148,000 women and girls from 31 community samples nationwide Three-year short-term plan; eight-year medium-term plan and a nine-year long-term plan to eventually eliminate this practice from Nigeria and the rest of Africa 	<ul style="list-style-type: none"> 1997 1996-1998; 1999-2006; 2007-2013

Types and Names of Stakeholders	Types of Activities	Reference Years Intervention
d) United States Agency for International Development (USAID) and US Embassy's Democracy and Human Rights Fund	<ul style="list-style-type: none"> Partnership with the women caucus of the National Assembly in their campaigns addressing women's health issues, including the problem of FGM/C; providing grants to NGOs in its campaign to ban the practice in five southeastern states 	<ul style="list-style-type: none"> 2001
e) DfID of Great Britain	<ul style="list-style-type: none"> Funding Nigerian NGOs in addressing the practice 	<ul style="list-style-type: none"> 2001
f) British High Commission in Nigeria	<ul style="list-style-type: none"> Support for Nigerian NGO in campaign at reduction of discrimination and violence against women in South West Nigeria 	<ul style="list-style-type: none"> 2016
g) DANECO of Sweden	<ul style="list-style-type: none"> Funding Nigerian NGOs in addressing the practice through knowledge generation 	<ul style="list-style-type: none"> 2001
3. NGOs and CSOs		
a) Leaders of the Nigerian National Committee (also known as the Inter-African Committee of Nigeria on Harmful Traditional Practices Affecting the Health of Women and Children [IAC]) b) National Association of Nigerian Nurses and Midwives, Nigerian Medical Women's Association, and Nigerian Medical Association c) Women's Centre for Peace and Development (WOPED) d) Calvary Foundation International Inc (Golgothas), est. 1975 in Thessaloniki, Greece and incorporated in Nigeria as an international NGO, involved in many since inception	<ul style="list-style-type: none"> Knowledge generation by state to state study of the FGM/C practices; holding meetings and programmes in both urban and rural communities throughout the country to inform the public about FGM/C Active campaigning against FGM/C; Knowledge generation and dissemination through the creation of national information package; national workshops and training trainers; the inclusion of FGM/C and VAPP in the medical curriculum for nurses and doctors by the Nursing Council of Nigerian (NCN) and the Medical and Dental Council of Nigeria Enlightenment campaigns against FGM/C Humanitarian and philanthropic activities, including FGM/C workshops and seminars to enlighten policy makers and stakeholders on the ill effects of FGM/C and other malpractices 	<ul style="list-style-type: none"> 1997 2016 2000. 2001; 2011
e) New Initiative for Social Development	<ul style="list-style-type: none"> Training of journalist and creating awareness of the 2015 VAPP Act as part of the search for pathways to ensure its awareness and enforcement 	<ul style="list-style-type: none"> 2016
f) Child Protection Network	<ul style="list-style-type: none"> Help prevent and respond to abuses, exploitation and harmful practices against children across the country; capacity building to address myriad of child right issues 	<ul style="list-style-type: none"> 2010-2016
g) Women's Health and Action Research Centre (WHARC)	<ul style="list-style-type: none"> Educating women, youth, community gatekeepers and policymakers about sexual and reproductive health; advocates for policy change at the local, state and federal levels; legislation banning FGM/C; and knowledge generation through the publication of the African Journal of Reproductive Health (AJRH) 	<ul style="list-style-type: none"> 2009-2015
h) The Women Aid Collective (WACOL)	<ul style="list-style-type: none"> Legal protection and fight for better choices for abused women and children; facilitate flow of information and experiences between organisations, and develop appropriate Information, Education and Communication materials used in advocacy for human rights of women and young people 	<ul style="list-style-type: none"> 1997-2016
i) The Centre for Women Studies and Intervention (CWSI)	<ul style="list-style-type: none"> Women empowerment and education; upholding the dignity of women through conscientisation; holistic empowerment of women; and knowledge generation through research, e.g. The publication of The Root Causes of Gender based Violence in Nigeria, A case study of Delta and Ebonyi States in 2012 	<ul style="list-style-type: none"> 1999-2014

Federal and state agencies

Besides the enactment of legal instruments in support of addressing the FGM/C in Nigeria, various federal, state, and local government agencies have been identified as partners in various intervention activities, centered on awareness and sensitisation campaigns. Following the VAPP Act 2015, and the launch of the new global target and call to action to eliminate FGM/C by 2030, the Nigerian national response to accelerate change and eliminate the practice within a generation—estimated at 20 years—was launched in Abuja on 9 February 2016 by the wife of the President on Nigeria.

This was a joint effort of the UNICEF/UNFPA in collaboration with Federal Government of Nigeria through the Federal Ministry of Women's Affairs and Social Development. The support of the Government and state counterparts was manifested in the attendance of key policy makers and top government officials: the wives of the Vice President and Senate President, Minister of Women's Affairs and Social Development, Minister of Information and Culture, Minister of State for Health, country directors of UNFPA and UNICEF, a *Guardian* reporter, former Deputy Governor of Plateau State, and the wives of the governors of Ebonyi, Anambra, Imo, and Kebbi states.

While the show of support for the campaign across the high echelons of government is not in doubt, the challenge with government agencies in Nigeria does not seem to be lack of interest and political will; rather it has always been the lag in implementation and sustainability of interventions over time. Whether the show of force by the federal government at the launch of the FGM/C campaign will be sustained by a structured engagement across the country and overtime remains to be seen and will be an important research agenda in Nigeria moving forward.

International organisations and diplomatic missions

Nigeria as a major player in the global community was one of five countries that sponsored a resolution at the 46th World Health Assembly calling for eradication of harmful traditional practices, including FGM/C (US Department of State 2001). UNFPA and UNICEF have been at the center of interventions and campaigns against FGM/C in Nigeria, including the latest 2016 launch of the abandonment of FGM/C in Nigeria by 2030 (UNICEF 2016c). More than campaigns, UNICEF and UNFPA have been joint players in filling the knowledge gap to inform policy and action by launching nationwide research to understand FGM/C. A 2015 joint study by UNICEF, UNFPA, and partners in six high prevalence states, Ebonyi, Ekiti, Imo, Osun, Oyo and Lagos, generated data on current beliefs, knowledge, and practices that informed the most recent Zero FGM/C campaigns in the country and highlighted the need for sustained communication with communities and collaboration with the media to promote the social change needed for abandonment (*ibid*).

In the decade of the 1990s, several international organisations including WHO, UNICEF, the United Nations Development Programme (UNDP), and UNFPA, partnered with the Nigerian Federal Ministry of Women's Affairs and FMoH and funded national knowledge generation for FGM/C. They contracted the Center for Gender and Social Policy Studies, Obafemi Awolowo University, Ile-Ife, who conducted the 1997 study of 148,000 women and girls from 31 community samples nationwide. USAID worked with members of the Women's Caucus of the National Assembly in addressing women's health issues including FGM/C.

The Calvary Foundation, based in Enugu State, was awarded a grant of US\$20,000 through the US Embassy's Democracy and Human Rights Fund to continue its campaign to ban FGM/C in five southeastern States (US Department of State 2001). Before the current renewed push under the new federal legal regime, international organisations WHO, UNDP, DFID, and Daneco of Sweden were actively funding Nigerian NGOs addressing this practice. International organisations have adopted plans of action to eradicate these practices in Nigeria. WHO developed a three-year short-term plan (1996-1998), an eight-year midterm plan (1999-2006), and a nine-year long-term plan to eventually eliminate FGM/C from Nigeria and the rest of Africa.

Available evidence suggests that most of these international organisations have been funding research studies for FGM/C knowledge generation and awareness creation campaigns. The 1997 WHO study found an estimated 30,625 million women and girls, or about 60 percent of Nigeria's total female population, had undergone one of the four forms of FGM/C. Similarly, a 1996 UN Development Systems study reported a similar number of 32.7 million Nigerian women affected (US Department of State 2001). These studies were the critical first steps in generating data

needed in understanding the magnitude of the FGM/C challenge in Nigeria and guides to inform policy and action towards addressing the practice.

Non-governmental organisations and civil society organisations

Many of the activities implemented over the years in Nigeria to combat FGM/C practices have been initiated by international and national NGOs. One such organisation was the Leaders of the Nigerian National Committee (also known as the Inter-African Committee of Nigeria on Harmful Traditional Practices Affecting the Health of Women and Children [IAC]). It has been engaged in knowledge generation by conducting state by state study of the FGM/C practices and holding awareness creation meetings and programmes in both urban and rural communities throughout the country, to inform the public, using videos, booklets, and the mass media to reach school age children (*ibid*).

Also, actively campaigning against this practice are the National Association of Nigerian Nurses and Midwives, the Nigerian Medical Women's Association, and the Nigerian Medical Association. These three groups in particular were against the legitimization of this practice as a medical necessity for females and worked to inform all Nigerians and health practitioners about the harmful effects of the practice. The National Association of Nigerian Nurses and Midwives created a national information package about the harmful effects of the various FGM/C procedures (*ibid*). Pediatricians and doctors have campaigned nationwide starting with national workshops in Lagos and trained trainers who in turn conducted informational activities about this practice at the state and local levels, using a variety of methods: dramas, community mobilizations, national television talk shows, radio broadcasts, articles in newspapers, all which moved the once taboo subject to open public discussion (*ibid*). A significant legacy of the activities of these groups is the inclusion of FGM/C in the medical curriculum, used in the teaching of nurses and doctors by the Nursing Council of Nigerian (NCN) and the Medical and Dental Council of Nigeria (MDCN), which includes the introduction of aspects of the VAPP Act 2015 covering violence and practices against women and children and the decree that it has become a punishable offence for any medical practitioner to be involved in the practice (Akosile 2016).

Prior to the VAPP Act in 2015, the Women's Centre for Peace and Development (WOPED) had been a strong voice in support of the campaign against FGM/C as far back as May 2000. Several local non-governmental and civil organisations have been involved in activities relating to FGM/C practices (US Department of State 2001). The Calvary Foundation International, Inc (Golgothas), was established in 1975 in Thessaloniki, Greece and incorporated in Nigeria as an international NGO, and has been involved in so many humanitarian and philanthropic activities since its inception including education, health care services, humanitarian services, and spiritual ministry. The group was reported to have received a grant of US\$20,000 from the US Embassy's Democracy and Human Rights Fund and collaborated with UNICEF and other International, regional and local NGOs, organising workshops and activities for public benefit and campaigns to ban FGM/C in five southeastern states (*ibid*). Calvary organised workshops and seminars to enlighten policy makers and stakeholders on the negative effects of FGM/C and other malpractice against widows and women (Calvary Foundation 2011). Another group, the New Initiative for Social Development, has trained journalists, with the support of the British High Commission in Nigeria, with 'Reduction of Discrimination and Violence Against Women in South West Nigeria' in Ado-Ekiti in 2016 (Akosile 2016). This one day training was aimed at creating awareness for the 2015 VAPP Act as part of the search for pathways to ensure its awareness and enforcement remains.

One important NGO is the Nigeria's Child Protection Network, which was launched in 2010, and by 2012, was active in 24 out of 36 states of the country and recognised by UNICEF Nigeria as a dedicated NGO coalition growing in strength and number (Warren 2012). A report from 9 April 2012 announced a 16-month partnership contract between Keeping Children Safe and UNICEF

Nigeria to help prevent and respond to abuses, exploitation and harmful practices against children in 23 states. The project, which builds on the human rights approach, was to build the child safeguarding and child protection capacities of Child Protection Networks (CPNS) in Benue, Cross River, Rivers, Imo, Bayelsa, Akwa Ibom, Enugu, Abia, Anambra, Ondo, Osun, Lagos, Sokoto, Kwara, FCT, Kaduna, Borno, Kano, Plateau, Jigawa, Gombe, Delta, and Edo states (*ibid*). The project was built on the existing strengths of the CPNs and the communities where they work to minimize child abuse, violence, and exploitation, as well as to respond to reports of violations in a timely and effective manner, while always keeping the best interest of the child in mind (*ibid*). Available evidence before and after the VAPP Act confirm that CPN, in partnership with UNICEF, have been active across the country, addressing a myriad of child rights issues and capacity building (Kayode-Adedeji 2013^{abcd}, UNICEF 2013b, Nkwopara 2015). It is important to note, however, that Nigeria's CPN generally covers child rights issues beyond FGM/C, especially before the passage of the 2015 VAPP Act.

The Immigration and Refugee Board of Canada (2010) reported on various NGOs with public awareness activities on FGM/C in Nigeria. One notable NGO is the Women's Health and Action Research Centre (WHARC), headquartered in Benin City, Edo's capital, whose work is linked to improving the RH and social wellbeing of women and adolescents in Africa as well as knowledge generation through the publication of the *African Journal of Reproductive Health* (AJRH), an international peer-reviewed journal, which have contributed to knowledge of FGM/C practices among the Edo in the South South geopolitical zone of Nigeria (Osifo and Evbuomwan 2009). WHARC educates women, youth, community gatekeepers and policymakers about sexual and reproductive health, and advocates for policy change at the local, state, and federal levels and legislation banning FGM/C in the country (WHARC 2015).

The Women Aid Collective (WACOL) is another local NGO identified to be working to eliminate harmful traditional practices in the South East of Nigeria (WACOL 2016). It is committed to helping women and young people in need and working towards gender equality and human rights for all. WACOL was founded in November 1997 with its headquarters in Enugu and branch offices in Port Harcourt, and the Federal Capital Territory of Abuja. WACOL's aim is to increase legal protection and fight for better choices for abused women and children, facilitate flow of information and experiences between organisations, and develop appropriate IEC materials that will be used in advocacy for human rights of women and young people.

The Centre for Women Studies and Intervention (CWSI) was another a non-governmental, non-religious, and non-profit organisation founded by the Handmaids of the Holy Child Jesus and registered with the Corporate Affairs Commission of Nigeria in 1999, headquartered in Abuja, with structures in five states (CWSI 2014). The Centre envisions women's empowerment, educational attainment, and active participation to create a better world through upholding women's dignity by raising their consciousness and holistic empowerment and promoting gender equity. Its activities cover good governance, reproductive rights, and economic and social rights. In pursuit of its objectives, the Center published its research on *The Root Causes of Gender-based Violence in Nigeria, A Case Study of Delta and Ebonyi States in 2012* (*ibid*). Consistent with its holistic women empowerment ideal, CWSI employed multi-sectorial approaches to address gender equity, reproductive rights and upholding the dignity of women in Nigeria.

Fundamentally, Nigeria has not been, and is not currently, lacking willing and able organisations to confront the FGM/C challenge, at all levels and permutations. This list is long and obviously not exhaustive, yet their coverage of the issues very extensive. Besides UNICEF's and UNFPA's activities that reached different parts of the country and have lasted over time, it is not clear how coordinated these organisations are and whether their commitments to FGM/C are overshadowed by other commitments. The possibility of duplication of visions, efforts, and programmes at many

levels is high. It is unclear from the reviewed literature what stakeholders' activities are beyond awareness campaigns and training, more so after the 2015 VAPP Act. There is no visible focus on economic empowerment and promotion of alternative livelihood initiatives for FGM/C practitioners. There is no evidence presented of legal challenges to the practice, especially following the VAPP Act. For most groups identified, their activities are all located in the South West, South East, and South South geopolitical zones of the country. There seem to be little activities, if any, in the northern parts of the country, although with lower prevalence has a predominance of the most extreme forms of FGM/C.

Finally, most, if not all, interventions in Nigeria are designed as behaviour change mechanisms providing information about FGM/C to increase knowledge, improve attitudes, and alter FGM/C practices. Consequently, dissemination of information was the proposed engine and pathway to changing FGM/C behaviours. Yet not many baseline studies seem to have been conducted to establish where communities and individuals are before such IEC interventions. The case in point was the summit organized by CDAN in South West Nigeria to drum up their support for the zero tolerance for FGM/C in the region with the highest prevalence. They particularly raised the issue that they were being ignored by stakeholders and agencies working on the campaigns, and pointing out that what should be prioritized for them is not IEC campaigns but interventions focusing on creating alternative livelihoods for their members who were professional circumcisers (Ezeamalu 2016b). Consequently, critical review of interventions and their appropriateness for target audiences may be as important as rolling out multiple interventions.

In sum, the interventions outlined, highlights the complexity of the challenge, the inadequacy of a one model fits all intervention, and the need for a nuanced and context specific interventions for different regions and population sub-groups. What is however gratifying and holds hope to FGM/C eradication in the country is the massive network of stakeholders at all levels of the Nigerian society that are active in the field and will need to be mobilized and coordinated for the final push towards FGM/C eradication in the country.

CHAPTER 5: EVALUATION OF THE EFFECT OF VARIOUS FGM/C INTERVENTIONS IN NIGERIA

Efforts promoting the abandonment of FGM/C in Africa have used several approaches and types of interventions. These approaches in Nigeria, discussed in the preceding chapter, include knowledge and awareness creation, attitude and behaviour change interventions, and legal and human rights interventions, which targeted stakeholders at individual, interpersonal, community, and national levels. FGM/C has persisted, however, and positive change has been slow. Consequently, knowledge of what works, or otherwise, and under what conditions, remain critical necessary information for both eradication policies and actions. There is a dearth of research, however, in the region assessing not intervention effectiveness but what facilitates, or hampers, success in different contexts. Most interventions in the region have not been evaluated, and those that have been lacked systematic appraisals of their evidence. Most studies' observational designs make causal inferences difficult, hampering valid conclusions about their effects (Berg and Denison 2013, Askew 2005). This chapter examines the state of knowledge and evaluation of FGM/C interventions' effectiveness in Nigeria, focusing on evaluation types, their measures of success, and contextual factors explaining their effectiveness, or lack thereof.

The effect of various FGM/C interventions in Nigeria

The February 2016 launch of the Zero FGM/C campaign in Abuja made a new disciple of a traditional chief from southwest Nigeria, who, after the launch, stated that the programme made him view FGM/C in a different light, even though he was actively involved in the practice in his community (Akosile 2016). He pledged to create awareness of the danger and harmful effects of the practice among his contemporaries when he returned home (*ibid*). The summit that launched the zero tolerance for FGM/C in southwest Nigeria included the Circumcisers Descendants Association of Nigeria (CDAN), and Ezeamalu (2016b) reported the campaign succeeded in convincing about 70 percent of those circumcisers to stop the practice. The remaining 30 percent were reluctant to abandon the practice, due to FGM/C being the only source of livelihood for some of them (*ibid*). After the summit, the association issued a statement directing all its members to implement the resolution of zero tolerance in the region.

After 13 years in the National Assembly, the VAPP Act became law in 2015. The then Deputy President of the Senate who presided over the session that passed the Act, acknowledged stakeholders' roles in ensuring the bill was passed, adding that it was a good step in the fight against violence in Nigeria (Premium Times 2015). The law itself was favourably reviewed, especially with the hope it will deliver on its mandate. The law was heralded as fantastic news and a landmark moment, taking advocates and stakeholders one step closer to ending FGM/C (Topping 2015). Journalists' consistent reporting on FGM/C and campaigns to eradicate it likely indicate results of the media trainings in different parts of the country. This is anecdotal and random evidence about these efforts, however, unable to say whether they have had verifiable positive impacts on the FGM/C challenge in Nigeria. Except for VAPP's passage, which needs no further verification, most FGM/C successes cited from across the country were not borne from systematic evaluations of those campaigns or other interventions.

What has emerged from Nigeria and all countries with FGM/C practice is a general dearth of studies, or lack of high quality studies, evaluating their strategies for reducing FGM/C (Nour 2010). Nigeria's VAPP Act marked a substantially raised threshold, but it is new and implementation is in its infancy, so evaluation of its outcomes will take some time. The only available evidence with insights for the last couple of years comes from grey literature. Importantly, few or no interventions

are recorded for the country's core northern states, where prevalence was reported as low but several harmful forms of FGM/C are practiced.

Despite the dearth of FGM/C intervention evaluation studies in Nigeria, one intervention study stands out methodologically. The study was conducted in the southeast, an FGM/C elimination communication programme in Enugu state, the impact of which was assessed by changing relevant knowledge, attitudes, and behavioural intentions compared with a non-intervention site in neighbouring Ebonyi (Babalola et al 2006). The programme combined a community mobilisation component with targeted advocacy and mass media activities. Data assessing the impact of the programme were derived from two sources: a baseline survey in July and August 2003 and a follow up survey in September 2004. Both surveys were based on an intervention-comparison group design and took place in Enugu (intervention) and Ebonyi (comparison) states.

The surveys were cross-sectional, with comparable samples: Three intervention LGAs in Enugu state and three comparative LGAs in Ebonyi were selected. An ideation model of behaviour change guided analyses of the programme's impact on personal advocacy for FGM/C, perceived self-efficacy to refuse pressure to perform FGM/C, perceived social support for FGM/C discontinuation, perceived benefits of FGM/C, its perceived health complications, and intention not to perform FGM/C on daughters. Analytical methods compared change in pertinent outcome variables from baseline to follow up in the two study states, with logistic regression on follow up data for the intervention state, to assess the link between programme exposure and relevant outcome indicators. The resulting evaluation data show that while the pertinent ideational factors and intentions not to perform FGM/C either worsened or remained stagnant in Ebonyi, they improved significantly in Enugu.

Logistic regression results show programme exposure is associated with the expected improvements in all pertinent indicators. Consequently, the authors concluded that the multimedia communication programme was effective in changing FGM/C attitudes and promoting the intention not to perform FGM/C. Behaviour changes were observed in encouragement of others not to perform FGM/C. Positive attitudes and belief in benefits to FGM/C, as well as personal approval of FGM/C, persisted. There was a perceived self-efficacy to resist pressure from spouse to perform FGM/C on daughters; and the belief that most men and women in the intervention than non-intervention community favour discontinuation of FGM/C and the intention not to perform FGM/C on daughters (*ibid*).

Identifying the types of evaluations of interventions and measures of success

The two related evaluations, in 2009 and 2013, of intervention studies in Nigeria are by authors from the Norwegian Knowledge Centre for the Health Services (NOKC). The first evaluation assessed interventions to reduce FGM/C prevalence in seven African countries: Burkina Faso, Egypt, Ethiopia and Kenya (single study), Mali, Nigeria and Senegal. The evaluation was a systematic review with inclusion criteria of systematic reviews, randomised controlled trials (RCTs), and controlled before-and-after studies, with exclusion criteria of non-systematic reviews, studies without control or comparison groups, cross-sectional studies, studies without pre- and post-measures, studies that did not assess change in knowledge or behaviour, and studies in which FGM/C was not practiced. The population included communities where FGM/C is practiced, girls or women are at risk of FGM/C, and other members practice FGM/C (NOKC 2009). This evaluation of intervention effectiveness in Nigeria was based on the only intervention study in Enugu and Ebonyi states that fit not all but most of the inclusion criteria (*ibid*).

Interventions included must have reduced FGM/C prevalence. The NOKC authors focused on outcomes that demonstrated rates of FGM/C, public declaration to abandon FGM/C, changes in FGM/C behaviours, awareness, knowledge, beliefs, and attitudes. Of the 3,667 publications found,

16 were selected for analysis, and only six met the inclusion criteria. The studies were conducted in Burkina Faso, Egypt, Ethiopia and Kenya (single study), Mali, Nigeria, and Senegal. The Nigerian and Egyptian studies were published in peer-reviewed journals; the others were published as reports to funding agencies. Two studies were individual-based (lasting around 2 weeks), and four studies were community-based (lasting, on average, 18 months). They cumulatively included 6,803 participants among whom prevalence, ethnicity, religion, and education varied significantly. The sample size of each study ranged from 108 to 2,259 participants. All studies had a control group of no intervention. No biological data were collected. Using the Quality Assessment Tool, the authors judged all six studies as “weak” and their quality of evidence poor with "high" or "unclear" risk of bias. The intervention and control groups at baseline were not the same, the evaluators may not have been blinded, and data were incomplete. Given that the studies were not randomised, their validity was questionable.

For the Nigerian intervention study, Babalola and colleagues (2006) specified that their intervention programme would lead to increased awareness, which would lead to self-examination of beliefs and values, which in turn would trigger ways of thinking and value orientations. They also specified that the programme would lead to dialogue and group/social interactions and advocacy, which in turn would improve self-efficacy and perceived social support. The effectiveness report further postulated that high degree of programme exposure, mainly through radio, would improve FGM/C-related ideation, and that programme exposure through both mass media and community activities affected change more than exposure through either one alone.

Despite the data quality challenges acknowledged by the evaluators of the interventions, they concluded that the results of the multi-faceted community studies in Ethiopia and Kenya, and Nigeria, showed increased knowledge and awareness among men and women, with intent not to continue the practice (NOKC 2009). In the Nigerian study 37 percent of respondents were not exposed to any programme components (*ibid*). Presumably, progress could have been greater had more community members been exposed to the communication programme. Consequently, Berg and Denison (2013) suggest that if an intervention based on convention theory is implemented, it is essential that both programme fidelity and programme exposure are high and consistent with convention theory. In the Nigeria study, education about FGM/C, public discussions and declarations of opposition to FGM/C all contributed to developing a critical mass of individuals who changed their beliefs about FGM/C (*ibid*).

The second evaluation of intervention effectiveness covered the same countries⁴: Burkina Faso, Egypt, Ethiopia, Somalia and Kenya (single study), Mali, Nigeria, and Senegal. To be included in the evaluation, the population covered by an intervention must have included girls or young women at risk of FGM/C and other members of communities practicing FGM/C; an intervention must have intended to prevent, or reduce, FGM/C prevalence; with a comparison group with no FGM/C intervention, waiting for an intervention, or running another active FGM/C intervention. The success measure, as in the other evaluation, included rates of FGM/C as well as changes in FGM/C behaviours, intentions, attitudes, beliefs, and knowledge, and rights awareness.

The effectiveness evaluation included eight studies of 7,042 participants total in the seven countries. All studies employed a controlled before-and-after study design. The quality assessment resulted in a final determination of weak study quality for all eight studies. The results show that the effectiveness of the included interventions was limited, but noted potential advantageous developments as a result of FGM/C abandonment interventions.

⁴ Except for Sudan, which is not covered in the intervention evaluation study, all other six countries are the same that are under the focus of the FGM/C Research Programme of the Population Council and its partners.

Especially for Nigeria, the lack of more studies fitting these selection criteria is glaring. In fact that the only study included in the second evaluation was the same intervention study from the 2008-2009 evaluation, emphasises the research gap in Nigeria that needs to be filled. To meaningfully pursue that goal will require investment in interventions allowing critical evaluation, based on an intervention-comparison group design, interventions that will be built, first, with baseline data to allow for controlled before-and-after evaluation, or intervention designs that are RCTs, quasi-randomized trials, or interrupted time series designs.

Contextual factors explaining the effectiveness of interventions

One important question in seeking understanding of the effectiveness of interventions relevant to this scoping review is knowledge of contextual factors such as social norms, community enforcement mechanisms, religious beliefs, witchcraft, secret societies, patriarchy, and other social forces determining whether interventions succeed or fail. In pursuit of this objective, the inclusion criteria for studies comprised relevant population, interest, and geographical and historical contexts (Berg and Denison 2013). The included studies examined the factors related to FGM/C's continuance and discontinuance. The geographic context was Africa, in which controlled studies of interventions to reduce FGM/C's prevalence had been carried out, and historical context meant the studies must have collected data no more than five years prior to the intervention to be relevant. Study designs of included studies were cross-sectional quantitative study designs, qualitative study designs, or a combination of the two (mixed-methods studies).

For all countries evaluated, the authors identified controlled effectiveness studies in seven contexts and included 27 eligible studies. Nine of the context studies had high methodological quality, 12 were moderate, and six had low methodological quality. The synthesis of context studies shows that factors related to continuance and discontinuance of FGM/C varied across contexts, but the main factors supporting FGM/C were tradition, religion, and reduction of women's sexual desire. The main factors combatting FGM/C were medical complications and prevention of sexual satisfaction. Context-mechanism outcome configurations determined that all interventions were based on a theory that information dissemination improves cognition about FGM/C, but interventions' successes were contingent on a range of contextual factors. Where FGM/C and Islam are closely related, the failure to involve religious leaders and base programmes on beneficiary communities' needs and wants triggered low attendance and programme drop out. These observations included studies from Burkina Faso, Egypt, Somalia and Kenya, Mali, Nigeria, and Senegal, but not Ethiopia, where no context study was identified (*ibid*).

Besides the study by Babalola et al (2006) reviewed for the two effectiveness evaluations, 13 other studies in Nigeria included 30,749 participants total, mainly from the south, with only 2,607 men. They were evaluated for contextual factors related to FGM/C continuance and discontinuance in the country (Berg and Benison 2013). The reports of the 13 studies' methodological quality attest to adequately described sample populations, adequate response rates, standardised data collection methods used, and appropriate statistical methods in their analyses.

Nine of the study designs were cross sectional and of moderate methodological quality (Abubakar et al 2004, Aigbodion et al 2004, Briggs 2002, Dare et al 2004, Odimegwu et al 1998, Odimegwu et al 2001, Okemgbo et al 2002, Osifo and Evbuomwa 2009, Snow et al 2002, Ugboma et al 2004). All studies included men and women. Apart from Abubakar et al (2004), the other eight studies were in southern Nigeria. Three studies were nationally representative and of high methodological quality and included all women at risk of FGM/C (Frey Meyer and Johnson 2007, Kandala et al 2009, Nigeria DHS 2000). Relationships between researchers and participants were not adequately considered, data analysis was not sufficiently rigorous, and it was unclear whether the recruitment strategy was appropriate to the aims of the research (Berg and Benison 2013).

The ability to reach a conclusion about the effectiveness of FGM/C abandonment interventions, and how contextual factors explain their effectiveness, was hampered by general lack of information. The findings show that much work remains to be able evaluate FGM/C abandonment efforts, with a need for methodologically rigorous intervention evaluations. Such studies should address local communities' enforcement systems supporting FGM/C, and be guided by a sound theory of behaviour change. These suggestions and conclusions are consistent with the observation that community leadership is key to decreasing FGM/C prevalence on a large scale and that programmes ignoring key stakeholders in communities experience resistance to change. Accordingly, FGM/C programmes cannot be transferred from one community to another, and must be molded to each community's specific needs (Nour 2010). In Nigeria, this gap is glaring, with a lack of recent studies, especially since the 2015 VAPP Act.

All reviewed studies arrived at their conclusions based on the fact there was no law banning FGM/C throughout Nigeria, and the new law requires an important research agenda for investments in knowledge generation on the effectiveness of intervention evaluations under the new legal context and studies on how other societal contextual factors help explain their effectiveness, or otherwise. Studies will need to methodologically incorporate designs addressing the paucity of high quality evidence. Accordingly, FGM/C interventions will need to use a controlled before-and-after design, or pre-post intervention questionnaires or interviews, for systematic evaluation.

CHAPTER 6: SUMMARY CONCLUSION POLICY ISSUES

Summary of key findings and Conclusion

An estimated global burden of more than 200 million girls and women have undergone FGM/C in 30 countries in Africa, the Middle East, and Asia (WHO 2016a), with 19.9 million of them in Nigeria, behind only Egypt (27.2 million) and Ethiopia (23.8 million) (UNICEF 2013a). Twenty-seven percent of Nigerian women and girls have undergone FGM/C (NPC Nigeria and ICF International 2014). The persistence of different types of FGM/C in different ethno-geographical zones of the country is clear from the prevalence levels identified over the last 15 years. There has been little change in the practice during this period, as FGM/C remains a recognised and accepted practice that can occur at any time from a few days after birth until a few days after death, and is considered important for women's socialisation (*ibid*).

Despite strong cultural and customary beliefs continuing to support FGM/C, justifications from the practice's proponents, and factors supporting its persistence, have continued to wane and cannot withstand moral, legal, or ethical scrutiny, especially after the global and local momentum for ending the practice. Education remains an important empowerment tool with positive intergenerational effect on ending FGM/C, as mothers with higher levels of education are less likely to have their daughters cut. There is also an almost monotonical decrease in prevalence levels, from older women to younger age cohorts, suggesting declining support over time. FGM/C abandonment efforts will need to build on the potential of accelerated decrease among educated mothers and younger age groups. This trajectory was strengthened by Nigeria's 2015 Violence Against Persons (Prohibition) Act, which specifically prohibits FGM/C and other violence including forceful ejection from homes and harmful widowhood practices. The Act is expected to bring succor and effective remedies to millions of victims who have suffered violence in silence, providing recourse to justice or rehabilitative, psychological, or social support for recovery and reintegration. Legal enforcement is acknowledged as necessary but insufficient alone, however, for eradicating FGM/C. Besides sensitisation activities educating citizens on the new law and accompanying legal sanctions, this review identifies several types of FGM/C interventions in the last 15 years and their implementing organisations, including awareness and training campaigns, circumciser conversion interventions, and legal and human rights, health and behaviour change interventions.

This review identifies a coalition of international agencies, the diplomatic community, national and state government agencies and officials, NGOs, civil and traditional societies, and media with important voices in campaigns and interventions to eliminate FGM/C in Nigeria throughout the years. Fundamentally, this review shows that Nigeria has not been, and is not currently, lacking organisations willing and able to address the FGM/C challenge, at all levels. Most groups' activities are in the southwest, south, and southeast, with few or no activities in the north, where various forms of Type IV predominate. There is no visible policy or programme focus on economic empowerment or promotion of alternative livelihood initiatives for FGM/C practitioners. Besides expressions of intent by relevant officials, there is also no evidence of legal challenges anywhere in the country, even after the passage of laws enabling prosecution.

There is a general dearth of intervention studies on FGM/C in Nigeria and equally little evaluation of their effectiveness. For the few evaluation studies identified, their methodologies were weak, raising questions about the validity of their conclusions. There is lack of systematic appraisal of evidence and use of observational designs, making causal inferences difficult. Adequately judging the effectiveness of FGM/C abandonment interventions in Nigeria and how contextual factors might help explain their effectiveness was hampered by general lack of information. These findings show that much work remains on the evaluation of FGM/C abandonment efforts, especially for methodologically rigorous intervention evaluations.

Policy and programme issues moving forward

The findings of this review and results from the analyses of quantitative data raise key social policy questions with profound implications for future programmes and research.

Focused and multi-pronged and nuanced approaches to interventions

The studies of the determinants of FGM/C, despite their limitations, emphasise the complexity of factors determining and sustaining FGM/C in Nigeria and the need for focused, multi-pronged, and nuanced approaches to address the challenge. Options range from enforcement of federal and state laws, economic empowerment of professional circumcisers, awareness creation and behaviour change campaigns among specific groups, and educational opportunities and general empowerment of women across the country. The lack of visible focus on economic empowerment and promotion of alternative livelihood initiatives for FGM/C practitioners calls for specific policy and programme actions. No evidence is found of any legal challenges or charges, even after the passage of legal prohibitions. Enforcement interventions are, therefore, an option promising dividends for the FGM/C eradication campaign.

Most activities are in southern Nigeria, with few, or no, activities in the northern parts of the country, where different forms of TYPE IV are widely practiced, such as scraping tissue surrounding the vaginal orifice (*angurya* cuts) and vaginal cutting (*gishiri* cuts), as well as use of corrosive substances and herbs to narrow the vagina.

This review identifies interventions partnered with message campaigns as key for changing norms and traditions. While media trainings and coverage of eradication campaigns have increased, experts opine that media involvement remains thin, hence the call for more media campaigns, especially to counter associated misinformation peddled in many communities on the benefits of FGM/C.

There is widespread lack of awareness of FGM/C's health consequences. More information and education on its harmful effects on women's health is needed across the country. Alternative symbols to FGM/C, such as chastity rings or bangles that can be worn to signify virginity and readiness for marriage, are suggested for girls. Alternatives need to be identified, further explored, and studied in Nigeria.

Stakeholder roles: community, government, non-governmental organisations

Community leadership and study participation, in identifying their needs and fully participating throughout the intervention process, creates goodwill and long-lasting partnerships. Programmes that ignore key community stakeholders experience resistance, with the important lesson of the importance of understanding every community and recognising that programmes cannot simply be transferred from one community to another. Programmes must be moulded to the underlying needs of each community they serve (Nour 2010). Mechanisms must ensure community dialogues involving men and women, boys and girls, old and young, in knowledge generation and intervention development.

There is a need to enforce laws against early marriage, and encourage people to speak out against the practice, especially men and boys. Understanding men's reproductive motivations and behaviours is necessary because of the considerable authority and power invested in men generally as decision makers in the African social context (Isiugo-Abanihe 2003), and this necessitates significant investment in its research across the country.

Breaking the culture of silence may expose latent factors supporting the practice. Observers believe that the number of victims may be highly underestimated and that improved social justice can empower people to be accounted, as survivors and victims of FGM/C presently cannot speak for themselves, for fear of stigmatisation. Legislation at lower levels of government may be helpful

but can be slow in responding to constituent women's needs without campaign outreaches. More peer activities, peer education, and multi-pronged approaches are required, through persuasion, community enlightenment, and family and peer discussions. Campaigns against FGM/C need to travel to the grassroots, where the deadly practice is still rampant.

Weak law enforcement is a key hindrance, leading to concerns of whether the new federal law will be enforced throughout the country or offenders will be punished. During campaigns for stopping the practice, measures for punishing perpetrators were advocated. Stressing the need for governmental enforcement, now that the law has been enacted, this review emphasises that sporadic enforcement will not reduce prevalence throughout the country. The extent to which the law is enforced can be influenced by interventions advocating enforcement, with evaluations of such interventions, will remain important research and programme agendas moving forward.

Research and intervention evaluation

One key challenge identified in this review is the lack of a standard definition of FGM/C in data collection across the country. This was addressed in the 2013 NDHS, which explicitly followed the WHO definition and thereby captured *angurya* and *gishiri* cuts, practiced mostly in northern Nigeria. The challenge is utilising the same definition in the future to ensure prevalence rates are standardised and thus comparable over time.

The challenge of disaggregating FGM/C statistics and figures for different subcategories such as survivors or victims, and for smaller geographic units, attests to the in-depth nature of accurately measuring FGM/C within communities, which is often blurred by national or state averages. Disaggregated, specific data will help implementing agencies and local governments identify priorities and measure intervention progress, identifying those that work or those that do not.

Most interventions in Nigeria are not informed by rigorous scientific baseline studies. While dissemination of information is the dominant model of interventions in changing FGM/C behaviours, few baseline studies established reliable community and individual indicators of knowledge prior to such IEC interventions. IEC campaigns are not needed for CDAN, instead interventions for alternative livelihoods for its members who were professional circumcisers are necessary (Ezeamalu 2016b).

Critical reviews of interventions and their appropriateness for target audiences may be as important as campaigns themselves, necessary to establish the effectiveness of current interventions: What has been achieved? What gaps need to be addressed? What levels of investment are still needed? The evaluation of the Enugu and Ebonyi intervention (Babalola et al 2006) revealed that 37 percent of the intervention community did not receive appropriate treatment, with the logical inference that much more progress could have been achieved if it had been more effectively implemented.

Enforcement of FGM/C within communities is primary women's purview, underscoring that FGM/C is, to some extent, an issue of women against women. Female circumcisers are found in villages across the country, calling for campaigns focused on female circumcisers, perhaps providing them with alternative livelihood opportunities such as loans to invest in trade or acquire vocational skills. Successful interventions such as the pilot training and circumciser conversion sponsored by DfID and implemented by IAC Nigeria among female excisors (US Department of State 2001) need to be further evaluated, understood, and scaled up. Engagement models such as focus group discussions with women's groups have the capability of creating a "snowball effect" among women.

The overall lack of interventions fulfilling this review's selection criteria underscores the dearth of research studies with robust methodologies. There is need for investment in interventions that will lend themselves to critical evaluation in an intervention-comparison group design, interventions built first with baseline data, to allow for controlled before and after evaluations, or intervention designs as RCTs, quasi-randomised trials, and interrupted time series designs.

The lack of recent research is glaring, especially since the 2015 VAPP Act. This gap does, however, provide a unique opportunity for collection of baseline data, to determine the current state of FGM/C as the law comes into full force, followed by implementation of interventions and evaluations over time to establish both changes and continuities after the law. All the studies reviewed in this report arrived at their conclusions with no national law banning FGM/C. The new law creates an important research agenda for investments in knowledge generation and effectiveness of intervention evaluations and studies on how contextual factors help explain the effectiveness of interventions under the new legal regime.

The gaps in knowledge and research identified in Nigeria attest to the huge research investments needed to generate robust evidence for informing strategic investments in policies and programmes to end FGM/C across the country. This review discusses the need for robust data collection to understand prevalence over time, factors of FGM/C practice in different cultures, specific interventions, and the need for coordination to enjoy the economies of scale and wider impacts. Strengthening intervention monitoring and evaluation, to establish what works and what does not, together with investments in methodologically robust data collection and analysis, are important parts of the process for generating credible evidence to inform FGM/C policy and action in Nigeria.

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APPENDIX 1: COMMUNIQUÉ OF THE EBONYI STATE COUNCIL OF TRADITIONAL RULERS IN SUPPORT OF FGM/C CAMPAIGN OF THE FIRST LADY OF THE STATE ON JULY 12, 2016

OFFICE OF THE CHAIRMAN
EBONYI STATE COUNCIL OF TRADITIONAL RULERS

Our Ref: _____

Your Ref: _____



No. 1 Onwe Road,
Abakaliki

Date: 21/7/2016

A COMMUNIQUE ISSUED AT THE END OF ONE DAY MEETING OF EBONYI STATE TRADITIONAL RULERS HELD AT THE COUNCIL CHAMBER, NO1 ONWE ROAD, ABAKALIKI.

PREAMBLE: In line with Her Excellency, Chief (Mrs.) Rachel Umahi, Wife of Ebonyi State Governor's pet project, Family Succor and Upliftment Foundation, particularly the recent launch of campaign against Female Genital Mutilation/Cutting (FGM/C), the Traditional Rulers of Ebonyi State in their meeting of Tuesday 12th July 2016, resolved as follows:

1. We condemn out rightly and in its entirety, any form of Female Genital Mutilation (FGM) and cutting in Ebonyi State, but only encourage male-child circumcision.
2. We advocate for proper legislation against this ugly trend and urge appropriate government agencies to impose sanctions on defaulters.
3. That the Royal Fathers will introduce traditional laws against the practice of Female Genital Mutilation/Cutting in all Autonomous Communities in Ebonyi State.
4. We give full support to Ebonyi State Government in the actualization of this dream and promise on our part to give grass-roots sensitization and to check the practice in our various communities.
5. That the traditional rulers give kudos to all Her Excellency's programmes geared towards the actualization of this lofty ideal and for the good of the generality of our people, particularly the women.

All replies to be addressed to the Chairman, Ebonyi State Traditional Rulers Council