



Home Office

Country Policy and Information Note

Nigeria: Female Genital Mutilation (FGM)

Version 2.0

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Preface

Purpose

This note provides country of origin information (COI) and analysis of COI for use by Home Office decision makers handling particular types of protection and human rights claims (as set out in [the basis of claim](#) section). It is not intended to be an exhaustive survey of a particular subject or theme.

It is split into two main sections: (1) analysis and assessment of COI and other evidence; and (2) COI. These are explained in more detail below.

Assessment

This section analyses the evidence relevant to this note – i.e. the COI section; refugee/human rights laws and policies; and applicable caselaw – by describing this and its inter-relationships, and provides an assessment on whether, **in general**:

- A person is reasonably likely to face a real risk of persecution or serious harm
- A person is able to obtain protection from the state (or quasi state bodies)
- A person is reasonably able to relocate within a country or territory
- Claims are likely to justify granting asylum, humanitarian protection or other form of leave, and
- If a claim is refused, it is likely or unlikely to be certifiable as 'clearly unfounded' under section 94 of the Nationality, Immigration and Asylum Act 2002.

Decision makers **must**, however, still consider all claims on an individual basis, taking into account each case's specific facts.

Country of origin information

The country information in this note has been carefully selected in accordance with the general principles of COI research as set out in the [Common EU \[European Union\] Guidelines for Processing Country of Origin Information \(COI\)](#), dated April 2008, and the Austrian Centre for Country of Origin and Asylum Research and Documentation's (ACCORD), [Researching Country Origin Information – Training Manual, 2013](#). Namely, taking into account the COI's relevance, reliability, accuracy, balance, currency, transparency and traceability.

The structure and content of the country information section follows a [terms of reference](#) which sets out the general and specific topics relevant to this note.

All information included in the note was published or made publicly available on or before the 'cut-off' date(s) in the country information section. Any event taking place or report/article published after these date(s) is not included.

All information is publicly accessible or can be made publicly available and is from generally reliable sources. Sources and the information they provide are carefully considered before inclusion.

Factors relevant to the assessment of the reliability of sources and information include:

- the motivation, purpose, knowledge and experience of the source
- how the information was obtained, including specific methodologies used
- the currency and detail of information, and
- whether the COI is consistent with and/or corroborated by other sources.

Multiple sourcing is used to ensure that the information is accurate, balanced and corroborated, so that a comprehensive and up-to-date picture at the time of publication is provided of the issues relevant to this note.

Information is compared and contrasted, whenever possible, to provide a range of views and opinions. The inclusion of a source, however, is not an endorsement of it or any view(s) expressed.

Each piece of information is referenced in a brief footnote; full details of all sources cited and consulted in compiling the note are listed alphabetically in the [bibliography](#).

Feedback

Our goal is to continuously improve our material. Therefore, if you would like to comment on this note, please email the [Country Policy and Information Team](#).

Independent Advisory Group on Country Information

The [Independent Advisory Group on Country Information](#) (IAGCI) was set up in March 2009 by the Independent Chief Inspector of Borders and Immigration to support him in reviewing the efficiency, effectiveness and consistency of approach of COI produced by the Home Office.

The IAGCI welcomes feedback on the Home Office's COI material. It is not the function of the IAGCI to endorse any Home Office material, procedures or policy. The IAGCI may be contacted at:

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Information about the IAGCI's work and a list of the documents which have been reviewed by the IAGCI can be found on the Independent Chief Inspector's pages of the [gov.uk website](#).

Contents

Assessment	6
1. Introduction.....	6
1.1 Basis of claim.....	6
1.2 Points to note.....	6
2. Consideration of issues.....	6
2.1 Credibility.....	6
2.2 Exclusion.....	7
2.3 Refugee convention reason(s).....	7
2.4 Risk.....	7
2.5 Protection.....	10
2.6 Internal relocation.....	11
2.7 Certification.....	12
3. Overview.....	13
3.1 Introduction.....	13
4. Prevalence of FGM in Nigeria.....	15
4.1 Overview.....	15
4.2 Repeat FGM.....	16
4.3 By type.....	16
4.4 By age.....	18
4.5 By education.....	19
4.6 By region.....	19
4.7 By religion.....	22
4.8 By ethnic group.....	23
5. Actors of harm.....	24
5.2 Medicalisation of FGM.....	27
6. Legal context.....	28
6.1 Laws against FGM.....	28
6.2 Federal and State Law.....	29
6.3 State attitudes to FGM.....	31
6.4 Protection - Enforcement and effectiveness of the law.....	35
6.5 Cross border FGM.....	37
6.6 Investigations and convictions.....	38
7. Societal attitudes to FGM.....	38
7.2 Support groups.....	43
8. Freedom of movement.....	44

Terms of Reference..... 45

Bibliography 46

 Sources cited..... 46

 Sources consulted but not cited..... 49

Version control..... 50

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Assessment

Updated: 13 August 2019

1. Introduction

1.1 Basis of claim

- 1.1.1 Fear of persecution or serious harm by non-state agents because:
- (a) the person will be subjected to female genital mutilation (FGM); or
 - (b) the person is the parent of a minor child who is opposed to the procedure in a place where there is a real risk of it being carried out.

1.2 Points to note

- 1.2.1 The World Health Organisation defines FGM as ‘all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons’¹.
- 1.2.2 Sources use various terms to refer to FGM, including female circumcision, female genital circumcision or female genital cutting. It can be abbreviated to FGC or FGM/C. For the purposes of this note, it is referred to as FGM.
- 1.2.3 Where a child is granted asylum, their accompanying parents may also be eligible for refugee status or humanitarian protection. The act of enforced FGM on a child could result in their parents being subject to persecution or serious harm where they are opposed to it. Decision makers should therefore consider whether, on the facts of each case, the accompanying parents require asylum on the basis of a well-founded fear of persecution.
- 1.2.4 For more general information on women in Nigeria, see the country policy and information note on [Nigeria: Women fearing gender-based violence](#).
- 1.2.5 Decision makers must also consider the [Asylum Instruction on Gender Issues in Asylum Claims](#) and the [Multi-Agency statutory guidance on FGM](#).

[Back to Contents](#)

2. Consideration of issues

2.1 Credibility

- 2.1.1 For information on assessing credibility, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).
- 2.1.2 Decision makers must also check if there has been a previous application for a UK visa or another form of leave. Asylum applications matched to visas should be investigated prior to the asylum interview (see the [Asylum Instruction on Visa Matches, Asylum Claims from UK Visa Applicants](#)).
- 2.1.3 Decision makers should also consider the need to conduct language analysis testing (see the [Asylum Instruction on Language Analysis](#)).

¹ World Health Organisation, ‘Female Genital Mutilation – Fact Sheet’, 31 January 2018, [url](#).

[Back to Contents](#)

2.2 Exclusion

- 2.2.1 Decision makers must consider whether one (or more) of the exclusion clauses is applicable. Each case must be considered on its individual facts and merits.
- 2.2.2 For further guidance on the exclusion clauses and restricted leave, see the [Asylum Instruction on Exclusion: Article 1F of the Refugee Convention](#) and the [Asylum Instruction on Restricted Leave](#).

[Back to Contents](#)

2.3 Refugee convention reason(s)

- 2.3.1 Women and girls in Nigeria, including those in fear of FGM, form a particular social group (PSG) within the meaning of the 1951 Refugee Convention. This is because they share a common characteristic – their gender – that cannot be changed and have a distinct identity which is perceived as being different by the surrounding society as evidenced by widespread discrimination in the exercise of their fundamental rights.
- 2.3.2 Although women and girls in Nigeria, including those fearing FGM, form a PSG, this does not mean that establishing such membership will be sufficient to be recognised as a refugee. The question to be addressed in each case is whether the particular person will face a real risk of persecution on account of their membership of such a group.
- 2.3.3 For further guidance on particular social groups, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).

[Back to Contents](#)

2.4 Risk

- 2.4.1 Depending on the facts of the case, for example the extent to which they have already been subjected to FGM, a girl or woman is unlikely to demonstrate a need for protection if they have already undergone FGM unless they fear additional mutilation. See also the FGM section in [Asylum Instruction on Gender Issues in Asylum Claims](#) with regard past FGM and future risk.

[Back to Contents](#)

a. Women and girls fearing FGM

- 2.4.2 UNICEF categorised Nigeria as a 'moderately' low prevalence country for FGM.
- 2.4.3 Although against the law and in decline, FGM continues to be practiced in Nigeria. Most FGM is Type 1 and Type 2 which is carried out on girls between the ages of 0 and 15 years (see [By type](#)).

- 2.4.4 The National Bureau of Statistics/BS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018 report is an international survey programme designed to support countries in the collection of internationally comparable data on a wide range of indicators on the situation of children and women. The report interviewed 34,440 women (95% response rate) and 28,085 (mothers/carers) on behalf of children (98.3% response rate). The report found that overall 18.4% of women aged 15-49 years had undergone FGM, this has dropped from 24.8% in 2013 and 27% in 2011. The same survey found that 25.3% of daughters aged 0-14 years are reported to have undergone FGM, however this reflects their current status and not necessarily the final prevalence rate for this age group. A 2013 UNICEF report found that in the last 20 years the prevalence among adolescent girls has dropped by a half to 19% (see [Prevalence: Overview](#) and [Prevalence: By age, region and ethnic group](#)).
- 2.4.5 Of the 18.4% of women estimated to have undergone FGM, 82% were subjected to FGM before the age of 5. Therefore, the general risk to women over the age of 5 appears to be low.
- 2.4.6 The mother's education appears to have a direct bearing on whether her daughter is subject to FGM. Of those who had allowed their daughters to undergo FGM 76% of daughters had mothers who had none, or no formal, education whereas 9.8% of daughters had mothers who had received a higher level of education (see [Prevalence: By education](#)).
- 2.4.7 However, prevalence varies across urban/rural areas, regions, ethnic groups and religions. Women living in urban areas are reported to be more likely to have undergone FGM, compared with women living in rural areas, while girls 0-14 years old living in rural areas are reported to have a higher incidence of FGM for that age range compared to girls in urban areas. However, prevalence by place of residence is not necessarily an indicator of where FGM is carried out, as a woman may have lived in a different area at the time she underwent FGM (see [Prevalence by region](#)).
- 2.4.8 There is also variation across different regions of Nigeria. The highest prevalence rates for women 15-49 years are in the south east and south west of the country (32.5% and 41.1% respectively). This compares with the north east of the country which has the lowest prevalence (1.4%), there are also prevalence's by state (see [Prevalence of FGM in Nigeria](#)).
- 2.4.9 Although FGM is more common in the southern, predominantly Christian regions, it is practiced within both Christian and Muslim communities across the country (see [Prevalence: By religion](#)).
- 2.4.10 Nigeria is ethnically diverse, with over 250 ethnic groups and societal mobility has blurred the lines (intermarriage and physical and social mobility) between ethnic groups and the parts of the country they now occupy. Broadly speaking, of the main ethnic groups, the Hausa-Fulani are located in north east and north west regions, the Yoruba in south west, north central and central regions, and the Igbo in south and south east. FGM prevalence among Yoruba and Igbo women is 45.4% and 29.2% respectively which shows a decline since 2013. Prevalence among Hausa-Fulani combined is 13.9%. By comparison the percentage of women who had undergone FGM

was only 8.6% across all other ethnic groups in Nigeria. More specifically, and according to 2013 data, FGM was virtually unknown among Igala and Tiv women who mostly live in the south and central belt of the country (see [Prevalence: By ethnic group](#)).

- 2.4.11 Girls may be ostracised, disgraced, shunned or assaulted by their family or community if they have not undergone FGM (see [Overview: Introduction](#)).
- 2.4.12 Prevalence rates can cover several factors (age, ethnicity, education) and these may overlap. However, it does not necessarily follow that a woman or girl is at increased risk because of these factors independently. Those from ethnic groups with a high incidence may not be at risk, while those from ethnic groups with a low incidence may be at risk.
- 2.4.13 The factors to be considered by decision makers when assessing risk include but are not limited to:
- the ethnic background of the girl/woman taking into account high levels of intermarriage;
 - the prevalence of FGM amongst the extended family, as this may increase or reduce the relevant risk which may arise from the prevalence of the practice amongst members of the ethnic group in general;
 - the region of Nigeria she lived before coming to the UK;
 - whether she lived in an urban or rural area before coming to the UK;
 - her age;
 - her and her parents' education;
 - the practice of the ethnic group and extended family into which she has married (if married).
- 2.4.14 Each case will need to be considered on its facts, taking into account the factors above, to determine whether a girl or women is vulnerable to FGM or further mutilation which would amount to persecution.

[Back to Contents](#)

b. Parents who resist/oppose FGM for their minor children

- 2.4.15 Cultural and societal norms support the continuation of FGM in Nigeria. The most common justification for FGM is the concern that contact between the clitoris and the baby's head during birth is lethal or harmful for the baby. Other cultural considerations are cleanliness or hygiene, prevention of promiscuity, enhancing fertility, marriage prospects and fidelity, and fulfilled womanhood. It is also reported that 'intergroup relationships' affect one's ability to refuse FGM, for example, grandmothers carrying out the practice without the parents' permission (see [Societal attitude to FGM](#)).
- 2.4.16 A person who is the parent of a minor child who is opposed to her undergoing FGM within communities that practice it may face societal discrimination, blackmailing, denial of intracultural benefits and ostracism for going against cultural or family traditions. Decision makers need to consider each case on its facts. However, in general, this treatment is unlikely by virtue of its nature and repetition to reach the high threshold to constitute

persecution or serious harm. The act of enforced FGM on a child, where the parents are opposed to the act, could result in the child's parents being subject to persecution or serious harm.

- 2.4.17 In those cases where there is an absence of a link to one of the five Convention reasons necessary for the grant of refugee status, it is still necessary to consider whether the particular person will face a real risk of serious harm sufficient to qualify for Humanitarian Protection.
- 2.4.18 For further information on assessing risk, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).

[Back to Contents](#)

2.5 Protection

- 2.5.1 The Violence against Persons (Prohibition) Act 2015 (VAPP Act) prohibits FGM, making it a federal offence and provides for proportionate penalties. The VAPP Act applies within the Federal Capital Territory, however it still needs to be passed in each of the 36 States of the Federation. To date, some states have passed the VAPP Act, others have not, particularly those where FGM is prevalent. There are low rates of reporting given that family members are often the perpetrators and to date there have been no prosecutions (see [Laws against FGM, Federal and State Law and Investigations and Convictions](#)).
- 2.5.1 Implementation of the law varies across the country and depends on state and federal police capacity and willingness. NGOs have found that they have to convince local authorities that state laws apply in their districts. The laws are reportedly harder to enforce in rural areas where there is limited police presence and activity (see [Law enforcement](#)).
- 2.5.2 Police are also reported to treat the practice as a family or community affair, who [police] may also respect the tradition themselves, and may not intervene at all (see [State attitudes to FGM](#)).
- 2.5.3 Although the Nigerian Police Force (NPF) is one of the largest police forces in the world, the ratio of police officers to citizens is below the UN-recommended number. The police's effectiveness is undermined by a lack of staff, funding, proper equipment and facilities, inadequate training, as well as poor pay and wide-spread corruption. Further, the NPF reportedly focuses its resources on protecting important persons, including politicians and wealthy individuals, rather than on community policing. As a result, the NPF is generally perceived to be corrupt and ineffective by the population. Nonetheless, people continue to approach it for assistance (See country and policy information note on [Nigeria: Actors of Protection](#)).
- 2.5.4 The police force is, however, working with other agencies to improve its response and attitude to gender-based violence generally, including establishing sexual assault referral centres and a dedicated unit to deal with gender-based crimes. There are also many women's advocacy groups which offer practical help to women (see the country policy and information note on [Nigeria: Women fearing gender-based violence](#)).
- 2.5.5 Prominent public figures such as the President's wife, the Minister of State for Health and some State Governors have all spoken out against FGM

demonstrating the authorities' willingness to tackle the issue (see [State attitude to FGM](#)).

- 2.5.6 There are also non-governmental organisations in Nigeria who are active in FGM matters and can potentially assist the person to avail themselves of the protection of the state (see [Support groups](#)).
- 2.5.7 In some parts of the country, however, the capacity of the Nigerian State to provide effective protection is limited, in particular in the states of Borno, Adamawa, Yobe, Plateau, Benue, Nasarawa, Taraba, and Zamfara. (see [State attitudes to FGM](#)).
- 2.5.8 In general, the Federal State is likely to provide protection. However, it remains difficult to obtain protection in all states outside the Federal capital of Abuja where FGM is prevalent. Each case will need to be considered on its particular circumstances taking into account factors such as the person's age, socio-economic circumstances, education, ethnicity and the area they will return to. A person's reluctance to seek protection does not mean that effective protection is not available. The onus is on the person to demonstrate that the state is not willing and able to provide them with effective protection.
- 2.5.9 For an assessment of risk and information on women in Nigeria generally, and on protection generally, see the country policy and information notes [Nigeria: Gender-Based Discrimination/Harm/Violence Against Women](#), and [Nigeria: Actors of Protection](#).
- 2.5.10 For further information on assessing the availability of state protection, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).

[Back to Contents](#)

2.6 Internal relocation

- 2.6.1 Nigeria is a large country (around 4 times the size of the UK), relatively densely populated, culturally and ethnically diverse with a population of around 190 million people. The constitution and law provide for freedom of internal movement for all, regardless of age or gender, although government-imposed curfews and insecurity in areas of civil conflict - the north-east; the 'Middle Belt'; the Niger Delta region; and Zamfara state in particular - are likely to make travel difficult and unsafe in these parts of the country. Freedom of movement for women and children in Muslim communities in northern areas is, however, more restricted. Nonetheless, many Nigerians move within the country for economic and other reasons (see [Freedom of movement](#) and the country policy and information notes, Nigeria: [Internal Relocation](#) and Nigeria: [Fear of Boko Haram](#)).
- 2.6.2 Decision makers must give careful consideration to the relevance and reasonableness of internal relocation on a case-by-case basis, taking full account of the individual circumstances of the particular person.
- 2.6.3 The constitution and law provide for freedom of internal movement for all, regardless of age or gender. At times freedom of movement can be restricted by the imposition of curfews in areas experiencing terrorist attacks and ethno-religious violence. Women's and children's freedom of movement

in Muslim communities in northern areas is however more restricted (see [Freedom of movement](#)).

- 2.6.4 In general, it will not be unduly harsh for a child, with accompanying family, to internally relocate to escape localised threats from other members of their family or other non-state actors. Internal relocation for a lone child without any accompanying family member may on the other hand be unduly harsh, especially if there is no other support network. The individual circumstances of each case must be taken into account.
- 2.6.5 For further information on considering internal relocation, see the [Asylum Instruction on Assessing Credibility and Refugee Status](#).
- 2.6.6 For country information and a general assessment of internal relocation and on gender-based violence, see the country policy and information notes on [Nigeria: Internal Relocation](#) and [Nigeria: Gender-Based Discrimination/Harm/Violence Against Women](#).

[Back to Contents](#)

2.7 Certification

- 2.7.1 Nigeria is listed as a designated state under section 94 of the Nationality, Immigration and Asylum Act 2002 in respect of men only.
- 2.7.2 Where a claim made by a woman (or girl) on the basis of fear of FGM is refused, it is unlikely to be certifiable as 'clearly unfounded' under section 94 of the Nationality, Immigration and Asylum Act 2002.
- 2.7.3 For further guidance on certification, see the appeals instruction on [Certification of Protection and Human Rights claims under section 94 of the Nationality, Immigration and Asylum Act 2002 \(clearly unfounded claims\)](#)

[Back to Contents](#)

Country information

Section 3 updated: 27 June 2019

3. Overview

3.1 Introduction

3.1.1 HM Government in their 'Multi-Agency Statutory Guidance on female genital mutilation' publication of April 2016 stated that 'FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death.'²

3.1.2 The Australian Government's Department of Foreign Affairs and Trade Country Information Report 2018 (2018 DFAT report), which is '[...] informed by DFAT's on-the-ground knowledge and discussions with a range of sources in Nigeria. It takes into account relevant and credible open source reports', examples are then listed³, noted:

'Female genital mutilation (FGM) is widely practised in Nigeria. [...] The practice is closely tied to concepts of family honour and girls' marriageability. Girls may be ostracised, shunned or assaulted by their family or community if they have not undergone FGM.'⁴

3.1.3 The World Health Organisation in their fact sheet dated January 2018 gives the following key points regarding FGM:

'Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.

'The procedure has no health benefits for girls and women.

'Procedures can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of new born deaths.

'More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated.

'FGM is mostly carried out on young girls between infancy and age 15.

'FGM is a violation of the human rights of girls and women.'⁵

3.1.4 The report goes onto state:

'FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The

² HM Government, 'Multi-Agency Statutory Guidance on female genital mutilation', April 2016, [url](#).

³ DFAT, Country of Information Report – Nigeria, (para 1.4), 9 March 2018, [url](#).

⁴ DFAT, Country of Information Report – Nigeria, p21, 9 March 2018, [url](#).

⁵ World Health Organisation, 'Female genital mutilation fact sheet', 31 January 2018, [url](#).

practice also violates a person's rights 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. [...] Where FGM is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice. In some communities, FGM is almost universally performed and unquestioned.⁶

- 3.1.5 According to UNICEF, FGM 'is performed in line with tradition and social norms to ensure that girls are socially accepted and marriageable, and to uphold their status and honour and that of the entire family'.⁷
- 3.1.6 European Asylum Support Office (EASO) country guidance, Nigeria, February 2019 which represents the common assessment of the situation in the country of origin by senior policy officials from EU Member States, concluded: [...] 'the family or family members can be an actor of persecution or serious harm, such as in the case of [...] female genital mutilation or cutting (FGM/C), etc. FGM/C practitioners, including traditional circumcisers and health care professionals, are another potential example of non-State actors of persecution or serious harm, due to the violation of the rights of the child and dignity of the woman that the practice involves.'⁸
- 3.1.7 A 2012 Annals of Medical and Health Sciences Research paper noted '[...] FGM is still deeply entrenched in the Nigerian society where critical decision makers are grandmothers, mothers, women, opinion leaders, men [...] Mothers chose to subject their daughters to the practice to protect them from being ostracized, beaten, shunned, or disgraced...FGM was traditionally the specialization of traditional leaders' traditional birth attendants or members of the community known for the trade.'⁹
- 3.1.8 The same report goes onto state that:
'FGM is recognized worldwide as a fundamental violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It involves violation of rights of the 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. Furthermore, girls usually undergo the practice without their informed consent, depriving them of the opportunity to make independent decision about their bodies.'¹⁰

[Back to Contents](#)

⁶ World Health Organisation, 'Female genital mutilation fact sheet', 31 January 2018, [url](#).

⁷ UNICEF, 'Nigeria Country Profile', February 2019, [url](#).

⁸ EASO, 'Country Guidance: Nigeria', p43, February 2019, [url](#).

⁹ Annals of Medical and Health Sciences Research – An Overview of FGM in Nigeria, June 2012 [url](#).

¹⁰ Annals of Medical and Health Sciences Research – An Overview of FGM in Nigeria, June 2012 [url](#).

4. Prevalence of FGM in Nigeria

4.1 Overview

4.1.1 The statistical sources used in this CPIN stem primarily from two bodies of work, the first published in 2013 (National Population Commission - Nigeria Demographic and Health Survey of 2013) and the second in 2018 reporting on a survey undertaken for 2016-17 (The National Bureau of Statistics/United Nations Children's Fund (NBS/UNICEF), Multiple Indicator Cluster Survey (MICS), 2016-17). Both reports are widely cited by several of the sources used.

4.1.2 It should be noted that as reported by UNICEF:

'Self-reported data on FGM/C need to be treated with caution for several reasons. First, women may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice. In addition, they may be unaware that they have been cut or of the extent of the cutting, especially if FGM/C was performed at an early age. [...]

'A key point to remember is that prevalence data for girls aged 0 to 14 reflect their current FGM/C status and do not reflect final prevalence for this age group.'¹¹

4.1.3 In 2011, the prevalence rate for women aged 15-49 was 27% (UNICEF press release February 2019)¹². In 2013, that rate had dropped to 24.8% (Nigeria Demographic and Health Survey 2013)¹³. In 2016/17, that rate had dropped further to 18.4% (MICS data)¹⁴.

4.1.4 The National Bureau of Statistics/United Nations Children's Fund (NBS/UNICEF), Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018 gave the following statistics:

18.4% of women aged 15-49 years report to have undergone some form of FGM/C.

25.3% of daughters aged 0-14 years report to have undergone some form of FGM/C¹⁵.

4.1.5 A UNICEF press release, 'Take action to eliminate female genital mutilation by 2030', dated 6 February 2019, stated:

'In 2015, world leaders overwhelmingly backed the elimination of female genital mutilation as one of the targets in the 2030 Agenda for Sustainable Development. This is an achievable goal, and we must act now to translate that political commitment into action. [...]

'UNICEF and partners' interventions to ensure the elimination of FGM by 2030 has resulted in a break in the barrier against discussing FGM publicly. Religious leaders, community stakeholders and young people now speak out

¹¹ UNICEF – FGM/C: A statistical overview (p24), July 2013 [url](#).

¹² UNICEF, 'Take action to eliminate female genital mutilation by 2030' 6 February 2019, [url](#).

¹³ NPC - Nigeria Demographic and Health Survey 2013 (p350), June 2014 [url](#).

¹⁴ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018, [url](#).

¹⁵ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018, [url](#).

against this practice. Subsequently, last year, more than 309 communities publicly declared abandonment of the practice.

“Despite this decline, millions of girls and women are still faced with the scourge of genital mutilation every year in Nigeria. There is, therefore, an urgent need for decision makers and political leaders to take concrete action towards ending the harmful practice of FGM in Nigeria”, said Mohamed Fall, UNICEF Country representative.¹⁶

- 4.1.6 The 2013 UNICEF FGM Statistical Overview report categorised Nigeria as a ‘moderately low prevalence country’ for FGM with 27% of girls and women aged 15-49 having been cut¹⁷ and that ‘In [...] Nigeria, prevalence has dropped by about half [to 19%] among adolescent girls [15-19 year olds].’¹⁸
- 4.1.7 28 Too Many in their 2018 report stated: ‘[...] 20 million women and girls in Nigeria have undergone FGM. This represents 10% of the global total. ‘The highest prevalence is in South East and South West Zones.’¹⁹
- 4.1.8 According to the 2013 NDHS [Nigeria Demographic and Health Survey] findings, 25% of Nigerian women are circumcised.²⁰
- 4.1.9 The 2019 UNICEF country profile report also noted that in Nigeria the prevalence of FGM varied significantly by state, and that almost eight out of ten adolescent girls who experienced the practice were cut before the age of five. Over half of girls and women and boys and men think FGM should stop and there is evidence of significant generational change in the prevalence of FGM in Nigeria as women aged 45-49 are more than twice as likely to have been cut than girls aged 15-19²¹.

[Back to Contents](#)

4.2 Repeat FGM

- 4.2.1 At the time of compiling the CPIN, CPIT was not able to find specific information on repeat FGM in Nigeria in the sources consulted (see [Bibliography](#)). However, this does not mean to say there are no incidents of repeat FGM in Nigeria.

[Back to Contents](#)

4.3 By type

- 4.3.1 The World Health Organisation (WHO) stated on their website factsheet, dated January 2018 that:

Female genital mutilation is classified into 4 major types:

‘Type 1: Often referred to as clitoridectomy, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

¹⁶ UNICEF, ‘Take action to eliminate female genital mutilation by 2030’ 6 February 2019, [url](#).

¹⁷ UNICEF – FGM/C: A statistical overview (p27), July 2013 [url](#).

¹⁸ UNICEF – FGM/C: A statistical overview (p99), July 2013 [url](#).

¹⁹ 28TOOMANY, Nigeria – the Law and FGM, p1, June 2018, [url](#).

²⁰ NPC - Nigeria Demographic and Health Survey 2013 (p345), June 2014 [url](#).

²¹ UNICEF, ‘Nigeria Country Profile’, February 2019, [url](#).

'Type 2: Often referred to as excision, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).

'Type 3: Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).

'Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.'²²

- 4.3.2 Epundu UU, Ilika AL, Ibeh CC, Nwabueze AS, Emelumadu OF, Nnebue CC. The Epidemiology of Female Genital Mutilation in Nigeria. - A Twelve Year Review Afrimed Journal 2018; 6 (1): 1-10 describes further the practice of FGM that falls within WHO's type 4 classification:

'Any other harmful procedure performed on the female genitalia for non-medical purposes, for example: pricking, piercing and incision of the clitoris and/or labia, stretching and/or cutting of the vagina ('gishiri'), scraping of tissue surrounding the vaginal opening ('angurya') and cauterization. It also includes the introduction of corrosive substances into the vagina to cause bleeding or to tighten or narrow the vagina.'²³

- 4.3.3 The NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018 recorded that provided the following tables of FGM by type for women and girls, showing that the most common type of FGM in Nigeria is Type 1 and 2 which both involve some form of cutting and removal of the female genital area²⁴:

Table CP.10: Female genital mutilation/cutting (FGM/C) among women

Percentage of women age 15-49 years by FGM/C status and percent distribution of women who had FGM/C by type of FGM/C, Nigeria, 2016-17

	Percentage of women who had any form of FGM/C ¹	Number of women age 15-49 years	Percent distribution of women age 15-49 years who had FGM/C:				Total	Number of women age 15-49 years who had FGM/C
			Had flesh removed	Were nicked	Were sewn closed	Form of FGM/C not determined		
Total	18.4	34,376	61.8	3.4	4.9	29.8	100.0	6,312

Table CP.11: Female genital mutilation/cutting (FGM/C) among girls

Percentage of daughters age 0-14 years by FGM/C status and percent distribution of daughters who had FGM/C by type of FGM/C, Nigeria, 2016-17

	Percentage of daughters who had any form of FGM/C ¹	Number of daughters age 0-14 years	Percent distribution of daughters age 0-14 years who had FGM/C:				Total	Number of daughters age 0-14 years who had FGM/C
			Had flesh removed	Were nicked	Were sewn closed	Form of FGM/C not determined		
Total	25.3	17,529	76.6	7.5	5.3	10.6	100.0	4,443

- 4.3.4 An Oxford Journals 2014 study noted that 'The types of FGM commonly practiced in Nigeria are Types I, II and III, with Type II reported to be the most common. Type IV is practiced more in the north as "Gishri" cuts.'²⁵

²² World Health Organisation, 'Female genital mutilation fact sheet', 31 January 2018, [url](#).

²³ Epundu UU, et al, 'The Epidemiology of FGM in Nigeria', Afrimed Journal 2018; 6 (1): 1-10, [url](#).

²⁴ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, p 236-9 February 2018, [url](#).

²⁵ Oxford Journals – Mothers' perceptions of female genital mutilation, 16 July 2014 [url](#).

4.3.5 A 2008 World Health Organisation interagency statement on Eliminating Female Genital Mutilation defined ‘gishiri’ and ‘angurya’ cuts (mentioned in the previous paragraph):

‘[...] reference was made to “gishiri” cuts and “angurya” cuts, which are local terms used in parts of Nigeria “Gishiri” cuts are generally made into the vaginal wall in cases of obstructed labour. The practice can have serious health risks, including fistula, bleeding and pain. It differs from most types of female genital mutilation, as it is not routinely performed on young girls but more as a traditional birthing practice. “Angurya” cuts are a form of traditional surgery or scraping to remove the hymen and other tissue surrounding the vaginal orifice.’²⁶

[Back to Contents](#)

4.4 By age

According to the NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018, 18.4% of women aged 15-49 years report to have undergone FGM/C and 25.3% of daughters aged 0-14 years are reported to have undergone FGM/C. The table below breaks the data further down into age ranges²⁷.

Age	% Women and daughters who have had any FGM/C	Number of women/girls aged 0-49	Number of women/girls who have had FGM/C
0-4	26.6	7265	1936
5-9	23.9	5709	1363
10-14	25.1	4556	1144
15-19	12.3	6822	842
20-24	15.4	5816	896
25-29	16.9	5915	1000
30-34	20.1	5390	1084
25-39	21.3	4339	924
40-44	24.4	3571	871
45-49	27.6	2524	696

4.4.1 The 2013 Nigeria Demographic and Health Survey (DHS 2013) stated that 82% of women that had been circumcised had their circumcision before they were 5 years old, 4% between 5 and 9 years, 5% between 10 and 14 years and 7% were 15 or older²⁸.

4.4.2 The DHS 2013 report continues:

²⁶ WHO - interagency statement on Eliminating Female Genital Mutilation, 2008 [url](#).

²⁷ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018, [url](#).

²⁸ NPC - Nigeria Demographic and Health Survey of 2013 (p351), published June 2014, [url](#).

'The results show variations among ethnic groups in age at circumcision. Ninety-two percent of Hausa women underwent the procedure before age 5, while 38 percent of Ijaw/Izon women were circumcised at age 15 or older. By zone, 90 percent of women in the South East were circumcised before age 5, while 34 percent in the North East were circumcised at age 15 or older (this may be the result of a ritual for initiation into womanhood). Almost all women in Imo, Enugu, and Abia were circumcised before their fifth birthday, as compared with 11 percent in Benue.'²⁹

- 4.4.3 The United Nations Population Fund noted in a December 2015 report: 'In some areas, FGM is carried out during infancy – as early as a couple of days after birth. In others, it takes place during childhood, at the time of marriage, during a woman's first pregnancy or after the birth of her first child. Recent reports suggest that the age has been dropping in some areas, with most FGM carried out on girls between the ages of 0 and 15 years.'³⁰

[Back to Contents](#)

4.5 By education

Overall, when analysing the data shown in the NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018 the higher the level of the mother's education, the lower the FGM rates for girls aged 0-14 years can be observed. The education of the mothers who reported about their daughters between 0 and 14 who had any form of FGM, is as follows³¹:

Table CP.11: Female genital mutilation/cutting (FGM/C) among girls

²⁹Percentage of daughters age 0-14 years by FGM/C status and percent distribution of daughters who had FGM/C by type of FGM/C, Nigeria, 2016-17

	Percentage of daughters who had any form of FGM/C ¹	Number of daughters age 0-14 years	Percent distribution of daughters age 0-14 years who had FGM/C:				Total	Number of daughters age 0-14 years who had FGM/C
			Had flesh removed	Were nicked	Were sewn closed	Form of FGM/C not determined		
Mother's Education							100.0	
None	31.9	3,665	69.5	9.2	2.5	18.7	100.0	1,170
Non-formal	44.2	3,002	83.9	5.9	5.5	4.6	100.0	1,327
Primary	23.6	3,378	78.4	8.8	4.4	8.3	100.0	797
Secondary	17.2	5,576	74.8	7.1	7.3	10.7	100.0	961
Higher	9.8	1,909	69.4	5.4	13.3	12.0	100.0	188

[Back to Contents](#)

4.6 By region

The NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018 shows the following data with regard FGM by region. For women aged 15-49 years the highest prevalence is shown in the South East and South West zones with 32.5% and 41.1% respectively, followed by South 23.3% and North West 19.3%. The lowest rates are found in the North Central 8.6% and North East 1.4%. Urban areas in Nigeria account for 23.4% of women who have undergone FGM compared to 15.6% in rural

²⁹ NPC - Nigeria Demographic and Health Survey of 2013 (p351), published June 2014, [url](#).

³⁰ United Nations Population Fund – FGM frequently asked questions, December 2015 [url](#).

³¹ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, p 238, February 2018, [url](#).

areas³².

Table CP.10: Female genital mutilation/cutting (FGM/C) among women

Percentage of women age 15-49 years by FGM/C status and percent distribution of women who had FGM/C by type of FGM/C, Nigeria, 2016-17

	Percentage of women who had any form of FGM/C ¹		Number of women age 15-49 years	Percent distribution of women age 15-49 years who had FGM/C:				Total	Number of women age 15-49 years who had FGM/C					
	Had flesh removed	Were nicked		Were sewn closed	Form of FGM/C not determined									
Total	18.4	34,376	61.8	3.4	4.9	29.8	100.0	6,312						
Geopolitical zone														
North Central	8.6	6,006	65.5	5.1	6.2	23.3	100.0	517						
North East	1.4	6,584	71.8	0.0	28.2	0.0	100.0	89						
North West	19.3	10,932	72.5	5.1	2.0	20.5	100.0	2,112						
South East	32.5	2,445	50.1	2.3	9.9	37.7	100.0	795						
South South	23.3	3,668	67.1	2.8	12.2	17.8	100.0	853						
South West	41.1	4,741	51.3	2.0	1.5	45.2	100.0	1,947						
Residence														
Urban	3.6	7.8	41.6	44.0	3.0	100.0	154	1.9	15.0	35.3	43.9	3.9	100.0	873
Rural	2.2	12.2	31.8	48.0	5.8	100.0	1,359	2.6	14.3	32.6	45.5	5.0	100.0	2,762

- 4.6.1 The same report demonstrates that for girls aged 0-14 years the highest prevalence is North West with 56%, followed by South West, North Central and South East with 21.6%, 16.1% and 12.7% respectively. The lowest rates are found in the South with 6.1% and North East 1.4%. In contrast to women aged 15-49 years, urban areas in Nigeria account for 20.5% of girls who have undergone FGM compared to 28.8% in rural areas³³.

Table CP.11: Female genital mutilation/cutting (FGM/C) among girls

Percentage of daughters age 0-14 years by FGM/C status and percent distribution of daughters who had FGM/C by type of FGM/C, Nigeria, 2016-17

	Percentage of daughters who had any form of FGM/C ¹		Number of daughters age 0-14 years	Percent distribution of daughters age 0-14 years who had FGM/C:				Total	Number of daughters age 0-14 years who had FGM/C
	Had flesh removed	Were nicked		Were sewn closed	Form of FGM/C not determined				
Total	25.3	17,529	76.6	7.5	5.3	10.6	100.0	4,443	
Geopolitical zone									
North Central	16.1	2,323	87.1	2.6	7.6	2.6	100.0	373	
North East	1.4	2,761	85.8	0.0	7.2	7.0	100.0	39	
North West	56.0	5,329	75.8	8.1	5.3	10.7	100.0	2,982	
South East	12.7	1,476	65.3	12.1	7.8	14.8	100.0	187	
South South	6.1	2,311	75.9	2.1	11.8	10.2	100.0	141	
South West	21.6	3,329	76.9	7.9	1.7	13.5	100.0	720	
Residence									
Urban	20.5	7,254	79.6	5.6	6.0	8.8	100.0	1,487	
Rural	28.8	10,276	75.1	8.5	4.9	11.6	100.0	2,956	

- 4.6.2 The report also breaks these zones down further into 37 states ([see NBS/UNICEF, Multiple Indicator Cluster Survey \(MICS\), 2016-17](#)).
- 4.6.3 The 28 Too Many FGM in Nigeria Country Profile, largely using the Nigeria 2013 DHS figures, noted:

³² NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, p 236, February 2018, [url](#).

³³ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, p238, February 2018, [url](#).

‘Specific practices in relation to FGM and its prevalence vary across all regions, ethnic groups and religions in Nigeria. There is a variation in FGM prevalence according to place of residence, with 32.3% of women living in urban areas having undergone FGM, compared with 19.3% of women living in rural areas. There is also variation across Nigeria’s six Zones and 36 states. South East and South West Zones have the highest prevalence (49% and 47.5% respectively). This is further evidenced by Ebonyi State in South East and Osun State in South West having the highest prevalence by state (74.2% and 76.6% respectively). North East is the Zone with the lowest prevalence, at 2.9%, and Katsina (in North West Zone) is the state with the lowest prevalence, at 0.1%.’³⁴

- 4.6.4 However, the same report also notes the following on data reliability and regional prevalence:

‘Prevalence by place of residence is not necessarily an indicator of where FGM is carried out, as a woman may have lived in a different area at the time she underwent FGM. This is particularly relevant in relation to the urban/rural split, as girls or women now living in urban areas may have undergone FGM in their familial village and relocated upon marriage. [...] In Nigeria, although the prevalence of FGM appears to be highest among the wealthier, better-educated women who live in urban areas, these same women are the least likely to have their daughters cut before the age of 15, which suggests a decline in the practice from generation to generation in these families. This same group of women is also most in favour of discontinuing the practice. Conversely, although the prevalence of FGM is lowest among poorer women with little or no education who live in rural areas, these women are more likely to have their daughters cut. In other words, this cohort is the most likely to continue the practice, and shows the highest level of support for the continuation of FGM.’³⁵

- 4.6.5 The 2013 Nigeria Demographic and Health Survey (DHS 2013) stated that ‘Infibulation is more prevalent in Nasarawa, Kaduna, and Bayelsa than in other states.’³⁶

- 4.6.6 The same source further noted that:

‘Thirty-two percent of urban women are circumcised, as compared with 19 percent of rural women. There are also urban-rural differences in the proportion of women who had cutting with flesh removed (65 percent and 60 percent, respectively). More women in the southern zones than the northern zones are circumcised. Osun has the highest prevalence of circumcised women (77 percent), followed by Ebonyi (74 percent) and Ekiti (72 percent); Katsina has the lowest prevalence (0.1percent). The practice of sewing the genital area closed after cutting is most prevalent in Nasarawa (22 percent), Kaduna (21 percent), and Bayelsa (20 percent).’³⁷

[Back to Contents](#)

³⁴ 28 Too Many – Country Profile: FGM in Nigeria (p8), October 2016 [url](#).

³⁵ 28 Too Many – Country Profile: FGM in Nigeria (p6), October 2016 [url](#).

³⁶ NPC - Nigeria Demographic and Health Survey of 2013 (p345), published June 2014, [url](#).

³⁷ NPC - Nigeria Demographic and Health Survey of 2013 (p348), published June 2014, [url](#).

4.7 By religion

4.7.1 The Harvard University Divinity School Religious Literacy Project Nigeria country profile (undated) noted:

'In Nigeria FGM is slightly more common in the southern, predominantly Christian regions, but it is practiced within both Christian and Muslim communities across the country. The ban of FGM in Nigeria was reached by culmination of the efforts of organizations such as the Inter-African Committee, UNICEF, and the World Health Organization (WHO), together with Muslim and Christian groups. Christians belonging to the Seventh Day Adventist tradition in Nigeria have been particularly outspoken against FGM and cite the Bible in their rejection of the practice.'³⁸

4.7.2 An Annals of Medical and Health Sciences Research paper from 2012 noted 'Practice of FGM has no relationship with religion. Muslims and Christians practice it, but it is more widely spread in Christian predominated parts of Nigeria.'³⁹

4.7.3 Daughters of Eve is a UK based non-profit organisation who state on their website that they work to protect girls and young women who are at risk from female genital mutilation (FGM). Their website (undated) gives their understanding of religion and belief and the practice of FGM.

'Some people practice FGM as part of their religion and there can be huge pressures to make girls have it done. However, FGM is not recommended by any religion or in any religious texts. It is not religious but might have become symbolic in some communities as a demonstration of faith. In fact, it is not a condition of belonging to any faith group.

'Christianity, Judaism and Islam unanimously agree that your body is a temple of God. The practice of FGM is a harmful custom that is not advocated in any holy script.'⁴⁰

4.7.4 WHO state on its January 2018 website factsheet:

'Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.

'Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.

'Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.

'In most societies, where FGM is practised, it is considered a cultural tradition, which is often used as an argument for its continuation.

³⁸ Harvard University Divinity School Religious Literacy Project - Nigeria country profile, undated [url](#).

³⁹ Annals of Medical and Health Sciences Research – An Overview of FGM in Nigeria, June 2012 [url](#).

⁴⁰ Daughters of Eve, website – 'About FGM', undated, [url](#).

'In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.'⁴¹

4.7.5 The 2013 Nigeria Demographic and Health Survey contained a table setting out prevalence of FGM by religion (Table 18.2, p.349) [Nigeria 2013 Demographic and Health Survey](#)

Percentage of women age 15-49 who have been circumcised and percent distribution of circumcised women by type of circumcision, according to background characteristics, Nigeria 2013

Background characteristic	Percentage of women circumcised	Number of women	Type of circumcision			Total	Number of circumcised women
			Cut, no flesh removed	Cut, flesh removed	Sewn closed		
Religion					Don't know/missing		
Catholic	31.4	4,316	5.3	73.2	6.7	14.7	1,355
Other Christian	29.3	13,922	3.9	69.3	6.5	20.3	4,081
Islam	20.1	20,149	8.2	51.6	3.6	36.6	4,051
Traditionalist	34.8	359	1.3	82.3	6.1	10.3	125

[Back to Contents](#)

4.8 By ethnic group

4.8.1 The NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018 shows the following data with regard FGM by ethnic group. The figures suggest that female circumcision is experienced more commonly by Yoruba women aged 0-49 but is more prevalent for Hausa girls 0-14⁴².

Ethnicity of household head	% Women who have had any form of FGM/C	Number of women aged 15-49	Number of women 15-49 who have had FGM/C
Hausa	13.9	15920	2218
Igbo	29.2	3558	1040
Yoruba	45.4	4380	1989
Other	8.3	4608	380

43

Ethnicity of household head	% Girls who have had any form of FGM/C	Number of Girls aged 0-14	Number of daughters 0-14 who have had FGM/C
Hausa	38.6	7785	3004
Igbo	11.3	2153	242
Yoruba	27.3	2984	816
Other	8.3	4608	380

4.8.2 The 2016 28 Too Many FGM in Nigeria Country Profile, largely using the Nigeria 2013 DHS figures, noted:

⁴¹ World Health Organisation, 'Female genital mutilation fact sheet', 31 January 2018, [url](#).

⁴² NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018, [url](#).

⁴³ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, p236, February 2018, [url](#).

'Nigeria is ethnically diverse, with over 250 ethnic groups, ten of which comprise 80% of the country's population [...] Social and physical mobility [including intermarriage] have blurred the lines between ethnic groups and the parts of the country they now occupy. Broadly speaking, the Hausa-Fulani (who constitute 30% of the population) are located in North East and North West Zones, the Yoruba (21%) in South West, North Central and Central Zones, and the Igbo (18%) in South and South East Zones. FGM prevalence among Yoruba women aged 15 to 49 is 54.5%, among Igbo it is 45.2%, and among Hausa-Fulani combined it is approximately 16.3%. FGM is virtually unknown among Igala (0.5%) and Tiv women (0.3%).'⁴⁴

- 4.8.3 The 2013 Nigeria Demographic and Health Survey contained a table setting out more detail of prevalence of FGM by ethnicity. (Table 18.2, p.349 and figure 18.1, p.350) [Nigeria 2013 Demographic and Health Survey](#)

Percentage of women age 15-49 who have been circumcised and percent distribution of circumcised women by type of circumcision, according to background characteristics, Nigeria 2013

Background characteristic	Percentage of women circumcised	Number of women	Type of circumcision			Don't know/missing	Total	Number of circumcised women
			Cut, no flesh removed	Cut, flesh removed	Sewn closed			
Ethnic group								
Ekoi	(56.9)	22	*	*	*	*	100.0	13
Fulani	13.2	2,565	2.6	57.5	2.0	37.9	100.0	338
Hausa	19.4	10,699	11.9	38.4	3.6	46.2	100.0	2,074
Ibibio	12.8	841	2.1	71.4	9.4	17.2	100.0	108
Igala	0.5	371	*	*	*	*	100.0	2
Igbo	45.2	5,636	5.7	74.9	5.4	14.0	100.0	2,546
Ijaw/Izon	11.0	751	9.2	65.8	18.8	6.2	100.0	82
Kanuri/Berberi	2.6	680	*	*	*	*	100.0	18
Tiv	0.3	836	*	*	*	*	100.0	3
Yoruba	54.5	5,482	3.2	67.4	3.0	26.4	100.0	2,989
Others	13.4	11,002	3.8	66.0	12.2	18.1	100.0	1,470
Don't know/missing	14.8	64	*	*	*	*	100.0	9

45

- 4.8.4 EASO country guidance, Nigeria, February 2019 stated 'Some of the ethnic groups with highest prevalence rate of FGM/C are Yoruba (52 – 90 % in different studies), Edo/Bini (69 – 77 %), Igbo (45 – 76 %). The prevalence rate for the Hausa Fulani is estimated at 13 – 30 %.'⁴⁶

- 4.8.5 For background information on ethnicity in Nigeria, see the [Nigeria Country Background Note](#).

[Back to Contents](#)

Section 5 updated: 27 June 2019

5. Actors of harm

- 5.1.1 The World Health Organisation in their fact sheet dated January 2018 commented that: 'The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths.'⁴⁷
- 5.1.2 The Population Council, funded by UKAid published a paper 'Understanding Medicalisation FGM/C: A Qualitive study of parents and health workers in Nigeria', January 2018, which stated:

⁴⁴ 28 Too Many – Country Profile: FGM in Nigeria (p24), October 2016 [url](#).

⁴⁵ NPC - Nigeria Demographic and Health Survey of 2013 (p349/350), published June 2014, [url](#).

⁴⁶ EASO, 'Country Guidance: Nigeria', p63, February 2019, [url](#).

⁴⁷ World Health Organisation, 'Female genital mutilation fact sheet', 31 January 2018, [url](#).

[...] social norms driving FGM/C practice remain entrenched despite a shift to medicalisation. They also reflect the tendency of parents and health workers to view FGM/C, whether traditional or medicalised, as a minor procedure with few complications and significant benefits that would positively impact a daughter's future status as a wife and mother. [...]

'With respect to decision making, parents made FGM/C decisions, with the male household head having the final say despite being removed from the mechanics and healing process. In some instances, men deferred to their wives' opinions as they were deemed most knowledgeable about girls' and women's issues, and in some study communities grandmothers were highly influential in parents' decision making.'⁴⁸

5.1.3 The EASO, 'Country Guidance: Nigeria', February 2019, stated that:

'The final decision whether or not to circumcise their daughter is most often with the parents, but there is a considerable variation both individually and among different ethnic groups whether it is the father or the mother who makes this decision. The grandparents or the eldest female on the paternal side may also have a decisive role. When other relatives try to influence the decision, they may pressure the parents by threats to withhold support due to their "wrong" decisions. However, it is considered a "family issue" and parents are usually not subjected to violence or threats of violence. A few cases of relatives disregarding the parents' decision and subjecting the girl to FGM/C are reported, although this is considered to be very unusual.'⁴⁹

5.1.4 The 28TOOMANY FGM 'Nigeria: The Law and FGM', June 2018 stated that: 'Around three-quarters of FGM is carried out by "traditional circumcisers".'⁵⁰

5.1.5 According to data gathered by the 2013 NDHS [Nigeria Demographic and Health Survey] the majority of circumcisions amongst girls and women are performed by a Traditional Agent as illustrated in the table below⁵¹.

⁴⁸ Population Council, 'Understanding Medicalisation FGM/C, p.v-, January 2018, [url](#).

⁴⁹ EASO, 'Country Guidance: Nigeria', p63, February 2019, [url](#).

⁵⁰ 28TOOMANY – 'Nigeria: The Law and FGM', p1, June 2018, [url](#).

⁵¹ NPC - Nigeria Demographic and Health Survey of 2013 (p357), published June 2014 [url](#).

Table 18.8 Aspects of circumcision among circumcised girls age 0-14 and women age 15-49

Percent distribution of circumcised girls age 0-14 by current age and women age 15-49, according to person performing the circumcision and type of circumcision, Nigeria 2013

Background characteristic	Current age of girls			Girls age 0-14	Women age 15-49
	0-4	5-9	10-14		
Person who performed the circumcision					
Traditional agent	87.8	87.2	84.2	86.6	79.5
Traditional circumciser	84.8	84.7	82.0	84.0	72.2
Traditional birth attendant	2.9	2.4	2.1	2.5	7.0
Other traditional agent	0.1	0.1	0.1	0.1	0.2
Medical professional	10.8	11.3	14.1	11.9	12.7
Doctor	0.8	1.1	1.0	0.9	2.3
Nurse/midwife	9.6	9.6	12.5	10.4	9.9
Other health professional	0.4	0.7	0.6	0.6	0.5
Don't know/missing	1.3	1.5	1.7	1.5	7.9
Total	100.0	100.0	100.0	100.0	100.0
Type of circumcision					
Sewn closed	3.1	2.4	2.4	2.7	5.3
Not sewn closed	92.4	92.4	92.6	92.5	77.4
Don't know/ missing	4.5	5.2	5.0	4.9	17.3
Total	100.0	100.0	100.0	100.0	100.0
Number	2,292	2,200	1,658	6,150	9,652

Note: The circumcision status of girls is reported by their mothers.

52

5.1.6 The Premium Times, a Nigerian media organisation based in Abuja, reported in May 2016 that:

‘The Circumcision Descendants Association of Nigeria have advocated the provision of alternative means of livelihood for their members as a way of curbing Female Genital Mutilation practice in south-west Nigeria.

‘At a Summit to End FGM in Nigeria held in Ibadan, Monday, the group said the FGM agenda would be difficult to achieve without the “full involvement” of their members.

‘[...] “Government should also consider a programme for the circumciser’s family to limit the effect on the loss of revenue.”

‘Money is the reason.

‘Gift Abu, a nurse and activist, said native customs contribute to the practice of FGM across the country.

“The circumcisers are the issues,” Ms. Abu told Premium Times.

“So if we get to them first and get their consent for them to drop their knives and accept the campaign, then FGM will be history.”

‘Ms. Abu said the campaign succeeded in convincing about 70 percent of the circumcisers to stop the practice, with the remaining ones being reluctant to follow suit.’⁵³

[Back to Contents](#)

⁵² NPC - Nigeria Demographic and Health Survey of 2013 (p357), published June 2014 [url](#).

⁵³ Premium Times, ‘Nigerian genital cutters give conditions [...]’, 24 May 2016, [url](#).

5.2 Medicalisation of FGM

5.2.1 28 Too Many Nigeria: The Law and FGM', June 2018 noted that 'The VAPP Act does not clearly address FGM carried out by health professionals or in a medical setting; the broad nature of the law, however, would suggest that any member of the medical profession who performs or assists in FGM would also be guilty of a criminal offence and punished accordingly.'⁵⁴

5.2.2 The Population Council published paper 'Understanding Medicalisation FGM/C: A Qualitative study of parents and health workers in Nigeria, January 2018, noted that:

'Despite the local and international call to abandon the practice, there is evidence that some Nigerian families, instead of abandoning the practice outright, are opting for medicalised forms. Medicalisation of FGM/C involves the use of health care providers-doctors, nurses/midwives, or other health professionals-to perform the practice either at facilities or at home; [...]

'Although medicalisation is presumed to reduce the risk of complications, it does not eliminate them and does not alter the fact that FGM/C is a violation of women's and girls' rights to life, health, and bodily integrity. Medicalisation accounts for 12.7 percent of FGM/C practice in Nigeria. There is minimal information on medicalisation in Nigeria beyond the prevalence rates available in the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS). Additionally, there is limited understanding of how medicalisation has evolved or is evolving in Nigeria especially as it relates to the prospect of abandonment. The context of decision-making and rationale around medicalisation for families and health workers and the effect of medicalisation on the severity of cutting is also poorly understood. [...]

'Contrary to widely held views that medicalisation occurs because parents are knowledgeable about the health risks of FGM/C and are attempting to mitigate them through the use of health professionals, we found that parents reported being unaware of FGM/C's possible physical and psychological complications but chose to use health workers because they perceived them as more careful, knowledgeable, skilled, and hygienic when dealing with any health related matter. Health workers were also viewed as providing more options in cases of emergency and complications. Due to the early age at cutting, typically during infancy, the choice of FGM/C provider was often tied to the type of birth attendant (health worker or traditional birth attendant) who delivered the child. The dynamics of convenience, trust, and cost saving drove the choice of birth attendants. For some parents, FGM/C was offered to them as part of routine neonatal care services. The transition to medicalisation in these communities may be an unintended consequence of improved health seeking behaviours and safe birthing messages.

'Although health workers were more knowledgeable than parents about the risks of FGM/C, they performed FGM/C mostly because they shared the same beliefs as community members, on its supposed benefits and perceived approval (or lack of disapproval) by their professional peers.'⁵⁵

⁵⁴ 28TOOMANY – 'Nigeria: The Law and FGM', p.4, June 2018, [url](#).

⁵⁵ Population Council, 'Understanding Medicalisation FGM/C, January 2018, [url](#).

5.2.3 The World Health Organisation in their fact sheet dated January 2018 stated that: 'In many settings, health care providers perform FGM due to the erroneous belief that the procedure is safer when medicalized. WHO strongly urges health professionals not to perform such procedures.'⁵⁶

5.2.4 In the UNFPA-UNICEF, 'Reflections on Phase II of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation' 2018, it was stated that:

'Nigeria is one of the five countries with the highest rates of FGM medicalization in the world. Parents turning to trained health workers to avert the health concerns of FGM has become more common, especially in more developed countries.

'The increase in medicalization among Nigerian girls in younger cohorts suggests the trend is not improving. Moreover, a study of 250 health workers in south-western Nigeria found that almost half had been asked to perform FGM. About a fourth of 182 nurses in Benin City, Nigeria reported that some forms of FGM are not harmful, with 2.8 per cent supporting the practice. In the same sample, well over half of respondents (57.7 per cent) reported that they would still perform FGM in certain circumstances, such as under significant pressure from a girl's or woman's family, for significant financial benefits or to prevent patients from going to traditional cutters.'⁵⁷

5.2.5 The report continues to state that:

'To counteract these tendencies, service providers have been given relevant information, education and communication materials. But clearly this is an area where more progress is needed. Part of the planned strategy to address medicalization in the third phase of the Joint Programme is to engage more with medical associations and regulatory bodies at national, state and community levels. In addition, the Joint Programme will scale up the use of community and health surveillance systems to monitor health workers.'⁵⁸

[Back to Contents](#)

Section 6 updated: 27 June 2019

6. Legal context

6.1 Laws against FGM

6.1.1 The Violence against Persons (Prohibition) Act 2015 prohibits female circumcision, making it a federal offence, with the following penalties:

'6(2) A person who performs female circumcision or genital mutilation or engages another to carry out such circumcision or mutilation commits an offence and is liable on conviction to a term of imprisonment not exceeding 4 years or to a fine not exceeding N200,000.00 or both.

'6(3) A person who attempts to commit the offence provided for in subsection (2) of this section commits an offence and is liable on conviction to a term of

⁵⁶ World Health Organisation, 'Female genital mutilation fact sheet', 31 January 2018, [url](#).

⁵⁷ UNFPA-UNICEF, 'Reflections on Phase II Joint Programme on FGM', 2018, [url](#).

⁵⁸ UNFPA-UNICEF, 'Reflections on Phase II Joint Programme on FGM', 2018, [url](#).

imprisonment not exceeding 2 years or to a fine not exceeding N100,000.00 or both.

'6(4) a person who incites, aids, or counsels another person to commit the offence provided for in subsection (2) of this section commits an offence and is liable on conviction to a term of imprisonment not exceeding 2 years or to a fine not exceeding N100,00.00 or both.'⁵⁹

- 6.1.2 EASO country guidance, Nigeria, February 2019 stated 'In 2015, Nigeria passed new legislation, the Violence Against Persons Prohibition (VAPP) Act, which aims to provide legal framework for the prevention of violence, especially against women and girls. Rape and other forms of violence are penalised. However, this is a federal act and only applies to the Federal Capital Territory. 13 states have similar laws in place.'⁶⁰
- 6.1.3 The US State Department Human Rights report for 2018 (US SD Human Rights Report) noted: 'The VAPP penalizes a person convicted of performing female circumcision or genital mutilation with a maximum of four years in prison, a fine of 200,000 naira (\$635), or both. It punishes anyone convicted of aiding or abetting such a person with a maximum of two years' imprisonment, a fine of 100,000 naira (\$317), or both.'⁶¹
- 6.1.4 The same report continued:
'According to the VAPP, any person convicted of subjecting another person to harmful traditional practices may be punished with up to four years' imprisonment, a fine not exceeding 500,000 naira (\$1,590), or both. [...] For purposes of the VAPP, a harmful traditional practice means all traditional behaviour, attitudes, or practices that negatively affect the fundamental rights of women or girls, to include denial of inheritance or succession rights, FGM/C or circumcision, forced marriage, and forced isolation from family and friends.'⁶²
- 6.1.5 28TOOMANY's 'Nigeria: The Law and FGM', June 2018 observed that: 'The VAPP Act does not provide a clear definition of FGM; Section 6(1) of the law opens with the simple statement, "The circumcision or genital mutilation of the girl child or woman is hereby prohibited." [...]
'The VAPP Act does not expressly criminalise failure to report FGM that has taken place or is due to take place.'⁶³

[Back to Contents](#)

6.2 Federal and State Law

- 6.2.1 28TOOMANY's 'Nigeria: The Law and FGM', June 2018, citing the Constitution of the Federal Republic of Nigeria (1999), noted:
'Nigeria has a federal system of government comprising 36 states, and a mixed legal system of English common law, Islamic law (in 12 northern

⁵⁹ Nigeria: Violence Against Persons (Prohibition) Act, 2015 (VAPP) [Nigeria], 25 May 2015, [url](#).

⁶⁰ EASO, 'Country Guidance: Nigeria', p62, February 2019, [url](#).

⁶¹ US SD Human Rights Report 2018', section 6, 13 March 2019, [url](#)

⁶² US SD Human Rights Report 2018', section 6, 13 March 2019, [url](#)

⁶³ 28TOOMANY – 'Nigeria: The Law and FGM', June 2018, [url](#).

states) and traditional law. The legal system is complex and both levels of government play a role in the enactment of laws prohibiting FGM in Nigeria: although the federal government is responsible for passing general laws, the state governments must then adopt and implement them in their respective states.

'The Constitution of the Federal Republic of Nigeria (1999)⁶⁴ does not specifically refer to violence against women and girls, harmful traditional practices or FGM; Articles 15(2) and 17(2) prohibit discrimination and set out equality of rights respectively, and Article 34(1) provides that every individual is entitled to respect for the dignity of their person and, accordingly, no one 'shall be subject to torture, or to inhuman or degrading treatment.

'The Violence Against Persons (Prohibition) Act, 2015 (the VAPP Act), which came into force on 25 May 2015, is the first federal law attempting to prohibit FGM across the whole country. The VAPP Act aims to eliminate gender-based violence in private and public life by criminalising and setting out the punishment for acts including rape (but not spousal rape), incest, domestic violence, stalking, harmful traditional practices and FGM.

'The VAPP Act, as a federal law, is only effective in the Federal Capital Territory of Abuja, and, as such, the remaining states must pass mirroring legislation to prohibit FGM across the country.'⁶⁵

6.2.2 In the UNFPA-UNICEF, 'Reflections on Phase II of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation' 2018, it was stated that:

'Nigeria's legal landscape is an overlay of federal, state and customary jurisdictions. Harmonization of these requires many steps and can result in wide variations in applicable law, particularly regarding familial matters. Strategic partnerships with political actors and community-based organizations have facilitated adoption of the national statute at the state level. At the time of this publication, 14 of Nigeria's 36 states had passed laws prohibiting FGM, while advocacy continues in the others.'⁶⁶

6.2.3 As explained by a source cited by the Immigration and Refugee Board of Canada in 2016, 'until the completion of the legislative process within the 36 Nigerian states, the VAPP Act "is a mere paper document outside the Federal Capital Territory [FCT]"'.⁶⁷

6.2.4 CEDAW concluded in 2017 with regards to the VAPP that 'The Committee is particularly concerned that the Act, which proscribes female genital mutilation, applies only in the Federal Capital Territory and not in those federal states in which female genital mutilation is prevalent.'⁶⁸

6.2.5 28 Too Many Nigeria: The Law and FGM', June 2018 noted that:

'Some individual states set out their own penalties for FGM. For example:

'Cross Rivers state – The Girl-Child Marriages and Female Circumcision (Prohibition) Law (2000), Section 4 sets out that any person who performs

⁶⁴ The Constitution of the Federal Republic of Nigeria (1999), [url](#).

⁶⁵ 28TOOMANY – 'Nigeria: The Law and FGM', June 2018, [url](#).

⁶⁶ UNFPA-UNICEF, 'Reflections on Phase II Joint Programme on FGM' p.7, 2018, [url](#).

⁶⁷ IRBC – 'Nigeria: Application and enforcement of the May 2015 ban on FGM', 25 January 2016 [url](#).

⁶⁸ CEDAW Concluding observations [...], para 23, 24 July 2017, [url](#)

FGM, offers herself for FGM, coerces, entices or induces another to undergo FGM or allows any female who is either a daughter or ward to undergo FGM is liable on conviction to a fine of not less than 10,000 Naira (US\$27.7011) or to imprisonment not exceeding two years for a first offender (and to imprisonment not exceeding three years without an option of fine for each subsequent offence).

‘Ebonyi state – Following introduction of the VAPP Act, it brought in a five-year prison sentence for anyone who carries out FGM.

‘Edo state – The Prohibition of Female Genital Mutilation Law (1999) sets out the penalty for performing FGM as not less than three years’ imprisonment or a fine of not less than 3,000 Naira (US\$8.3012) or both.

‘Rivers state – The Child Rights Act (2009), Section 25 sets out that any person who directly or indirectly causes a female child to be subjected to FGM is liable on conviction to a fine not exceeding 50,000 Naira (US\$138.6014) or imprisonment for a term of one year, or both.’⁶⁹

[Back to Contents](#)

6.3 State attitudes to FGM

6.3.1 An Immigration and Refugee Board of Canada (IRBC) response on the availability and effectiveness of state and police response in both urban and rural areas of southern Nigeria, for people who refuse to participate in ritual practices November 2016, and citing several sources, showed that:

‘[...] people can report to the police if they do not want to undergo a ritual practice. [...] someone in this situation can either submit a complaint to have such a ceremony stopped or to seek protection. [...] actions taken by police may include the police going to the community and telling the community that the complainant should not be compelled to participate in the ritual practices [...] police may provide police personnel to guard the person. [...]’⁷⁰

6.3.2 However, reporting with specific regard to rituals relating to marriage, marital relations and pregnancy the source noted that ‘The legal practitioner stated that the police would, in general, treat ritual practices related to marriage, marital relations, and pregnancy or widowhood "as a family [or] community affair and not interfere at all”’.⁷¹

6.3.3 The same report went on to state that Southern Nigerian Police appear discriminatory in their treatment of victims of ritual practices, in particular women. Furthermore, an absence of trust in the police stops reporting such practices. Police themselves can be part of the culture and fail to recognise that such ritual practices are criminal. Particularly as some Nigerian police would have originated from communities where these rituals take place who have to respect the culture and traditions and are reluctant to provide protection. The higher the status of the person seeking protection may also influence the likelihood of police protection⁷².

⁶⁹ 28TOOMANY – ‘Nigeria: The Law and FGM’, p.5, June 2018, [url](#).

⁷⁰ IRBC – ‘Availability and effectiveness of state and police response’, November 2016, [url](#).

⁷¹ IRBC – ‘Availability and effectiveness of state and police response’, November 2016, [url](#).

⁷² IRBC – ‘Availability and effectiveness of state and police response’, November 2016, [url](#).

- 6.3.4 The report also indicated that Nigerian police have begun to collaborate with governmental agencies, state governments and women's advocacy groups to improve its response and attitude to harmful ritual practices. This included establishing a Gender Unit at police command and providing shelter for victims as well as prosecuting perpetrators⁷³. (See also [Legal context: Investigations and convictions](#)).
- 6.3.5 The EASO, 'Country Guidance: Nigeria', February 2019, concluded that '[...] in some parts of the country, the capacity of the Nigerian State to provide effective protection is limited, in particular in the states of Borno, Adamawa, Yobe, Plateau, Benue, Nasarawa, Taraba, and Zamfara.'⁷⁴
- 6.3.6 A study brief by the Population Council, 'Exploring the Nigerian Health System's Response to Female Genital Mutilation/Cutting', May 2018 stated:
 'Although Nigeria has shown a steady long-term decline in female genital mutilation/cutting (FGM/C) prevalence, the practice remains widespread. The health system offers a good platform to facilitate FGM/C abandonment and provide care to survivors. However, it is unclear if and how the health system in Nigeria implements existing FGM/C related policies, guidelines, and laws. [...]
 'Little is known about the capacity of different cadres of health workers to implement FGM/C prevention and management activities or the existence of protocols, guidelines, policies, and training courses to guide such activities. The quality of care that women and girls receive when they present to a health facility with FGM/C related complications also remains unclear.'⁷⁵
- 6.3.7 Furthermore, the Population Council published a paper called Understanding Medicalisation FGM/C: A Qualitative study of parents and health workers in Nigeria, January 2018, in which it was noted that:
 '[...] it is important to note that medicalisation of FGM/C in Nigeria is occurring within a health system that is weak and plagued by poor coordination, the fragmentation of services, insufficient resources including drugs and supplies, inadequate and decaying infrastructure, inequity in resource distribution and access to care, and very poor quality of care. The Nigerian health system is also ineffectively regulated which contributes to the existence of phenomena such as non-trained or unlicensed individuals providing health services to an unknowing public and trained health providers violating professional and/or health facility norms by engaging in unethical behaviour like the provision of FGM/C.'⁷⁶
- 6.3.8 According to the 2016 Annual Report of the UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, published July 2017:
 'The National Response Plan to FGM/C and the Campaign to End FGM/C were launched by the wife of the President. Sixty-four media houses (18 television, 13 radio and 33 newspapers) reported on the event. This event

⁷³ IRBC – 'Availability and effectiveness of state and police response', November 2016, [url](#).

⁷⁴ EASO, 'Country Guidance: Nigeria', p95, February 2019, [url](#).

⁷⁵ Population Council, Study Brief, May 2018, [url](#).

⁷⁶ Population Council, 'Understanding Medicalisation FGM/C, p3, January 2018, [url](#).

was repeated in six states (Ebonyi, Ekiti, Imo, Osun, Lagos and Oyo) by wives of governors of these states in collaboration with other key stakeholders. Twelve key policy statements supporting FGM/C abandonment from government (executive, legislature, judiciary), traditional rulers and religious leaders were delivered at the launch of the governors wives' campaigns to end FGM/C.⁷⁷

6.3.9 They also reported that: 'The Violence Against Persons Prohibition Act was enacted in Oyo State.'⁷⁸

6.3.10 The report went onto note that:

'High-level discourse was strengthened and leveraged to generate stronger commitments from policy, legislative and community actors to enact legislation and provisions to curb impunity for FGM/C. Immediate results have been the formation of state committees and a taskforce to (a) review provisions within FGM/C legislation, with a view to advancing efforts for reforms, and (b) promote advocacy to develop enforcement mechanisms for existing legislation.

'Support is being provided to the initiative to review and integrate FGM/C indicators into the National Health Information Management Systems. Efforts are also being made to integrate FGM/C into gender-based violence provisions within humanitarian programming and assistance.'⁷⁹

6.3.11 In the UNFPA-UNICEF, 'Reflections on Phase II of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation' 2018, it was stated that:

'The message that the federal government stands against FGM has been widely publicized across multiple media channels [...] and in community forums, schools and health centres. This is a critical first step in ending impunity. More needs to be done in terms of judicial responses and enforcement, however. The National Policy and Plan of Action for the Elimination of FGM in Nigeria (2013-2017) has been widely disseminated to ensure alignment with the provisions of the new law. Information about current laws and the mechanics of application has reached nearly 10,000 people including legislators, government actors and community members. A workshop for lawyers addressed interpretation and implementation of the new act, and 2,000 copies of the workshop report were shared with community service organizations, government partners and youth organizations. Multisector state teams, including health workers, social workers, child protection networks, social media advocates and the Federation of Women Lawyers have been engaged to work with schools and communities, fuelling momentum.'⁸⁰

6.3.12 A This Day report from June 2016 noted:

'[...] the Governor of Oyo state, Sen. Abiola Ajimobi, said the administration is highly committed to tackling the issue, noting that the state would not

⁷⁷ 2016 report UNFPA-UNICEF Joint programme on FGM/C: Accelerating Change, July 2017, [url](#).

⁷⁸ 2016 report UNFPA-UNICEF Joint programme on FGM/C: Accelerating Change, July 2017, [url](#).

⁷⁹ 2016 report UNFPA-UNICEF Joint programme on FGM/C: Accelerating Change, July 2017, [url](#).

⁸⁰ UNFPA-UNICEF, 'Reflections on Phase II Joint Programme on FGM', 2018, [url](#).

hesitate to bring the full force of the law to bear on anyone found guilty of any acts of mutilation, harmful traditional practice or act of violence.

'Ajimobi stressed that the elimination of FGM is a specific target under Goal 5 of the Sustainable Development Goals (SDGs), adding that his government would ensure that all the requisite laws and policies are put in place and enforced in order to achieve this goal.

'[...] "Let me state here that even though the legal framework has been put in place to fight this menace, we must now support it with deliberate action by seriously advocating for a culture shift. Community leaders have a role to play in bringing this issue to its knees.

"We must also take note that while advocating for a culture shift, the advocates of this gruesome act must also have a rethink and a mind reset in order for the laws passed to become effective. They must have a change in attitude stemming from a personal conviction of the incalculable harm that is done to victims of these acts of mutilation." ⁸¹

6.3.13 The 28 Too Many FGM in Nigeria Country Profile noted '[...] Speaking at a recent meeting on violence against women organised by New Initiative for Development, its Executive Director, Abiodun Oyeleye, said, 'There is a general apathy on the issue of violence against women on the part of the police institution. [...]' ⁸²

6.3.14 Another 2016 Immigration and Refugee Board of Canada response to information request noted:

'[academic] sources report that in cases of refusal to take part in ritual practices, it is possible to turn to state actors and civil society organizations... as well as religious institutions as a means of protection...According to [a] Lecturer [professor of African history], women seeking recourse against a forced FGM procedure may seek assistance from the police, the Lagos State Ministry of Social Welfare, the Office of the Public Defender, numerous NGOs, churches/mosques, and community leaders...The doctoral candidate added that it is possible to seek counselling from traditional rulers, priests, and pastors. However, according to German political research foundation Bertelsmann Stiftung, "[c]oncerning women and girls, in particular of lower [socio-economic] status, the State still lacks the capacity to protect them against violence, including [...] female circumcision and abuse by customary law" ⁸³

6.3.15 A Punch article from May 2016 noted:

'The Nigeria Police Force had created a "public friendly" gender unit across the country to prosecute anyone culpable of Sexual and Gender-Based Violence [...] According to [The Inspector General of Police] the project is scheduled to cover the six geo-political zones and with pilot schemes done in, Kano, Imo, Edo, Ondo, Lagos and Borno States and the FCT respectively. The North-West, South-West, North Central, South-South and

⁸¹ This Day – Female Genital Mutilation: Another Hindrance to Devt, 23 June 2016 [url](#).

⁸² 28 Too Many – Country Profile: FGM in Nigeria (p63), October 2016 [url](#).

⁸³ IRBC - Nigeria: 'Prevalence of FGM [...]' 13 September 2016 [url](#).

North-East had been covered, using Kano, Imo Edo and Gombe States as well as the FCT for their pilot schemes [...]' ⁸⁴

- 6.3.16 The 2016 Bertelsmann Stiftung Transformation Index Nigeria country profile noted that: 'Concerning women and girls, in particular of lower status, the state still lacks the capacity to protect them against violence, including [...] female circumcision and abuse by customary law.'⁸⁵

[Back to Contents](#)

6.4 Protection - Enforcement and effectiveness of the law

- 6.4.1 The US SD Human Rights Report noted: 'Federal law criminalizes female circumcision or genital mutilation, but the federal government took no legal action to curb the practice. While 12 states banned FGM/C, once a state legislature criminalizes FGM/C, NGOs found they had to convince local authorities that state laws apply in their districts.'⁸⁶

- 6.4.2 EASO country guidance, Nigeria, February 2019, stated 'Federal legislation prohibits FGM/C of a girl or a woman and relevant state legislation is in place in several Nigerian states. However, no legal action to curb the practice is reported.'⁸⁷

- 6.4.3 The 2018 DFAT report stated:

'The federal government publicly opposes FGM, but it has not criminalised the practice [this statement conflicts with other information provided in this report with regard the VAPP Act 2015 which prohibits female circumcision, making it a federal offence]. The government has predominantly focused on public education campaigns run by the Ministry of Health. Some southern states, including Bayelsa, Edo, Ogun, Cross River, Osun, and Rivers States, have criminalised FGM under state law. Several other states are introducing similar legislation. Several international and local NGOs are also working to reduce the practice in Nigeria, including the World Health Organisation, United Nations International Children Emergency Fund and the African Union.

'DFAT assesses as credible advice from local sources that it remains extremely difficult for women and girls to obtain protection from FGM. Despite an increase in reports received by the Nigerian Police Force (NPF) and the National Human Rights Commission (NHRC), strong community support for the practice and traditional attitudes of police suggest FGM is likely to continue.'⁸⁸

- 6.4.4 The Organisation for Economic Co-operation and Development (OECD) Social Institutions and Gender Index, citing various sources, stated:

'Under the Violence against Persons Prohibition (VAPP) Act 2015, female genital mutilation (FGM) is prohibited, penalizing those who perform the act with varying lengths of imprisonment and a fine. Moreover, those who engages another to perform FGM may also be prosecuted. While the VAPP

⁸⁴ Punch – Police inaugurates gender unit to fight sexual, gender-based violence, 13 May 2016 [url](#).

⁸⁵ Bertelsmann Stiftung Transformation Index – 2016 Nigeria Country Profile, 1 January 2016 [url](#).

⁸⁶ US SD Human Rights Report 2018', section 6, 13 March 2019, [url](#)

⁸⁷ EASO, 'Country Guidance: Nigeria', p62, February 2019, [url](#).

⁸⁸ DFAT, 'Country of Information Report – Nigeria', p21, 9 March 2018, [url](#).

Act applies within the Federal Capital Territory, it still needs to be passed in each of the 36 States of the Federation in order to become national law. To date, some states have passed the VAPP Act, however others have not, particularly those where FGM is prevalent. Reportedly, 12 states have banned FGM including the Bayelsa, Edo, Ogun, Cross River, Osun, and Rivers States.⁸⁹

- 6.4.5 28 Too Many Nigeria: The Law and FGM', June 2018 and citing other sources noted that: 'Civil society is concerned that the law is not yet deterring the traditional cutters who rely on FGM to maintain their income and status in the community, and that the law will push the practice underground. It is also suggested that medicalised FGM, which the law does not directly address, is on the increase in Nigeria and there is an urgent need to engage key medical regulatory bodies such as the Nigerian Medical Association.'⁹⁰
- 6.4.6 Citing several sources OECD in 'Social Institutions and Gender Index', 2019, stated 'The government and local NGOs and women's groups have made efforts to raise public awareness about the health risks of FGM. Other states default to customary law where FGM is legal and widely practiced. Given the lack of uniformity in law, ineffective monitoring mechanisms of the practice, minimal penalties for practicing FGM and overall public lack of awareness of the law, FGM continues to be prevalent in the country.'⁹¹
- 6.4.7 28 Too Many Nigeria: The Law and FGM', June 2018 and citing other sources noted that:
'The details of anti-FGM legislation are not yet widely known or understood by many, including local police, and the public generally do not generally have access to the law or justice stakeholders. A recent survey by a local NGO, Society for the Improvement of Rural People (SIRP), among its community of the southern state of Enugu, found that 95% of respondents had not heard of the VAPP Act. [...] Where public information is available, it is not always translated into local languages. Anti-FGM projects are also hampered by a lack of enforcement of the law at the local level and the continuing challenge of violence against women across Nigeria. It is noted that the lack of both reported cases of FGM and information-sharing across the country is due to the reluctance of families to report FGM and risk going to court, and the absence of a centralised information-gathering and reporting system. Civil society identifies a need for local police and judiciary to be sensitised around anti-FGM legislation, but there are positive signs in some states where laws are in place; for instance law-enforcement agencies, including the police, the Nigeria Security and Civil Defence Corps (NSCDC) and Nigeria Immigration Services (NIS), have received training in Osun where FGM prevalence is highest at 76.6%.⁹²
- 6.4.8 A Nigeria Observer News article from June 2016 noted:

⁸⁹ OECD 'Social Institutions and Gender Index', 2019, [url](#).

⁹⁰ 28TOOMANY – 'Nigeria: The Law and FGM', June 2018, [url](#).

⁹¹ OECD 'Social Institutions and Gender Index', 2019, [url](#).

⁹² 28TOOMANY – 'Nigeria: The Law and FGM p.6', June 2018, [url](#).

'The Chief Judge while advising that emphasis be laid on sensitizing the people on the health implications of the practice however noted that the challenge of enforcement of the law stems from the fact that the practice is accepted by some traditions and customs as a rite of passage.

'[...] the commissioner of Police, Edo State, Mr. Chris Ezike represented by DCP Walter Inyang rebuffed the allegation that the police had failed in arresting offenders of the FGM law. He stressed that the major reason the police were yet to either charge or convict anyone guilty of FGM, was because there have been no reported complaints from anyone on the issue as the police cannot act in vacuum in such regard. However, there have been some claims that even where such incidents have been reported to the police in the past, they have been inclined to perceive such as issues within *traditional domains that are better resolved without police intervention.*'⁹³

6.4.9 *The Freedom House 2018 Freedom in the World Report noted: 'Despite the existence of strict laws against rape, domestic violence, female genital mutilation, and child marriage, these offenses remain widespread, with low rates of reporting and prosecution.'*⁹⁴ This repeated their assessment from their [2016](#) and [2017](#) reports.

6.4.10 An Immigration and Refugee Board of Canada response to information request from January 2016 noted:

'The Regional Director for Africa of the ICRW [International Center for Research on Women] stated that "evidence of [the VAPP's] enforcement since it came into force has not yet emerged" and that "[t]he most significant impact [of the law] has been in the form of publicity"... According to the same source however, [c]riminalisation of entrenched cultural practices has its limitations. While legal safeguards are an important step towards ending FGM, they are not enough to eliminate it. Ending violence against women and girls requires investment, not just laws written in statute books.'⁹⁵

[Back to Contents](#)

6.5 Cross border FGM

6.5.1 The 28 Too Many 'Nigeria: The Law and FGM', June 2018, stated:

'In some countries where FGM has become illegal, the practice has been pushed underground and across borders to avoid prosecution. Nigeria shares borders with other countries where the existence and enforcement of laws varies widely, including Benin, Cameroon and Niger. There is a lack of information on whether the movement across national borders for the purpose of FGM is an issue for Nigeria.

'The VAPP Act does not directly address cross-border FGM: it neither criminalises nor punishes FGM carried out on or by Nigerian citizens in other countries.'⁹⁶

[Back to Contents](#)

⁹³ Nigeria Observer News – 'FGM: Growing Incidence Generates Fresh Concern', 3 June 2016 [url](#).

⁹⁴ Freedom House – 2018 Freedom in the World Report, 4 February 2019, [url](#).

⁹⁵ IRBC – 'Nigeria: Application and enforcement of the May 2015 ban on FGM', 25 January 2016 [url](#).

⁹⁶ 28TOOMANY – 'Nigeria: The Law and FGM', June 2018, [url](#).

6.6 Investigations and convictions

- 6.6.1 According to the 2016 Annual Report of the United Nations Population Fund/United Nations Children's Fund (UNFPA–UNICEF) Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, published July 2017: 'There were no cases of law enforcement in 2016.'⁹⁷
- 6.6.2 28 Too Many stated: 'It has not been possible to identify any prosecutions brought under the VAPP Act in Nigeria since its introduction in 2015.'⁹⁸
- 6.6.3 An article by The Cable, a Nigerian on-line newspaper, 'Two years after ban, FGM still rampant in Nigeria' published 3 August 2017 also comments that despite the prevalence of FGM in Nigeria still no one has been convicted. Family members who are usually the offenders are hard to condemn or report as the occurrence of FGM often stays in the family⁹⁹.
- 6.6.4 For information generally on the willingness and ability of the state to offer protection, see the country policy and information notes on [Nigeria: Actors of Protection](#) and [Nigeria: Gender-Based Discrimination/Harm/Violence Against Women](#).

[Back to Contents](#)

Section 7 updated: 27 June 2019

7. Societal attitudes to FGM

- 7.1.1 A 2016 Immigration and Refugee Board of Canada response to information request noted:
- 'According to sources, FGM is a "deeply" engrained cultural practice. [...] it is incumbent on both woman and man, either from the same or different ethnic groups (especially in the Southwest, Southeast and South-South) to socialise their children according to the traditions of their home towns since they know the appropriate ritual practice is part of the ways their children can prove they are rightful members of their mother's and father's kin groups or home communities.[...]
- "intergroup relationship[s]" sometimes affect one's ability to refuse FGM, and cited the example of a "family where the [grandmother] from the wife's side would carry out this act unknown to the father of the victim". [...]
- 'The Professor of African history stated that that "[i]n a conservative family a refusal could lead to withdrawal of family/communal support" and that "poor women risk neglect by their husbands". [...] The Lecturer also indicated that consequences for refusing to take part in FGM within Lagos State or by members of the Edo ethnicity could include ostracism, stigmatisation and blackmailing, denial of intracultural benefits and physical abuse. [...]
- 'The same source indicated that while there are laws at the national level and in some states to protect girls or women who refuse to take part in FGM, she expressed the doubt that many would have the courage "to take their

⁹⁷ 2016 Annual report UNFPA-UNICEF, FGM/C: Accelerating Change, July 2017, [url](#).

⁹⁸ 28TOOMANY – 'Nigeria: The Law and FGM', p.5, June 2018, [url](#).

⁹⁹ The Cable, 'Two years after ban, FGM still rampant in Nigeria' 3 August 2017, [url](#).

parents or grandparents to court", explaining that "[t]hese are the persons who demand compliance of the practice in culture[s] where it is the norm".¹⁰⁰

7.1.2 The EASO, 'Country Guidance: Nigeria', February 2019, stated that:

'Social factors, such as the level of education of the parents, further influence the practice of FGM/C. The most widespread justification for FGM/C in Nigeria is the concern that contact between the clitoris and the baby's head during birth is lethal or harmful for the baby. Other cultural considerations are cleanliness or hygiene, prevention of promiscuity, enhancing fertility and fulfilled womanhood. There are also concerns that men refuse to marry women who have not been circumcised.'¹⁰¹

7.1.3 Furthermore, the Population Council published a paper entitled 'Understanding Medicalisation FGM/C: A Qualitative study of parents and health workers in Nigeria, January 2018, in which it was noted that:

'Decision-making for whether a girl is cut usually revolved around her parents and grandmother, either paternal or maternal. In some families, the decision was an agreement between husband and wife. The mother did not have FGM/C performed on the child without the father's knowledge, and indeed fathers seemed to hold the power in final decision-making. Although it was often the mother who would take the child for the procedure, the father was fully aware of the decision and gave money for that purpose. In some cases, husbands were the sole decision-makers and wives complied with their wishes while in others, husbands deferred to their wives' decisions as they felt their wives would know better about the need for the practice since they were female. [...]

'In one instance, a maternal grandmother took the girl to be cut against the wishes of the child's mother and although the mother was angry there was nothing done about it. [...]

'Reasons parents gave for cutting their daughters were largely tied to the ideas that they had about the clitoris and the negative consequences of its non-removal. As described above, parents cut their daughters for the following reasons: to prevent promiscuity and marital infidelity, to ensure marriageability and fertility, to ease child birth, prevent neonatal mortality, to meet cultural standards for the appearance of female genitalia, and to prevent genital itching. Some parents also felt a strong desire to fulfil the culture/tradition that had been passed down from their ancestors or to conform to the social norms around them. Two parents (a mother and a father) in Kaduna, expressed the belief that female "circumcision" was required or viewed positively by Islam.'¹⁰²

7.1.4 Epundu UU, Ilika AL, Ibeh CC, Nwabueze AS, Emelumadu OF, Nnebue CC. The Epidemiology of Female Genital Mutilation in Nigeria. - A Twelve Year Review Afrimed Journal 2018; 6 (1): 1-10 describes that:

'Several reasons have been advanced for FGM, many of which border on tradition and culture. Other reasons include ensuring better marriage

¹⁰⁰ IRBC - Nigeria: 'Prevalence of FGM [...]' 13 September 2016 [url](#).

¹⁰¹ EASO, 'Country Guidance: Nigeria', p63, February 2019, [url](#).

¹⁰² Population Council, 'Understanding Medicalisation FGM/C' p.16-17, January 2018, [url](#).

prospects for the women, protection of their virginity, preventing promiscuity by reducing a woman's sexual desire and increasing her faithfulness to her husband, promoting cleanliness as well as increased sexual satisfaction for husbands. Some others have the belief that women who have undergone FGM are more fertile and have an easier time giving birth as it improves their ability to tolerate the pain of childbirth. Research has shown that social factors such as peer pressure, societal acceptance and parental pressure borne out of fear of ostracism and family shame contribute to the perpetuation of FGM.¹⁰³

7.1.5 In the UNFPA-UNICEF, 'Reflections on Phase II of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation' 2018, it was stated that:

'The Nigerian case also reveals the complexity of the challenge: The country comprises about 374 identifiable ethnic groups, with the Hausa, Yoruba and Igbo as the major ones. Each speaks its own distinct indigenous language, and practises a variety of forms of FGM in different contexts and with different rationales, although taming female sexuality seems to be the predominant one.

'While sociocultural beliefs vary across communities, they are often sustained by the gender inequality embedded in Nigeria's mostly patriarchal cultures. FGM remains widespread in the five Nigerian states (Ebonyi, Ekiti, Imo, Osun and Oyo).¹⁰⁴

7.1.6 A Nigeria Observer News article from June 2016 noted:

'Early this year, in Ebhoiyi quarters of Uromi, Esan North East Local Government Area of Edo State, a prince who reportedly rebuffed attempts by the locals to circumcise his daughter met with stiff resistance and serious threat to his life and that of his immediate family. Determined not to succumb to the practice, he fled the community to escape jungle justice. However, this experience is not peculiar to the said prince from Uromi as ample cases of such incidences abound across the length and breadth of Uromi and Ivue.¹⁰⁵

7.1.7 The Nigeria Guardian reported that in December 2017 a woman 'who lives in Ifira, Akoko South East council of Ondo State, was threatened with banishment by community youths and leaders for her refusal to allow a forcible circumcision of her two daughters. [...] The Akoko community, despite international outcries against the cultural practice, threatened to attack and banish them, subjecting the victims to serial abuses and dehumanisation. Out of despair, the couple had no option than to concede to the community's demands, though they knew it was an abuse of their daughters, womanhood and humanity at large.¹⁰⁶

7.1.8 The same source described a further case of a man who had received five letters from elders' warning him to circumcise his daughters. [...] The fifth letter stated: "If you refuse to heed our demand before your first daughter clocks two years in November, 2017, we will initiate the family rituals and

¹⁰³ Epundu UU, et al, 'The Epidemiology of FGM in Nigeria', Afrimedical Journal 2018; 6 (1): 1-10, [url](#).

¹⁰⁴ UNFPA-UNICEF, 'Reflections on Phase II Joint Programme on FGM', 2018, [url](#).

¹⁰⁵ Nigeria Observer News – 'FGM: Growing Incidence Generates Fresh Concern', 3 June 2016 [url](#).

¹⁰⁶ The Guardian (Nigeria), [...] still a big threat to Nigerian girl-child survival, 14 January 2018, [url](#)

invoke the spirit of our ancestors against you, your wife and daughter; and you know the repercussions.’¹⁰⁷

- 7.1.9 A May 2018 This Day article described that in Lagos, one woman’s ‘attempt to prevent her daughters from being subjected to the outlawed tradition of Female Genital Mutilation (FGM) has seen her go through the worst kind of torture; from mental and physical abuse to abduction and then rape at the hands of her abductors.’¹⁰⁸ It should be noted however that this is a one-off news article and isn’t necessarily reflective of the general situation.
- 7.1.10 The NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, February 2018 with regard the approval of FGM in Nigeria reported that 67.5% of women aged 15-49 years state that FGM/C should be discontinued¹⁰⁹.

Table CP.12: Approval of female genital mutilation/cutting (FGM/C)

Percentage of women age 15-49 years who have heard of FGM/C, and percent distribution of women according to attitudes towards whether the practice of FGM/C should be continued, Nigeria, 2016-17

	Percentage of women who have heard of FGM/C	Number of women age 15-49 years	Percent distribution of women who believe the practice of FGM/C should be:					Total	Number of women age 15-49 years who have heard of FGM/C
			Continued ¹	Discontinued	Depends	Missing /Don't know	Total		
Total	52.1	34,376	21.6	67.5	7.6	3.3	100	17,925	
110									

- 7.1.11 The figures provided by MICS above are comparable to those in the National Population Commission - Nigeria Demographic and Health Survey of 2013 which showed that 64% of women and 62% of men think that the practice of female circumcision should not continue¹¹¹.

- 7.1.12 The Population Council published a paper ‘Understanding Medicalisation FGM/C: A Qualitative study of parents and health workers in Nigeria, January 2018, concluded that:

‘Families in these [Nigerian] communities still hold strongly to societal beliefs and expectations sustaining FGM/C practice and choose medicalisation due to their trust in the quality of services of health workers and health facilities and not out of being knowledgeable or afraid of health complications. Families still view FGM/C as a minor, highly beneficial, and essential procedure with minimal negative effects, which is detrimental to current abandonment efforts. This perception may be due to minimal public discussion of FGM/C, early ages for cutting, the predominant type of FGM/C practiced (clitoridectomy), limited knowledge of the extent of the FGM/C procedure and its complications, and possibly fewer FGM/C complications in their communities than in those practicing more extensive types of cutting.’¹¹²

- 7.1.13 The 2016 Annual Report of the UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, published July 2017

¹⁰⁷ The Guardian (Nigeria), [...] still a big threat to Nigerian girl-child survival, 14 January 2018, [url](#)

¹⁰⁸ This Day, Nigeria: A Mother's Fight Against Female Circumcision, 30 May 2018, [url](#)

¹⁰⁹ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, p240, February 2018, [url](#).

¹¹⁰ NBS/UNICEF, Multiple Indicator Cluster Survey (MICS), 2016-17, p240, February 2018, [url](#).

¹¹¹ NPC - Nigeria Demographic and Health Survey of 2013 (p345), published June 2014 [url](#).

¹¹² Population Council, ‘Understanding Medicalisation FGM/C, p28, January 2018, [url](#)..

noted that social media was being used to reach out to a wider audience with regard FGM in Nigeria. The hashtag #Endcuttinggirls was mobilized on Twitter, and a Facebook page of the same name has received 3341 “likes”. A 13-part radio drama on FGM/C (Pim Pim) was produced by 10 stations in five states, and 124 media professionals participated in the International day of Zero Tolerance for FGM/C. Media platforms in use are: Twitter (www.twitter.com/endcuttinggirls and hashtag #endcuttinggirls), Facebook (www.facebook.com/endcuttinggirls), Blogsite (www.endcuttinggirls.org) and WhatsApp (EndFGM/C #endcuttinggirls)¹¹³.

- 7.1.14 The #endcutting girls website draws attention to its: ‘Weekly Twitter Conference of the Endcuttinggirls Social Media Campaign; a UNICEF-supported activity under the UNFPA-UNICEF Joint Programme on Elimination of FGM): Accelerating Change (Phase III) in Nigeria.’¹¹⁴
- 7.1.15 PM News, a daily newspaper published in Lagos reported on 6 February 2019 that while marking International day of Zero Tolerance the Wife of the Ebonyi State Governor, Mrs Rachael Umahi, declared that the prevalence rate of Female Genital Mutilation (FGM) in the Ebonyi state dropped from 74.4% in 2016 to 42.3% in 2018. Mrs Umahi commended the state government as well as traditional and religious leaders and UNFPA, for their support to end the practice in Ebonyi¹¹⁵.
- 7.1.16 A Nigeria Observer News report from June 2016 noted:
‘[...] investigations have revealed that FGM is an acceptable traditional practice observed by the female gender in most communities in Nigeria, Edo State inclusive, which is believed to prepare the female gender, culturally, for a fulfilled womanhood and motherhood. And there are elements in every community that are determined to ensure that this illicit practice continues in perpetuity despite legislative prohibition. Normally, those who refuse to subject their infant children and wards to this practice are regarded as renegades who are invariably targeted for primitive punishments and attacks.
‘Although it negates global best practices, the level of obduracy of the adherents of Female Genital Mutilation is alarming and today; it seems as if there is a violent clash of culture and tradition with the law on FGM as passed by the State Assembly.’¹¹⁶
- 7.1.17 The Population Council published a paper ‘Understanding Medicalisation FGM/C: A Qualitive study of parents and health workers in Nigeria, January 2018, concluded that:
‘FGM/C elimination strategies have to consider the entire spectrum of risk involved in the practice and address issues of gender equality including women’s sexual rights and bodily integrity. Abandonment messages need to target mothers, fathers, and grandmothers, who serve as the key decision-makers for whether girls are cut or not. Actively engaging health workers in advocacy efforts is also necessary, as they can support community

¹¹³ 2016 Annual report UNFPA-UNICEF, FGM/C: Accelerating Change, p28, July 2017, [url](#)

¹¹⁴ #endcuttinggirls, Blog – tweet conference script, 25 June 2019, [url](#).

¹¹⁵ PM News, ‘We have achieved reduction in FGM in Eonyi – Rachael Umahi’ 6 February 2019, [url](#).

¹¹⁶ Nigeria Observer News – ‘FGM: Growing Incidence Generates Fresh Concern’, 3 June 2016 [url](#).

sensitisation efforts and de-legitimise the practice for their peers and patients. Interventions focused on health workers must view them not only within their professional capacities but also as community members functioning within FGM/C friendly socio-cultural milieus who may share community social norms.’¹¹⁷

[Back to Contents](#)

7.2 Support groups

7.2.1 The 2016 Annual Report of the UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, published July 2017 gave the following Nigerian NGOs and support groups working with UNFPA–UNICEF Joint Programme:

‘Action Health Incorporated

‘Centre for Women Studies and Intervention

‘Family Succour and Upliftment Foundation, Ebonyi State

‘Hope for Women in Nigeria Initiative

‘Shericare Foundation

‘Society of Obstetric and Gynaecology of Nigeria

‘Young Men’s Network

‘Youthhubafrica’¹¹⁸

7.2.2 The ‘about us’ on the #endcuttinggirls webpage states that they work in 5 states of Nigeria (Ebonui, Ekiti, Imo, Osun, Oyo) and describe their mission and aims on their website as:

‘To contribute to the abandonment of FGM/C and other forms of violence against women and girls through accelerating positive change towards a social norm of not cutting girls by Youth Advocates of diverse organisations, duty bearers, rights holders and affected communities.’¹¹⁹ And ‘Our aim is to provide a knowledge base, good practice models and support networks to help anti-FGM/C campaigners and organisations working with communities to end FGM/C.’¹²⁰

7.2.3 The October 2016 28 Too Many FGM in Nigeria Country Profile noted:

‘Although there are many NGOs active in particular areas of Nigeria to eliminate FGM through the education of traditional and religious leaders, working with health professionals, and talking to women and girls about the dangers of FGM, 28 Too Many has been unable to find a national or state level network that brings these organisations together. The setting up of such a network at a federal level, with state-level subsidiaries, would help facilitate exchanges of information and ideas as to what works most effectively to achieve abandonment of the practice.’¹²¹

¹¹⁷ Population Council, ‘Understanding Medicalisation FGM/C’ p.vi, January 2018, [url.](#)

¹¹⁸ 2016 Annual report UNFPA-UNICEF, FGM/C: Accelerating Change, (p 58) July 2017, [url.](#)

¹¹⁹ #endcuttinggirls, ‘About us’, – Our vision and mission, undated, [url.](#)

¹²⁰ #endcuttinggirls, ‘About us’, – Our vision and mission, undated, [url.](#)

¹²¹ 28 Too Many – Country Profile: FGM in Nigeria, p54, October 2016 [url.](#)

7.2.4 The same report provided information about a number of international, national and local organisations employing wide-ranging strategies in the country¹²². (See also the country policy and information note on [Nigeria: Women fearing gender-based violence](#)).

7.2.5 The UK published in 2016 a [Multi-Agency Statutory guidance](#) on FGM.

[Back to Contents](#)

Section 8 updated: 27 June 2019

8. Freedom of movement

8.1.1 For information on freedom of movement, see the country policy and information notes on [Nigeria: Internal Relocation](#) and [Nigeria: Gender-Based Discrimination/Harm/Violence Against Women](#) as well as the [Nigeria Country Background Note](#).

8.1.2 For background information on Nigeria, including transport and the provision of health and social care see [IOM Country Fact Sheet: Nigeria](#) and [Country policy and information note: medical and healthcare issues, Nigeria](#) .

[Back to Contents](#)

¹²² 28 Too Many – Country Profile: FGM in Nigeria (p54-60), October 2016 [url](#).

Terms of Reference

A 'Terms of Reference' (ToR) is a broad outline of what the CPIN seeks to cover. They form the basis for the [country information section](#). The Home Office's Country Policy and Information Team uses some standardised ToRs, depending on the subject, and these are then adapted depending on the country concerned.

For this particular CPIN, the following topics were identified prior to drafting as relevant and on which research was undertaken:

- FGM
 - Prevalence
 - FGM by Type
- Actors of Harm
- State attitudes, incl. the law on FGM
 - Protection and effectiveness of the Law
 - Investigations and convictions
- Societal attitudes
 - Attitudes to FGM
 - Social Media
 - Support available

[Back to Contents](#)

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[Back to Contents](#)

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Version control

Clearance

Below is information on when this note was cleared:

- version **2.0**
- valid from **14 August 2019**

Changes from last version of this note

Updated country information.

[Back to Contents](#)

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