
28 TOO MANY
FGM... let's end it.
ORCHID PROJECT
FGM/C in Nigeria:
Key Findings
March 2023

The **Nigeria Country Profile Update (2023)** provides comprehensive information on the most recent trends and data on FGM/C in Nigeria. It includes an analysis of the current political situation, an outline of the legal frameworks and recommendations on how to move toward eradicating the practice. The report serves as an update to **28 Too Many's 2016 Nigeria Country Profile**. Its purpose is to equip activists, practitioners, development partners and research organisations with the most up-to-date information to inform decision-making on policy and practice in the Nigerian context.

What is Happening?

The prevalence of FGM/C in Nigeria appears to be decreasing. In 2013, 24.8% of women aged 15–49 years had been cut, and in 2018 this figure was down to 19.5%.[1] In 2018, 13.7% of women in Nigeria aged 15–19 had undergone FGM/C, as opposed to 31.0% of women aged 45–49.[2]

Prevalence among women aged 15–49 who reside in **urban** areas has dropped from 32.3% to 24.2%. There has been a similar drop among women in this age group who reside in **rural** areas, from 19.3% to 15.6%

Although these figures indicate that there has been significant progress in Nigeria, when the data are broken down into different cohorts, **there are some worrying trends**.

Particularly, there is a trend emerging among **girls aged 0–14**. Within this age group, there was no change in FGM/C prevalence among girls living in urban areas and those whose mothers have secondary-level or higher-level educations. However, among girls aged 0–14 who live in rural areas, there was an *increase* in prevalence from 17.0% (in 2013) to 21.1% (in 2018). Among girls in this age group whose mothers do not have formal educations, prevalence increased from 19.3% to 24.4%, and for those in the lowest wealth quintile, prevalence increased from 19.4% to 26.6%.[3] Among girls who have been cut, the percentage whose mothers are *not* cut has doubled.[4]

There is some evidence from interviews that at least part of the reported decrease in prevalence is due to **social-desirability bias** and **communities' self-surveilance of cutting**, a result of which is that women are more reluctant to report that they or their daughters have been cut. It is likely that the introduction of the Violence Against Persons (Prohibition) Act is one cause.

This is unusual and a matter of concern. Further research into why this is so would be useful, but in a 2013 report UNICEF emphasies the problem of **a 'culture of silence'** in Nigeria, in which there is a gap between people's personal views of FGM/C and their feelings of social obligation to have girls undergo cutting and a lack of agency in decision-making.[5]

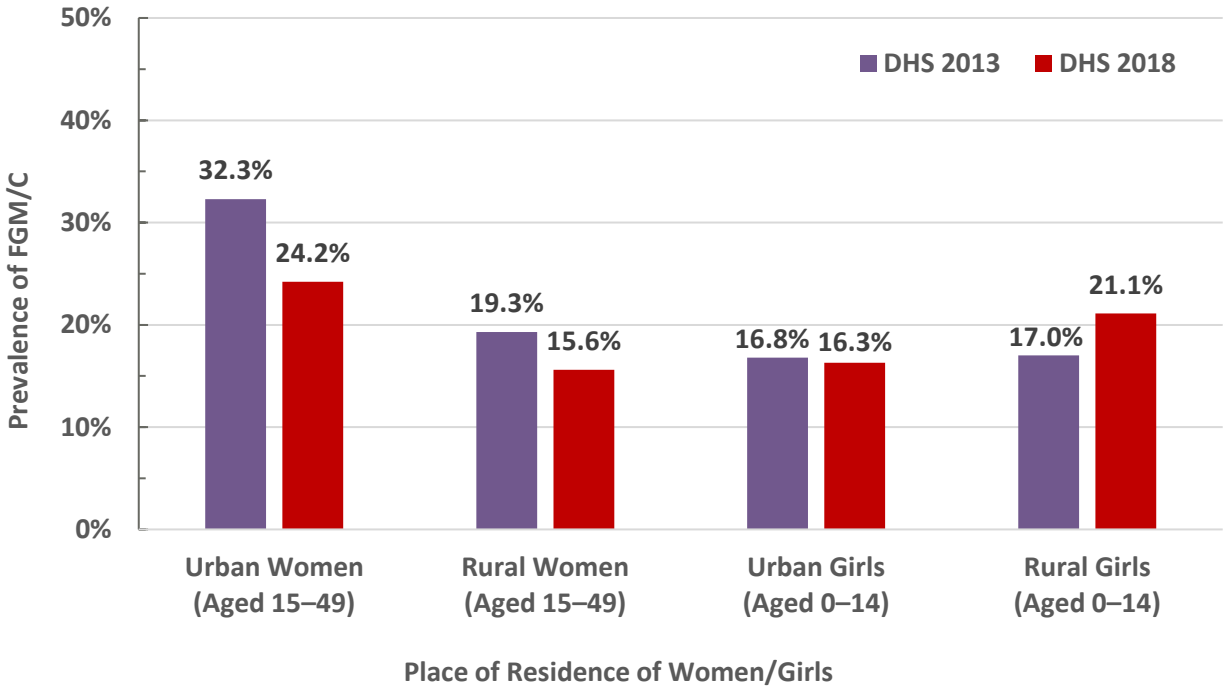

Figure 1: Prevalence of FGM/C in Nigerian women (aged 15–49) and girls (aged 0–14), according to urban/rural place of residence (2013 and 2018)[6]

Historically, FGM/C in Nigeria has been practised on women and girls in higher wealth quintiles, with higher levels of education and living in urban areas, in contrast to the trends in other countries. However, this appears to be changing: prevalence is dropping in each of these groups, but increasing among girls in rural areas, in the lowest wealth quintiles and whose mothers have lower levels of education.

40.9% of the Nigerian population is under 15 years of age, which represents 87,838,000 young people (44,896,360 male/42,943,785 female).[7] The prevalence of FGM/C among girls aged 0–14 (19.2% in 2018) means that, given the current population, more than **8.2 million girls have been cut**.

Where is FGM/C Happening?

The **states with the highest prevalence of FGM/C** among women aged 15–49 include **Imo** (61.7%), **Ekiti** (57.9%), **Ebonyi** (53.2%), **Kaduna** (48.8%), **Kwara** (46.0%) **and Osun** (45.9%).[8]

In Nigeria, it is particularly important to use population estimates to understand the number of women affected by FGM/C according to state, Zone or ethnic group. **The states with the most women affected by or at risk of FGM/C are not necessarily those with the highest prevalence.** States with higher population numbers but lower prevalence may have a higher number of actual women and girls affected.

When population numbers are used, **the priority states change** from those with the highest percentages (Imo, Ekiti, Ebonyi, Kaduna, Kwara and Osun) **to Lagos, Kaduna, Imo, Kano and Oyo**. Using population numbers instead of percentages presents a substantially different approach to targeting FGM/C in Nigeria, by focusing where the biggest number of girls are at risk.

This is critical when prioritising programming and making policies, to effectively target and improve results.

How is FGM/C Happening?

'Cut, flesh removed' is the most common type of FGM/C in Nigeria (40.7% of women aged 15– 49 who have been cut), followed by 'cut, no flesh removed' (9.6%) and 'sewn closed' (5.6%).[9]

It should be noted that 44.1% of women don't know what type of cut they underwent. This is likely because they were cut at a young age and have not been exposed to education on the different types of FGM/C. The percentage of women who don't know what type of cut they experienced has increased from 2013, when this figure was 26.3%.[10]

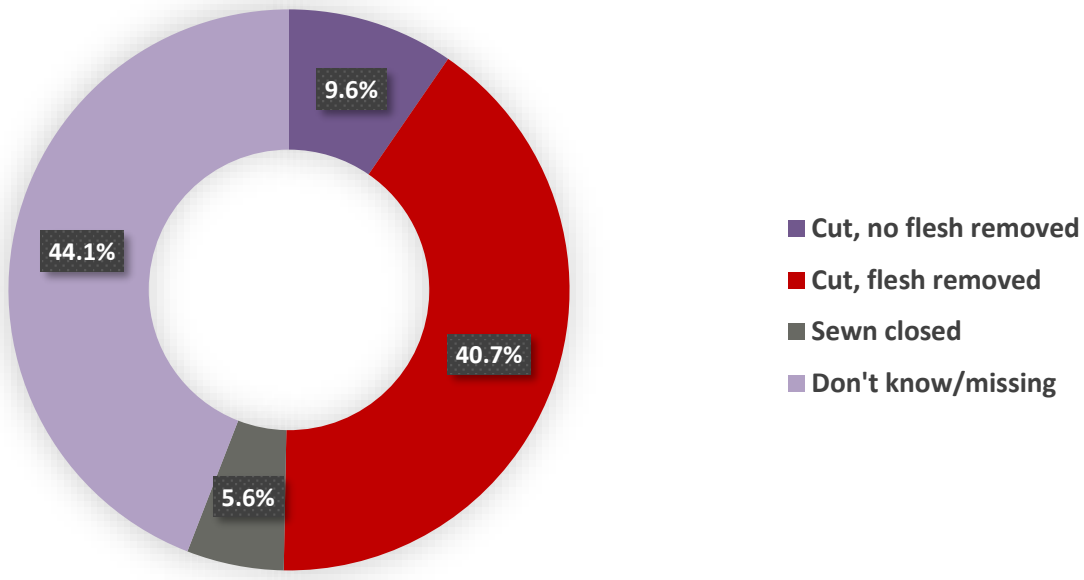

Figure 2: Percentage distribution of type of FGM/C undergone by women aged 15–49 in Nigeria[11]

Type of Cutting	2013	2018
Cut, no flesh removed	5.8%	9.6%
Cut, flesh removed	62.6%	40.7%
Sewn closed	5.3%	5.6%
Don't know/missing	26.3%	44.1%

Table 1: Comparison of types of cutting of Nigerian women aged 15–49, 2013 and 2018[12]

There at first appears to be a shift away from removing flesh during cutting, but **the change may in fact be due to the increased percentage of women who do not know what type of cutting they underwent**. Such a large percentage is likely because of the taboo nature of FGM/C and because the age of cutting is so low (the mean age was 1.7 years in 2018): girls/women are thus unfamiliar with their natural genitalia and the different types of cutting.

The Nigerian DHS discusses variations of Type 4 FGM/C, which include *angurya* (scraping the tissue around the vaginal opening), *gishiri* (incising the anterior or posterior vaginal wall) and the use of corrosive substances to narrow the vaginal tract. **There appears to have been an increase in angurya cutting, from 24.9% in 2013 to 40.4% in 2018.**

Age of Cutting

In Nigeria, 85.6% of women aged 15–49 who have undergone FGM/C are cut before the age of five.[13] **The mean age of cutting decreased from 3.1 years in 1999 to 1.7 years in 2018.**

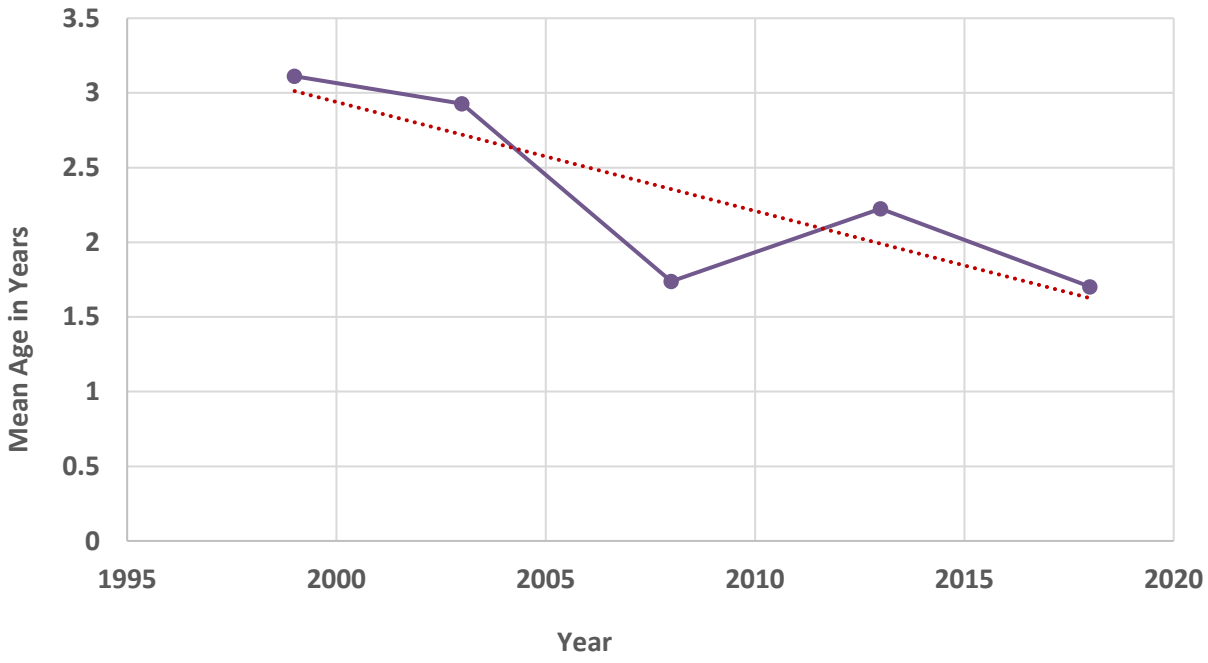

Figure 3: Mean age of cutting for girls aged 0–14 in Nigeria[14]

Practitioners

Traditional cutters are the primary agents performing FGM/C in Nigeria (85.4% of women aged 15–49 and 92.8% of girls aged 0–14). Approximately 8% of women and girls are cut by traditional birth attendants and 7–9% by medical professionals, primarily midwives and nurses.[15] It should be noted that the traditional cutter role often overlaps with the traditional birth attendant role in Nigeria.

Why is FGM/C Happening?

Socio-Economic Status: The prevalence of FGM/C is decreasing among Nigerian women aged 15–49 who are in the highest wealth quintile: from 31.0% in 2013 to 20.0% in 2018. Among women in the lowest wealth quintile, prevalence has stayed the same: 16.5% in 2013 and 16.4% in 2018. **The gap in prevalence between the lowest and highest wealth quintiles is closing over time**.[16]

Education: Among Nigerian women aged 15–49 with a secondary level of education or higher, the prevalence of FGM/C is dropping. For women with no formal education or only a primary level of education, prevalence is decreasing, but not nearly as quickly. **As with wealth quintiles, the gap in prevalence is closing between women with a secondary or higher level of education and those with no formal education or only a primary level.**

Place of Residence: Given that a significant portion of Nigeria's population lives in rural areas, **the rising prevalence of FGM/C among girls in rural areas is a significant concern**.

Tradition: Women who adhere to Islam (34.2%) and traditional religions (39.1%) are far more likely to believe that FGM/C should continue than Catholics (10.5%) and other Christians (10.7%). This supports other data that show **the major reason for the continuation of cutting in Nigeria is tradition.** There are 374 identifiable ethnic groups in Nigeria, each with their own cultural beliefs and practices. Again, tradition plays a major role in each group's motivations for continuing practices such as FGM/C. The highest prevalence is among Yoruba (34.7%) and Igbo (30.7%) women and girls, and the lowest is among Tiv and Igala women and girls (less than 1% each).[17]

Violence Against Persons (Prohibition) Act: The Violence Against Persons (Prohibition) Act (the *VAPP Act*), which came into force on 25 May 2015, criminalises violence against women and specifically prohibits FGM/C. However, each state must pass 'mirroring laws' for the VAPP Act to be enforceable at the state level. Without such mirroring laws, the VAPP Act is only effective in the Federal Capital Territory of Abuja. As of October 2022, 32 of the 37 states and territories have passed the VAPP Act. Of those remaining, two states have not yet assented; Lagos and the Ekiti states have, respectively, the Protection Against Domestic Violence and the Gender-Based Violence Prohibition laws, which contain some of the provisions of the VAPP Act. The states that have not assented to the VAPP Act are primarily Sharia law states in the northern parts of the country.

Key Challenges

A. Actual Numbers vs Percentage Prevalence

The population of Nigeria is very high (215 million), and the overall prevalence of FGM/C is relatively low (19.5%).[18] However, when this is viewed in terms of the actual number of women and girls affected by FGM/C, rather than the percentage, Nigeria is one of the top four affected countries in the world (together with Indonesia, Ethiopia and Egypt).

Many programmes target the states that have highest prevalence, which prioritises the following:

- Ekiti (57.9%);
- Imo (57.9%);
- Ebonyi (53.2%);
- Kaduna (48.8%);
- Kwara (46.0%);
- Osun (45.9%); and
- Ondo (43.7%).[19]

However, the states with the highest actual number of girls and women potentially affected by FGM/C are:

- Lagos (prevalence 23.7% – approximately 2,080,000 women/girls affected);
- Kaduna (48.8% – 1,475,000);
- Imo (57.9% – 1,200,000);
- Kano (22.2% – 988,000);
- Oyo (31.1% – 864,000);
- Osun (45.9% – 772,000); and
- Ondo (45.9% – 772,000).[20]

Some of these states overlap with the prioritised states listed above, but what emerges from this viewpoint is that a large number of women and girls affected in Lagos, Kano and Oyo may be left out if only prevalence is used to determine priorities.

B. A Change in Practising Cohorts

Nigeria has historically been one country where typical trends in FGM/C are reversed. In the past, FGM/C in Nigeria has been mainly practised by those living in urban areas, those in the highest wealth quintiles and those with the highest levels of education. It has also been practised by primarily Christian/Catholic groups.

However, this trend is now changing. Among girls 0–14 years of age, there is an increase in cutting among those in rural areas, from the lowest wealth quintiles and whose mothers have the lowest levels of formal education. There is also an increase in the number of Muslim women who believe that FGM/C is a requirement of their religion.[21]

FGM/C was typically practised in the South East and South South Zones of Nigeria. While these remain areas of focus, it should be noted that the data show increases in the North East Zone.[22]

There is also an increase in angurya, a practice unique to Nigeria that involves scraping the hymen. 40.4% of women who have undergone FGM/C report that they have also experienced angurya.[23]

C. Social Obligation Within Ethnic Traditions

Social obligation as a driver of FGM/C in Nigeria outweighs drivers linked to religion, purity/chastity or hygiene. Mothers, mothers-in-law and grandmothers are key protectors of the tradition and impose social pressure on women to have their daughters cut.

Women in the lowest wealth quintiles and with the lowest levels of formal education have less agency than wealthier and better-educated women to resist this social pressure, because of the consequences they may face in doing so.

The major ethnic groups that practise FGM/C are the Yoruba (34.7%), Igbo (30.7%), Hausa(19.7%) and Fulani (12.6%).[24] These four groups represent 68% of the Nigerian population.

D. A Young Age of Cutting

The age of cutting in Nigeria is very young and getting younger. In 2013, the mean age of cutting was 3.1 years, and, as of 2018, the mean age is 1.7 years.[25]

Age of cutting is strongly linked to ethnicity and to naming ceremonies performed in the first ten days of life. There is also anecdotal evidence from implementing organisations that, in communities that traditionally cut later, the age of cutting is getting younger as adolescents resist the cut later in life.

A very young age of cutting has implications for programming, as it requires focusing on adolescent girls before they become mothers, together with pregnant women and breastfeeding mothers, to shift attitudes and beliefs about FGM/C before their daughters are cut.

E. Assenting To and Implementing the VAPP Act

The Violence Against Persons (Prohibition) Act was passed in the Federal Capital Territory of Abuja in 2015. However, the system of legislation in Nigeria requires that the Act be assented to by each state government before it is enforceable at the state level.

As of October 2022, five states have not yet assented the VAPP Act. Of those, Kano has the highest estimated number of women and girls affected by FGM/C (988,000). Unfortunately, where the VAPP Act has been assented to, it is not consistently implemented.

F. Lack of Progress Towards SDGs

Nigeria is falling behind on numerous Sustainable Development Goal targets, but most notable is its drop on the Human Development Index – the country currently ranks 130th out of 144 countries.[26]

Of significant concern is the rise of the maternal mortality ratio to 917 per 100,000 live births in 2020. This rate is well above the global average (211 per 100,000) and almost double the average for sub-Saharan Africa (542 per 100,000).[27]

Nigeria has approximately ten million children out of school, 50% of whom are girls.[28]

Additionally, Nigeria has one of the highest rates of child marriage in West and Central Africa: an estimated 22 million girls are affected.[29]

What is Needed?

Next Steps

As outlined above, there are five major challenges that programmatic and legislative responses in Nigeria must address. While there are a number of organisations working to reduce the prevalence of the practice and, ultimately, see it eradicated, as the response to FGM/C is changing in Nigeria, the following aspects must be addressed to effectively reach those goals:

- **focus** programmatic response in the states that have the highest estimated numbers of women and girls affected by FGM/C, which include Lagos, Kaduna, Imo, Kano, Oyo, Osun and Ondo;
- **shift** the focus of programming to include women in rural areas, those in the lowest wealth quintiles and those with the lowest levels of formal education, among whom the practice is increasing;
- **work with** those who serve as protectors of the practice to shift the norms that contribute to women's senses of social obligation to cut (this includes mothers, mothers-in-law and grandmothers, as well as traditional birth attendants);
- **target** adolescent girls and pregnant and breastfeeding women with interventions, to shift social norms that influence the cutting of daughters at young ages;
- **promote** assenting to the VAPP Act in all states and effectively implement it, especially in Kano and other states where there are large estimated numbers of women and girls affected by FGM/C; and
- **give urgent attention** to the Sustainable Development Goals and reversing the downward trends in each area, with particular emphases on maternal health and education.

Recommendations

Considering our findings, we recommend that:

- within programming, target states be identified using both prevalence of FGM/C and actual numbers of women/girls affected by FGM/C, to ensure those living in densely populated states are not forgotten;
- within the states identified, women and girls in rural areas, those in the lowest wealth quintiles and those with the lowest levels of formal education be targeted for interventions that support poverty reduction, building of agency and decision-making, and shifts in social norms;

- key demographics within programmes include:
    - adolescent girls and pregnant/breastfeeding women, to shift social norms around the cutting of daughters at young ages; and
    - mothers, mothers-in-law and grandmothers (via community and intergenerational dialogues), to shift norms related to social and ethnic obligations for women and girls to undergo FGM/C;
- humanitarian agencies working with children in the North East Zone of Nigeria (primarily Save the Children and Plan International) allocate resources to intergenerational dialogues on FGM/C, engage with religious (especially Muslim) leaders to militate against the growth of the practice, and improve access to education and poverty-reduction schemes as means of increasing women's agency and decision-making around FGM/C;
- investment be made to progress towards the Sustainable Development Goals targets, especially where progress has reversed in recent years – the SDGs related to poverty, healthcare, gender equality and education are critical;
- advocacy efforts be made to ensure that the VAPP Act is assented to in all states and pressure placed where there are high numbers of girls affected by FGM/C (for example, Kano state);
- investment be made into evaluating programmes to discover which are most effective; and
- international partners recognise the vital role of local organisations and activists and meaningfully include them in programming, giving them voices in the design and implementation of policies and practices in response to FGM/C in Nigeria.

Call To Action

Government of Nigeria

We call on the Government of Nigeria to:

- **launch** the national action plan against FGM/C in Nigeria as a roadmap for implementing organisations to follow and contribute to;
- **place** pressure on state governments to assent to the VAPP Act, where it has not yet been assented to; and
- **reverse** the trends in relation to the Sustainable Development Goals in Nigeria, placing particular emphases on increasing access to education for girls and improving maternal health outcomes.

Stakeholders

We call on stakeholders, including government bodies, non-governmental organisations and others in Nigeria to:

- **target** states where the greatest numbers of women and girls affected by FGM/C are living;
- **include** rural areas in programmes within the states that are targeted;
- **focus** programmes on shifting the strong social obligation to have daughters cut, by engaging with protectors of the practice (mothers, mothers-in-law and grandmothers), targeting adolescent girls and pregnant and breastfeeding women, and promoting intergenerational dialogues;
- **embed** poverty-reduction strategies into FGM/C programmes to support increased agency and decision-making among women and girls in the lowest wealth quintiles and with the lowest levels of formal education;
- **evaluate** programmes to understand and share best practices for eradicating FGM/C in Nigeria;
- **advocate** for all states to assent to the VAPP Act, focusing particularly on Kano, and for local by-laws to be passed that prohibit FGM/C.

Donors

We call on donors to actively support programmes and initiatives that:

- **target** states where the highest estimated number of women and girls are affected by FGM/C;
- **prioritise** work in rural areas, among those in the lowest wealth quintiles and among those with the lowest levels of formal education;
- **focus** on shifting social norms;
- **embed** poverty-reduction strategies;
- **evaluate** and **share** best practices;
- **aim to reverse** the current trends in relation to the Sustainable Development Goals.

References

Recommended citation: Orchid Project and 28 Too Many (2023) *FGM/C in Nigeria: Key Findings*. Available at www.28toomany.org/nigeria.

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'DHS 2013' refers to National Population Commission – NPC/Nigeria and ICF International. (2014) *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria: NPC/Nigeria and ICF International. Available at https://dhsprogram.com/publications/publication-FR293-DHS-Final-Reports.cfm.

'DHS 2018' refers to National Population Commission – NPC/Nigeria and ICF (2019) *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF. Available at https://dhsprogram.com/publications/publication-FR359-DHS-Final-Reports.cfm.

1 - DHS 2013, p.349–350.
- DHS 2018, p.473–474.
2 DHS 2018, pp.473–474.
3 - DHS 2013, p.354–355.
- DHS 2018, p.477–478.
4 - DHS 2013, p.355.
- DHS 2018, p.478.
5 UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview nd exploration of the dynamics of change*. Available at https://data.unicef.org/resources/fgm-statisticaloverview-and-dynamics-of-change.
6 - DHS 2013, pp.349 & 354.
- DHS 2018, pp.473 & 477.
7 Country Meters (2022) *Nigeria Population* (accessed 25 April 2022). Available at https://countrymeters.info/en/Nigeria.
8 DHS 2018, pp.473–474.
9 DHS 2013, p.350.
10 DHS 2013, p.350.
11 DHS 2018, p.466.
12 - DHS 2013, p.350.
- DHS 2018, p.474.
13 DHS 2018, p.476.
14 *Calculated from original DHS dataset.*
15 DHS 2018, p.469.
16 - DHS 2013, p.350.
- MICS 2016–17, p.236.
- DHS 2018, p.474.
17 DHS 2018, p.473 & 483.

18 DHS 2018, p.474.
19 DHS 2018, pp.473–474.
20 DHS 2018, pp.473–474.
21 - DHS 2013, p.359.
- DHS 2018, p.481.
22 - DHS 2013, p.349–350.
- DHS 2018, p.473–474.
23 DHS 2018, p.475.
24 DHS 2018, p.473.
25 Calculated by Orchid Project from the original DHS dataset.
26 UNDP (2020) 'Nigeria', *Human Development Insights*. Available at http://hdr.undp.org/en/content/latest-human-development-index-ranking.
27 *Ibid*.
28 Rita Nketiah (2021) 'Nigerian States Should Protect Girls by Ending Child Marriage', *Human Rights Watch*, 24 September. Available at https://www.hrw.org/news/2021/09/24/nigerian-states-should-protect-girls-ending-child-marriage.
29 UNFPA/UNICEF West Africa Office (2018) *Child Marriage in West and Central Africa: At a Glance*. Available at https://www.unicef.org/wca/media/2596/file.

Images

Cover: Tayvay (undated) *Beautiful Nigerian Tiv woman fetching water from the River* [cropped]. Shutterstock ID 2226362341.

Please note the use of this woman's image does not imply that she has, nor has not, undergone FGM/C.

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