



SITUATION ASSESSMENT AND ANALYSIS OF FEMALE GENITAL MUTILATION/CUTTING IN IMO AND EBONYI STATES

A BASELINE REPORT

**CIVIL RESOURCE DEVELOPMENT AND DOCUMENTATION CENTRE (CIRDDOC)
IN PARTNERSHIP WITH THE COALITION OF EASTERN NON-GOVERNMENTAL
ORGANISATIONS (CENGOS) AND WITH FUNDING SUPPORT FROM AMPLIFY
CHANGE**



This report summarizes the findings of the 2020 Female Genital Mutilation/Cutting Baseline Survey commissioned by Civil Resource Development and Documentation Centre (CIRDDOC) Nigeria in collaboration with the Coalition of Eastern Non-Governmental Organisations (CENGOS) and with funding support from Amplify Change.

CIRDDOC Nigeria is an independent, non-governmental and not-for-profit organisation committed to the protection and promotion of human rights, gender equity and access to justice and the strengthening of civil society; CENGOS is a network of over 100 civil society organizations in nine states of the old Eastern region; and AmplifyChange is a fund to break the silence on Sexual and Reproductive Health and Rights (SRHR).

This baseline study was conducted by Charles Uzundu, PhD, FIMC of the Centre for Health, Education and Environmental Research (CHEERs) December, 2020.

ABOUT CIRDDOC NIGERIA

The Civil Resource Development and Documentation Centre (CIRDDOC) Nigeria is an independent, non-governmental and not-for-profit organisation established in 1996 for the protection and promotion of human rights and women's human rights and the strengthening of civil society. CIRDDOC is also committed to the institutionalization of good governance, gender equality and the rule of law. CIRDDOC is registered under Part C of Company and Allied Matters Act laws of the Federation of Nigeria 1990. (RC 10,928).

Our Vision: A world, in which human rights are guaranteed, protected and enforced on the basis of equality and non-discrimination.

Our Mission: To promote and protect human rights and women's rights, gender equity, and good governance through the empowerment of civil society and the promotion of access to justice and rule of law.

Our strategic Objectives are:

1. To promote human rights, women's rights, gender equality, and good governance.
2. To facilitate access to justice and the rule of law.
3. To build capacity of civil society to demand accountability from leaders and policy makers.
4. To facilitate networking, collaboration and partnerships among civil society organizations, and between government and civil society organizations.

Our Values: Resilience, Mutual Respect, Integrity, Transparency and accountability, Education and Empowerment, Equality and Equity.

Program Focus Areas: Education and empowerment, Democracy & Governance Human Rights and women's rights, Gender equality, Conflict Resolution, Violence against women and HIV/AIDS

CIRDDOC has operational offices in three states: Enugu, Anambra & Ebonyi, and Abuja but its mandate is to implement its programmes in Nigeria as a whole. In addition, CIRDDOC has established 15 Community Information Centres (CIC) in three states to provide a forum for citizens to access information.

For more information, contact:

Civil Resource Development and Documentation Centre (CIRDDOC) Nigeria
9 Second Avenue, Independence Layout, Enugu, 08033132493.

Email: cirddoc96@yahoo.com

Website: www.cirddoc.org

ACKNOWLEDGEMENT

This baseline study was successfully completed with the support and cooperation of numerous individuals, groups and stakeholders at different stages. Financial support for the survey was provided by the Civil Resource Development and Documentation Centre (CIRDDOC) in partnership with the Coalition of Eastern NGOs (CENGOS). This is greatly appreciated.

We are grateful to the senior management and board members of CIRDDOC and CENGOS for their interest and collaboration in commissioning this study. Specifically, we acknowledge the support of the Executive Director (CIRDDOC), Mrs. Raluchukwu Nwankwo-Obioha for believing in us to conduct this baseline survey.

This survey would not have been possible without the active and continued support of Mr. Pascal Anozie, the Project Coordinator, who responded to our needs in the execution of the research. Both the Executive Director and Project Coordinator as well as Coordinators of Ebonyi and Imo State Chapters of CENGOS, Nancy Oko-Onyia and Ahamdi Okpara also patiently reviewed the draft report and made inputs that strengthened this final copy. The Desk Officers at the Imo State Ministry of Women Affairs and Social Development readily helped in clarifying key issues on the Imo State 2017 Law Prohibiting Female Genital Mutilation. They are all appreciated.

We appreciate and acknowledge the ready support of the Traditional Rulers, Presidents Generals, Women and Youth leaders of the surveyed communities, not just in participating as respondents but also in ensuring that the right participants were available, sometimes at short notices, to support the study. The task of developing database for the survey quantitative tool was accomplished by Mr. Charles Igbokwe, while Pastor Ifeyinwa Uzundu and Joan Ekeh reviewed the data collection tools. Our community leads; including those nominated by CIRDDOC contributed to this success and are highly appreciated. We are grateful to Mr. Raymond Uche and Mrs. Nkechi Uche who provided linkage to the supervisors and research assistants who were knowledgeable about dialects and community traditions, as well as ensured the research team was well taken care of all through the stay in Ebonyi.

This acknowledgement cannot be concluded without recognizing the support of all our respondents who voluntarily participated and responded to all discussions and questions.

But it was God who gave us life and safety to conduct this survey. To Him is all the glory.

Cover Page	1
About CIRDDOC Nigeria	2
Acknowledgement	3
Table of Contents	4
List of Tables	7
Introduction and Magnitude of the Problem	8
Background	8
Problem statement	8
Origin and Significance	9
FGM/C in NIGERIA	10
Perceived justifications for sustaining FGM/C	10
Health implications of FGM/C	11
Nigerian Government Response: Legislation and Efforts to Eliminate FGM/C	12
Limitations of the VAPP Act	13
Limitations of the Imo state Law prohibiting FGM/C, 2017	14
Baseline survey objective	14
Rational for baseline on FGM/C	15
Limitations of the baseline survey	15
Study Methodology	16
Description of study area	16
Ebonyi State	16
Imo State	17
Study Population	17
Study Design and scope	18
Materials and methods for data collection	18
Quantitative Data Collection Methods	18

Qualitative Data Collection Methods	19
Focus Group Discussion	19
Key Informant Interviews	19
Validity and Reliability	20
Validity	20
Reliability	20
Pretesting of tools	20
Training of Research Assistants/Data Collectors	20
Inclusion criteria	21
Exclusion criteria	21
PROCEDURE FOR DATA GATHERING	21
Administration of Questionnaires	21
Focus Group Discussion	22
Key Informant Interviews	22
RESULTS AND ANALYSIS	22
Quantitative Results	22
Qualitative Results	28
FOCUS GROUP DISCUSSIONS	28
Key Findings on Knowledge, Attitude and Practices	29
Key findings on the prevalence of FGM/C in the states	31
Key findings on the social norms and dynamics	32
Key findings on the existence and strength of laws addressing FGM/C	34
Key findings on recommendations for banning FGM/C	34
Key Informant Interviews	36
Key findings from Traditional Rulers	36
Key findings from Female Circumcisers	39

Key findings from Church Leaders	40
Key findings from Elderly men	40
Key findings from Elderly women	40
Key findings from Youth Leaders	41
Key Findings from Health workers	41
DISCUSSION, CONCLUSION, RECOMMENDATIONS, LESSONS LEARNED	42
DISCUSSION	42
Characteristics of Respondents	42
Respondents' Knowledge, Attitude and Practice of FGM/C	42
Prevalence of FGM/C	43
Age at Circumcision	44
Circumcision of Daughters	44
Person who performed circumcision	45
Social norms and dynamics on social motivation	45
Attitudes towards Female Circumcision	46
Existence, availability, strength of laws addressing FGM/C	47
CONCLUSION	48
RECOMMENDATIONS	50
Elderly women as targets	50
Target unmarried adolescents for FGM/C education	51
Teach, demonstrate evidence and create awareness about the evils of FGM/C	51
Domesticate and enforce the VAPP law	52
Multi-dimensional approach	52
Lessons Learned	52
References	55

LIST OF TABLES

Table i FGM/C survey coverage area	16
Table 1: Distribution of respondents by age, sex, education and religion	23
Table 2: Respondents' sources of income	24
Table 3: Knowledge of female genital mutilation?	24
Table 4: Prevalence of FGM/C among WCBA	25
Table 5: Prevalence of FGM/C among adolescents	25
Table 6: Intention to circumcise daughters in future	26
Table 7: FGM/C approved by my religion	26
Table 8: Should FGM/C be continued or not	27
Table 9: Age of respondent vs. ever been circumcised	27
Table10: Circumcised women, circumcised daughters, and education level	28

SITUATION ASSESSMENT AND ANALYSIS OF FEMALE GENITAL MUTILATION/CUTTING IN SELECTED COMMUNITIES IN EBONYI AND IMO STATES

1.0. Introduction and Magnitude of the Problem

1.1 Background

Women and young adults constitute an important challenge to the future and advancement of any country. About a quarter (24.9%) of Nigeria's population is women of reproductive age (15-49 years) and 31.7% are young people aged 10-24 years.¹ Nigeria has a young population structure – 62% of the population is in the age range of 0 to 24 years and the median age is 17.9 years, while 22% of the country's total population are between the ages of 10 and 19 years ². With a maternal mortality rate of 576 pregnant women per 100,000 live births, Nigeria accounts for 14 percent of the global burden of maternal mortality ^{3,4} Further global evidence suggests that young girls bear a higher burden of this maternal mortality and morbidity. Nigeria's data on sexual and reproductive health (SRH) outcomes underscore the importance of focusing studies and interventions on women, adolescent females and young female adults.

Despite the growing influence of globalization, socio-cultural norms and traditional practices are still very strong in most Nigerian communities. The conflict between tradition and modernity is apparent in many areas, particularly with regards to gender and human rights issues, the development and behaviour of young people and the health beliefs and health-seeking behaviour at community and household levels. On one hand, a number of cultural norms and practices in Nigeria have positive values and implications for health, example, HIV prevention, treatment and care. On the other hand, practices such as female genital mutilation may increase vulnerability to other infections including HIV/AIDS.

1.1. Problem statement

South-East Nigeria has a disproportionate burden of female circumcision. Female Genital Mutilation (FGM), Female Genital Cutting (FGC) or Female Circumcision, is a fundamental violation of womanhood accounting for about 55% of the female rights abuse all over the world.⁵FGM is an unhealthy traditional practice inflicted on girls and women worldwide. It is widely recognized as a violation of human rights which is deeply rooted in cultural beliefs and perceptions over decades, and which is stoutly resisting extinction. Female Genital Mutilation/Cutting (FGM/C) encompasses all illegal surgical procedures involving partial or total removal of the external female genitalia for cultural or other non-therapeutic reasons.^{6,7} The NDHS (2018)⁸ reported that the national FGM/C prevalence among women age 15-49 is 20%. However, the prevalence of FGM is highest in the South East (35%) and South West (30%) and lowest in the North East (6%). The NDHS (2018) further revealed that in the South East, the distribution of FGM prevalence is as follows: **Imo (61.7%); Ebonyi (53.2%);** (Enugu 25.3%); Anambra (21.4%) and Abia (12.2%).

The continued practice of Female Genital Mutilation/Cutting in Ebonyi and Imo states is a burden which both states must commit to overcome. Although both states have demonstrable evidence of efforts targeted at stopping this gender-based abuse, female circumcision has remained endemic in many communities in the two states. In spite of its gravity as an abuse of human rights of the victims, the practicing communities still see the act as an integral part of their cultural identity and customs. In collaboration with the Civil Resource Development and Documentation Centre (CIRDDOC) Nigeria, the states are exploring different ways to stop the age-old tradition where a large proportion of women and girls are violated by family members, acquaintances and stakeholders.

1.2.Origin and Significance

FGM/C is a practice whose origin and significance are shrouded in secrecy, uncertainty and confusion. According to Okeke et al⁹ the origin of FGM is fraught with controversy either as an initiation ceremony of young girls into womanhood or to ensure virginity and curb promiscuity, or to protect female modesty and chastity ¹⁰. It is a practice that transcends status, age and geography. Categories of the female population subjected to this practice include infants, teenage girls, young brides and pregnant women.

Globally an estimated two hundred million girls and women are living with FGM/C. World Health Organization (WHO, 2014) classifies FGM/C into four main categories:

Type I: **Clitoridectomy**: Removing the clitoral hood and at least part of the clitoris

Type II: **Sunna**: Removing the full clitoris and part of the labia minora

Type III: **Infibulation**: Removing the clitoris, labia minora, and labia majora. This also involves stitching the vaginal opening with a minuscule hole for urination and menstrual bleeding.

Type IV: Other unclassified forms of FGM/C may involve pricking, piercing, stretching of the clitoris and/or labia, cauterization by burning of the clitoris and surrounding tissue, scraping of tissue surrounding the opening of the vagina (**Angura cuts**), or cutting of the vagina (**Gishiri cuts**); and introduction of corrosive substances or herbs into the vagina to cause bleeding or to tighten or narrow the vagina

Though FGM/C is practiced in more than 28 countries in Africa and a few scattered communities worldwide, its burden is seen in Nigeria, Egypt, Mali, Eritrea, Sudan, Central African Republic, and northern part of Ghana where it has been an old traditional and cultural practice of various ethnic groups. The highest prevalence rates are found in Somalia and Djibouti where FGM is virtually universal (UNICEF)¹¹

1.3.FGM/C in NIGERIA

Nigeria, with 21.6 million women and girls, currently has the third largest number of females who have undergone FGM/C in the world, coming behind Egypt and Ethiopia.¹² The implication of this for Nigeria is that one in four women of Child bearing age (WCBA 15-49 years) in Nigeria has been mutilated. It also means that about ten percent of the global totals of genitally mutilated women are Nigerians, that is, 1 out of every 10 mutilated women in the world is a Nigerian. Contrary to many peoples' assumptions, FGM/C is reported to be more prevalent in the urban areas than the rural areas with a difference of thirteen percent rating (MICS, 2018)¹³. Likewise the dynamics again changed in consideration of educational level as the practice increased by 11.9% from women without formal education to women with secondary education and above. The Multiple Indicator Cluster Survey (MICS) concludes that the prevalence of FGM/C in Nigeria is associated with age, education and wealth status

In Nigeria, Female Circumcision/Female Genital Mutilation/Female Genital Cutting is customarily a family tradition that the young female between the ages of 0-15 typically would experience. It is a procedure that involves partial or completely removing the external female genitalia or other injury to the female genital organs whenever for non-medical reasons.¹⁴ FGM is a human rights violation deeply rooted in beliefs and perceptions over decades and generations. Currently, 13 out of 36 states in Nigeria have their own individual state laws expressly prohibiting FGM/C. These states are Lagos, Osun, Ondo, Ekiti, Bayelsa, Ogun, Delta, Ebonyi, Oyo, Imo, Edo, Cross-River, and Rivers. According to researchers, three major forms of FGM/C are practiced in Nigeria. These are female circumcision, hymenectomy (angurya), and gashiri cuts¹⁵.

The NDHS (2018) reported that in Nigeria, 20% of women age 15-49 are circumcised. The most common type of FGM/C in Nigeria is Type II (some flesh removal), with 41% of women undergoing this procedure. Ten percent of women underwent a Type I procedure (clitoris nicked, no flesh removed), and 6% underwent a Type III procedure (infibulation). Findings of the 2018 NDHS further reported that the prevalence of FGM/C seems to be decreasing in Nigeria. Only 14% of women age 15-19 have been circumcised, as compared with 31% of women age 45-49. The prevalence of FGM is highest in the South East (35%) and South West (30%) and lowest in the North East (6%). Sixty-two percent of women in Imo have experienced FGM/C, as compared with less than 1% of women in Adamawa and Gombe.

1.4.Perceived justifications for sustaining FGM/C

There are many reasons adduced by families and communities for practicing FGM/C in Nigeria, ranging from cultural reasons to its use in curbing sexual appetites of women and girls in the community: rite of passage into adulthood and as part of naming ceremony. For example, in some communities in Enugu state in South East Nigeria, FGM/C is conducted on the eighth day after a girl's birth, to coincide with the child's naming ceremony. The combined ceremony is a festive

event that attracts gifts for the new-born baby and refreshments/entertainments for guests, but the naming and cutting are linked together.¹⁶ Because of this linkage, poor mothers cannot resist the mutilation of their female child because if they did, there would be no naming ceremony for the child. Other reasons adduced are: preservation of chastity and purification of the girl child¹⁷; family honour, hygiene, aesthetic reasons, protection of virginity and prevention of promiscuity, modification of socio-sexual attitudes (countering failure of a woman to attain orgasm), increased sexual pleasure of husband, enhancing fertility and increasing matrimonial opportunities. Other reasons are to prevent mother and child from dying during childbirth, and for legal reasons (one cannot inherit property if not circumcised).¹⁸

Furthermore, due to immense social pressure and fear of exclusion from the community, families conform to the tradition. In Nigeria and other societies, girls who have not gone through FGM/C are considered as unmarriageable, unclean and as social taboos. Girls who remain uncut may be teased or looked down upon in the society. Most times, the girls themselves desire to conform to peer as well as societal pressure out of the fear of stigmatization and rejection by their own community. They accept the practice as a necessary and normal part of life. In many communities this particular practice is upheld as a religious requirement. FGM/C is performed by Muslims, Christians, and Jews. However, it is carried out in some Muslim communities with the belief that it is demanded by Islamic faith. Nevertheless, there is no documentation of this practice in the scriptural texts of these religions. Moreover, the historical origin of the practice asserts that it predates the advent of all major religions of the world including Islam. Often older women become the moral gatekeepers pushing for this ritual to justify their own experience of genital cutting and they tend to see any effort to eliminate the practice as a threat to their culture.¹⁹

1.5. Health implications of FGM/C

There is no documented evidence that FGM has any health benefits for the victim. Rather, an abundance of research evidence exists which reveal health issues resulting from FGM/C. WHO (2018) asserted that FGM/C increases the short and long term health risks to women and girls and is unacceptable from a human rights and health perspective. Abbas Abel Anzaku, et al²⁰ in their study “Implications of female genital mutilation in Nigeria as portal for infectious diseases”, reported that FGM can induce secondary infections resulting from microbial pathogens, example sexually transmitted infections (STI), pelvic inflammatory diseases (PID), as well as recurring urinary tract infections (UTI).FGM/C increases susceptibility to HIV/AIDS through various mechanisms such as increased need for blood transmission due to hemorrhage either when the procedure is performed at child birth or result of vaginal tear during defibulation and intercourse; the use of same unsterilized blade for different persons. Mandara (2000)²¹ and Berg et al (2016)²² reported that during intercourse penetration, there are difficulties which often result in tissue damages , lesions and postcoital bleeding which tends to make the squamous vaginal epithelium similar in permeability to the columnar mucosa of the rectum, thus facilitating the possible transmission of HIV.

FGM/C does irreparable harm to the female reproductive organ and health as a whole which can result to death through severe bleeding, pain and trauma as well as overwhelming infections²³. Obstetric complications include injury to rectum, urethra and bladder, prolonged labour, delayed second stage and obstructed labour leading to fistulae formation. The opening passages between the vagina and bladder or anus can result to Vesico-Vaginal Fistula (VVF)²⁴. The mental and psychological agony which the girl child is subjected to before, during and after FGM/C is deemed the most serious complication because the problem does not manifest outwardly for help to be offered. Odoi, AT (2005)²⁵ opined that the young girl is in constant fear of the procedure and after the ritual she dreads sex because of anticipated pain and dreads childbirth because of complications caused by FGM/C. Such girls may not complain but end up becoming frigid and withdrawn resulting in marital disharmony.

1.6.Nigerian Government Response: Legislation and Efforts to Eliminate FGM in Nigeria

In 1994, Nigeria joined other members of the 47th World Health Assembly (WHA) to resolve to eliminate FGM/C. In 1995, Platform of Action adopted by the Beijing conference called for the eradication of FGM/C through the enactment and enforcement of legislation against the practice. Other steps taken to achieve this goal included the establishment of multisectorial technical working group on Harmful Traditional Practices (HTPs), conduct of various studies and national surveys on HTPs, launching of regional plans of action, and formulation of national policy and plan of action, which was approved by the then Federal Executive Council for the elimination of FGM/C in Nigeria.

In 2000, the Federal Ministry of Women Affairs conducted zonal advocacy and sensitization visits to traditional rulers, religious leaders and policy makers to increase awareness on harmful traditional practices resulting in state legislations and consequent reduction in FGM/C practices. The FGM/C National Response has updated state and zonal prevalence in 2003, 2006, 2008, 2013, 2018 National Demographic and Health Surveys and the National Baseline Survey of positive and harmful traditional practices affecting women and girls in Nigeria.

In May 2015, the Federal Government of Nigeria passed the Violence Against Persons Prohibition Act 2015 (VAPP)²⁶, a law banning FGM/C and other harmful traditional practices; however, this legislation applied only in the Federal Capital Territory (FCT) of Abuja and needs to be domesticated in the states to be effective. The VAPP legislation is an Act to eliminate violence in private and public life, prohibit all forms of violence against persons and to provide maximum protection and effective remedies for victims and punishment of offenders. The Legislation provides for 26 offences, and effectively protects all genders. It especially remedies the lacuna in existing penal laws that are gender blind to the plight of male sexual assault victims, and thus exclude them from the protection of the law. The VAPP explicitly mentions FGM/C as a criminal act. It also makes FGM/C and other forms of gender-based violence such as rape, spousal battery, and forceful ejection from home and harmful widowhood practices, punishable offences in

Nigeria. The VAPP Act also arranges provisions for the maximum protection of victims and for the distribution of effective remedies to them. The VAPP Act outlines a set of punishments for FGM/C. The punishments include:

Anybody who conducts or engages another to conduct FGM/C on any person is liable to a term of imprisonment not exceeding four years or to a fine not exceeding N200,000 or both.

Anybody who attempts, aids, abets or incites another to conduct FGM/C is liable to a term not exceeding two years imprisonment or to a fine not exceeding N100,000 or both. .

In 2017, the Imo state Government, rather than domesticate the VAPP Act, enacted a law to prohibit the act of Female Genital Mutilation/Cutting in Imo state and for other related matters^{26(b)}. The law prescribes imprisonments ranging from 3 to 14 years and/or fines ranging from N100,000 to N200,000, for different offenders, including those who discriminate against girls for non-circumcision, and those who aid and abet the conduct of FGM/C.

Although the Imo state law prohibiting FGM/C recommends that the Commissioner of Health should liaise with state ministry in charge of women affairs to initiate and carry out educative and preventive outreach programs in communities that “traditionally perform FGM/C for the purpose of informing members of those communities the health risks and complications associated with FGM/C, as well as bringing the provisions of the law to their notice there is no evidence of awareness created on this sensitive issue and neither is there any evidence of anybody arraigned and/or convicted for FGM/C in the state.

1.7.Limitations of the VAPP Act

Although the passage of the VAPP Act was a welcome development, there has not been a single FGM/C conviction in Nigeria, five years after the Act became law. There are two major reasons the Act has been ineffective. First, as a Federal law the FGM/C Act can only be effective in the states if domesticated in those states. So far, 14 states and the FCT have domesticated the law. Ebonyi is among the states where this law has been domesticated. But Imo state has not domesticated the VAPP Act. Another reason why the VAPP is ineffective is because of limited awareness. Many Nigerians do not know about the existence of the law. Currently it is estimated that only 1 in 100 Nigerians know about the anti FGM/C law. In a study conducted at Nsukka Local Government Area (LGA) of Enugu state to verify the level of peoples’ awareness about VAPP, only ten (10) out of two hundred and ten (210) female respondents (4.8%) had heard about the VAPP Act. This implies that 95.2% of the respondents had no knowledge of the law²⁷.

1.7.1 Limitations of the Imo state Law prohibiting FGM/C, 2017

We consider that there are inadequacies and gaps that have led to seeming ineffectiveness of the Imo State law prohibiting FGM/C

This study considers that the Imo state government would have achieved more if it had domesticated an existing national law rather than enacting a different law that presents many gaps.

Awareness of the existence of a new law is necessary for its success. The Imo State Law on FGM hinged its awareness creation first on the State ministries of Health and Women Affairs and Social development, and surprisingly on International Donor Agencies and Non-Governmental Organizations (NGOs). Granted that the Health ministry had the responsibility to breakdown the medical terminologies associated with FGM/C risks, the law completely neglected the core government agencies responsible for information, education and culture. The ministry of information which is skilled in information management was completely left out in the quest to take the law to the communities.

Secondly, the Ministry of Chieftaincy, Culture and Tourism was not listed as potential implementers of this law. At the time this law was made (2017), the state prided itself with a Ministry of Community Government, Culture and Traditional Affairs. We consider that this “specialized” ministry should have been given the responsibility in conjunction with the Information Ministry to disseminate the law and bring it to the community level, where it is seriously needed. The Ministry of Education was also noticeably not on the list of government agencies that would have given the law the needed impetus to succeed. Another challenge limiting the implementation of the law draws from a question posed to the researcher by a desk officer who should be leading the implementation in the State Ministry of Women Affairs to the effect: *“If you imprison the father and mother of the victim (an infant), who will take care of the infant?”* This shows the unpreparedness of even the government agencies to prosecute the law.

1.8. Baseline survey objective

The broad objective of the survey is to conduct a situation assessment and analysis including knowledge, attitude and practices (KAP) and social norms that will inform strategies for the implementation of the CIRDDOC/CENGOS/AmplifyChange project on strengthening campaign to end FGM/C in Ebonyi and Imo states

The specific objectives include

1. To establish the current situation, trends and prevalence of FGM/C in Imo and Ebonyi states
2. To investigate the knowledge, attitude and practice including a sound analysis of the social norms, social networks that influence and sustain FGM/C in Imo and Ebonyi states

3. To obtain in-depth understanding of social norms and its dynamics on social motivation of individuals, families, communities and the practice of FGM/C in the states
4. To determine the existence, availability, strength as well as level of public awareness and implementation of instruments/laws addressing FGM/C in the states
5. To make recommendations from the findings (including the roles of relevant stakeholders) for sustainable program to end FGM/C in the states

1.9.Rational for baseline on FGM/C

Although many studies report reduction in the prevalence of FGM/C in Nigeria, the persistence of the practice in some communities and families in Imo and Ebonyi states leading to the reported high prevalence in the two states is of concern to all stakeholders. Sustainable Development Goal (SDG) 5 calls for gender equality and empowering all women and girls, but in Nigeria it faces many problems due to many different resolutions not being in line with the religious and cultural beliefs of most of the Nigerian population and thus, difficult to be enacted as a Nigerian law.)²⁸. Where laws have been successfully enacted, they are obeyed only in breach.

Various research data shows that the majority of people believe female genital cutting should end, but they cite social pressures to continue the practice with their daughters.²⁹ UNICEF (2016) reported that of women aged 15 to 49 polled between 2004 and 2015, 64% want to end the practice. Those few communities and families who still secretly indulge in the ritual occupy a key position in plans to totally eliminate the scourge and therefore need to be targeted for FGM/C awareness and education. A baseline survey is therefore necessary to identify the knowledge, attitude, practices and motivations enabling continued FGM/C practice even in the face of national, state and community laws to the contrary. The survey findings will address best strategies for successful intervention to end FGM/C in Imo and Ebonyi states.

1.11. Limitations of the baseline survey

This baseline is limited to three local government areas (LGAs) and six communities in each of Imo and Ebonyi states. Even in the LGAs, not up to half of the communities were covered. An original suggestion to delineate one community in each state as “control” community was not followed primarily because the selected research method does not give meaning to a “control” research method. Moreover, there was no evidence that the identified “control” communities had same characteristics as the “benefitting” communities, since they were not in same local government areas as any of the “benefitting” communities.

2.0. Study Methodology

A descriptive cross-sectional research method was adopted to describe and quantify the distribution of variables in the study populations at one point in time. Cross-sectional studies are also called prevalence studies because they examine the relationship between a disease (or any other health-related characteristic, (in this case, FGM/C) and other variables of interest as they exist in a defined population at one particular time. The current baseline is a survey on the prevalence of Female Genital Mutilation (FGM/C) in the selected communities in Ebonyi and Imo states and therefore justifies the use of cross-sectional method. The method adequately captures the physical, socio-economic, and behavioural characteristics of the study populations (Women of Child bearing age and unmarried adolescent females) as well as events related to Female Genital Mutilation/Cutting in the population. For example, the physical characteristic of note in this survey is the prevalence of FGM/C in the study communities. The Socio-economic characteristics of the respondents are age, education, marital status, number of children and income. The study describes the behaviour or practices of the study population and the knowledge, attitudes, beliefs, opinions which help to explain that behaviour. Moreover, a cross-sectional research method was used because the survey needed to cover a selected sample of the population, in this case women of childbearing age who had daughters who were also alive, and unmarried adolescent females.

2.1 Description of study area

2.1.1 Ebonyi State is in southeastern Nigeria. Ebonyi is inhabited and populated primarily by the Igbo with the city of Abakaliki as its capital and largest city. Other major towns include Afikpo, Onueke, Ezzamgbo, Edda, Effium, Aba Omege, Amasiri, Unwana, Echara Ikwo, Egu-Ubia, Uburu, Onicha. With an estimated area of 5,533km², its estimated total population is 2880,383 (2016 projection) with a population density of 390/square km. There are several Igbo dialects spoken in Ebonyi. These include Edda, Ehugbo (Afikpo), Izzi-Ezza-Mgbo-Ikwo dialect cluster, Akpoha, Okposi, Onicha, Korri, Effium, Unwana, and Uburu.

Ebonyi state was carved out from parts of Enugu and Abia States in 1996 and has thirteen local government areas as well as local development centres created by the state government. This baseline survey was conducted in three of these thirteen local governments, viz., Abakaliki, Afikpo North and Ebonyi. It is home to six prominent higher institutions of learning: Ebonyi State University, Abakaliki (EBSU); Alex Ekwueme Federal University Ndufu Alike Ikwo; Akanu Ibiam Federal Polytechnic, Unwana; Federal College of Agriculture, Ishiagu; Ebonyi State College of Education Ikwo (EBSCOEI) and College of Health Sciences, Ezzamgbo.

Ebonyi is an agrarian state and a leading producer of rice, yam, potatoes, maize, beans and cassava in Nigeria. Ebonyi is also credited with several mineral resources including lead and salt. Ebonyi is called the “Salt of the nation” for its huge salt deposit at the Okposi and Uburu Salt Lakes. A lot of rock quarrying goes on in the state.

2.1.2 Imo State:

Imo state located in the south east region of Nigeria is one of the 36 States of Nigeria with Owerri as its capital. The state lies within latitudes 4°45'N and 7°15'N, and longitude 6°50'E and 7°25'E with an area of approximately 5,530 sq km. Its other notable towns include Okigwe, Oguta, Orlu, Atta Ikeduru, Akokwa, Mbaise, Emekuku, Isu, Mbaitoli, Mbieri, Ohaji/Egbema, Orodo, Nkwerre, Ubulu, Ngor Okpala, Omuma, Mgbidi, Awo-Omamma, Izombe, Orsu, and Amaigbo. There are 27 Local governments and 637 autonomous communities. This baseline study was conducted in three of these 27 local government areas namely: Orlu, Ohaji/Egbema and Ikeduru. With a population of about 5.5 million, (2016 projection) an annual growth rate of 3.18%, and a population density that varies between 230 and 1,400 persons per sq.km (average 983), Imo state is as populated as some independent African countries. Forty-five (45) percent of the population or 2.5 million persons are under 18 years of age. The literacy rate is projected at 82 percent.

Imo State was created in 1976 from the former East-Central State. Part of it was split off in 1991 as Abia State. Imo State is bordered by Abia State on the East, River Niger and Delta State to the West, Anambra State on the North and Rivers State to the South.^[5]

Although there are known oil wells in the state, and Imo is listed as an oil producing state, agriculture is the primary occupation. The economy of the state depends primarily on commerce and agriculture. However, due to over-farming and high population density, the soil has greatly degraded. One of the primary agricultural products is the palm oil.

2.2. Study Population

The FGM/C baseline survey was conducted in November 2020 in six communities in each of Imo and Ebonyi states, leading to a total of twelve communities surveyed in six local government areas (Orlu, Ohaji/Egbema, Ikeduru in Imo State; and Ebonyi, Afikpo North and Abakaliki in Ebonyi State). Table (i) highlights the survey coverage areas by state.

Table i FGM/C Baseline Survey Coverage Area

State	LG	Community	Village
Imo	Orlu	Ogberuru	Ezimba
		Ihitteowerri	Ezenwabachiri
	Ohaji/Egbema	Umuokanne	Umuezita
		Ilile	Ubeke
	Ikeduru	Atta	Atta
		Umudim	Dimodu
Ebonyi	Ebonyi	NkalekeEchara	UgboenyiNkaleke
		NkalekeEcharaNdegu	UburuNkaleke
	Afikpo North	Ohaisu	Ibbi
		Amasiri	Ohaechara
	Abakaliki	OkpitumoNdebor	Ndumbam

			Odeligbo
--	--	--	----------

To achieve a comprehensive perspective on envisaged interventions on FGM/C and to answer all the baseline objectives the following populations were requested to participate in the study:

- Women of childbearing age (15-49) who have female children who are alive
- Unmarried female adolescents and young adults
- Traditional rulers and community gatekeepers, including women and youth leaders
- Community health workers, Traditional birth attendants (TBA), and traditional circumcisers
- Religious leaders

The target populations were women and female children who are victims of female genital mutilation/cutting.

2.3. Study Design and scope

A combination of qualitative and quantitative research methods was used to collect data on individual, family and community perception about FGM/C. The qualitative component of the study was anthropological in nature and was designed to understand the social phenomena within the communities, using an inside perspective approach (traditional rulers, community development managers, elderly women, TBAs, traditional circumcisers, etc.), rather than imposing an investigative framework from outside. The following qualitative methods were used: Focus group discussions (FGD), Key Informant Interviews (KII), In-depth Interviews. The quantitative data tool used was the 24 question Kobotool platform. Multiple methods of data collection were used so that the weaknesses of one can be counter-balanced by the strength of the other. Furthermore, the study used the findings of the questionnaire tool to compare data with the NDHS (2018) data. The study was limited in scope to the exploration and documentation of the characteristics of respondents as well as their knowledge, attitudes towards, perceptions and practices which may predispose to FGM/C. The survey was also limited only to rural communities in both states.

2.4. Materials and methods for data collection

2.4.1 Quantitative Data Collection Methods: Questionnaire/Structured Interview

An online application, Kobocollect, was adapted for questionnaire data collection. A semi-structured questionnaire was developed by the Research Consultant for collecting quantitative data from a cross-section of respondents. As a quality control measure, the Kobocollect survey tool contained Local Government, Community and village sections, backed up by GPS locations. (Appendix D). The questionnaire contained 24 questions. A server was developed by the IT unit of Centre for Health, Education, Environmental Research (CHEERs) for accessing the data.

2.4.2 Qualitative Data Collection Methods

The information needed to develop meaningful and appropriate interventions regarding FGM/C is often difficult to obtain. This is because many of the issues relating to the conduct and or prevention of FGM/C border on personal sexual lifestyle and other practices that are culturally sensitive. This is more so in rural communities characterized by fear, mistrust, rumours, and suspicion. Moreover, with recent government awareness creation and laws against FGM/C, both circumcised and uncircumcised females see themselves as already stigmatized by society, either for yielding to and/or not being circumcised. Many women, both old and young, therefore perceive participation in FGM/C related studies as an attempt to compound their stigmatization condition.

Conscious of these limitations, care was taken in the selection of the study methods and materials for eliciting reliable information from the victims and nonvictims alike. Since the baseline purposes to establish human angle stories with direct quotes from the interactions and dialogues, qualitative methods were considered the best. Qualitative methods amplified the voices of the women and girl participants, who in this study are also the primary victims of FGM/C.

2.4.3 Focus Group Discussion

A focus group discussion guide (Appendix A) was developed by the Research Consultant. Apart from the introductory section which dealt with the socio-demographic characteristics of respondents, the guide consisted of five sections. Each section of the FGD guide represented one objective of the baseline study. A modified focus group discussion guide was used for the unmarried female adolescents. It also comprised of five sections (Appendix B).

Focus group discussions were used as diagnostic tool to gain insight into the social and cultural norms that drive FGM/C in each community. A focus group discussion is a discussion in which a small number of persons (usually 6-12) under the guidance of a moderator talk about topics that are of special importance to the investigation.

2.4.4 Key Informant Interviews:

Key Informant interview (KII) is a qualitative research technique consisting of intensive individual interviews to explore what people think and say they do about a given topic of discussion. Key Informant Interview (and in-depth interview) is one of the data collection methods commonly used to obtain information in community diagnosis and was used in this study to identify men and women who could supply reliable information on the issue of FGM/C in the communities. The rationale behind the use of key informant or in-depth interview for data collection is based on the premise that “every individual who has been socialized and hence learnt the customs, rules and behavioural norms of the society, possesses a store of knowledge that the researcher or field worker can profitably tap from” (Barrett, 1984). A Key Informant Interview guide consisting of 42 short questions was developed by the Research Consultant and used for interviewing these community gatekeepers. (Appendix C).

2.4.5 Validity and Reliability

A number of steps were taken to enhance the validity and reliability of the instruments used for data collection.

Validity

Some experts in the field of instrument design reviewed the tools (FGD and KII guides, and the Kobocollect online application) to ensure clarity of the questions and confirmed that they addressed the variables of interest. Consequently, irrelevant questions were eliminated and the ambiguous ones restructured to ensure clarity.

Reliability

To test for general reliability, the Research consultant and his supervisors constantly cross-checked information by asking informants the same questions earlier asked by the data collectors. Some questions were purposely repeated to check the feedback from interviewees. The absence of “community influencers” during the group discussions and the friendly atmosphere of the interviews and group discussions reduced the problems of inter-observer variability. The use of multiple research tools and the particular sequence whereby one tool phased into another was aimed at strengthening the validity and consistency of the data gathered.

2.4.6 Pretesting of tools

The FGD guides and the questionnaire were pretested on five women of childbearing age and ten female adolescent IT students at the Bishop MCGettrick Pastoral Centre, Abakaliki. The Key Informant Interview (KII) guide was pretested among three Clergy at the same centre. After the pre-test the IT students and Clergy were given time to comment on the clarity of the questions. Through their responses and those of the Research assistants and data collectors during data collection training, confusing questions were removed or restructured as the case may be. Content validity was assured by meticulously deriving the contents of the questionnaire from the progressive review of previous instruments and related literature, e.g., the NDHS 2013 and 2018 questionnaires. The assurance of anonymity of respondents and the insistence on voluntary consent to participate further enhanced the validity of responses. The Research Consultant routinely monitored the progress of the discussions and interviews and also regularly debriefed the interviewers, so as to identify problems being encountered in the field. Daily review meetings were held at the end of each day’s interviews. These meetings were also used by the supervisors and Research Consultant as opportunities for effecting necessary correction or for making clarifications.

2.4.7 Training of Research Assistants/Data Collectors

Eleven research assistants (7females, 4males) were recruited to facilitate gathering of data. All the data collectors were university graduates with minimum of 4 years’ experience in data collection. Eight of the data collectors, particularly the focus group discussion moderators were recruited from

the states to ensure local language and dialects did not constitute hindrance to quality of data collected. Four of the data collectors were fluent in the key dialects of Edda, Ehugbo, Izzi-Ezza-Mgbo-Ikwo, and Echara in Ebonyi state, and the other four were fluent in the key dialects of Egbema, Owerri and Orlu. Training of research assistants and data collectors was conducted at the training hall of the Bishop MCGettrick Pastoral Centre, Abakaliki.

Data collectors were trained on the rudiments of conducting focus group discussions, best practices in key informant interviews, data collection using the Kobotool platform and research ethics. During the data training, all data collectors and supervisors were supplied with smart phones with the Kobotool platform already installed. Data collectors also had interactions with online server manager while practicing data collection with the smart phones. Most of the data collection training was practical in nature

Inclusion criteria

Women of Childbearing age who had daughters who were also alive and available to be interviewed were included. Elderly women and Traditional rulers were purposively selected for the individual interviews. Unmarried adolescent females were included in both FGD and questionnaire. Traditional Rulers, women leaders, youth leaders, circumcisers and health workers were also included for key informant interviews because of their perceived knowledge of FGM/C practices.

Exclusion criteria

Participants who opted out after the informed consent was read to them were ineligible to participate. Also women of childbearing age who had no daughters from whom information could be validated were excluded.

2.5. PROCEDURE FOR DATA GATHERING

2.5.1 Administration of Questionnaires

The questionnaires were administered within six days. Questionnaire administration was conducted by data collectors and supervisors (Research Assistants) using smart phones. Each interviewer's smart phone had been installed with the Kobotool platform. A total of 263 respondents (229 females, 34 males) were interviewed using the survey questionnaire. Each respondent was interviewed in an atmosphere of confidentiality. After the interviewer had introduced her/himself, and explained the objectives of the study, further consent was required from the respondent to commence. On reconfirming her/his consent to participate, the research assistant would ask the respondent in which language (Igbo dialect or English) that she preferred to be interviewed. The respondent's choice determined which research assistant conducted the interview.

2.5.2 Focus Group Discussion

Two groups of participants were selected for the FGD. The first groups were women of childbearing age (WCBA, 15-49) years, who also had daughters who were alive and available for interview. The preference for women who also had daughters was to enable such daughters to be interviewed independently to provide evaluative information on the FGDs. The second groups of FGD discussants were unmarried female adolescents. FGD participants were identified and selected purposively to participate in the discussions with the assistance of community guides. Each discussion session was moderated by a female research assistant who also had a female recorder and time keeper. At each session of FGD, the moderator asked the questions and allowed the discussants to talk freely and spontaneously about FGM/C.

2.5.3 Key Informant Interviews

A total of 36 key informants were interviewed in the 2 states (Ebonyi 19, Imo 17). Key Informant Interview sessions (KIIs) were held with the traditional rulers and/or Presidents General of community development unions, women leaders, youth leaders and circumcisers, where available. Key Interview participants were selected purposively from within the study communities. Where any of the listed persons was not available, their designated representatives who are knowledgeable in the subject areas were interviewed in their place. The traditional ruler-in-council, the president general of the development union, elderly men and women, experienced health workers, Traditional birth attendants and traditional circumcisers are considered knowledgeable about FGM/C, community norms and values. Hence, they were selected as key informants in this survey.

3.0 RESULTS AND ANALYSIS

3.1.0 Quantitative Results

Of the 263 respondents, interviewed with the questionnaire, 32 (26.7%) were daughters of some of the 120 WCBA who participated in the FGD discussions. Other persons interviewed with the questionnaire tool were 143 WCBA, and 54 other women aged 45-66 years and above, who had lived in the community for over 35 years. Fewer men 34 (both married and unmarried) were also interviewed using the rapid assessment questionnaire tool.

3.1.1 Demographic and Social Characteristics of respondents

TABLE 1: Distribution of respondents by age, sex, education and religion

VARIABLE	FREQUENCY	PERCENTAGE
Age (in years)		
≤14	6	2.3
15-19	26	9.9
20-24	34	12.9
25-34	62	23.6
35-44	47	17.9
45-54	45	17.0

55-64	21	8.0
≥66	22	8.4
Total	263	100
Sex		
Female	229	87
Male	34	13
Total	263	100
Education Status		
No formal education	36	14
Completed Primary school	72	27
Completed Secondary school	115	44
Completed Tertiary education	40	15
Total	263	100
Religion		
Christian	257	98
Muslim	0	0
Traditional	6	2
Atheist	0	0
Total	263	100

Table 1 shows the distribution of questionnaire respondents by age, sex, education and religion. A total of 263 persons were interviewed using the questionnaire tool. Table 1 shows that a majority of the respondents were female (229=87%). Males made up 13% of the respondents. Close to one quarter (23.6%) of the respondents were between ages 25-34. This was followed by those aged 35-44 (17.9%), and 45-54 (17.0%). Those 19 years and below [32 (12.2%)] were primarily children of women who participated in the Focus groups and whose responses were to give credence or otherwise to the FGD findings regarding daughters' circumcision. The grandmothers made up about 16% of the respondents.

Close to half 115(44%) of those interviewed had completed secondary education. Forty (15%) completed tertiary education. Only a minority 36(14%) had no formal education. (Table1).

Two hundred and fifty-seven (98%) of the questionnaire respondents were Christians. Nobody reported being a Muslim or atheist. However, 6 persons representing 2% of the respondents were traditional worshippers.

Table 2: RESPONDENTS' SOURCES OF INCOME

Source of Income	Ebonyi	Imo	Total	%
Trading	3	60	63	24.00

Farming	45	22	67	25.00
Civil Servant	5	18	23	9.00
Private Business	20	24	44	17.00
Others (Specify)	53	13	66	25.00
Total	126	137	263	100.00

Questionnaire respondents were asked their sources of income. Table 2 reveals that one quarter of the respondents were farmers 67(25%), another one quarter were traders 63(24%). Another one quarter 66(25%) reported “others”. Seventeen percent engaged in private business while a minority 23(9%) were civil servants. Among those who reported trading, 60(95%) were from Imo compared to 3(5%) from Ebonyi. However, Ebonyi reported higher ratio of farmers 45(67%) than Imo 22(33%). There were more civil servants from Imo compared to Ebonyi (68.3% vs 21.7%).

3.2. Knowledge of Female Genital Mutilation

Table 3: HAVE YOU EVER HEARD OF FEMALE GENITAL MUTILATION/CUTTING? (F=263)

State	Ever heard of FGM		
	YES (Frequency)	NO (Frequency)	Total
Ebonyi	126 (100.0%)	0 (0.00%)	126 (100%)
Imo	136 (99.3%)	1(0.7%)	137 (99.3%)
Total	262 (99.6%)	1 (0.4%)	263 (99.6%)

To verify the knowledge of FGM/C among the respondents, they were asked if they ever heard about Female Genital Mutilation.

Table 3 indicates that all 126 respondents from Ebonyi had heard about female genital mutilation before this study. In Imo, 136 (99.3%) out of 137 respondents reported they also have heard about female genital mutilation. However, one person in Imo reportedly never heard about female genital mutilation before this survey.

3.3 Prevalence of Female Genital Mutilation

TABLE 4: PREVALENCE OF FGM AMONG WCBA (F=229)

State	Ever been circumcised
-------	-----------------------

	YES (Frequency)	NO (Frequency)	Total
Ebonyi	74 (67.3%)	36 (32.7%)	110 (100%)
Imo	101 (84.9%)	18 (15.1%)	119 (100%)
Total	175 (76.4%)	54 (23.6%)	229 (100%)

To establish the prevalence of FGM among the 229 WCBA respondents, they were asked if they were ever circumcised

In response, almost four-fifths (76.4%) of all female respondents age 15-49 were circumcised. This means that the FGM prevalence among the female respondents (Ebonyi and Imo combined) is 76.4%. In Ebonyi state 74 (67.3%) of all women surveyed were circumcised, compared to 101(84.9%) who were ever circumcised in Imo state. Therefore, the FGM/C prevalence among surveyed WCBA in Ebonyi state is 67.3%, compared to 84.9% of surveyed WCBA in Imo. These prevalence are indifference to the national prevalence rate of 20%.

Table 5: PREVALENCE OF FGM/C AMONG ADOLESCENTS (F=261)

State	No. of female children alive	No. of female children circumcised	% (Prevalence)
Ebonyi	125	123	98.4
Imo	136	136	100
Total	261	259	99.2

To deduce the current prevalence of FGM/C among the cohort of the children of the surveyed mothers in both states, 229 female questionnaire respondents were asked how many of their daughters who are alive were circumcised. Table 5 reveals that the 229 female respondents reported a total of 261 live daughters, out of whom 259 were circumcised, giving an FGM/C prevalence of 99.2%. Respondents from Imo state reported one hundred percent circumcision of all their 136 live daughters, while Ebonyi reported 98.4%.

3.4 Circumcision of Daughters

TABLE 6: INTENTION TO CIRCUMCISE DAUGHTERS IN FUTURE (F=229)

State	YES %	NO %	Don't Know
Ebonyi	17(15.0%)	93(85.0%)	0 (0%)

Imo	15 (12.6%)	100 (84.0%)	4 (3.4%)
Total	32(14.0%)	193(84.0%)	4 (2%)

To project into the future of FGM/C in the two states, the 229 female respondents were asked if they would circumcise their daughters in the future. A total of 193 (84%) of respondents would not circumcise their female children in the future. Thirty-two respondents (14%) reported in the affirmative, that is, they would circumcise their daughters in the future. Four respondents (2%) were undecided. (Table 6)

Table 6 also reveals that more Ebonyians 17(15%) would be willing to circumcise their daughters in future, than Imolites 15(12.6%). However, if the 4 respondents in Imo state who are currently undecided later decide to circumcise their daughters, then 19(16%) of Imo respondents would in future circumcise their daughters. The challenge of completely eradicating FGM is created by families and individuals who, despite existing laws, are determined to continue the unwholesome practice. This minority should be the target for future interventions.

3.5 Attitudes towards Female Genital Mutilation/Cutting

TABLE 7: FGM/C APPROVED BY MY RELIGION (Frequency=263)

State	YES%	NO	%	DON'T KNOW %
Ebonyi	42 (33.3%)	81 (64.3%)		3 (2.4%)
Imo	10 (7.3%)	117 (85.4%)		10 (7.3%)
Total	52 (19.8%)	198 (75.3%)		13 (4.9%)

Respondents were asked if their religions approved female circumcision. Table 7 shows that fifty-two respondents (Ebonyi 42:33.3%) and Imo (10:7.3%) responded in the affirmative, stating that their religions approved of the practice. Thirteen respondents (Ebonyi, 3; Imo, 10) do not know if their religions approve of female circumcision. If the number of respondents (52) who reported that their religions approve of FGM/C is added to those who do not know (13) what their religion says about FGM, those who may be conducting FGM/C out of religious ignorance increases to 65 (24.7%). This translates to a quarter of all the respondents. Apart from traditional religion, it is not known if any of the other religions reported here approves FGM/C. And there are only 6 reported traditional worshippers. In effect about 46 Christian interviewees believe that their religion approves of FGM/C. The 13 respondents who also “do not know” are more likely to be Christian adherents. This portends focusing FGM/C interventions on Christian adherents and involving Christian leaders in every program aimed at halting FGM/C.

TABLE 8: SHOULD FGM/C BE CONTINUED OR NOT (FREQUENCY=263)

STATE	CONTINUE		DIS CONTINUE	DEPENDS	DON'T KNOW
EBONYI	19	(15.0%)	101(80.2%)	5(4.0%)	1(0.8%)
IMO	17	(12.4%)	109 (79.6%)	10 (7.3%)	1 (0.7%)
TOTAL	36	(13.7%)	210(79.8%)	15 (5.7%)	2 (0.8%)

All 263 respondents (women and men) were asked if they would want FGM/C to continue, or they wanted the practice discontinued. Two hundred and ten respondents out of 263 (Ebonyi=101(80%), Imo=109(79.6%) opted for discontinuation of FGM/C practice. Thirty-six (13.7%) of 263 respondents want FGM/C to continue. Another 17 respondents could not make up their minds regarding the practice. More respondents from Ebonyi 101(80.2%) out of 126 than 109(79.6%) out of 137 from Imo opted for discontinuation of FGM/C. However, more respondents from Imo (11) than (6) from Ebonyi were undecided on whether FGM/C should be stopped or continued (Table 8).

TABLE 9: AGE OF RESPONDENT VS. EVER BEEN CIRCUMCISED (F=229)

Have you yourself ever been circumcised?				
Age Category	Ever been circumcised?			
Age Category	No	Yes		Grand Total
≤14	6(100%)	0 (0.0%)		6
15-19	18 (69.2%)	8 (30.8%)		26
20-24	11 (36.7%)	19 (63.3%)		30
25-34	12 (28.6%)	30 (71.4%)		42
35-44	7 (18.9%)	30 (81.1%)		37
45-54	8 (18.0%)	37 (82.0%)		45
55-64	3 (14.3%)	18 (85.7%)		21
≥65	2 (9.0%)	20 (91.0%)		22
Grand Total	67 (29.3%)	162 (70.7%)		229

Table 9 relates the age categories of respondents with their personal history of circumcision. The table shows that FGM/C increased as age grades increased. Conversely, FGM/C prevalence decreased with younger generations. Table 9 showed that respondents aged 65 years and above reported 91% prevalence, those aged 55-64 years reported 86% prevalence, while those aged 45-54 years reported 82% FGM/C prevalence. This FGM/C prevalence reduced progressively until nobody aged 14 years or below was circumcised.

TABLE 10: DISTRIBUTION OF CIRCUMCISED WOMEN, CIRCUMCISED DAUGHTERS BY THEIR EDUCATION LEVEL

Education level of women	No. of women ever Circumcised	Number of female children ever circumcised
No Formal Education	34 (97.1%)	35
Completed Primary Education	51 (70.8%)	72
Completed Secondary Education	86 (76.1%)	113
Completed Tertiary Education	29 (72.5%)	40
Grand Total	200 (76.9%)	260

Table 10 represents the distribution of circumcised children by the educational level and circumcision status of their mothers. Among the 229 female respondents, 200 were circumcised. These 200 circumcised women had 260 of their own daughters circumcised. Circumcised women who had no formal education (97%) were more likely than those who completed primary (70.8%) and those who completed secondary education (76%) and those who completed Tertiary education (72.5%) to have circumcised daughters. Education was a determinant in who circumcised or did not circumcise her daughter. Although 200 (77%) of circumcised women also had circumcised daughters, the more educated a woman is, the less likely that she will circumcise her daughters.

QUALITATIVE RESULTS

3.6 FOCUS GROUP DISCUSSIONS

Civil Resource Development and Documentation Centre (CIRDDOC) held focus group discussions with women of childbearing age (15-49 years) and unmarried female adolescents in six communities of Ebonyi and Imo states. The focus group discussions were conducted as part of CIRDDOC's efforts to find lasting solutions to the endemic practice of FGM/C in both states and to document the perception of the different groups on the FGM/C situation in the two states. The participants/discussants provided information in the group discussion in relation to the questions and note taker captured their responses on paper while a recording device was also used to ensure that responses were captured verbatim. The discussions were designed to gather information from the various groups in regard to the baseline study objectives.

In total, twenty-three (23) focus groups were conducted with the two categories in 6 communities each in Ebonyi and Imo states. Thirteen of the group discussions were held with women of childbearing age (15-49 years) and ten sessions were held with unmarried female adolescents. The group size ranged from 6 to 10 participants each and lasted from between 60 and 90 minutes. Using an open-ended discussion protocol to guide the discussion, the moderators and the discussants used a local language where applicable to facilitate the discussions. The findings from this study are highlighted below with the use of participant verbatim comments. These comments originated through either group discussion

(and were captured through a review of taped discussions) or through written worksheet exercises. Where necessary, responses have been modified to reflect correct grammar.

The FGD tape-recordings were carefully transcribed and subjected to several phases of cleaning, analysis and interpretations. A preliminary analysis was conducted in order to get a general sense of the data and reflect on its meaning. Other detailed analysis was performed and data was divided into segments/units that reflected specific thoughts, attitudes, and experiences of participants. At the conclusion of this process of analysis, a list of topics was generated, and the topics were compiled into categories that were labeled as key findings.

Data from each participant group was also analyzed separately to determine trends of issues that are unique to each group considering the levels of agreement about these issues and significant consistency in how the issues were discussed among the groups.

Overall, a total of 120 WCBA participated in group discussions in the two states (Ebonyi 63, Imo 57). Another 120 unmarried adolescent females participated in 10 FGD sessions (Ebonyi 57, Imo 63).

This section outlines the findings of the group discussions in the two states.

3.7 Key Findings on Knowledge, Attitude and Practices that influence and sustain FGM/C in the states

Analysis of FGD transcripts revealed a number of key findings related to KAP experiences in the states. These findings include:

- i. Although virtually all the women age 15-49 have heard about female circumcision, not all understand it to be synonymous with “mutilation” and/or “cutting”. No discussant could tell the story and origin of female circumcision.
- ii. All discussants have knowledge about FGM/C, but there were gaps in knowledge. For example, there were variations in time of circumcision, whether it was at infancy, adolescence, or just before marriage. Among those who reported that FGM/C was conducted as part of marriage preparation, there were divergent views as to whether cutting was done before or after a suitor had been found? One common belief however is that...
“I do it because my mother did it, and wanted it”, or “because my mother-in-law insisted”.
There was also a consensus that...
“Female circumcision is a woman’s tradition and the men/fathers had little or no resistance to this and that efforts to abolish FGM/C is male interference in women tradition”
The women further stressed that
“Even the victim, whether infant, adolescent or adult, had no choice. She is merely informed about the date for the “cutting”.
One group of discussants at Imo was asked, suppose the victim runs away before the date? They all responded in unison ...

- “*She will come back here to meet me. The place she ran to did they not circumcise them?*”
- iii. Another gap in knowledge about FGM/C is in the area of the different types of cutting. All discussants merely agree on “*Removal of or pressing down the skin at the genital area (clitoridectomy)*”, but do not know the details of the different types. The women confessed that... “*It is the traditional circumciser that determines what she can and will do. We only watch her cut what she wants to cut. We don’t tell her what to do. She knows what to do*”.
 - iv. The main sources of information about FGM/C are mothers, grandmothers and mother in-laws. The history of FGM/C is as old as any community. However, discussants also reported that media houses- radio, television, print (newspapers) have been sources of information on FGM/C. Other sources of information mentioned were churches and nongovernmental organizations (NGOs)
 - v. Discussants agreed that the information handed down include that FGM/C is the removal of excessive flesh on a woman’s genital to keep her “pure” and enhance her virginity before marriage.
 - vi. Discussants opined that they were told that FGM/C enhances the woman’s fertility and ensures safe and painless delivery at birth. They were also told that “*Female circumcision brings honour to the woman because once circumcised, she will not be promiscuous*”, but “*Nwanyi ebeghi ugwu ahu na agho ya nko (meaning: an uncircumcised woman is promiscuous, and engages in extra-marital sex)*.”
 - vii. Questions, doubts and fears about FGM/C: Discussants would want to know the authenticity of the information that FGM/C “*leads to difficulty in child delivery, increases tear during labour and excessive bleeding during circumcision*”
 - viii. In response to the question about circumcision increasing sexual pleasure for the men and reducing same for the woman, there was a consensus to the effect that “*FGC neither increases nor reduces sexual satisfaction for either man or woman.*” Some commented: “*all we know is that both circumcised and uncircumcised women have been found to be wayward*”
 - ix. No woman in the discussion groups ever suggested she will in future circumcise her daughter. Responding to the discussion question: “How many of you will like your unborn daughters to be circumcised”, the consensus answer was portrayed in the reactions such as: “*Not me, never again, God forbid*”. This is probably because all of them reported that they feel the pain when their daughters are circumcised, but merely endured the pain because of tradition and also “*to belong*”
 - x. Nevertheless, from the body language of the respondents, we deduce that the general opposing attitude against FGM/C is that of defiance. Even mothers who oppose FGM/C

- (particularly in Ebonyi) do so more because of fear of the law and punishment, than by conviction of the bad effects of FGM/C.
- xi. None of the unmarried adolescent discussants knew when they were circumcised because they were infants then. In Ubeke Ilile in Imo state, an adolescent discussant said:
“Here in my village, our mothers do it (FGM/C) to us at birth...my sisters are also circumcised, me too”
 - xii. There seems to be improved knowledge about the health effects of FGM/C among the unmarried adolescent discussants. While none of the WCBA named any example of health risks associated with FGM/C, the unmarried adolescents were able to mention bleeding at point of circumcision and birth, difficulty in urination, difficulty in walking, pain, and death.

3.8 Key findings on the current trends and prevalence of FGM/C in the states

- i. Women discussants surmised that the matter of FGM/C was no longer serious, and therefore not on the front burner of discussions in the states.
 In Ebonyi, discussants believe that the practice of FGM/C has been largely reduced and therefore were no longer of consequence. They base their argument on the fact that the wives of their immediate past governor and that of the present governor have put laws and community byelaws into effect to deal with the practice. They confirm the effectiveness of the domesticated VAPP Legislation in the state. The domesticated VAPP comes with a fine of N200, 000 and/or imprisonment for 6 months. In addition, the community byelaws prescribe a fine of N50, 000 if found guilty before you are reported to the state law enforcement for prosecution.
- ii. Moreover, they argued that since female circumcision is no longer considered a priority for marriage, its force is no longer tenable compared to ten years ago.
- iii. According to the discussants in both Ebonyi and Imo states, three out of every five females (60%) in their communities are circumcised. Among themselves as discussants, they narrated that more than half (57%) have circumcised their daughters. This means 60% FGM/C prevalence among their age grade (20-49 years), and 57% prevalence among their daughters. Yet, they don't see the situation as serious!

Women discussants in Imo believe FGM/C is no longer a serious matter because according to them:

We (mothers) no longer cut our daughters; we only use Vaseline to press down the genitals”

This is another knowledge gap and misconception regarding FGM/C in Imo state when mothers don't see pressing the female genitalia with Vaseline as mutilation.

In Umuezita community in Imo state, discussants reported that:

“Some (people) are still doing it (FGM/C) secretly, but if they are caught, they would be fined”

Asked who will catch them, he responded

“Anybody. Anybody can report to the village head or traditional Ruler”

In Atta Ikeduru a discussant was more succinct when she said:

“Ime nka, or igba nka (FGM/C) is a dying tradition, but it is still serious because about four women in every ten now do it secretly. It is serious because they are doing it secretly”

- iv. For the adolescent females at Ogberuru and Atta in Imo state, 80% of them were circumcised. They also reported that 4 out of every 5 of their sisters were circumcised. This means an FGM/C prevalence of 80%. They further explained that mainly those (20%) born in the last 13 years were uncircumcised.
- v. At Ohaechara, Amasiri in Ebonyi state, three out of every four (75%) of the unmarried female discussants were circumcised and seven out of every ten (70%) of their sisters were circumcised
- vi. In Ugboenyin Nkaleke Echara, Ebonyi State, 6 out of 10 (60%) adolescent discussants were circumcised. They also reported that 9 of their elder 12 sisters (75%) were circumcised. These findings on FGM/C prevalence among adolescent females from the focus group and Key informant interviews were similar and strengthened the qualitative interview findings.

3.9 Key findings on the social norms and dynamics that motivate individuals, families, communities and that enhance the practice of FGM/C in the states.

To address this variable of study, the discussants reviewed 13 questions.

The key findings show that:

- i. Women (mothers, grandmothers and mother-in-laws) determine whether or not their daughters or granddaughters should be circumcised. The women see FGM/C as the pride and glory of womanhood, and its discontinuation as a loss of this glory and pride
“We (the women) decide to do it, and even if our husbands oppose, they wouldn’t know when we conduct it. It is a girl’s rite of passage to womanhood. After all the men have their age grade rite of passage, why are they not asked to stop it?”

ii. This message of the female ego is further supported by the assertion by the women discussants that...
“It is a pride to a mother that her daughters are circumcised, will be presented to their suitors as pure and clean; will not flirt, and will be fruitful in marriage”

iii. According to some of the discussants,

“For a mother, it is a mark of quality and responsible motherhood and respect that her daughters are circumcised and their virginity preserved for their husbands.

In this context, female circumcision is seen as a deliverable that defines a good and disciplined mother.

iv. The women further stressed that:

“Female circumcision could determine the bride price of a girl”.

That is why they emphasize that in the olden days families saw uncircumcised girls as wayward and unfit for marriage. So circumcision of the female child had to be associated with family honour. On the part of the suitor, it was honourable to marry a circumcised woman. It was a necessary and normal part of life in the community. It was considered dishonorable and error for a young man who belonged to an age grade to marry an uncircumcised girl. It was assumed he married her because he could not pay the full bride price for a circumcised girl. That is why the men would also boast:

“Ebiri nwanyim ugwu (meaning: my wife was circumcised)”.

v.

Discussants in Ohaechara, Afikpo North consider the issue of FGM/C serious because bleeding and deaths had occurred in the past during and among circumcised women at delivery. So they see the secret persistence of the tradition as an act that puts their daughters at some health risk in future.

This is the reason why the women spoke with nostalgia over the dying tradition:

“Oh we remember the olden days... But these things cannot happen now. The government has banned it, and we don't do it again, except those who do it secretly”

3.10 Key findings on the existence, availability, strength as well as public awareness and implementation of instruments/laws addressing FGM/C

Women discussants in Ebonyi state speak with conviction that there are laws prohibiting FGM/C in the state, even if they have not seen copies of the law. They have felt it. Ebonyi discussants mentioned three laws: Government laws, Council or community laws and Church laws. Further probes showed that the VAPP law has been domesticated and is vigorously enforced by the government. The communities with approval of the local government councils also developed byelaws prohibiting FMM/C. Both laws have heavy fines for offenders. The Ebonyi discussants stated that the church (Christianity) does not have any approval for female circumcision. They adjudged that since the Bible expressly enacted male circumcision and if God deemed female circumcision as needful, He would have stated so. The Ebonyi groups also agreed that the government, council and church laws are 80% obeyed.

In Ihite Owerri, Orlu LGA, Imo state, discussants reported that there is no law banning or regulating FGM/C. However, at Atta in Ikeduru, discussants talked of *laws introduced by the Eze*, and suggested that everyone obeys the law. Further probes revealed that Imo state has not domesticated the VAPP and therefore, there are no solid legal grounds for intervention on FGM/C.

3.11 Key findings on recommendations for banning FGM/C

One characteristic of action research is ensuring that the beneficiaries are treated as equal stakeholders in researches that may lead to interventions in their communities. This principle of participatory research was applied in this baseline survey by letting the women contribute to suggestions that may lead to effective banning of FGM/C. The women were asked questions whose responses would guide effective and sustainable interventions.

- i. As mothers, the women have taken informed decisions to support the prohibition of FGM/C
- ii. They made suggestions regarding how effective interventions on FGM/C can be conducted in their communities. They listed the entry point for this intervention to come through the Ezes, the women leaders and women groups, particularly older women who have become the moral gatekeepers pushing for the perpetuation of this ritual to justify their own experience of genital cutting and who tend to see any effort to eliminate the practice as a threat, not only to their culture, but to their ego. The old women see the banning of FGM/C as a failure on their part to pass on to future generations of women, what they inherited from their own grandparents.
- iii. A notable finding of this baseline is the gnashing feeling by the old women that stopping female circumcision is a direct assault on their ability to transmit a culture they inherited, and upon which the pride of womanhood hinged to future generations. To the old women it is a bitter personal failure, an indictment on womanhood of their generation. An old woman at Uburu Nkaleke, Ebonyi state, quipped...

“Amam na nna gi dunyelu gi ulo akwukwo, ruo mahadum. Oru gi naka, inwegh kwa ike idinye umu gi ulo akwukwo? Ogagh aburu gi ihe ihere? Otua ka ihea na ewe anyi iwe (meaning: I know your father sent you to school, even to university level. How will you feel if you cannot send your own children to school? Will you not be ashamed of yourself if you

cannot send your own children to school? This is the same way we feel as women not being able to sustain female circumcision”)

She continued

“Umu okolobia na awa akwa, nuo iyi, duo isi, gba ndu obala, ana asi umu ngboto nwanyi ebikwana ubu. Umu oko no na nghogbu umu nwanyi si na ana gbachitara nwanyi. Ele ugwu nwanyi an’ebigh ubu? (meaning: Young men undergo many different processes to achieve manhood: they take oaths, perform rituals, some of them blood covenants. Why should young men continue with their rites of passage to manhood, including some practices that involve blood covenant, and you want the women to stop their own rite of passage to womanhood? You men keep cheating the women and claim you are defending them? What is a woman without honour, without circumcision?)

It is advisable to note that deep nostalgic feelings of this nature are not cured by stringent laws alone, but by continuous advocacy, awareness creation, appeals, ego massaging, full involvement of the old women and education for them to understand the dangers associated with FGC. This calls for one-on-one repeated discussions with the oldest women in the communities. Advocacies and communications of this nature are conducted also by mature women, not just any NGO staff.

- iv. All the communities support any intervention that will permanently ban FGM/C. In response to the question...As mothers what is your stand on FGM/C? More than eighty percent (80%)of the discussants voiced their support for total abrogation of the age-old tradition. In Imo state the discussants called for domestication of laws to ban FGM/C and empowerment of local councils and communities to report secret proponents of FGM/C. They emphasize that community members are not aware of any existing laws and noted that laws not embedded in the communities will not be effective.
- v. All women discussants in both Ebonyi and Imo proffer that any laws should be stepped down to women leaders, “umu ada” (those born and married within the communities) as change agents for effective implementation and monitoring of the laws against FGM/C. They also suggested close working of governments with churches.
- vi. The unmarried female adolescents requested that in addition to any laws against FGM/C, the subject and its dangers should form part of local school curriculum to ensure generational sustainability. They also requested regular awareness creation targeted at mothers and grandmothers to enhance informed decisions on the subject.
- vii. Some of the adolescent discussants revealed that their mothers still indulge in secret cutting of their daughters’. Example, an adolescent discussant in Imo state reported:

“ It is our mothers who carry us to the nurse to do it (FGM/C) at night”

3.2 Key Informant Interviews

One-on-one interviews were held with Traditional Rulers/Village heads, Community leaders (Presidents General of Community Development Unions, women leaders, youth leaders, religious leaders), health workers, elderly men and women, and traditional circumcisers. A total of 36 key informant interviews were conducted. The average age of the interview respondents was 62 years. This section summarizes the findings from the interviews.

3.2.1 Key findings from Traditional Rulers:

Source of information on FGM/C has always been from generation to generation, and nobody has a clear definitive starting point in history or location.

“We came into existence and met women being circumcised. Initially it was a taboo to even discuss it. Men were not involved. It was an all-women affair. Women decide when their daughters are ripe for circumcision, and in some cases they merely inform their husbands after agreeing on a date with fellow women and the circumciser. Sometimes the men are not even carried along. But no man took offence because it was all considered a traditional affair of the women”---Traditional Ruler from one of the surveyed communities in Imo state

However, another 73-year-old village head in Imo state who has all his 3 daughters circumcised said

“I will like to know why you said we should stop it. Since I am this old nobody has come to this village to tell us about it, only you people. I still believe it (FGM/C) keeps them (women) away from following men”.

This Village head said he does not know of any law against FGM/C. To confirm his lack of knowledge of any law, he fired back

“if there are laws, why then are women still doing it till today?”

He went further to suggest *“they should establish a law and enforce it. Communities should also obey any government law enforcing FGM/C.”*

Asked if he considers FGM/C a dying tradition in his community, he stressed

“With me I don’t know because they still do it, although the frequency of conducting it has reduced”

Asked what the essence of FGM is, a traditional ruler in Abakaliki, Ebonyi state who brandished awards he received from the Human Rights Commission (HURIC) for his fight against Gender Based Violence (GBV) opined

“It was traditionally important as passage to womanhood. It was mandatory. Every parent felt fulfilled that their daughter was circumcised and has attained womanhood. In this community it was conducted just before marriage, not a few weeks after birth. It was conducted close to marriage so that the experience will be fresh in the mind of the lady and knowledge of the suitor. The essence of female circumcision was to deter the woman from being promiscuous and going after men who are not her husband. It was also believed that if a woman was not circumcised the gods of the land would punish her by making her barren, or if she ever conceived, child delivery was a punishment for her. So every long labour was considered a punishment for some offence, including uncircumcision. It was strongly believed that uncircumcised women were infertile. Today we know that all these views were ignorantly peddled to sustain a deadly culture”.

He added *“as a father, before I felt elated, satisfied and fulfilled that my daughters were circumcised, but today, when I look back at my level of ignorance I feel ashamed, and even dehumanized to have been part of this tradition. Today, I am fiercely against female circumcision and indeed against any form of gender violence, hence the awards I have so far received...”*

In responding to the question on the essence of FGM/C, a traditional ruler in Imo state said:

“na oge ochie ana asi na nwanyi ebeghi ugwu na agba n’ilo. Ma ugbua anyi ma na nwanyi choro igba nilo ga agba n’ilo. Nke kacha bu na’anyi amatala na ibi nwanyi ugwu nebuta oke igba obara ma odiri ime, ma obu kwa n’oge imu nwa. Ibi nwanyi ugwu bu ihe ojoo. O negbu nwanyi. (in the olden days, it was said that an uncircumcised woman was promiscuous. Now we are wiser and know that promiscuity among women has nothing to do with circumcision or noncircumcision. Moreover, now we know that female circumcision causes excess bleeding during pregnancy and delivery. Female circumcision is evil. It is a killer of women).

To the question “how common is female circumcision in this community today?”

Traditional ruler in Ohaji/Egbema reported

“Although it has reduced, it is still done secretly. It is 60% dead, and 40% alive”

The ruler, a retired police officer explained further

“As a police officer I conducted interview with some known prostitutes in Onitsha and discovered that 80% of them were circumcised, yet were prostituting to feed themselves and family. The Eze surmised

“if someone cut off his or her tongue, he can’t talk well and his/her ability to taste food will reduce”.

Therefore, he concluded

“Circumcision would rather reduce the sexual urge in a woman, make her frigid and create marital disharmony in the family”.

A 66-year-old Traditional Ruler in Imo state who claimed he has travelled to different parts of the world summarized his interview responses as follows:

- i. *“I am very ignorant about the pay (to the circumciser) because it is done secretly by my wife and her mother”*
- ii. *Nwanyi ebereugwu anaghi enwe sexual satisfaction (a circumcised girl cannot have sexual satisfaction).*
- iii. *There is no law yet (against FGM/C) in Imo state*
- iv. *To address the issue of FGM/C in the state, he said
Introduce the law and implement it”*
- v. *Communities must say “NO” to FGM/C*
- vi. *Sensitize members through teaching the evils of female circumcision*

Another 63-year-old Traditional Ruler in Ohaechara, Ebonyi state, a retired civil servant summarized his interview as follows

- i. *In the olden days females were circumcised at the point of marriage and we have had issues of bleeding, but it would be resolved*
- ii. *It (FGM/C) is a primitive belief that anyone (female) not circumcised is going to be promiscuous*
- iii. *In the old (days) many people died not knowing it was because of circumcision, now we know it has no benefit*
- iv. *When a lady wants to marry, she must be circumcised, not as a baby*
- v. *The practice is called “obubu” in this community*
- vi. *The man is not allowed to come near the site where the circumcision is conducted*
- vii. *In my house I preach against it and tell my wife that if there is a problem I won’t be involved*
- viii. *I have one daughter and she is not circumcised*
- ix. *Although the practice is declining, it is still being practiced secretly*
- x. *Quack nurses still conduct it secretly*
- xi. *“There is a law against FGM/C but minimal number of people still disobey it because of huge consequences. Our LGA is very serious about the law and I consider the law adequate”*

The 58 year old President General of the Community Development Union also corroborated the findings from the Traditional Ruler by emphasizing that

“...yes, it (FGM/C) is prevalent despite the level of awareness from NGOs, government agencies and others. He identified “churches, women groups, development union groups, conventional media and town hall meeting as best ways CIRDDOC can reach the perpetrators with regular education to abolish the practice. The President General asserts

“There is a VAPP Law to control FGM/C with a penalty of N200,000 or six months imprisonment or both. There is problem of implementation of this law”.

3.2.2 Key findings from Female Circumcisers:

A 74-year-old **female circumciser** who has five daughters said

I grew up here in my community to see and meet female circumcision. We call it “ibe ugwu or akpi”. She surmised that the beliefs she met and agreed to about FGM/C are...if a girl child is circumcised she will give birth freely; she will take in (pregnancy) with ease. A girl that is circumcised will be more decent and stay and remain with one man.

Then she quipped...*If it is not a good thing then tell me why and also the dangers in it so that I can stop...Now that I hear it is not good, I think I will try to stop...*”

Asked the best way CIRDDOC can share information regarding FGM/C to her general community, and the specific community of circumcisers, the 74 year old circumciser responded

“come back again to spread the news, and do it as often times as you wish...come and teach and help us...send people to teach and sensitize us. Teach it in churches and say it in radio”

Asked if she is aware of any law banning FGM/C, the old circumciser reacted

”ama gi mi ooo...(meaning I don’t know).We hear government say it is not good, that we should stop it...I don’t know the stand of the community on female circumcision, I am not the Eze”

Asked how she will feel if FGM/C is abrogated in the community, she responded

“ogadikwa nma ooo”(It will be good) and added “If I see a better thing doing, I will stop the circumcision of girl child”

3.2.3: Key findings from Church Leaders:

Two church leaders (one male, one female) were among those interviewed. Both clergy revealed that though reduced in frequency, FGM/C is still secretly conducted by mothers and grandmothers. The female clergy narrated that both her mother and grandmother were TBAs. She reported that her grandmother revealed to her that circumcised women had more difficulty during delivery than uncircumcised women. Bearing this in mind, she never circumcised any of her three daughters. Moreover, she emphasized, it was not biblical to circumcise females. Both clergy believe that the use of media –radio/TV, Newspapers and continuous community-based enlightenment and awareness creation, targeted at traditional Rulers, health workers will be helpful to “bury” the

tradition of FGM/C. Churches and mosques they stressed will be good partners in awareness creation against FGM/C.

3.2.4. Key findings from Elderly men:

Female circumcision is no longer common, although still practiced by some families. In the recent past female circumcision was a process for stratifying age grades in the community as well as part of the ceremony of giving daughters out in marriage (ikpo efu).

They posited that those to be held responsible today for sustaining FGM/C are government health workers who conduct this act secretly. *There are also some young girls (adolescents) who demand to be cut “so as to be like their peers”*

One 67-year-old elder said

“If I identify any woman still practicing FGM/C I shall personally report the person to the Traditional Ruler even if the person is my wife, I will report her. I will not advocate for circumcisers to be given alternative means of livelihood because the practice was not supposed to be a means of livelihood”

3.2. 5: Key findings from Elderly women:

One elderly woman from Ugboenyim Nkaleke was angry with those still practicing FGM/C. She surmised

“Female circumcision was conducted out of ignorance. All those arguments about circumcision preventing promiscuity, enhancing fertility and ensuring painless delivery were all rubbish and deceitful. It is rather a very harmful primitive practice that dehumanized womanhood. Female circumcision is a measure of primitivity and ignorance. In olden days it was a taboo not to be circumcised. Today women in my community are working hard with the Eze to make it a taboo to be circumcised...”

In contrast, another old grandmother from Umuezita in Umuokanne in Imo State who identified herself as *“mmuru nuyo, luo di nuyo”* (meaning “I was born here and married here”) interjected *...we do it in this village. It is by choice, not a do or die affair. We call it “ikpukan”...it does not concern anybody, it is my business...we do it because our mothers and grandmothers did it, and they did not die. Yes they say (FGM/C) is dying, but secretly they are still doing it here”* She went further to query *“Ele ihe m’gagwa ndi iche mam nwuo? M’gagwa ha na omenala ibi ugwu ha nyeferem naka, oku amunyerem n’ aka na afunyuolm ya? Chime kwela. Bia unu kuziere anyi uzo ozo anyi g’eso, ma obugh’a anyi ga nebi ugwu, a ga na acha ikpukan* (meaning: *What will I tell our ancestors? Will I tell them that the tradition they handed down to us we are not able to pass it on to other generations? God forbid. Give us an alternative tradition else we must continue to conduct female circumcision”*

Virtually all the women interviewed in Imo state reported that there is no law prohibiting FGM/C. This differs from findings in Ebonyi where both traditional rulers, community gatekeepers, health workers work in awe of the law and community byelaws banning the practice. For example, a woman leader in Ogberuru, Orlu local government area stressed that *“No law existing (banning FGM/C). The community supports it (FGM/C). It is very common here...”*

3.2.6: Key findings from Youth Leaders:

In Ihite Owerri(Orlu), a youth leader said...*No existing law (banning FGM/C), but Igwe said no to it. It (FGM/C) is done here in the community. I know it is done secretly with the mother.* Insisting that repeated and consistent sensitization, workshops and teachings will be needed to stop FGM/C, one youth leader posited

“Mma izizi egburu osisi a ma gbutuo ya (meaning the first cut on a tree does not bring it down), therefore consistent enlightenment would be required to put a stop to female circumcision”, he stressed.

In Ibii community, the youth leader reported there is a law banning FGM/C, but he explained that the existing law did not take the major stakeholders into reckoning, neither considered the host communities. Furthermore he said the laws were not translated into local dialects, so the existing laws, are not obeyed. Hence the need for community bye-laws that are community initiated and driven to address FGM/C.

3.2.7: Key Findings from Health workers:

Of three health workers interviewed, the one from Ebonyi confirmed the availability of state and community laws that prohibit FGM/C. He reported that those mothers who, a few years ago would approach you with

“ichoro ikwusi nwam ime ihe ndi ogbo ya mere ?(meaning: do you want to prevent my daughter from doing what her peers are doing) are now afraid of mentioning female circumcision for fear of being reported to the “Gate catchers”, a watch group created by the community byelaws to address FGM/C.

He said two layers of community-based monitoring outfits-

“Ekpokoto Age Grade and Essa Age Grade (for appeals) are approved by the community byelaws and also empowered by the Office of the Governor to deal with cases pertaining to FGC in Afikpo Local Government of the state. Furthermore any health worker found guilty of conducting FGM/C loses his/her license and job.

In Imo state, there are no such stringent community laws enforcing the ban on FGM/C and related offences.

4. DISCUSSION, CONCLUSION, RECOMMENDATIONS, LESSONS LEARNED

4.1. DISCUSSION:

4.1.1 Characteristics of Respondents

Female Genital Cutting (FGM/C) also known as female circumcision or female genital mutilation (FGM/C) is practiced in many communities in Nigeria, and is present throughout the country. In many communities, FGM/C is a recognized and acceptable tradition that is considered important for the socialization of women, curbing their sexual appetites, and preparing them for marriage. But the practice has both short- and long-time medical complications and health effects on the women, as well as infringement on women's rights. There is no shortage of literature on FGM/C.

This baseline survey collected information on knowledge, attitude and practice about FGM/C, prevalence, social norms and social motivations, age of circumcision, existence of laws and by-laws prohibiting FGM/C.

Two hundred and sixty-three persons (229 females, 34 males) responded to the questionnaire tool; two hundred and forty females (120 mothers and 120 female adolescents) participated in the focus group discussions, and 36 (13 females, 23 males) key informants were interviewed in-depth on the matter of Female Genital Mutilation/Cutting, totalling 539 (482 females, 57 males) respondents who contributed to the baseline survey (females = 89%, males = 10%). The average age of the adult respondents was 58 years (range: 24-78 years), while the average age of the adolescents was 17 years (range: 14-20 years).

4.1.2 Respondents' Knowledge, Attitude and Practice of FGM

Awareness about FGM/C was high in both states. Almost all (99.6%) of respondents have heard about FGM/C. This ratio is higher than the national ratio reported among rural dwellers surveyed by the NDHS on FGM/C, 2008 (61%), and NDHS, 2018 (61%). However, having heard about FGM/C did not translate to comprehensive knowledge about FGM/C. The respondents in this survey could not differentiate between the different types of mutilation and/or cutting. Therefore, they could not relate the different types of cutting to the serious medical risks which this study adduced to in the study tools. There was also a concern of knowledge gap as shown by respondents who reported that they do not mutilate their daughters, rather *"we only use Vaseline ointment to massage the clitoris so as to reduce its size. By so doing we do not cut anything"*. The greatest gap in FGM/C knowledge among the respondents remains the age-old misconception and erroneous belief that female circumcision is not harmful to the girl child, rather that it preserves the girl's virginity, increases sexual pleasure among men, increases women's fertility and ability to procreate, enhances painless delivery at birth and child survival after delivery. This finding agrees with that of Anzaku, et al (2018) who studied implications of female genital mutilation as portal for disease infection in Nigeria. Anzaku et al reported a level of internalization of these misconceptions which contradict the reality that FGM/C leads to multiple medical and health effects among the circumcised women. This internalization of misconceptions of FGM/C is a key knowledge gap that needs to be addressed.

4.1.3 Prevalence of FGM/C

This baseline survey finding shows that the FGM/C prevalence is higher in Imo (85%) than in Ebonyi (67%). The finding agrees with that of NDHS (2018) and corroborates with both the quantitative data and the focus discussion and KII which reveal a profuse secret practice of female genital cutting and near non-existence of intervention laws in Imo state.

However, this prevalence rate differs significantly from the findings of NDHS (2018) in the two states which reported a prevalence of 53.2% for Ebonyi and 61.7% for Imo. In concrete terms, the difference in reported prevalence rates is because the spread of communities and number of respondents in the two studies differ. NDHS (2018) surveyed a total of 1221 women in the two states (Ebonyi = 675, Imo = 546) whereas the current CIRDDOC survey covered a total of 539 (Ebonyi = 265, Imo = 274) in both states. Moreover, the NDHS survey included urban communities, whereas the current survey is limited to the six rural communities per state. The CIRDDOC study is more saturated than that of NDHS. It is also noteworthy that all the reported FGM/C prevalent rates (whether by the NDHS or CIRDDOC) are a lot higher than the national rate of 20%, hence a justification for intervention.

Among the unmarried adolescent respondents, the prevalence was found to be 100% in Imo and 98.4% in Ebonyi. These figures are certainly high and of concern. The implication of this high prevalent rate is that every circumcised mother ensured that her daughters were also circumcised, *“to maintain a family tradition and honour”*. This reported high FGM/C prevalent rate among unmarried female adolescents contradicts the FGD and KII responses where most women respondents vowed never to circumcise their daughters in future. However, the finding represents increased awareness of the dangers of FGM/C **only after** the respondents had circumcised their present cohort of female children. Only 14% of the 229 women respondents had suggested they would in future circumcise their daughters, while 2% were undecided. A combination of the proportion asserting that they will circumcise their daughters in the future and those undecided represent the proportion (16%) of grandmothers in this study.

During focus group discussions, all the adolescent girls had indicated never to circumcise their daughters.

When the age categories of respondents was cross tabulated with their personal history of circumcision, the findings revealed that female circumcision reduced progressively from older age grade of women to the younger. The finding showed that FGM/C increased as age grades increased. Conversely, FGM/C prevalence decreased with younger generations. For example, respondents aged 65 years and above reported 91% prevalence, those aged 55-64 years reported 86% prevalence, while those aged 45-54 years reported 82% FGM/C prevalence. Younger women/mothers aged 25-34 reported 71.4% prevalence. The FGM/C prevalence reduced consistently until nobody aged 14 years or below was circumcised. This finding corroborates similar finding by NDHS (2018) which reported that prevalence of circumcision seems to be

decreasing in Nigeria, and that only 14% of women age 15-19 have been circumcised as compared with 31% of women aged 45-49. This finding gives hope that future female age grades may not circumcise their daughters as they suggested during group discussions. Therefore females 14 years and below should be targeted for FGM/C awareness education to stop them from being polluted with the idea of circumcising their own daughters.

4.1.4 Age at Circumcision

In Nigeria, female circumcision occurs mostly during infancy. However, there are reports of females circumcised after age 15 (NDHS, 2018). In this survey, most respondents, both women and adolescent females were unable to mention when they were circumcised because they were circumcised when they were infants. Nevertheless, findings of this study also revealed that some female circumcisions were conducted when the female had attained late puberty or age of marriage. This finding that some adolescents are circumcised at ages above fifteen years corroborates similar findings by NDHS (2018) which reported that about 5% of women were circumcised at age 15 or older. In one community in Ebonyi, the traditional ruler explained that FGM/C is conducted as part of the preparation for marriage when the girl enters “*fattening room*” one or two months before actual marriage. This finding that circumcision could be conducted at different ages by different communities confirms its diversity even within the same geopolitical zone.

4.1.5 Circumcision of Daughters

Daughters of women who are circumcised are more likely to be circumcised themselves. The focus group discussions with unmarried female adolescents revealed that all the 260 female children ever circumcised, all their (200) mothers were also circumcised. This differs from the 6 daughters who were under 14 years old whose mothers were also not circumcised. The finding that all (100%) of under 14 children was not circumcised agrees with similar finding by NDHS (2018) which reported that 81% of children 0-14 years had not been circumcised. Daughters of women who had no formal education (97%) are more likely to be circumcised than daughters of women who had secondary education (76%), or tertiary education (72.5%). This finding also corroborates that of NDHS (2018) which reported that daughters of women with more than a secondary education are less likely than daughters of women with no education to have been circumcised. This finding portends that the more the women get educated, the greater the chances of stopping female circumcision.

4.1.6 Person who performed circumcision

The CIRDDOC baseline on FGM/C included questions on the person who performed the circumcision. Information from the group discussions and key informant interviews revealed an array of persons that conduct the process. These include traditional circumcisers, traditional birth attendants (TBA), trained nurses or midwives. Traditional circumcisers are the most mentioned, followed by TBAs. These findings agree with similar reports by NDHS (2008, 2018) who opined

that traditional circumcisers are the most common persons who perform FGM/C across all backgrounds characteristics (NDHS, 2008). NDHS (2018) reported that traditional circumcisers conducted 82% for girls and 76% for women; while TBAs conducted 8% each for girls and women across Nigeria. NDHS (2018) added that slightly less than one in ten FGM/C are conducted by medical professionals, with nurses and midwives playing an important role. That the medical and health profession is involved in conducting FGM/C does not sound professional.

4.1.7 Social norms and dynamics on social motivation on individuals, families and communities and the practice of FGM

Social norms are at the root of female genital mutilation. The CIRDDOC baseline survey on FGM included questions for both male and female respondents on the perceived benefits of FGM/C. This information helps to explain the context in which FGM/C occurs. To the male gender, their initial belief in FGM/C is in the preservation of virginity or the prevention of premarital sex. Men were more likely than women to mention sexual pleasures as a social dynamic driving female circumcision. From the key informant interviews, most men asserted that the practice of FGM/C enhanced the prospects of a circumcised girl getting married. Men also chorused social acceptance for self as reasons why they silently support FGM/C. For example, a youth leader in Ebonyi said *“As a man, I felt good those days that my wife was circumcised because that was the order of the day”*. A Traditional Ruler in Imo state said *“Female circumcision is a good culture in our society, but some do shameful one”*. Fewer men mentioned cleanliness and/or hygiene as attractive benefits of FGM/C.

Among the older women, the most commonly reported benefit of FGM/C is to preserve virginity or prevent premarital sex. A lesser number of women mentioned better marriage prospects and social acceptance for the circumcised girl. Yet a fewer proportion of respondents indicated that their religion approves of FGM/C. Some women suggested that the naming ceremony of the girl child which traditionally comes up on the eighth day after birth is associated with the circumcision of the child. The ceremony is considered a festival in honour of the child and attracts gifts for the baby and refreshments for visitors. According to Ugwu Somtochukwu (2019), the naming and cutting are linked. Due to this affiliation, poor mothers cannot openly resist the mutilation of their female children. Doing so would mean cancelling the naming ceremony.

Among the adolescent girls, family honour, adequate bride price and cleanliness were key dynamics that attract FGM/C. Interestingly, neither the hard fighting traditional rulers, the concerned women, nor the adolescent girls see any of these reasons as strong enough to insist on FGM/C if the government and significant others consider it as a health risk, and rights abuse. Consequently, all the adolescents, and over 80% of the women and elderly men reported that there are no benefits to female circumcision. To underscore this decision, eighty percent of all respondents both in Ebonyi and Imo indicated willingness to discontinue the practice.

Another reported social dynamic that drives FGM/C is that it is often the mothers and grandmothers that execute this act. On their part, most fathers pretend not to know what is going on, only because they feel fulfilled with the traditions of their forefathers. Ironically, even a Traditional Ruler in Imo opined that he does not know the details, neither when it occurs, even in his own household, because, according to him, it is the women's affair.

It is important to note that some elderly women raised pertinent questions bordering on social norms and dynamics which they consider encroaches upon their (women's) honour. Six different old women at different communities in Ebonyi and Imo had raised the question:

What is the alternative dignifying norm to transit a young lady from adolescence to womanhood? Why should girls not retain their age grade tradition of passage from adolescence to womanhood through circumcision? Nobody has stopped the young men from transiting from adolescence to manhood. Why must the girls be stopped? Some of the old women perceive the total stoppage of female circumcision as part of male dominance, and have demanded an answer to these questions. One of them said "obu nghogbu (it is cheating). You are denying the women their rights and claim to be protecting them. This is not right" a 68-year old grandmother interjected. "Ele ihe m'gagwa ndi iche mam nwuo? M'gagwa ha na omenala ibi ugwu ha nyeferem naka, oku amunyerem n' aka na afunyuolm ya? Chime kwela. Bia unu kuziere anyi uzo ozo anyi g'eso, ma obugh'a anyi ga nebi ugwu, a ga na acha ikpukan (meaning: What will I tell our ancestors? Will I tell them that the tradition they handed down to us we are not able to pass it on to other generations? God forbid. Give us an alternative tradition else we must continue to conduct female circumcision"

4.1.8 Attitudes towards Female Circumcision

Respondents were asked whether they thought that female circumcision should be continued. Four out of every five women in discussion groups support discontinuation of female circumcision. This was further confirmed by same proportion (80%) among all respondents through the questionnaire tool. Fourteen percent of the respondents think it should be continued, while 6% are unsure. Again these findings are in consonance with similar reports by NDHS (2008) which indicated that 62% women and men who had heard of FGC want it discontinued; 22% want it continued and 15% are not sure. Surprisingly there is little variation in attitude towards circumcision by age. All 120 adolescent respondents support a discontinuation of FGM/C, with a proviso: "teach us the dangers of FGM/C" Only women in the older age group fifty-five years and above are slightly more likely than younger women to say that circumcision should be continued. Support for the practice decreases with increasing level of education.

4.1.9 Existence, availability, strength as well as level of awareness and implementation of instruments/laws addressing FGM/C

In all the qualitative tools, respondents were asked if they know of any laws that control FGM/C in their communities and if such laws were obeyed. They were also asked in what ways they think such law(s) have been able to meet the yearnings of the female children and adolescents. Discussants in Ebonyi are largely in agreement that there are “government laws as well as Council or community bye-laws that prohibit female circumcision”. They have felt the effects of the law. There are examples of people who breached the laws and have been penalized by the council and community. Ebonyi discussants mentioned three laws: Government laws, Council or community laws and Church laws. The task force has the backing of the local government on its enforcement duties. Further probes showed that the VAPP law has been domesticated and is vigorously enforced by the government. The communities with approval of the local government councils also developed byelaws prohibiting FMM/C. Both laws have heavy fines for offenders. For example, Ndumbam community in Ebonyi state has set up a task force on FGM/C. Beyond the VAPP law and the council/community byelaws prohibiting FGM/C, the Ebonyi respondents also quoted that the Bible which they say emphatically demanded male circumcision but has no such demand for female circumcision.

On the contrary, respondents from Imo reported absence of laws prohibiting female circumcision.

In Ihite Owerri, Orlu LGA, Imo state, discussants reported that there is no law banning or regulating FGM/C. Respondents in Imo state including the traditional rulers interviewed did not know about the existence of Imo state law for the prohibition of FGM/C. At Atta in Ikeduru, discussants talked of *laws introduced by the Eze*, and suggested that everyone obeys the law. Further probes revealed that Imo state has not domesticated the VAPP and therefore there are no solid grounds for intervention against genital mutilation. The lack of domestication of the VAPP Act leads to lack of enforcement. The failure of Imo state to domesticate and enforce the Violence Against Persons Prohibition Act (VAPP) is a major reason why the prevalence of FGM/C is so high, much above the national rate.

Although respondents from Imo state denied knowledge of any law prohibiting FGM/C in the state, the Imo State law prohibiting female circumcision was promulgated in 2017, two years after the VAPP law. That the existence of the Imo state law was denied by virtually all respondents, including traditional rulers, implies that the awareness has not been created about the law. The findings of this baseline indicate that the key government organs which should drive the implementation of the law (Ministry of Information, ministry of Community Government, Culture and Tradition, ministry of Chieftaincy and related matters, ministry of Education) were completely left out of the mobilization and awareness creation to back the implementation of the law. Hence the people whom the law was made for do not know about its existence. Even traditional rulers in the state clearly stated that there is no law prohibiting FGM in the state.

This study considers that specifically drafting International Donor Agencies and other NGOs into implementing this law is misplaced. The state government does not control or subvert these organizations; more so the organizations usually come into the states already determined where their

investments and program interests lie. Rather than NGOs, and International Donors as prescribed by the law, the Act should have drawn from the strength of Community Based Organizations (CBOs), traditional institutions and religious bodies for effective awareness creation and implementation. Overall, we consider that the Imo state law prohibiting FGM/C was done in a hurry, with no proof of technical input from the public and government technocrats, hence its ineffectiveness.

4.2. CONCLUSION:

Despite efforts to stop FGM/C, the tradition is resisting all moves, and is continuing in Ebonyi and Imo states, among others. Since the practice of FGM/C has been in the communities over many generations, and has naturally become part of the community and family life, and given the long-term health consequences of the practice, the focus of efforts to control FGM/C must include primary prevention. Primary prevention means elimination or alteration of those behaviours, attitudes and misconceptions that enhance the conduct of FGM/C. Female circumcision could be prevented absolutely only by eliminating those misconceptions [social acceptance, sense of fulfilment on the part of mothers, but more on the part of grandmothers and older women who believe that yielding to the total ban of FGM/C is yielding to male chauvinism since, to the old women, FGM/C is the only rite of passage left for the women, when the men still retain their age grade system]. An old woman asked *“Why should girls not retain their age grade tradition of passage from adolescence to womanhood through circumcision? Nobody has stopped the young men from transiting from adolescence to manhood.”* Therefore, the old women must be the target for change if FGM/C must be totally stopped. However, because the elimination of generational-seeking tradition is generally extremely difficult and may be impracticable, their alteration by substitution of alternative rites of passage for the girls has been proposed as a means to stop FGM/C. Nature abhors vacuum. What is an alternative to FGM/C as a rite of passage for girls? Until these questions are answered, the old women will continue to guard the tradition of FGM/C very jealously and FGM/C will continue. When the old women are given this task of finding an alternative and harmless rite of passage for adolescent girls, not only would they feel honoured and recognized, but our culture would have become dynamic. This is the essence of social change and improvement science.

Clearly, FGM/C education has much to offer in any effort to alter tradition-seeking and tradition-sustaining behaviour, particularly among the elderly. An old woman afraid of imprisonment or payment of fine of N200,000 may be forced to change her attitude towards female circumcision, but she has not changed her belief in the tradition, and its process. It is better for old women to give informed consent by convincingly educating them of the dangers of FGM/C.

Generally, the findings reveal that there is a range of attitudes, and behaviours that facilitate FGM/C practice in the states and communities. A high prevalence of FGM/C and a profuse but secret patronage of both traditional circumcisers and health worker circumcisers have been established. Also established, is the fact that the VAPP Legislation has not been domesticated in

Imo, and there is no awareness and knowledge of its existence in the communities. Even a traditional ruler in Imo affirmed there was no such law. In Ebonyi where there is community evidence of its existence, obedience to it is in breach because it is obeyed more out of fear than because of conviction of the evils of FGM/C. Therefore in Ebonyi, the very stringent implementation of the law has driven the practice underground hence FGM/C practice goes on more clandestinely than when there was no law. In all this, the powerful minority who still support the tradition have not come to the full knowledge of the health risks arising from FGM/C as well as the human rights concern associated. The high prevalence of FGM/C reported among the cohort of unmarried adolescents and daughters of surveyed mothers is of serious concern because it does not reflect the expected reduction in prevalence by age cohort. It should be expected that the prevalence of FGM/C among the adolescents should be lower than among their mothers. The reverse was the case (76% among mothers, vs. 99% among daughters). There can be no doubt that the present findings are alarming in their implication for the future generation of women. The degree of risk of sustaining FGM/C is serious not only because a large proportion of the present cohort of mothers have engaged in the past and intend to engage in the future (15%) in behaviours and attitudes that drive FGM/C but also because of the large proportion of current adolescents who are also circumcised. So, the problem is not that there are a lot of circumcised mothers who are replicating their experience in their own daughters. Rather, there are a lot of today's female adolescents who are already circumcised who need to be identified and convinced to change their belief in the tradition. There are also a lot of elderly women pushing for the continuation of FGM/C, who need to be identified and convinced to change their attitude, belief and practice.

In this regard, the findings indicate an urgent need to implement effective community-based FGM-specific educational programs in Ebonyi and Imo communities. FGM/C preventive programs especially targeted at the elderly women and unmarried adolescents will have to overcome particular barriers to behaviour and attitudinal change, such as low motivation and lack of self-esteem. To be successful, such older women-specific and adolescent girls-specific FGM/C prevention must be discussed openly, communicated widely and should be acceptable to old women and unmarried adolescents. The old women and adolescents must participate fully from planning to evaluation of end-FGM/C programs targeted at them. Forced laws only without convincing knowledge cannot change the tradition of FGM/C. By failing to focus sufficient resources in addressing the FGM/C problem among old women and adolescent girls in the communities, the states stand to lose an important opportunity to reach one of the largest pools of potential influencers of FGM/C in the country. The following salient recommendations are based on the findings of this survey.

4.3. RECOMMENDATIONS

4.3.1 Elderly women as targets

Efforts must be targeted at elderly women (grandmothers) who from the findings of this survey are key stakeholders in the practice of female circumcision. The elderly women (65 and above) are the critical minority who drive the continuation of FGM/C, and who must

be convinced of the dangers of FGC and be empowered to willingly drop the tradition. The potential for obliterating FGM/C is hidden in the grandmothers who see the termination of the tradition without an alternative route of rite of passage to womanhood as “another fraud by men and a means of taking away the rights of girls and women, all in the name of preserving the rights”. The grandmothers have spoken. They are not totally opposed to stopping FGM/C, but are demanding an alternative route for young girls as rite of passage to womanhood as men do.

Traditions and culture could be dynamic. Therefore, the elderly should be convinced to create a harmless alternative tradition to replace FGM/C as a rite of passage from adolescence to womanhood. It is time to play on the ego of the elderly to achieve a social and health change. If the alternative is created by the elderly women, it addresses not just the challenge of FGM/C, but the ego, pride and honour of the elderly who desire to leave a better legacy for generations of future women. Then they will live fulfilled and die without a guilt of betraying their ancestors. What is more, such a move will restore the confidence of the grandmothers and cancel the feeling of male domination in this regard.

We recommend an intervention which focuses on grandmothers (ages 60-75 years), where the old women will have free expression, free speech, and open debate among their own age grade, exclusively. We recommend a 3-day workshop where the grandmothers are taken away from their homes and “spoilt” a little. This will not be an elite workshop, rather, a heart-to-heart talk with grandmothers leading to a conviction that FGM/C does more harm than good and allowing the grandmothers to come out with an alternative rite of passage, which will be harmless, but which satisfies their pride and ego. Such a workshop should have as its deliverables – (1) an alternative rite of passage for females from adolescence to womanhood - crafted by grandmothers and presented for community and government approval and (2) Total abandonment of traditional FGM/C in the states and communities. After such an agreement, the grandmothers themselves will become the drivers of the laws prohibiting FGM/C. It will be a win-win situation.

4.3.2 Target unmarried adolescents for FGM/C education

Today’s female adolescents are the mothers of tomorrow. We recommend that society builds on their willingness to abandon the practice of FGM/C by targeting them for FGM/C education. Every female adolescent should be empowered with the details of the medical and health risks of FGM/C and further strengthened in their resolve to jettison the practice. The findings of this study reveal that there are adolescent girls who go out on their own wanting to be circumcised, just “to be like others”. Interestingly, more girls are determined not to perpetuate FGM/C in future. Therefore, such adolescent females should be identified and projected as ambassadors against female circumcision.

4.3.3 Teach, demonstrate evidence and create awareness about the evils of FGM

Stakeholders in the FGM/C project do not understand, and therefore do not believe in any health/medical challenges related with FGM/C. The public health and medical professions keep using terminologies unexplainable to rural, and highly uneducated women. This explains why most old people tell you “*obu oke oyibo a ka unu ji nemeghari ndi mmadu anya. Obu asi ka anatu (meaning: with these high sounding English and scientific languages, you professionals just deceive people. You are liars)*”. Other respondents had pleaded “*Teach us and show evidence that female circumcision has harmful effects. Don’t just say so, show us evidence of health or medical issue resulting from female circumcision*”. The health and medical profession need to come down to the level of the rural dweller to explain such health issues as perineal laceration, chronic pelvic infection, vulva adhesions, hematocolpos, dysmenorrhea, implantation dermoid cysts, and keloids, which are some of the reported complications of FGM/C. Experience has shown that there has not been any documented evidence that these complications have been clearly explained to rural women to enable them understand the justification for jettisoning the age old culture. Merely telling an old woman that FGM/C has medical implications is not enough. If it were, the practice would have received an overwhelming “red card” years back. **They need practical evidence. must be models developed to use in teaching both the old and young, some of these medical terms so as to engender enduring support for the total abandonment of the practice.**

Associated with the medical/health knowledge is the evil phenomenon called “medicalization” of FGM/C. This is the process where modern health practitioners and community health workers have been introduced into this trade (WHO, 2007). The WHO is strongly against this medicalization and has advised that FGM/C should neither be institutionalized nor any form of FGM/C be performed by any health professional in any setting, including hospitals or homes. The finding of this study reveals that some health workers are still conducting female circumcision in secret connivance with mothers... “*It is our mothers who take us to the nurses to do it...*” even in breach of existing laws. NGOs and other stakeholders must work in unison to sanction any health worker who indulges in this act.

4.3.4 Domesticate laws, and enforce the VAPP law.

All states should be encouraged to domesticate and enforce the VAPP legislation. CIRDDOC as an NGO should take the lead in advocating with the Imo state government to domesticate the VAPP. The simple evidence that the South east now has the highest FGM/C prevalence in the country and that Imo state has the highest FGM/C prevalence among the south east states is enough advocacy data for the state to domesticate the VAPP law and push for its enforcement. The Ebonyi template of backing the VAPP domestication with council/community-approved bye-laws and task force to enforce the laws is

recommended. Every community should be encouraged to have its own anti-FGM/C enforcement team.

4.3.5 Multi-dimensional approach

A multi-dimensional approach and inclusion of all stakeholders against female circumcision is suggested. NGOs, the church, mosque and age groups within the communities should be mobilized. The women groups, including the association of “Umu ada”, the South East Association of Town Unions (ASETU), the media, including the local town criers should be integrated and all work as a team. Awareness creation about the dangers of FGM/C and other interventions should not be a one-off event. Government and donor agencies must see the practice of FGM/C as one that needs as much sustained intervention as any other health/social or environmental issue.

4.4. Lessons Learned

The lessons learned from this baseline study are divided into two types: lessons from research finding and lessons from study implementation

Two lessons are learned from the research findings:

4.4.1 Failure to adequately engage key stakeholders during the process of law making could lead to laws not being rightly communicated to the polity and therefore not obeyed. This is clear with the Imo State law prohibiting FGM/C. Discussions with a desk officer in Imo state ministry of women affairs and social development who should be a driver to implement the law confirmed that stakeholders, including her ministry, were not consulted in the process of making this law. She reported that even traditional rulers were not invited to make input during the process of making the law. She queried “If you imprison the guilty parents of a five-year-old girl for 14 years for circumcising their daughter, who will take care of the child?” Law making is like action research which demands the input of critical stakeholders not just as beneficiaries, but also as participant implementers in the process. This differs from pure or basic research which is primarily aimed at just advancing knowledge, and which often ends gathering dust on bookshelves. To be effective laws aimed at altering customs and traditions such as female circumcision must carry all stakeholders including the “beneficiaries” along.

4.4.2 A second lesson learned from research finding is that the critical old women who want FGM/C sustained are bothered about their “failure” in not transmitting the same tradition they inherited to future generations. Our finding shows that the old women are not necessarily opposed to stopping FGM/C but they want its replacement with a harmless tradition that allows young girls initiate from adolescence to womanhood, just as their male counterparts have sustained their age grade and “iwa akwa” traditions. This lesson calls for a paradigm shift in the efforts to stop FGM/C, and will be relied upon to develop new FGM/C-prevention or FGM/C-replacement education that even the old women will support.

Lessons from study implementation

The lessons learned from the conduct of the baseline are related to use of qualified supervisors and data collectors, as well as research logistics. These include:

4.4.3 The use of supervisors and data collectors who were conversant with the dialect and terrain of the research communities was an enabling factor that enhanced data quality, including timeliness. Although the supervisors and data collectors were not from the communities, but their language and cultural efficiency were relied upon to provide the atmosphere of relaxation on the respondents, particularly during FGDs as well as enable deeper probing that got the respondents to talk freely during the discussions and interviews.

4.4.4 Team work: We were able to blend our supervisors and data collectors into a formidable team. The research manager was also open and left nothing to gossip. Everybody knew what the other was earning in this research and why. This openness led to a level of trust which in turn strengthened team work as each person saw his/her contribution germane to the overall success of the study. One of our supervisors in one of the states is a sitting local government councilor and was able to mobilize in advance her colleagues in the communities such that even when dates and times for visiting communities were altered the communities still obliged the changes and waited. Furthermore, we considered the sensitive nature of the study and the age range of respondents, and correspondingly structured our data collectors and supervisors to fall within the same age range. The age of our data collectors and supervisors ranged from 19-70 years. So we had men and women who themselves knew much about FGM/C in Igbo land and who could discuss it freely. This age mix was supportive and the team spirit was active.

4.4.5 Our supervisors served as advance parties by visiting the communities one day in advance. This lesson helped our logistics plans as we could learn first-hand how long it would take us to get to each community from our starting points.

4.4.6 Working with the list of traditional rulers supplied by CIRDDOC was highly supportive. Earlier phone calls to them to identify ourselves and introduce the focus of data collection were seen as a matter of respect and honour to them, and they gave their support. In one or two cases when the Eze would not be available, particularly due to change of date or time, they delegated their able subordinates.

References

1. 28 Too many (2016).Country Profile: Female Genital Mutilation in Nigeria. <https://www.28toomany.org/country/Nigeria>
2. Cortez, Rafael; Saadat, Seemeen; Marinda, Edmore; Oluwole, Odutolu (2015) 2015. Adolescent Sexual and Reproductive Health in Nigeria. Health, nutrition and population global practice knowledge brief;. World Bank, Washington, DC. © World Bank.
3. Nigeria Demographic and Health Survey (2013). Female Genital Cutting. National Population Commission/ICF Macro. P 373-396
4. Yoder, P. Stanley; Wang, Shanxio; Johansen, Elise (2013). Estimates of Female Genital Mutilation/Cutting in 27 African Countries and Yemen. *Studies in Family Planning* 44(2): 189-204
5. World Health Organization/AIE(1994). Health, Population and Development. WHO Position paper presented at the International Conference on Population and Development (ICPD), Cairo
6. World Health Organization (WHO)(2014). Classification of Female Genital Mutilation. Geneva. WHO
7. World Health Organization (WHO)(1998). Female Genital Mutilation: An Overview. Geneva. WHO
8. Nigeria Demographic and Health Survey (2018). Female Genital Mutilation. National Population Commission; pp. 465-487
9. Okeke, TC; Anyaehie, USB; Ezenyeaku, CCK (2012). An Overview of Female Genital Mutilation in Nigeria. *Annals of Medical and Health Sciences Research*. 2 (1); 70-3
10. Assad, MB (1980). Female circumcision in Egypt: Social Implications, current research and prospects for change. *Studies in Family Planning*, 11: 3-16
11. United Nations Children's Fund (UNICEF) (2001) Children's and Women's Right in Nigeria: A Wake up call. Situation Assessment and Analysis. Harmful Traditional Practice (FGM). Abuja, NPC and UNICEF Nigeria. pp195-200
12. United Nations Children's Fund (UNICEF) (2016). Female Genital Mutilation/Cutting: A global concern. UNICEF, New York
13. National Bureau of Statistics/UNICEF (2018). Multiple Indicator Cluster Survey 2016-2017/UNICEF Multiple Indicator Cluster Survey (MICS)
14. United Nations Children's Fund (UNICEF) (2013). Female Genital Mutilation/Cutting: A Statistics overview and exploration of the dynamics of change. UNICEF, New York.
15. Mandara, M. U. (2004). Female Genital Mutilation in Nigeria. *International Journal of Gynaecology and Obstetrics*. 84: 291-298
16. Ugwu, Somtochukwu Nnamdi (2019). FGM in Nigeria: Combative Legislation and the Issues's Impact on the Economic Growth of Women. *Equal Rights Impact*
17. Verzin, J.A (1975). Sequelae of female circumcision. *Tropical Doctor*, 5: 163-169

18. Worsley, A (1938). Infibulation and female circumcision. A study of a little-known custom. *British Journal of Obstetrics and Gynaecology* 45: 686-691
19. Hosken, F.P (1992). The Hosken Report. 3rd Review ed. Vol. 18. Vienna. Published by Women's International Network News (WINN). Genital and Sexual mutilation of females; p. 4
20. Anzaku, A.A; Angbalaga, A.G; Achetu, A. C; Pedro A.; Idibia, O. D; Okezue, C. J (2018). Implication of female genital mutilation in Nigeria as portal for infectious diseases. *Journal of Bacteriology and Infectious Diseases*; 2 (1): 28-30
21. Mandara, Mairo Usman (2000). Female Genital Mutilation in Nigeria: "View of Nigeria Doctors on the Medicalization Debate". In Shell-Duncan, Bettina, Hernlund, Ylva (eds). *Female Circumcision in Africa: Culture, Controversy and Change*. Boulder Lynne Rienner Publishers
22. Berg, Rigmor C; Underland, Vigdis; Odgaard-Jensen, Jan; Fretheim, Atle; Viot, Gunn, E (2014). Effects of Female Genital Cutting on physical health outcomes: a systematic review and meta-analysis. *British Medical Journal open* 4 (11)e 006316
23. Banks, Emily; Merik, Olav; Farley, Tim; Akande Oluwole; Bathija, Heli; Ali, Mohammed (2006). WHO study group female genital mutilation and obstetric outcome. WHO Collaborative Prospective Study in six African countries. *Lancet*; 376 (9525): 1835-1841
24. Akpuaka, F.C(1991). Vulval adhesion following female circumcision in Nigeria. *Postgraduate Doctor Africa*: 13. 98-99
25. Odoi, A.T(2005). Female genital mutilation. In Kwawukume, E.Y, Emuveyan EE, editors. *Comprehensive Gynaecology in the Tropics*. 1st ed. Accra. Graphic Packaging Ltd. p 268-278 [Google Scholar]
26. Federal Ministry of Women Affairs and Social Development [Nigeria] (2015). *Violence Against Persons Prohibition (Act)*. VAPP Act. Women and Gender Affairs Department. Federal Ministry of Women Affairs and Social Development
- 26(b). Imo State House of Assembly (2017): *Law to prohibit the act of Female Genital Mutilation in Imo State*
27. Ugwu, SN (2019). FGM in Nigeria: Combative Legislation and the Issues's Impact on the Economic Growth of Women. *Equal Rights Impact*
28. Ayodeji, Makinde Olusesan (2017). Rejection of the Gender and Equal Opportunity Bill in Nigeria: A setback for Sustainable Development Goal Five. *Gender in Management* 32 (3): 234-240
29. Muteshi, Jacinta K; Miller, Suellen; Belizan, Joe M (2016). The ongoing violence against women: Female Genital Mutilation/Cutting. *Reproductive Health*: 13:44