LANDINFO

Country of Origin Information Centre

Report

Nigeria

Female genital mutilation

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Summary

Female genital mutilation (FGM) is practiced in large parts of Nigeria, and within all the major ethnic groups, but there is great variation in how it is practiced. There is a clear tendency that the share of girls and young women subjected to FGM decreases with every generation. Formally, FGM is prohibited by national law, and the law has been implemented in most states. However, legal prosecution rarely occurs.

Contents

1 Introduction

This report provides a brief description of the prevalence of female genital mutilation in Nigeria and variations amongst different population groups. The report then explains some key features in terms of how and when the procedure occurs, attitudes in the population and various protection mechanisms. Finally, we discuss what freedom of choice parents have to choose not to circumcise their daughters, and the possible consequences there may be in Nigeria for not having been circumcised.

Landinfo uses the term (female) genital mutilation when we refer to the practise on a general level. This term is used by the World Health Organization (WHO), in Norwegian legislation and by human rights organisations. However, we use the word "circumcision" when we refer to conditions related to local reasons for the custom, or "circumcised" when we refer to the girls and women in question.[1]

The report does not present an exhaustive description of the prevalence of female genital mutilation in all areas or amongst all population groups in Nigeria, but focuses on the three southernmost geopolitical zones: South West, South South and South East.[2] This is because the majority of immigration cases in Norway relate to these areas and because the prevalence of female genital mutilation is greatest there. We have also placed a greater emphasis on research and data from Nigeria, and a lesser emphasis on studies that compare the practise with other countries in Africa. This is because there are major variations within Nigeria, and we have prioritised describing the national nuances rather than comparisons with other countries.

1.1 Sources

In order to describe the prevalence of and general trends relating to attitudes towards female genital mutilation in Nigeria, the report is mainly based on the latest demographic and health survey from UNICEF and Nigeria's National Bureau of Statistics – *Multiple Indicator Cluster Survey 2021* (we use the abbreviation MICS 2021 in this report).[3] The data is supplemented with data from

[1] For more about the discussion on the use of the term, see Johnsdotter (2020, p. 8-11).

[2] See Chapter 2.2 for more information on the zones and which states are included in them.

[3] MICS and NDHS are based on self-reporting, and women may have been reluctant to share information about whether they had undergone the procedure, or may not have been aware that they were circumcised, especially if female genital mutilation was performed at an early age (Omigbodun et al. 2022; UNICEF 2022a). A cross-sectional study from Lagos University Teaching Hospital in 2016 found that women's self-reporting of female genital mutilation was only 84 % correct (Okunade et al. 2016, p. 30). The study was conducted with a questionnaire and physical inspection of 254 women aged 17-72 years. The self-reporting found an incidence of 49.4 %, while the actual prevalence was 56.3 %. Another study with 2,000 respondents aged 13-19 years from the North Central zone showed that 21 % of the respondents were unsure whether they had been circumcised (Ezeoke et al. 2021, p. 1811). Surveys based on self-reporting thus do not necessarily accurately reflect reality.

Nigeria Demographic and Health Survey 2018 (we use the abbreviation NDHS 2018 in this report),[4] especially when it comes to conditions relating to religious affiliation and age at the time of the procedure, as this is not covered by MICS. The figures used in Chapter 2 were produced by Landinfo with data from MICS 2021 and NDHS 2018.

Note that the categorisation of different types of female genital mutilation varies. MICS does not use the World Health Organization's types to define female genital mutilation, but rather categorises circumcision based on the descriptions "had flesh removed", "were nicked" and "were sewn closed", which roughly corresponds to type I/II, type IV and type III accordingly. NDHS also does not use the World Health Organization's definition, but uses the descriptions "cut, no flesh removed", "cut, flesh removed" and "sewn closed", which broadly correspond to type I, type II and type III. See Chapter 3.1 for a more detailed account of the different types of female genital mutilation.

In addition to these larger statistical studies, Landinfo has consulted qualitative and anthropological research work on local norms, decision-making processes and practical aspects relating to female circumcision.

Landinfo has also been in contact with resource persons who work with or research female genital mutilation in Nigeria.

2 Prevalence

The population data for Nigeria is generally poor, and there are no representative surveys on the prevalence of female genital mutilation in Nigeria, either for the population as a whole or for individual groups. The closest is the Nigeria Demographic and Health Survey (NDHS) and the Nigeria Multiple Indicator Cluster Survey (MICS). However, while these surveys specify percentages of circumcised women within different groups, it is important to emphasise that information on percentages cannot be used to determine the probability that an individual, e.g. within a specific ethnic group, will be subjected to female genital mutilation. The same is true of other surveys referenced in medical research articles.

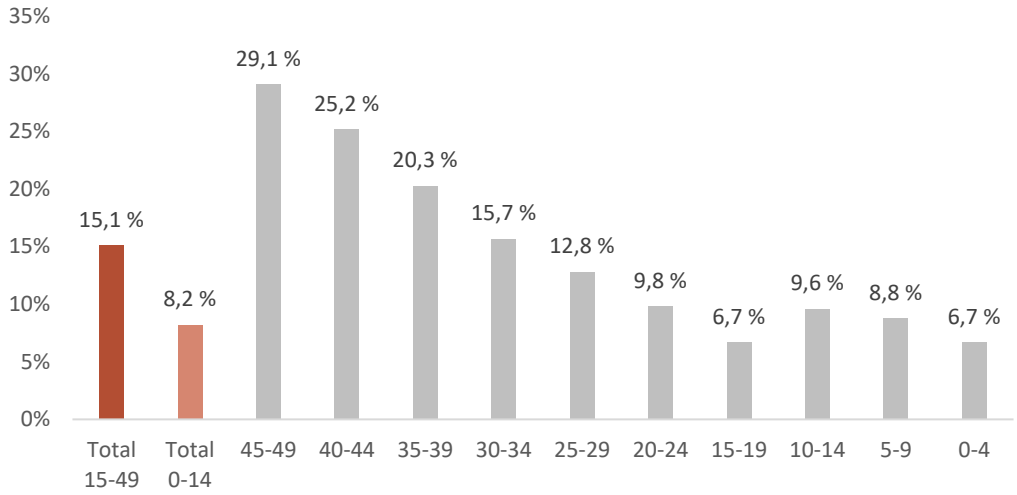
[4] NDHS is conducted approximately every five years by the Nigerian government in cooperation with US aid authorities. A new survey with field studies is planned for the period of October 2023 – January 2024, see https://dhsprogram.com/methodology/survey/survey-display-609.cfm.

2.1 The percentage of girls subjected to female genital mutilation is decreasing

Several studies have shown that the percentage of girls subjected to female genital mutilation in Nigeria has been steadily declining over the past ten years (NBS & UNICEF 2022; NDHS 2019). Circumcision usually takes place before the age of five (NDHS 2019, p. 468; Orchid Project & 28 Too Many 2023; Population Council interview 2023, p. 32), and one can therefore say something about the development over time by comparing the proportion of circumcised individuals in different age groups within the same survey.[5]

Figures from the MICS survey in 2021 showed that only 8.2 % of girls between 0 and 14 years old had been subjected to female genital mutilation, compared with 15.1 % of women between 15 and 49 years old. There has thus been a reduction in the percentage of those circumcised by almost 7 %. Figure 1-1 also shows this trend by comparing the oldest age group, 45 – 49 years old, with the youngest, 0–4 years old, where the percentage of those circumcised is respectively 29.1 % and 6.7 %. Figure 1-1 shows a slightly higher percentage amongst 10–14-year-olds and 5–9-year-olds. It is uncertain what the reason for this is, but as the percentage for the youngest age group has gone down, this indicates that there is a general downward trend.

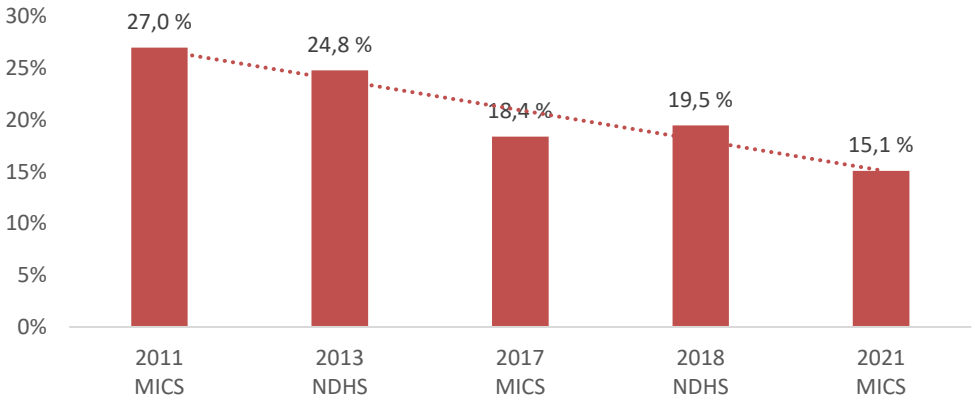
Figure 1-1 Percentage of women subjected to female genital mutilation within different age groups (MICS 2021)



[5] In some regions, particularly in the South South (where most Igbo live), there is a larger percentage, 24 %, of women who were circumcised at age 15 or older (NDHS 2019, p. 468). Therefore, it is possible that the figures for the age group 0–14 years old do not capture all cases of female genital mutilation, particularly in the South South.

Both the MICS and NDHS surveys show the same trend over time, namely that the percentage of those subjected to female genital mutilation is decreasing. This is shown in Figure 1-2. The total percentage of women subjected to female genital mutilation in MICS 2011 was 27 %, while this has gone down to 15.1 % in MICS 2021.

Figure 1-2 Percentage of women between 15 and 49 years old subjected to female genital mutilation 2011–2021



While the percentage of women subjected to female genital mutilation may seem low (approximately 15 %), Nigeria is still one of the countries with the most women subjected to female genital mutilation in the world. Estimates from 2018 show that approximately 20 million girls and women had been subjected to female genital mutilation in Nigeria at that time, making it the country with the most cases in the world after Ethiopia (23.8 million) and Egypt (27.2 million) (Orchid Project & 28 Too Many 2023, p. 53; UNICEF as quoted in UNFPA 2022, p. 13).[6] By ethnic group, Yoruba is the group estimated to have the most girls and women subjected to female genital mutilation, with almost 7.9 million, followed by Hausa with 6.2 million, Igbo with 6 million, Ijaw with approximately 760,000 and Ibibio-Efik with approximately 350,000 (Orchid Project & 28 Too Many 2023, p. 31). In the following sections the report goes into more detail on the geographical variations and variations amongst ethnic groups.

2.2 Geographical variations

Nigeria is a large country with 36 states in addition to Abuja, which is defined as a federal territory. The country is typically divided into six geopolitical zones

[6] Demographic data is a politically sensitive issue in Nigeria, and the most recent official census was conducted in 2006. As there was no data collected on ethnicity, religion or language, and the figures presented here are only estimates. Orchid Project and 28 Too Many base their estimates on the female genital mutilation figures from NDHS 2018 and population estimates from the World Directory of Minorities and Indigenous Peoples (2022) Nigeria https://minorityrights.org/country/nigeria. A new census was planned for 2023, which was then postponed, and at the time of this writing no new date has been determined (Onuah 2023).

comprising five to seven states, and these designations will also be used in this report:[7]

- North West: Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto and Zamfara
- North East: Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe
- North Central: Abuja (Federal Capital Territory), Benue, Kogi, Kwara, Nasarawa, Niger and Plateau
- South West: Ekiti, Lagos, Ogun, Ondo, Osun and Oyo
- South South: Akwa-Ibom, Bayelsa, Cross River, Delta, Edo and Rivers
- South East: Abia, Anambra, Ebonyi, Enugu and Imo

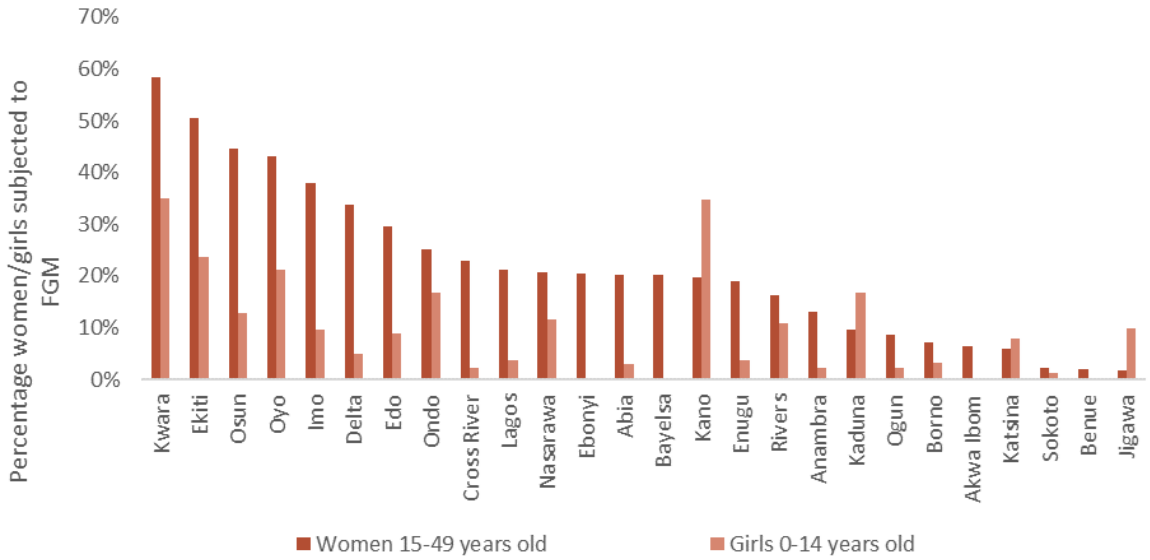
The zone where female genital mutilation is most prevalent is South West, where 28.5 % of women between the ages of 15 and 49 are circumcised, followed by South East (21.7 %) and South South (21.4 %) (NBS & UNICEF 2022). The appendix in Chapter 8 contains an overview comparing the percentage of those circumcised amongst women 15–49 years old and 0–14 years old. The table shows that there are 16–18 % fewer circumcised girls compared to women in the three southern zones. In areas where there is a tradition of circumcision at a young age, this can be an indication that the practise has decreased.

Figure 1-3 shows an overview of the percentage of circumcised women and girls at state level. Kwara is the state with the highest percentage of women subjected to female genital mutilation at 58.3 %. Followed by Ekiti (50.4 %), Osun (44.7 %) and Oyo (43.2 %).[8] In all states, except for Kano, Kaduna, Katsina and Jigawa, the percentage of girls aged 0–14 who are subjected to female genital mutilation is lower than for women aged 15–49. This can be an indication that the practise of female circumcision has decreased in all regions except the North West. As Nigerian migrants to Norway primarily belong to ethnic groups affiliated with southern Nigeria, we will not go into more detail on the reasons for this trend in the North West.

[7] See map in NDHS 2018, p. xxxviii.

[8] The tables in the appendix in Chapter 8 show detailed percentages for all the states.

Figure 1-3 Percentage of women/girls subjected to female genital mutilation at state level (states where the percentage is <5 % are not included) (NBS & UNICEF 2022, p. 355, 359)



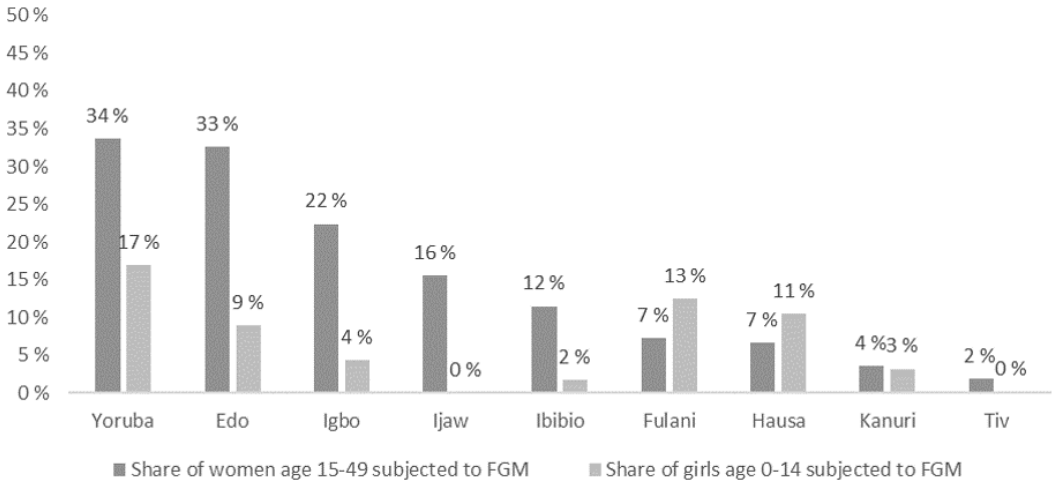
2.3 Ethnicity

The practise of female genital mutilation is largely legitimised by traditions linked to ethnicity or to clan affiliation within certain ethnic groups.

The population of Nigeria consists of many ethnic groups and there are major variations in the practise of female genital mutilation between the various groups. It is important to emphasise that there are currently no ethnic groups in Nigeria with near universal practise of female genital mutilation. There is thus significant variation today, including within ethnic groups where most or all women were circumcised in times past. As shown in the figure below, the groups where there is the highest occurrence of female genital mutilation are Yoruba, Edo and Igbo, who are mainly located in the South West, South South and Southeast. The lowest occurrence is amongst the northern groups such as Fulani, Hausa, Kanuri and Tiv.

As emphasised in the introduction to this chapter, the data must be interpreted in light of the fact that the samples cannot be considered representative of the various population groups. For example, the number of respondents varies from about 450 for the Edo group to 10,200 for the Hausa group (NBS & UNICEF 2022, p. 358). It is also worth noting that there are several smaller ethnic groups not covered by this figure. The figure only shows the groups that are mentioned in the MICS survey.

Figure 1-4 Prevalence of female genital mutilation in different ethnic groups (NBS & UNICEF 2022)



The next sections discuss the most common groups amongst Nigerian migrants to Norway.

2.3.1 Yoruba

The Yoruba are the dominant population in southwestern Nigeria, especially in the former capital city of Lagos, one of the largest cities in the world. The Yoruba also live in other large cities in the country, and many Yoruba have emigrated from Nigeria. The Yoruba practise both Islam and Christianity.

In the MICS survey from 2021, 33.7 % of women between ages 15 and 49 with a Yoruba background[9] reported that they were circumcised. Only 4.6 % were sewn closed (corresponding to type III in WHO 2020). 16.9 % of girls between the ages of 0 and 14 with a Yoruba background were reported to have been circumcised, including 5.1 % corresponding to type III (NBS & UNICEF 2022, p. 354, 358).

14.4 % of women from Yoruba households said that female genital mutilation is a custom that should be maintained. 75.1 % said that it should not be maintained and 8.3 % said that it depended on the situation (NBS & UNICEF 2022, p. 356).

A cross-sectional study in 2022 of 195 girls and boys aged 14–19 in Osun showed that 42 % of the respondents intended to circumcise their own children when they

[9] In the MICS survey, the data is sorted by the ethnicity of the head of the household. In many cases it is the man who is considered to be the breadwinner, and it may therefore be that some women who are counted as Yoruba may themselves come from another ethnic group. However, for practical reasons when interpreting the data, they are considered to have a "Yoruba background", which in this case means belonging to a household where the breadwinner is Yoruba. The same is true for the other ethnic groups mentioned in the report with reference to the MICS survey.

start a family. 47 % said that they did not want to continue this tradition and approximately 11 % had not decided (Fajobi et al. 2023, p. 74).[10]

The researchers I. O. Orubuloye, P. Caldwell and J. C. Caldwell has conducted a thorough review of the practise of female genital mutilation amongst the Yoruba (Orubuloye, Caldwell & Caldwell 2000). In brief, they present the following findings:

- The Yoruba have traditionally practised female genital mutilation with the exception of two subgroups, Ijebu and Egba.
- Female genital mutilation is mostly performed during the first week of life, and the procedure itself is increasingly performed by healthcare personnel. The forms of female genital mutilation that are performed mostly fall under type I, as defined by the World Health Organization (WHO 2020).
- The practise is not universal these days, although it is prevalent for the groups that practise it, with percentages up to 90 % in various samples.
- There is a greater trend for parents to stop circumcising their children in cities than in rural areas, but the figures are declining for both urban and rural areas. Furthermore, there is a trend towards a correlation between education and lower occurrence of female genital mutilation.
- Originally, female genital mutilation was only justified by the belief that contact between a baby's head and the clitoris during childbirth would lead to the child's death, and this is still a common belief. Uncircumcised women are not perceived as ugly or deformed, and few people associate a lack of circumcision with promiscuity in women. However, this last explanation is becoming increasingly more common, especially in urban areas.

2.3.2 Bini/Edo

Bini (also called Edo) is the largest population group in Edo state, and they are found as migrants in cities elsewhere in Nigeria. Bini are culturally and linguistically similar to Yoruba.

In the MICS survey from 2021, 32.6 % of women between ages 15 and 49 with an Edo/Bini background reported that they were circumcised. 43.3 % of these said that they had been sewn closed, which makes this the group where type III female genital mutilation is the most prevalent. (For comparison, the next group is Ijaw, where 21 % of those who were subjected to female genital mutilation had type III.) Of girls between 0 and 14 years old with an Edo/Bini background, 9 %

[10] The respondents attended school in the village of Imesi-Ile in the Obokun Local Government Area. The village is located in the middle of the cultural Yorubaland in Osun state. The survey was based on questionnaires answered by 100 girls and 95 boys.

reported being circumcised. There was not enough data to conclude how common it was to be sewn closed compared to other types of female genital mutilation.

8 % of women from Edo/Bini households said that female genital mutilation is a custom that should be maintained. 83.6 % said that it should not be maintained and 8 % said that it depended on the situation (NBS & UNICEF 2022, p. 356).

2.3.3 Igbo

Igbo is the dominant population group in the South East geopolitical zone in Nigeria, but large numbers of Igbos also live in cities elsewhere in the country. Igbos are also highly represented amongst Nigerians who have migrated from Nigeria, particularly to Europe, the USA and South Africa.

In the MICS survey from 2021, 22.4 % of women between ages 15 and 49 with an Igbo background reported that they were circumcised. Only 4.6 % reported being sewn closed (corresponding to type III in WHO 2020). In this group, a large number (46.3 %) did not know or did not specify the type of female genital mutilation. Of girls between 0 and 14 years old with an Igbo background, 4.3 % reported being circumcised. This represents a decrease of 18.1 % in the percentage of those circumcised from the older groups to the younger groups. 10.7 % of women from Igbo households said that female genital mutilation is a custom that should be maintained. 84.7 % said that it should not be maintained and 3.5 % said that it depended on the situation (NBS & UNICEF 2022, p. 356).

2.3.4 Ijaw/Ijo/Izon

Ijaw (also called Ijo and Izon) is the fourth largest population group in Nigeria, and they primarily live in Bayelsa, Delta and Rivers state. Ijaws also live in Akwa-Ibom, Edo and Ondo, in addition to other cities in Nigeria where they have migrated to.

In the MICS survey from 2021, 15.6 % of women between ages 15 and 49 with an Ijaw background reported that they were circumcised. 21.1 % of these reported being sewn closed (corresponding to type III in WHO 2020). This is the group with the next highest occurrence of type III female genital mutilation, after the Edo group (43.3 %). However, the data must be read in light of the fact that only 658 women from Ijaw households participated in the MICS survey in 2021 (e.g. compared with 9,891 with a Hausa background and 6,010 with an Igbo background).

Of girls between 0 and 14 years old with an Ijaw background, only 0.1 % reported between circumcised. This may be due to the fact that it is common within this group to perform female genital mutilation in the teenage years.

6.3 % of women from Ijaw households said that female genital mutilation is a custom that should be maintained. 86.2 % said that it should not be maintained and 3.2 % said that it depended on the situation (NBS & UNICEF 2022, p. 356).

2.3.5 Ibibio

Ibibio is the dominant population group in Akwa-Ibom. Ibibios also live in Cross Rivers, in addition to other cities in Nigeria where they have migrated to. The Ibibio population is linguistically and culturally similar to Efik and Ekoi.

In the MICS survey from 2021, 11.5 % of women between ages 15 and 49 with an Ibibio background reported that they were circumcised. 4.1 % of these reported being sewn closed (corresponding to type III in WHO 2020). Of girls between 0 and 14 years old with an Ibibio background, only 1.7 % reported being circumcised. The survey shows that the percentage of those circumcised is approximately 10 % lower in the youngest age groups.

5.8 % of women from Ibibio households said that female genital mutilation is a custom that should be maintained. 91.2 % said that it should not be maintained and 0.9 % said that it depended on the situation (NBS & UNICEF 2022, p. 356).

2.3.6 Hausa

Hausa is the dominant population group in northern Nigeria, particularly in the North West. In addition, many Hausas live in cities elsewhere in Nigeria.

In the MICS survey from 2021, 6.7 % of women between ages 15 and 49 with a Hausa background reported that they were circumcised. Of these, 4.6 % reported being sewn closed (corresponding to type III in WHO 2020). Of girls between 0 and 14 years old with a Hausa background, 10.5 % reported being circumcised. The percentage of younger girls who were circumcised was also higher than the percentage amongst women 15–49 years old. 24.2% of respondents in the Hausa ethnic group believed that the practice should be maintained, making them one of the groups with the highest percentage of respondents in favor of the practice. 61.4 % said that it should not be maintained, and 11.6 % said that it depended on the situation (NBS & UNICEF 2022, p. 356).

2.3.7 Ekoi/Ejagham

Ekoi dominate Cross Rivers state. The Ekoi population is linguistically and culturally similar to Efik and Ibibio.

The MICS survey does not include disaggregated data on Ekoi as a separate group, and we therefore use the figures from NDHS 2018 here. Amongst women between the ages of 15 and 49 with an Ekoi background, 11.6 % said that they

were circumcised and 47 % had heard of female genital mutilation. 10.2 % of the women with an Ekoi background said that they believed circumcision was required by their religion, but only 5.2 % said it was a practice that should continue. 90 % said that it should not continue and 4.8 % were uncertain/did not have enough information or said that it depended on the situation (NDHS 2019, p. 471, 473, 481, 483).

Only 148 women with an Ekoi background participated in the survey, and this constituted the smallest group of those reported on as a separate group in NDHS 2018. The sample was thus too small to say anything about how common the different types of circumcision are within this group, nor the age at which female genital mutilation usually occurs.

2.3.8 Urhobo

Urhobo is one of the major population groups in Delta state. The Urhobos have cultural and linguistic similarities with Yoruba and Bini.

The Urhobos are not mentioned in the data material from the most recent NDHS and MICS surveys, but a study from 2002 based on a survey of 1,709 women at two clinics in Edo state found that approximately 51 % of the 125 women with an Urhobo background had undergone female genital mutilation (Snow et al. 2002, p. 97).

2.3.9 Other, smaller ethnic groups: Isoko, Esan, Itsekiri, Ogoni

There is little research on female genital mutilation amongst the smaller ethnic groups in southern Nigeria (Population Council interview 2023), and we thus do not have available figures to present on the prevalence within these groups.

2.4 Female genital mutilation and socio-economic indicators

The prevalence of female genital mutilation varies when looking at factors such as place of residence, education level and economic status. The results from MICS 2021 differ somewhat from the results of similar surveys in other countries with a high prevalence of female genital mutilation. The practise in Nigeria at a national level seems to be more prevalent amongst the higher socio-economic strata of the population. This mainly has to do with the fact that it is the ethnic groups originating in southern Nigeria who have mostly practised female genital mutilation, and that these groups belong to higher socio-economic strata in terms of urbanisation, education level and economic status. In the north, there are large population groups who, e.g. have a lower average education level (especially amongst women) but who do not practise female genital mutilation. Within the different ethnic groups, the pattern is the same as elsewhere in Africa: there is a

correlation between lower prevalence and less severe procedure on the one side and level of education on the other.

MICS 2021 points to the following correlation between social variation factors and prevalence of female genital mutilation, illustrated here with figures from the age group 15–49 years old. The results here should be read from the context described in the previous section:

- **Place of residence**. Women from urban areas are circumcised to a greater extent than women from rural areas, with 20.2 % and 10.8 % respectively (NBS & UNICEF 2022, p. 354).[11] Women from rural areas believe that female genital mutilation is a requirement of their religion to a greater extent than women from urban areas (22 % and 12 % respectively). Women from rural areas also to a greater extent believe that the practise of female genital mutilation should continue when compared to women living in urban areas (31 % and 16 %) (NDHS 2019, p. 467).
- **Level of education**. On a national level, women (15–49 years old) without schooling are circumcised to a lesser extent (8.3 %) than those with primary school (20.4 %), secondary school or higher (14–18 %). Daughters of women with higher education beyond upper secondary school are subjected to female genital mutilation to a lesser extent (5.1 %) than daughters of women without education (8.5 %). Daughters of women with primary, lower secondary or upper secondary school were about as likely to be subjected to female genital mutilation as those without education (7.2–10.6 %) (NBS & UNICEF 2022, p. 354).
- **Economic status**. On a national level, the figures show that the prevalence of female genital mutilation is somewhat lower amongst women in the lowest and second lowest economic strata (7.5 % and 10.5 % respectively) than among those in the higher income brackets (16.5 %, 19.9 % and 19 %). However, the correlation may be the opposite within a given ethnic group here. Economic status has less significance for whether the daughters are circumcised. Amongst girls 0–14 years old, the lowest percentage of those circumcised was amongst the richest (5.8 %), but the differences were marginal between the other economic strata. Comparing the lowest economic strata with the second highest, the prevalence was 8.3 % and 10.4 % respectively (NBS & UNICEF 2022, p. 354).

2.5 Religion

Based on the material Landinfo has collected, it seems that religion plays a relatively small role in the practise of female genital mutilation in Nigeria. Female genital mutilation is a custom that was practised in West Africa long before the

[11] The same trend was found in NDHS 2019, where 24 % of women from urban areas and 16 % from rural areas were circumcised (p. 467).

two dominant religions in modern Nigeria – Islam and Christianity – were introduced.

2.5.1 Theological view of female genital mutilation in Christianity and Islam

Landinfo has not found examples of anyone claiming that it is a Christian duty to circumcise women, either inside or outside of Nigeria. Rather, church leaders take a generally negative view of female genital mutilation, which they consistently view as a pagan custom. Harsh criticism of people who practise traditional religion (often referred to as paganism) parallel to Christianity is a common theme of sermons in church communities in Nigeria. When Christian Nigerians practise female genital mutilation, it is despite their religious identity, not because of it.

Amongst Islamic theologians, attitudes are more divided – including internationally. Some Muslims, both theologians and laypeople, view female circumcision as a religious duty, based on *hadiths.*[12] However, many Islamic theologians believe that these specific *hadiths* have low validity. For more on the discussion about female genital mutilation in an Islamic context, see UNICEF 2013 (p. 69-72).

2.5.2 Relationship between religious affiliation and practise of female genital mutilation

Two studies, one by Mandara (2004, p. 296) and another by Popoola (2007, p. 119), found no statistical correlation between religious affiliation and the practice of female genital mutilation. In Popoola's study of Yorubas, the share of circumcised women among Christians and Muslims was quite similar, and the attitudes towards female genital mutilation were also quite similar. Specifically, 68.7 % of the Christian respondents were positive towards female genital mutilation, compared to 70.4 % of Muslims in the survey. In this study, 24.5 % of the respondents said that female genital mutilation was in line with their family's religion, while 75.5 % said that it was not (p. 119).

In the national demographic and health survey conducted in 2018, 16.6 % of women who had heard of female genital mutilation said that female circumcision was a religious duty. In the North West zone, 24.8 % of women reported that they believed it was a religious duty, compared with 7.5 % in the South East. In the

[12] A *hadith* is an account of a statement from the prophet Muhammad or an episode in his life that illustrates what the first Muslims believed about various matters. This is an important source of law within the Muslim legal tradition, particularly for topics that are not mentioned in the Qur'an (which female genital mutilation is not). Theologians assess the validity of *hadith* based on whether they have been handed down by sources that there is reason to trust (Vikør 2006, p. 104–106).

other regions, the percentage was between 10 % and 20 % (NDHS 2019, p. 481-482).[13]

NDHS 2018 divided respondents into five different groups of religious affiliation: Catholic, other Christians, Islam, traditional and other. Of these, female genital mutilation was most prevalent amongst Catholics with 24.5 %, followed by 19.4 % amongst other Christians, 18.7 % Islam, 11.9 % traditional and 2.2 % other (NDHS 2019, p. 473). Where the percentage is high amongst Christians, this is due to Christianity being most prevalent in the southern part of Nigeria, where most ethnic groups practised female genital mutilation nearly universally when Christian missionaries began their work in the region.

Education and economic prosperity seem to influence whether a person believes that female circumcision is a religious duty. Only 8.6 % of women with education higher than upper secondary school believed that female circumcision was necessary because of religion, compared with 27.7 % of women without education. Women in the highest economic strata also believed to a much lesser extent (8,5 %) that circumcision was required by religion, compared to 29.3 % of those in the lowest economic strata (NDHS 2019, p. 482). Among the various religious groups, it was mostly traditionalists[14] (46.9 %) who believed that female circumcision was required by their religion, followed by 24.1 % of Muslims and only 7–8 % amongst Catholics and other Christians.

2.6 Covid-19

Many claim that the prevalence of female genital mutilation increased during the Covid-19 pandemic (The Lancet Public Health 2021; Orchid Project 2020; Udeme & Dadik 2022; UNICEF 2021, 2022b). National curfews and school shutdowns meant that girls had to stay at home and risked being subjected to the procedure. Local grassroots organisations reported an increase in the number of those circumcised, including in the South West and North Central, and in Enugu, helplines reportedly saw a high demand. Access to preventive services, protection and psychosocial support services were restricted, partly due to the reprioritisation of medical resources for the Covid-19 response (Orchid Project 2020, p. 7-8).

[13] Because the MICS survey in 2021 did not cover religious affiliation, we use data from NDHS 2018 in this section.

[14] NDHS (2019) uses the term "traditionalists" for respondents who do not identify as either Christian or Muslim and who are thus considered to follow the modern versions of the religions that dominated before Islam and Christianity were introduced. However, this segment was very small, accounting for only 219 out of 53,688 respondents, or 0.43 % (p. 51).

3 How, why and when is female genital mutilation performed?

3.1 Types of female genital mutilation

The WHO classifies female genital mutilation into four different types, which range in scope from "symbolic" pricking to infibulation:

- Type I (clitoridectomy): Partial or total removal of the clitoral glans and/or the prepuce/clitoral hood.
- Type II (excision): Partial or total removal of the clitoral glans and labia minora, with or without removal of labia majora.
- Type III (infibulation): 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 clitoral prepuce/clitoral hood and glans.
- Type IV: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, scraping and cauterizing the genital area (WHO 2020).

Type II seems to be the most common form of female circumcision in Nigeria (see table below).[15] The MICS 2021 survey showed that type II[16] was most common and was performed on 61.5 % of the respondents (p. 354). Figures from NDHS 2018 support this finding and the reports that type II was performed on 41 % of the women (p. 465-466). Being sewn closed (type III) is not particularly prevalent in Nigeria, and on average it is only 7.7 % who have been subjected to this type of female genital mutilation. However, the population groups Edo and Ijaw differ somewhat, where type II had been performed on 43.3 % and 21.1 % of the respondents, respectively, compared with approximately 4–5 % for the other groups (NBS & UNICEF 2022, p. 354). However, there are many in Nigeria who do not have a conscious attitude towards this categorisation, and there is a lack of classification of the type of circumcision for 44.1 % and 26.3 % of the respondents, respectively, in the most recent NDHS and MICS surveys.

Table – Types of female genital mutilation

	Type I	Type II	Type III	Don't know/data missing
NDHS 2018	9,6%	40,7%	5,6%	44,1%
MICS 2021	4,5%	61,5%	7,7%	26,3%

[15] The variation between the two sources here is probably primarily due to the fact that they cover two different cohorts of respondents.

[16] The MICS survey uses a slightly different classification than the World Health Organization. MICS uses the descriptions: "Were nicked", "Had flesh removed", "Were sewn close". These types can roughly be classified as corresponding to type I, type II and type III respectively.

3.2 Why is female genital mutilation performed?

The reasons for female circumcision in Nigeria are complex, and there are considerable local variations. Studies focusing on different regions have identified the following reasons for practising female genital mutilation:

- Respect for tradition and cultural identity, including social pressure to live up to traditions, preserve the family's honour and to be considered a woman (Ezeoke et al. 2021, p. 1811; NBS & UNICEF 2022; Omigbodun et al. 2022; Orchid Project & 28 Too Many 2023, p. 40; Orji & Babalola 2006; Sodje & Ilevbare 2020). Dotimi has studied the Odi community[17] and describes female circumcision as a cultural tradition in order to be recognised and accepted in the local community, and to be able to participate in social gatherings and ceremonies (Dotimi 2016).
- To preserve women's chastity and virginity, to supress women's sexual drive and to ensure that women are faithful to their husbands and to increase male sexual pleasure (IRB Canada 2015; NBS & UNICEF 2022, p. 353; Olagunuju 2018; Orchid Project & 28 Too Many 2023, p. 40; Orji & Babalola 2006, p. 322; Sodje & Ilevbare 2020, p. 885)
- Cultural myths that create fear: a common belief in southern Nigeria is that if the woman is not circumcised before she gives birth to her first child, and if the clitoris comes in contact with the child, the child and/or the woman will die or be injured during the birth (Dotimi 2016; Ezeoke et al. 2021, p. 1811; NBS & UNICEF 2022; Netherlands Ministry of Foreign Affairs 2021, p. 85; Orji & Babalola 2006, p. 322; Population Reference Bureau 2018, p. 13-14; Renne 2020, p. 14). In areas where this belief is held, female circumcision is often performed before the first pregnancy. However, this belief is also common amongst the Yoruba, where female genital mutilation is mostly performed during the first week of life. It is not usually performed after childbirth, and the operation is not repeated for the next pregnancy if the woman was circumcised during the first pregnancy (Netherlands Ministry of Foreign Affairs 2021, p. 85). Many of the women in Dotimi's study said that they no longer believed this cultural myth that the child would die, and many said that they did not want to continue this tradition (Dotimi 2016, p. 80-81).
- That female circumcision is necessary before marriage and that it leads to increased fertility (NBS & UNICEF 2022; Netherlands Ministry of Foreign Affairs 2021, p. 84; Odo et al. 2020; Orchid Project & 28 Too Many 2023; Sodje & Ilevbare 2020). This is particularly true in southern Nigeria, including in Ebonyi and amongst women with Efik or Ibibio backgrounds in Cross River. Sometimes the woman's family initiates the circumcision to increase her chances in the marriage market, and sometimes the future

[17] The Odi community is part of the Izon-speaking community in the Niger Delta (Yanga as quoted in Dotimi 2016) and is located in the Kolokuma/Opokuma Local Government Area of the federal state Bayelsa, part of the South South zone (Dotimi 2016, p. 4).

husband's family demands it. The latter is particularly common in Ebonyi (Netherlands Ministry of Foreign Affairs 2021, p. 84; Odo et al. 2020; Orchid Project & 28 Too Many 2023).

- Hygiene, cleanliness and aesthetic reasons (Ezeoke et al. 2021; NBS & UNICEF 2022, p. 353; Orji & Babalola 2006, p. 322; Population Reference Bureau 2018, p. 14).

While some of the reasons are widespread throughout Nigeria, others are more locally rooted. Often it is a combination of different reasons that constitute the justification for this practice.

There are few women who cite religion as the main reason, and religion plays an especially minor role in southern Nigeria (Orji & Babalola 2006, p. 322). See also Section 2.5 for more details on religion.

3.3 Who performs female genital mutilation?

Female genital mutilation is usually performed by traditional circumcisers (NDHS 2019, p. 467). In a minority of cases, the procedure is performed by traditional midwives or older women in the local community (NDHS 2019, p. 467; Odo et al. 2020, p. 1973).

Female genital mutilation is also performed by healthcare personnel (medicalised female genital mutilation), despite female genital mutilation being illegal in many states (NDHS 2019, p. 465). The procedure is often performed just after the child is born, and when the birth takes place at a hospital medicalised circumcision may be offered as part of the birth services (Obianwu, Adetunji & Dirisu 2018, p. v-vi). This connection between childbirth with the help of a professional healthcare worker, and female circumcision, may have contributed to legitimising and reinforcing existing norms around female genital mutilation (Population Reference Bureau 2018, p. 14).

It seems that there has been a slight decrease in the number of cases of female circumcision performed by medical health professionals, although not long ago it was thought to be an increasing phenomenon (Population Council 2020, p. 10). In total, female circumcision is performed by medical health personnel (doctors, nurses and midwives) in approximately 7–9 % of the cases (NDHS 2019, p. 467).

If we compare the age groups 0–4 years old and 10–14 years old, we see a decrease from 9.5 % in the older group to 5.6 % of the younger group (p. 480). If we compare different surveys, we also see a decrease from 11.9 % amongst 0–14-year-olds in 2013, to 7 % of 0–14-year-olds in 2018 (NDHS 2014, 2019). This is in contrast to the late 1990s and early 2000s, when there was a slight increase in medicalisation of female genital mutilation.

3.4 When is female genital mutilation performed?

Circumcision occurs at different ages in different parts of Nigeria, but it is most common for female genital mutilation to be performed before the age of five. In the national health and demographic survey from 2018, 85.6 % of the respondents answered that they went through the procedure before they were five. The percentage of those who were circumcised before the age of five was highest in the North West (97 %) and lowest in the South South (59 %) (NDHS 2019, p. 468).

In parts of Nigeria circumcision is practised after the age of 15. Almost a quarter (24 %) of women who had gone through female genital mutilation in the South South and only 15 % of women in the Northeast had undergone the procedure when they were 15 years old or older. In the other regions, it was only between 1 % and 2.5 % who were circumcised after the age of 15 (NDHS 2019, p. 468).

Some women are circumcised later in life, for example, if they are to marry into a family where it is "required" or expected that women are circumcised. Female genital mutilation may also be performed in connection with pregnancy, as many people believe that circumcision prevents injury to the child during childbirth. Sodje & Ilevbare describe an example of a 22-year-old woman (Yoruba, Muslim with a Christian mother) who in 2017 was circumcised when she was 38 weeks pregnant after a previous pregnancy ended with a caesarean section. The woman herself grew up in the state of Delta amongst Kwale/Urhobos with her Christian mother and was not circumcised, but married a Yoruba man who supported the practise of female circumcision. After pressure from the family, particularly from the husband's side, who was Yoruba/Muslim, the woman was circumcised to avoid a caesarean section at the next birth (Sodje & Ilevbare 2020).

Amongst Igbos in Ebonyi state, a study from 2020 (with data collected in 2017) described two types of circumcision: one for children (*ugu umu sukul*) and one for adults (*ugu umu okenye*). *Ugu umu sukul* corresponded to circumcision type I and was usually done "at an early age", typically before the age of five. They described that it could be done at any time of the year (Odo et al. 2020, p. 1972). *Ugu umu okenye* is performed when a woman is about to get married and is described as a traditional ritual where the woman's private parts are shaved. The participants described *ugu umu okenye* as an extension of the circumcision process, but that the women could also choose to skip over this tradition and get married without going through the ritual. However, the discussion in the article states that if it is discovered that the woman is not circumcised, she will be circumcised during the ceremony (Odo et al. 2020, p. 1972-1974). In this case, it would be more of an exception for circumcision to be performed on an adult woman.

4 Parents' freedom of choice and reactions against those who choose not to subject their own daughters to female genital mutilation

4.1 Who decides that female genital mutilation should be performed?

Female genital mutilation is often a matter for the extended family, as important life choices in Nigeria often involve more than just the children and their immediate guardians. In Nigerian families, as in all parts of the world, there is often disagreement about the extent to which one should follow local customs and traditions. There can be major variations in who makes the decision based on individual differences and different ethnic groups.

Many people believe that mothers and grandmothers are the most important decision-makers when it comes to female genital mutilation (Netherlands Ministry of Foreign Affairs 2021, p. 83-84; Orchid Project & 28 Too Many 2023, p. 41), while others believe that fathers are the central decision-makers in health-related matters (Obianwu, Adetunji & Dirisu 2018, p. 14; Population Council interview 2023). In situations where the parents disagree, a quantitative study shows that it is the mother's attitude that is the most important decision-making factor in whether the procedure is performed or not (Cappa, Thomson & Murray 2020, p. 4). This is also supported by Population Council, which in an interview with Landinfo described that men usually make health-related decisions in Nigeria, but "it can happen that the man relies on the women's expertise". They also describe that strong female family members, such as grandmothers, can influence the decision, or make the decision in full without the man being involved (Population Council interview 2023). Both maternal and paternal grandmothers can make this decision, and if there is disagreement about the decision, it is "the most influential" in the social network who decides. Usually, the grandmother on the father's side will have a stronger influence, as the woman usually marries into the man's family, and the children often spend holidays with the father's side of the family (Obianwu, Adetunji & Dirisu 2018, p. v-vi; Population Council interview 2023).

Anuforo, Oyedele & Pacquiao (2004, p. 109) found that it varied between different ethnic groups who was seen as the most important decision-maker:

> *Both parents are generally involved in decision making, with the greater role of older women among the Igbo people, and the father among the Yoruba and Hausa tribes. These statements supported this finding:*
>
> *(Igbo): "The eldest female on the side of the husband makes the decision."*

(Hausa): "The father of the child with the mother's support makes the decision."

(Yoruba): "Both parents make the decision, but the father seeks the circumciser."

Orubuloye, Caldwell & Caldwell (2000, p. 86) found in their research on female genital mutilation amongst Yorubas that the fathers are somewhat less involved than what is reported by Anuforo et al.:

Within the family, the influences are uneven. It is mainly the wife who hears the doctors and nurses, and she is also the one who most identifies with the daughters. But only 8 percent of those not circumcising refused to countenance their husbands' opposition or indecision. In the great majority of cases, the husband concurred that the operation should not be done, and this is the way the survey results are reported. Yet it is quite clear from the in-depth investigations that it was usually the wife who felt strongly on the matter and the husband who left such children's matters – especially as they concerned daughters – to their wives. Not infrequently the wife had the strong support of her mother.

It should be noted that the respondents have few worries about their uncircumcised daughters' chances of marriage.

In the same study (2000, p. 81), it seems that the opinions of the girls' grandparents were a minor deciding factor for parents who had circumcised their daughters or intended to do it – it was only true for 4 % of the respondents with a rural background and 2 % of those with an urban background. It was also not a given that the grandparents were asked for advice (p. 86-87):

When we explored further the social pressures on uncircumcised girls, we found they were less than we had anticipated […]. The spouses' relatives generally either support the decision or are not informed or asked. Only one in five or six of the respondents reported that opposition had been expressed.

In fact, the chief reaction to changing attitudes about female "circumcision" is silence. Parents quite often let the time for "circumcision" pass without discussing it with each other. They find it difficult and are usually reluctant to raise the matter with their own parents.

4.2 What freedom of choice do parents/women have when it comes to deciding whether to perform female genital mutilation?

Although members of the same family often share an ethnic and regional background, and essentially the same traditions, it is not unusual for there to be

some major differences internally in families in terms of level of education, approach to "modern values" and views on local traditions. Furthermore, the amount of knowledge in concrete terms that people have about the harmful consequences of female genital mutilation varies. Thus, parents who face pressure from various family members to subject their daughters to female genital mutilation may in many cases also find support for (a decision on) leaving it up to other family members.

4.2.1 Social sanctions

In Nigeria, the majority of people rely on a large network they can seek assistance from (and who they themselves are obligated to assist) in various situations – both to get practical and financial help. The backbone of such networks is close family and extended family, who, purely based on kinship, are essentially obligated to assist other family members where they can. In practice, however, such help is generally easier to get from family members with whom one has a good relationship. Disagreements and conflicts with family members can quickly lead to poorer access to help from these (specific) relatives when needed, and threats of withholding future help are not unusual in a conflict situation. In conflicts where other family members make such threats, it is up to the person being threatened whether they are willing to stand their ground, with the practical consequences this may have (which can perhaps be compensated for by supporters they have elsewhere in their network), or if they give in because they are not willing to pay the social cost it may involve to go against the wishes of certain relatives.

The social pressure may consist of various social sanctions such as teasing, bullying, exclusion from cultural activities and ceremonies and stigmatisation (Dotimi 2016; IRB Canada 2021 para 4.2; Netherlands Ministry of Foreign Affairs 2021, p. 86; Odo et al. 2020; Omigbodun et al. 2022, p. 8-9; Udeme & Dadik 2022). However, there are also major local and individual variations here. It is also reasonable to assume that the social pressure has decreased in line with the prevalence of female genital mutilation having decreased (see Chapter 2) and that the severity of the social sanctions is not particularly high in many cases. For example, one source told the Canadian authorities that "it can happen" that a girl experiences stigmatisation, but that she would not be subjected to "persecution or harassment", and she would still be able to attend church and school (head of the Centre for Women Studies and Intervention as quoted in IRB Canada 2021, p. 8).

We emphasise that it is not known whether disagreements on matters such as female genital mutilation lead to people collectively freezing out individuals from various types of networks. (Social sanctions with such major consequences almost always only affect people who have committed serious crimes such as murder or incest, and even then not everyone necessarily breaks ties with the person in question).

4.2.2 Use of force is not widespread, but can happen

In the sources Landinfo conferred with, most indicate that the use of force is not particularly prevalent in recent times. There is broad agreement amongst sources that the use of force is increasingly becoming a thing of the past (Aderibigbe 2023, p. 63; Dotimi 2016; Odo et al. 2020, p. 1973-1974).

A confidential source whom the Dutch authorities spoke with said that adult women who do not want to be circumcised cannot be forced to do so (2021, p. 85). Nevertheless, there are examples of force being used in some cases, either by parents or older family members. For example, Aderibigbe (2023) mentions an example of a legal case with a recent date where a grandmother was charged with having circumcised her granddaughter against the will of the child's parents. However, she emphasises that this is not common.

As mentioned in Section 4.1, there is often disagreement about the extent to which local customs and traditions should be followed, and there can be major individual differences and variations amongst different ethnic groups. In some areas (particularly in the south), the social pressure can be so great that the parents circumcise their child despite not supporting the custom themselves, or that women ask for it themselves (Netherlands Ministry of Foreign Affairs 2021, p. 86; Udeme & Dadik 2022). Resisting the social pressure can be more difficult for people with little resources, as there are few options for support or available crisis centres (IRB Canada 2021 paragraph 4.1; Netherlands Ministry of Foreign Affairs 2021; Udeme & Dadik 2022).

4.3 Are parents who choose not to subject their daughters to female genital mutilation subjected to violence or threats of violence?

There is no information in the material reviewed for this report that gives examples of parents or women who do not allow their daughters to be subjected to female genital mutilation facing violence or threats. This is hardly surprising, as violence and threats of violence against adult family members who one believes are making the wrong choice in raising their own children is viewed as socially unacceptable – also in a Nigerian context.

5 Government protection

5.1 Legislation against female genital mutilation

In May 2015, the federal government of Nigeria introduced a law banning female genital mutilation and other harmful practices. The law, Violence Against Persons (Prohibition) Act 2015 (VAPP), is the first federal law to ban female throughout

the country (28 Too Many 2022, p. 2). A piece of federal legislation only comes into force after the states have enacted the law, and at first was only in force in the federal territory of Abuja. As of April 2023, the law has been implemented in all other states except for Ekiti, Kano, Katsina, Lagos, Taraba and Zamfara (Partners West Africa Nigeria 2023). Ekiti and Lagos have separate laws from 2019 and 2007, respectively, that ban gender-based violence, which includes some of the provisions found in the VAPP.

5.1.1 Enforcement of legislation

The implementation of the legislation against female genital mutilation is inadequate and legal proceedings rarely occur (U.S. Department of State 2023, p. 27). In an interview with researchers from the Population Council, they confirmed that the implementation of the law is not very proactive ("relaxed") (2023) and 28 Too Many describes the implementation as "not consistent" (2023, p. 55).

5.2 Local statutes and work with traditional and religious leaders

What has a greater impact on changing the practise is local statutes, which are decided locally in public meetings known as "People's Assemblies" (Orchid Project & 28 Too Many 2023, p. 20). Traditional and religious leaders also play an important role when it comes to gaining acceptance for matters such as vaccination, family planning, and for changing attitudes around female genital mutilation (Population Council interview 2023). Others have also described that awareness campaigns, which are often done in collaboration with religious and traditional leaders, have influenced the way female circumcision is practised (Odo et al. 2020, p. 1976). A source Landinfo spoke with who works with the issue of female genital mutilation at a grassroots level and works with the United Nations Population Fund, says that local communities who draft their own laws or public declarations on ending female genital mutilation have a much greater impact than legislation at a federal or state level (Aderibigbe 2023).

5.3 National action plan against female genital mutilation

There was a national action plan against female genital mutilation at the federal level for the period of 2013–2017, which was extended to 2019 (UNFPA 2023a). According to 28 Too Many, as of March 2023 a new action plan has not been drafted, despite promises to this effect from the Nigerian authorities (2023, p. 19-20).[18]

[18] According to a press release from the World Health Organization in 2019, an official from the Federal Ministry of Health stated that there is a national plan for the period 2020–2024 ("National Policy on the elimination of FGM (2020–2024)") (WHO 2019). Neither Landinfo nor the Canadian authorities have found any further references to this document.

5.4 Inadequate legislation against medicalised female genital mutilation

Despite female genital mutilation being illegal in most states in Nigeria, female genital mutilation is practised openly by healthcare workers in many places. One of the criticisms against the Violence Against Persons (Prohibition) Act is precisely that it does not directly mention medicalised female genital mutilation (Orchid Project & 28 Too Many 2023, p. 19). The Population Reference Bureau describes that the healthcare workers they interviewed did not try to hide the fact that they practise female circumcision, and many mentioned that they had learned how to perform the procedure from other healthcare workers (Population Reference Bureau 2018, p. 14-15). This attitude amongst healthcare workers, as well as the absence of legislation addressing this practise directly, may indicate that there is a certain degree of social acceptance for medicalised female genital mutilation.

5.5 Government-operated agencies with responsibility for government protection

5.5.1 Police

Formally, the police can only be of help in states with legislation against female genital mutilation. Landinfo is not aware of it being common to seek help from the police for people who are opposed to female genital mutilation being performed on themselves or others. It is common knowledge that Nigerians generally have low trust in the police, and that it is not common to turn to the police for help in conflicts within the family. A source told the Canadian authorities that the police would rarely take requests for protection from female genital mutilation seriously, and that the police would not pursue the case. On the contrary, the source believes that the police would more likely make fun of a woman who turned to the police with such matters, which is considered a family matter. In addition, it is expensive to take cases to the police and to court, which reduces the incentive for turning to these agencies (head of the Centre for Women Studies and Intervention as quoted in IRB Canada 2021, p. 10).

5.5.2 The national human rights commission

Landinfo met with the National Human Rights Commission in Nigeria (NHRC) in March 2006 (Bello & Ojukwu 2006). Bukhari Bello, head of the NHRC at the time, said that the NHRC can provide legal help and assist with mediation in conflicts between family members involving female genital mutilation. The NHRC has offices in the capital city of Abuja and all 36 states (NHRC, unknown year).

6 Non-governmental measures against female genital mutilation

In a report from the Dutch authorities, a source (as quoted in Netherlands Ministry of Foreign Affairs 2021, p. 86-87) said that most women who want to avoid female genital mutilation for themselves or their daughters often try to leave the village and settle with family or friends elsewhere.

The options for being able to start a new life in another place depend on the woman's financial independence and whether she has an education or other opportunities to get a job and survive on her own. See Landinfo (2010) for more on this topic.

6.1 Non-governmental organisations

There are a number of grassroots organisations who work to combat female genital mutilation in Nigeria. Not only do these organisations conduct general educational work, they can also be active supporters of girls and women who need help when they are in conflict with other family members.

The UN system works actively to support grassroots organisations, governments and other stakeholders' work to combat female genital mutilation. For example, the United Nations Population Fund and the United Nations Children's Fund have since 2008 collaborated on one of the largest global programmes to end female genital mutilation, The Female Genital Mutilation Joint Programme. The fourth phase of implementation was launched in 2022 and works to eliminate female genital mutilation by 2030, in the context of UN Sustainable Development Goal 5.3 on eliminating all harmful practises (UNFPA 2023b).

The UN system in Nigeria also works actively to combat gender-based violence, including female genital mutilation, through the Spotlight Initiative (2022). In November 2020, the Nigerian government, in cooperation with the Spotlight Initiative, launched a digital portal, ReportGBV[19] with an overview of grassroots organisations and places where women can seek help. It also monitors the number of incidents reported by these organisations (Spotlight Initiative 2020).

6.2 Crisis centres and information services

There are many different initiatives, crisis centres and helplines in Nigeria, but it is difficult to make a concrete estimate of the capacity in this area. The ReportGBV portal, as mentioned above, can be used to identify organisations that

[19] https://reportgbv.ng

offer various services such as psychosocial support, shelter, legal assistance etc. at a state level.

However, the Orchid Project says that the crisis centres and helplines often lack funds or have limited capacity. This was particularly the case after many of the initiatives had to close during the Covid-19 pandemic (Orchid Project 2020, p. 8).

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