Nigeria
UNFPA-UNICEF Joint Programme on FGM/C
Baseline study

International Consultant's Final Report
Overview
FGM/C Rating
Social Norms

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CONTENTS

The international consultant's work in Nigeria is dedicated to the late Iyalode of Osogboland, Chief Bernice Alake Kolade JP. Thank you for the privilege of knowing you, thank you for sharing your knowledge and commitment. Rest in peace.

The international consultant's most sincere thanks go to:

Ms Adenike Etta, Director Family Health at Nigeria's Federal Ministry of Health – although our actual meeting was short, one hour or so, I know that without you none of the baseline study would have happened.

Ms Rachel Harvey, Chief of Child Protection at UNICEF – the same holds for you.

Thank you, first and foremost, **all the FGM/C experts**[1] in Abuja, Imo, Osun, Ekiti, Oyo and Lagos who spent your time and energy to share your knowledge and your views with me. All the good things that I hope to come out of my work are yours – all the errors are mine.

I particularly thank all my state guides who arranged and/or accompanied me to the interviews: Ms Aduke Obelawo (an extra thank you for introducing me to Chief Bernice Alake Kolade), Dr Jude Ohanele, Ms Tayo Olatilu, Ms Akinleye Olukemi and Mr Oderinde Akinyele.

And I am most grateful to Mr Chigozie Benjamin Mbakwem, Ms Aduke Obelawo, Ms Margaret Onah, Dr Jude Ohanele and Ms Oyefunso Orenuga for their comments on the draft of my report. Thank you for again spending precious time and energy for me – and against FGM/C.

May Nigeria's girls and women benefit!

[1] For the complete list see the Annex 3 of my Contributions to Nigeria's national anti-FGM/C strategy

1. **Introduction. Two potential trendsetters**

World-wide, Female Genital Mutilation/Cutting (FGM/C) is nowadays considered a women's and girls' rights problem first and foremost. It is, of course, also a health problem.

Any sort of FGM/C – from the least ("massage") to the worst (infibulation) – is a severe violation of the (baby) girl's or woman's rights.

FGM/C is about sexual control, it is about protecting propriety and decency at their most precious, at their most intimate, in a community's women.

The UNFPA-UNICEF Joint Programme against FGM/C in 2014 recruited Nigeria to participate in its 17 country programme "Accelerating Change". To base the Nigerian interventions on solid ground, once the intervention states selected, a baseline study was to be conducted. For this, data collection personnel, a state consultant for each of the intervention states, a national consultant and an international consultant were recruited. The latter was to be a social norms expert.

This is the international consultant's report.

The international consultant has been working on this assignment since September 2014. Of this time, only five weeks were spent in Nigeria, a highly productive time, meeting and interviewing experts in Abuja, Imo, Osun, Ekiti, Oyo and Lagos.

In his final results report, the international consultant presents his analysis and the conclusions he drew from the quantitative data collected by the data collection teams in the six baseline study states and from the qualitative information he himself collected during his Nigerian field work, all of it – true to his terms of reference – from a social norms theory viewpoint.

The major outcomes are two tools for analysis and presentation that the consultant proposes for standardisation. The first is an overview for a community that practices FGM/C, an overview that gathers the most essential information about FGM/C in that community and presents it "at a glance", on a single page. The second is an FGM/C rating. On the basis of 34 variables or indicators – selected from quantitative data collected in the field – the ranking calculates one single figure that tells us where a community is in terms of FGM/C or FGM/C abandonment.

Both of these tools work for communities of any size – from the very big to the very small. On the only condition that the necessary data are available and reliable, they work for villages or countries, for a diaspora community in London, for a Nigerian state, as they could work for all of West Africa. And they make for easy comparison. Inter-village, inter-LGA, inter-state, inter-country – and you can even mix categories, the comparisons will still be meaningful.

Both tools need to be discussed by FGM/C experts and could yet be adapted. From a social norms perspective, it seems unlikely that something be dropped from the overview, it is all essential information – but for the rating, while the basic structure should be maintained (four subindicators, mathematical simplicity), some of the 34 variables could be changed/improved/dropped before adaptation of the model. In fact, a reduction of the variables may be expedient – once the model is officially adopted, then any future community undergoing the rating will have to collect data for all the variables contained in the rating. Cost reduction may thus advocate for a smaller number of indicators – if this is done judiciously, then the quality of the rating need not suffer at all.

The FGM/C overview and the FGM/C rating are potential trendsetters. Nothing of the sort has been introduced anywhere so far. And the UNFPA-UNICEF Joint Programme could be the transmission belt for such an endeavour on the international stage.

What is of overriding importance is standardisation.

The following chapter two gives a very short methodological outline of the international consultant's work. The much bigger chapter three then presents his research results: the FGM/C overview first, then a chapter defining and explaining social norms for anti-FGM/C activists, then the FGM/C rating. A table with the rating results (overall rating plus the four subindices) for the six states and the 37 local government areas that participated in the baseline study is followed by a very short section for each of the six states: the state FGM/C overview first, and then a page of comments, interpretation and some more data of particular relevance in a social norms context[2]. Chapter four then gets us into the discussion and deals with social norms and the baseline study, breaking the definition down to the reality in the six states examined. The short chapter five draws a conclusion, finding a "virtual community, with grandmothers as guardians". And the final chapter six sets out the international consultant's recommendations – general ones at first, then more specific (for the federal, the state and the community level), before trying to establish a link between the Joint Programme's theory of change and the Nigerian efforts at FGM/C abandonment.

2. **Methodology. Quantitative & qualitative legs to stand on**

The results of this study are not representative for Nigeria – they were never meant to be. Six states were purposefully selected for the study: the five states for which Nigeria's 2013 Demographic and Health Survey (DHS)[3] had found the highest FGM/C rates, namely Ebonyi State, Ekiti, Imo, Osun and Oyo, and then, as a sort of control sample, the metropolis Lagos.

The baseline study was to rely on two sources of data – quantitative and qualitative. Quantitative data were to be collected by means of a questionnaire containing 62 questions, many containing sub-questions, the first twelve questions providing demographic information about the respondents. Qualitative data were to be collected in the form of key informant interviews, case studies and focus group discussions by the data collection team regrouped around each state consultant; and also by the international consultant by means of expert interviews.

The international consultant's analysis and his report are based on the quantitative data collected in the six states by the data collection team and only the qualitative data he himself collected through expert interviews as other qualitative results were not made available[4].

[2] In depth-analysis of collected data has been provided for each state by the state consultants in their reports.
[3] National Population Commission, Nigeria. Demographic and Health Survey 2013 (DHS 2013), Abuja, June 2014. This is often referred to as NDHS 2013.
[4] Promised transcripts of focus group discussions, case studies and key informant interview were not ready in time or were not sent to the international consultant. The state consultants' state reports contain some quotes from focus group discussions, key informant interviews and case studies, but not many, and selection was already made. State reports reached the international consultant on 2nd respectively 6th of July, the Osun state report so far never did.

For a description of the quantitative data collection, please turn to the national consultant's report, he supervised the process from Abuja, and also the state consultants' reports – they supervised the data collection on the ground. A statistician's services were resorted to for processing.

During his time in Nigeria, the international consultant was attached to the UNICEF Abuja office which organised all the logistics, partly relying on zone offices in Enugu and Lagos (thank you, also to all the drivers!). In the four states visited, there was always a guide assigned to the international consultant[5]; a guide who organised and mostly accompanied the consultant during his interviews. That the consultant went to an interview unaccompanied by a UNICEF programme officer from the Abuja office and/or the state guide was exceptional[6]. Experts interviewed were to represent stakeholders pertinent to the realm of FGM/C as completely as possible. With some broad indications given to the guide in advance and also during discussion at the outset or during the course of the stay in the respective state, the selection of the interview partners was largely left to the state guides, thus benefitting from their local expertise. Spontaneous additions to the set programme were sometimes made if need was felt or a new venue opened. The actual arrangement of the meetings was mostly also done by the guide[7]. Most of the "targeted" experts were – to the international consultant's knowledge – available for meeting him.

A list of the experts interviewed by the international consultant can be found in the Annex. The same holds for the list of interview topics and questions for anti-FGM/C experts that the international consultant used as a very loose guide during his meetings with experts.

3. **Results**

Let us jump to the heart of the matter right away. The next page presents an FGM/C overview for the six states that participated in the baseline study.

[5] These were, in chronological order: Imo: Dr Jude Ohanele; Osun: Ms Aduke Obelawo; Ekiti: Ms Tayo Olatilu assisted by Ms Akinleye Olukemi; Oyo: Mr Oderinde Akinyele.
[6] The two Lagos interviews were such exceptions as were the last interview in Imo and, of course, the two telephone /email interviews for Imo; some of the interviews with UN agency representatives were also unaccompanied.
[7] Not so in Lagos and not in Imo.

3.1 Overview six baseline study states

FGM/C rate: 54.5%

Public Declarations

Official:
Federal law against FGM/C: **yes**, state laws: Ebonyi, Ekiti, Osun: yes, Imo, Lagos, Oyo: no
Where yes: law applied: **no**

Community declarations: 10 communities in Oguta/ Imo

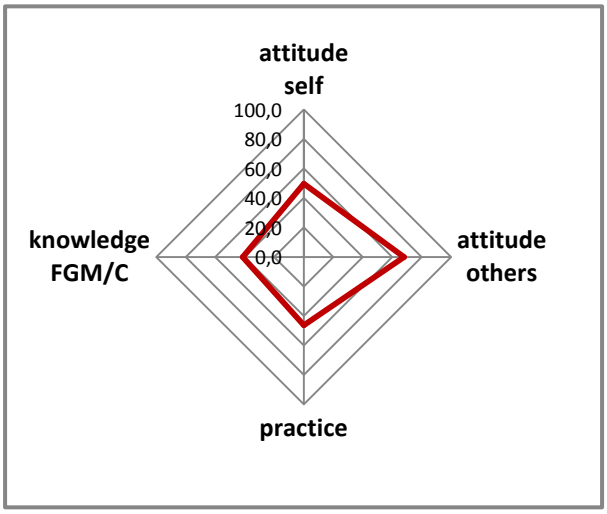
Traditional authorities: Iyalode of Osogbo/Osun, late Chief Bernice Alake Kolade J.P., Chief Rufus Falodu, Saade of Ijero kingdom/Ekiti (one of the kingmakers)

Religious authorities: diocesenal conference of Anglican Church/Imo

Other influential people: Ekiti's former governor's wife Ms Bisi Adeleye-Fayemi; a sort of *negative* public declaration was the Oyo governor's wife in 1999 having her granddaughter cut

FGM/C Rating: 51.5

(best LGA in sample: 71.0
best state in sample: 59.0
worst LGA in sample: 30.0
worst state in sample: 39.6)



FGM/C supporters/FGM/C abandoners – willing/reluctant

"practice FGM/C" here means
"has at least one cut daughter"

	are for FGM/C	*don't know*	*are against FGM/C*
practice FGM/C	**29.9% Willing Practitioners**		**15.7% Reluctant Practitioners**
		8.6% Contemplators	
do not practice	**13.6% Reluctant Abandoners**		**32.2% Willing Abandoners**

In red: those most likely to be "converted" to abandonment

Communication About FGM/C

56.0% have discussed FGM/C with spouse
66.1% have discussed FGM/C with family
72.9% have discussed FGM/C with friends
35.8% have discussed FGM/C in public

Opinion leaders who raise the issue publicly:
Development Dynamics/Imo as part of VAPP bill;
August meetings of Imo several times dealt with FGM/C

Radio programmes on FGM/C:
Few regular (OSBC/Osun – one Monday per month (MoH programme Mon. 5-5:30 p.m.)), several occasional (Ekiti FM, Flash FM+Amuludun FM/Oyo, Radio 99+ Gold FM+Ara Station+ Orisun/Osun, Heartland+ IBC/ Imo)

Other media treating FGM/C:
Ekiti State Television (occasional);
others: occasional if at all

3.2 Interpreting the Overview

The above overview resumes on one page the results of this study that are most pertinent in terms of social norms (see the next sub-chapter for a definition of social norms).

First (top left of the overview) we have public declarations: Since only very recently, we have a law against FGM/C in Nigeria[8]. But the federal level is not enough: the question also – or maybe even mainly – is: is there a law against FGM/C in the state? This is the public/administrative authority's official declaration that FGM/C is bad and that something needs to be done about it. Passing a law is good – it then needs to be made widely known and it needs to be put into practice, it needs to be applied. To my knowledge, this has so far not happened anywhere in Nigeria. Only the state can declare FGM/C "illegal". But other institutions also can "outlaw" the practice: traditional authorities, religious authorities or – maybe most importantly – communities themselves or influential people can publically declare their firm opposition to the harmful practice. Communities can, on top of that, make a public pledge, a solemn public promise to never cut again (this is the Social norms theory's public declaration in the strict sense) and to monitor the keeping of this promise.

Next (top-right of the overview) we have the result of the FGM/C rating. 100 is (unattainable) best and 0 is worst. The rating has four sub-indicators: attitude and views of the interviewees + attitude and views of relevant others as perceived by the interviewees + the actual practice of FGM/C + the interviewees' knowledge about FGM/C and their participation in discussions about FGM/C (see sub-chapter 3.4 for more explanations). For each sub-indicator, 100 is again the unattainable best and 0 the unattainable worst.

On the bottom left of the overview page, there is a table "FGM/C supporters/abandoners –willing/reluctant"[9]. The interviewees who have FGM/C done to their girls – do they approve of it or are they – secretly or openly – against it? And those who do not have it done to their girls, have they abandoned FGM/C with good conscience or would they "really" prefer to continue with the practice? Or don't they know, are they thinking about it, about whether it is a good thing or a bad thing, whether to continue with it or to abandon it?

The reluctant practitioners[10], those whose girls are cut but who are against it are probably the most likely to be "converted" to abandonment. And then the "contemplators" – some who have not uttered an opinion or say that they do not know whether they are against FGM/C or for it, some will just be hiding their opinion; but some of them may just be waiting for that little extra push – and they'll abandon. Knowing how many are in the category "reluctant practitioner" and how many in the category "contemplator" may give us an indication of how many in the sample/in the state/in an LGA are more or less "ready to abandon" even if they have not yet done so. The size of the category "willing practitioners" indicates the importance of staunch resistance, while "willing abandoners" shows how many amongst the interviewees

[8] Section 6 of the Violence Against Persons (Prohibition) Bill, passed by Nigeria's Senate and House of Representatives on 14/5/2015, signed by the President on 23/5/2015.

[9] The idea is from Bettina Shell-Duncan, Ylva Hernlund, Katherine Wander and Amadou Moreau, Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia. Summary Report, Seattle (Univ. of Washington) 2010, p.36.

[10] See the sub-chapter "Identifying stages of change", pp.33ff in Bettina Shell-Duncan, Ylva Hernlund, Katherine Wander and Amadou Moreau, Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia. Summary Report, Seattle (Univ. of Washington) 2010.

are already acquired to our anti-FGM/C cause. "Reluctant abandoners", on the other hand, shows that there are people who do the "right thing" but may need extra attention because they might tip back into bad old habits if free to do so.

To complete the tour of the one page-FGM/C overview, on the bottom right there is a section dealing with communication about FGM/C. Having it done to one's girl may be a lonely mother's or grandmother's decision. But as it is done "for society", this will be rather the exception – others around are typically involved/consulted/obeyed/etc. Where FGM/C is a custom/tradition/part of the culture, abandonment as a very first step needs FGM/C to become an issue to be discussed instead of doing it "automatically". The more a member of the community exchanges on the issue, the better, because it will tend to de-solidify long-held views and to spread information about the practice's disadvantages. The bottom right section thus includes the percentages of interviewees that have discussed FGM/C with their spouses, with their families, with their friends, and finally – and most importantly if we aim for public declarations of abandonment – in public.

On a different level, moving from communication on the individual to communication on the societal level, one could say that FGM/C is very much a problem in Nigeria, at least in some states and most of all in the states included in the baseline study, but that it is much too seldom an issue. Amongst the main culprits: the media – they deal with it much too rarely. So let us look at radios and other media and see which one deals with the issue regularly, which one at least occasionally. And let us also keep a record of opinion leaders who raise the issue.

NB: Completion of the overview pages is conceived as an ongoing process. While the rating and the table and the figures about the individuals' communication about the issue are based on the baseline study's quantitative data collection, information about public declarations (except the very first part about laws) and about media covering FGM/C is at this stage very incomplete[11] *and will need to be added on to as we proceed with our anti-FGM/C activities in the intervention states.*

Next we turn to social norms – note that the Social Norms Theory is very much reflected in the above overview. It underlies all of the UNFPA-UNICEF Joint Programme on FGM/C "Accelerating Change".

[11] The international consultant has, for one thing, not visited Ebonyi State nor Lagos (except in passing) nor any part of Oyo outside Ibadan.

3.3 Social Norms and FGM/C

In the past, activities against FGM/C targeted individuals, giving them information about its harmfulness and generally trying to persuade these individuals to stop doing it. For their girls' and also their own benefit.

Somehow, it did not work like it should have. While other traditional practices died a natural death far from the spotlights – for example facial scarification – and even without much effort from well-meaning campaigners, the efforts at FGM/C abandonment, though having positive effects, did not lead to total abandonment – far from it.

So we had to find out why. At first at Innocenti Research Centre in Florence, Italy, and then at UNICEF headquarters in New York and at universities in San Diego/California and Philadelphia /Pennsylvania[12], research was conducted. We moved away from old approaches – and we most of all moved away from targeting mainly individuals. Because FGM/C is a social thing. So the individual's knowledge about the harmfulness of that tradition is an important factor in going for abandonment – but an individual may know all there is to know about the problem and even be entirely convinced that she or he should not have it done to her or his daughter – "circumstances" may be such that having his or her daughter cut is the only viable thing for him or her to do. And "circumstances" mean society. FGM/C is a social norm.

Lots of people talk about social norms, but what are they really? The following definition is based on a power point slide presented by Cristina Bicchieri at the 2010 Social norms summer course at the University of Philadelphia[13].

> A behavioral rule that applies to a class of situations is a **social norm** in a population (group, community, society, etc.) if there is a sufficiently large part of the population for whom the following hold:
> **Contingency**: the individual knows that the rule exists and applies to that class of situations;
> **Conditional preference**: the individual prefers to conform to the rule in situations of this type if and only if:
> a) **Empirical expectations**: the individual believes that a sufficiently large part of the relevant population conforms to the rule in situations of this type
> *and either*
> b) **Normative expectations**: the individual believes that a sufficiently large part of the relevant population expects him/her to conform to the rule in situations of this type;
> *or*
> b') **Normative expectations with sanctions**: the individual believes that a sufficiently large part of the relevant population expects him/her to conform to the rule in situations of this type, prefers him/her to conform and may sanction (punish) behavior.
> A social norm is followed in a population if, for a sufficiently large number of individuals, empirical and normative expectations are met and, as a result, such individuals prefer to conform to the rule in situations of this type.

[12] The three central figures are Francesca Moneti at UNICEF headquarters, Gerry Mackie at University of California, San Diego, and Cristina Bicchieri at University of Pennsylvania, Philadelphia. The latter two co-direct the yearly UNICEF Learning Program on Changing Social Conventions and Social Norms at Philosophy, Politics and Economics (PPE), University of Pennsylvania, Philadelphia.
[13] Power point presentation of 5 July 2010 entitled "Social Norms"

If you want it a bit more formally, here is the definition Cristina Bicchieri gives in The Grammar of Society (that book, published in 2006, has become the standard reference for our social norms theory):

Conditions for a Social Norm to Exist

Let R be a *behavioral rule* for situations of type S, where S can be represented as a mixed-motive game. We say that R is a social norm in a population P if there exists a sufficiently large subset $P_{cf} \subseteq P$ such that, for each individual $i \in P_{cf}$:

Contingency: i knows that a rule R exists and applies to situations of type S;

Conditional preference: i prefers to conform to R in situations of type S on the condition that:

(a) *Empirical expectations*: i believes that a sufficiently large subset of P conforms to R in situations of type S;

and either

(b) *Normative expectations*: i believes that a sufficiently large subset of P expects i to conform to R in situations of type S;

or

(b′) *Normative expectations with sanctions*: i believes that a sufficiently large subset of P expects i to conform to R in situations of type S, prefers i to conform, and may sanction behavior.

A social norm R is *followed* by population P if there exists a sufficiently large subset $P_f \subseteq P_{cf}$ such that, for each individual $i \in P_f$, conditions 2(a) and either 2(b) or 2(b′) are met for i and, as a result, i prefers to conform to R in situations of type S. 14

Let us walk through this definition step by step. First of all the "population" is important – a social norm will be valid only for a given group; we usually speak of the "reference groups".
The next point sounds obvious but needs to be stated: contingency: the rule needs to be known and it must be known that a certain kind of situation calls for the application of that rule.
And now the heart piece of the definition: Conforming to the rule/norm is not an unconditional preference but requires empirical AND normative expectations: the concerned must believe that many/enough others conform to the norm and she/he must believe that many/enough others expect him/her to conform to the norm. On top of that (but this is no requirement), not-conforming may be punished, the individual may be ridiculed/ostracised/banned.

This is no place to fully expose the social norms theory[15]. But let us recapitulate its most important tenets and recommendations.

The main consequence is that anti-FGM/C campaigning needs to go beyond individuals. It is good and important that an individual knows the disadvantages and everything there is to know about cutting the girl's genital, but this will in very many cases not be enough for her or his abandoning the practice. Once the knowledge is there, and once the attitude has changed, the potential abandoner also needs to be sure that quite a few others will abandon (empirical ex-

[14] Cristina Bicchieri, The Grammar of Society. The Nature and Dynamics of Social Norms, New York (Cambridge University Press) 2006, p.11

[15] Besides Bicchieri's Grammar of Society, David Lewis' Convention (Oxford, Blackwell Publishers, 2002, first published in 1969 by Harvard Univ.Press) and Thomas C. Schelling's The Strategy of Conflict (Cambridge/Mass., Harvard Univ.Press, 1960/1980) are something like founding texts.
Malcolm Gladwell's The Tipping Point. How little things can make a big difference (London, Abacus 2001, first published in 2000 by Little, Brown) makes for easy, untheoretical reading.
For the authoritative University of Pennsylvania Social Norms summer courses of 2010ff see http://www.sas.upenn.edu/ppe/Events/UNICEFLearningProgramonSocialNorms.htm for the 1010 through 2013 editions, http://sites.sas.upenn.edu/penn-unicef-summer/classes for the 2014 and 2015 programme

pectations) and that others no longer expect her or him to cut their female offspring (normative expectations). A knowledge and attitudinal change of the lonely individual is not enough – the potential abandoner will really abandon if and only if she or he believes that many relevant others (reference group) have also turned abandoners.

How can the potential abandoner (the reluctant practitioner of the above overview) come to believe that others also will abandon the tradition? There will need to be talk, exchange, dialogue, discussion, debate. Hence the importance accorded to communicating about FGM/C in the above overview.

Since matters sexual tend to be considered taboo or shameful, such communication will require the right setting, the right other participants who inspire confidence, who make it possible to open up.

Once I am sure that others think like me, have changed their attitude like me, are no longer in favour of cutting but are against it, and will act upon that belief, once I thus know that, if I do not cut my girl, mine will not be the odd family out – then and only then will not-cutting be the best alternative available to me. Then I will be able to act on my new knowledge and my new attitude.

Without discussion and exchange, knowledge transmission to individuals and attitude changes by individuals can lead to a situation that, in social norms theory, we call "pluralistic ignorance". That is a situation where the majority of a community reject FGM/C– but believe that all or most of the others continue to adhere to the norm/tradition – and so, individually, they continue doing it to their girls – not to be the odd one out[16].

Once the norm change has been discussed in the concerned community and people know that many or most or even all others also want to abandon FGM/C, there remains a question of trust: will the others really do what they said? One – most likely the best – solution to this is, after thorough and extensive deliberation, to make a Public Declaration: a community solemnly and publicly promises to never do it again (and puts in place a surveillance mechanism, to monitor compliance to the new norm of not-cutting).

Note that this is a "public declaration" in the social norms theory's narrow sense: a public declaration of FGM/C abandonment by the entire community. The term "public declaration" is often used in a much broader sense, for any leader or person of influence publicly declaring FGM/C abandonment. This can be a "circumciser" declaring that she or he will no longer cut girls. It can be a religious or traditional leader declaring abandonment, possibly also threatening contraveners with sanctions. Or it can be another opinion leader making a public statement against the harmful practice. In the above overview, the concept has been stretched to include federal and state laws – they, too, are – very public if they are adequately published and broadcast and talked about – declarations of FGM/C abandonment, at the same time threatening offenders with substantial sanctions. All of these are valuable and important. But for the social norms theorist, the public solemn declaration of FGM/C abandonment by the entire community tops it all.

[16] Cristina Bicchieri at the 2010 Social norms summer course at the University of Philadelphia defined pluralistic ignorance as a "cognitive state in which one believes one's attitudes and preferences are different from those of similarly situated others, even if public behavior is identical"; slide 19 of Cristina Bicchieri's power point presentation of 5 July 2010 entitled "Social Norms".

Social norms are deeply embedded in a community's belief and value system. Changing them may require some profound rearrangements in this system. FGM/C is about sexual control, it is about protecting propriety and decency at their most precious, at their most intimate, in the community's women. Addressing FGM/C thus needs a lot of sensitivity. Close attention needs to be paid to people's beliefs and values. It will be especially important to stress how fundamental values – an ethical and honourable way of life, aiming for fit and healthy adults and their offspring, striving for an improved material future – remain untouched. It should become clear that, in comparison with the old tradition, the norm change provides the community with a better way of loving their girls and women and ensuring all their families' prosperity.

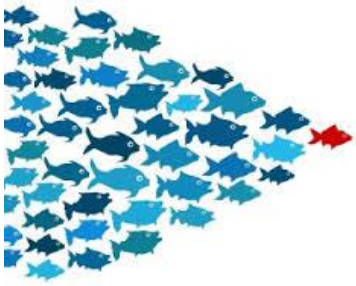
The following are recommendations of the social norms theory that are valid in general, also outside the social norms context.

Pay attention to context. This applies to Nigeria more than elsewhere, because the country is so big, so varied. Very different types of FGM/C are practiced – massaging a baby's clitoris so that it becomes smaller has, for example, little to do with infibulation, where the clitoris and labia are removed and the wound is sown to only leave a little hole for urine and menstrual blood to pass. And *chire angurya*, the Hausa term for hymenectomy, is said to be performed for facilitating intercourse. But all these are subsumed under the term FGM/C.

Even where the type of cutting is the same – as is very dominantly the case in the three Joint Programme intervention states of Nigeria's south-west – context varies widely. Westernised urban environments will, for example, require very different kinds of interventions and activities than rural communities far away from modern amenities.

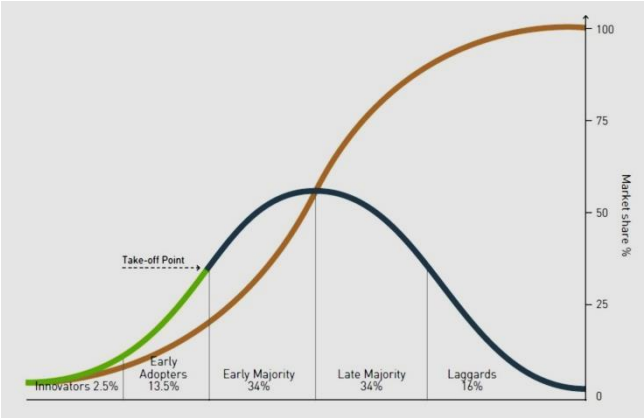
In the four states visited by the international consultant, FGM/C or "circumcision" does not seem to preoccupy most Nigerians. Where the practice continues, it is just done, not really hidden but hardly talked about – it is natural, it goes without saying. Yet it is deeply engrained in the communities' mores. If we want to make an issue of it, we'll have to (see above) address belief and value systems. Doing so means taking people seriously, entering into dialogue and discussion with them instead of just telling them what is best for them, instead of ordering them what to do. Taking people seriously also implies not isolating FGM/C from the rest of their lives – taking a holistic approach: what is of interest is material well-being, physical and spiritual health, people overall have no problem with "circumcision", if we think otherwise, if we think that they should have a problem with it, let us take the "targets" of our sensitisation seriously enough to deal with their lives as wholes. If we are aiming for sustainable change, then sensitisation will need to deal with many other issues beside and beyond FGM/C, many topics will have to be broached in the discussions. Ideally, anti-FGM/C activities are embedded in community improvement measures.

In a similar vein: past experience shows that the most efficient anti-FGM/C interventions come from a community's inside. On such sensitive issues that have to do with "our" customs and traditions, outsiders' views and opinions do not carry much weight and external campaigners are thus of much less use. Insider-driven activities are the ideal – an eternal paradox as the strategizers and planners on the federal or state level will necessarily be outsiders (except in "their" villages). Careful recruitment of insiders will be one of the decisive steps in any anti-FGM/C campaign. Such community members should be committed to the anti-FGM/C cause and at the same time be "influencers", i.e. have a standing in the community that makes them successful communicators and agents of change.



or, more integrated:

The social norms theory goes for change. Some inspiration came from economics where quite a lot of thought has gone into the way innovation spreads. The technology adoption lifecycle model, for one, distinguishes between innovators, early adopters, early majority, late majority and laggards. This model has been developed for farmers in the US and how they adopt technological change – it is certainly not applicable one-to-one in the Nigerian FGM/C context. But there are quite a few similarities.

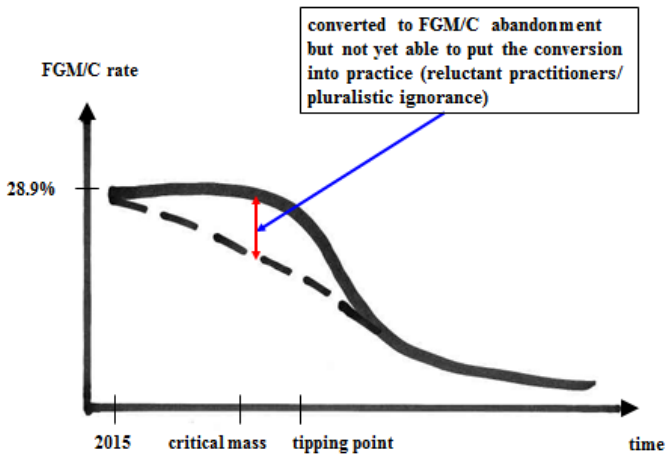


Adoption lifecycle for new technologies. The brown line represents the increase in market share with time, and the green-blue line represents the market share distribution among buyer types.[17]

When, in a traditional setting, introducing the innovation "NO FGM/C", we will first need an entry point into the community – maybe that will be the adventurous innovator of the above model, we would definitely want an agent of change who can set things going. Unlike technological innovation, early adopters will, however, be very careful about putting their new knowledge and attitude into practice – at the risk of being ridiculed or less respected or even ostracised. And most of all because they often do not know that there are others who think like them – the typical situation of pluralistic ignorance. This early phase of moving away from the old norm will be the hardest part of the task – the change not being "visible" yet. Then, finally, a "critical mass" will be reached. Now the abandoners are enough in number and know about each other so that not obeying the old norm becomes sustainable. This group (maybe it consists of the innovators plus the early adopters of the above model) can now work on the community to get more and more of the followers of the old tradition/norm onto their side and have them abandon FGM/C. Once the tipping point is reached, then change happens as if automatically: the late majority will follow the new trend, leaving only the laggards behind (amongst them, most probably, the traditional "circumcisers"). Because of these laggards, zero tolerance, an FGM/C rate of zero percent, will unfortunately still be some way off.

[17] Graph and text from: Kristian Handberg, The long road for electric vehicles, The Conversation. Africa Pilot, June 24, 2013, http://theconversation.com/the-long-road-for-electric-vehicles-13347

This would be a social norms theorist's view of what is in store for the Joint Programme states if the anti-FGM/C interventions go as planned and are successful:



28.9% is the percentage the baseline study found for respondents intending to cut their daughters in future

3.4 How far are we in terms of FGM/C? The FGM/C Rating

The five states to participate in the Nigerian Joint Programme against FGM/C were chosen on the basis of FGM/C rates – the five with the highest rates participate, according to the DHS 2013 that is two states from the South-East and three from the South-West. But these rates are not the only meaningful information we have about FGM/C. In fact, data collection in the 37 LGAs of the six states (the five intervention states plus Lagos as a sort of control sample) has yielded a substantial amount of information (see the state consultants' reports for each state). The purpose of the rating is to condense this multitude of information into one single figure per state/per LGA[18].

Beyond making an unruly mass of information easily digestible, this has the advantage of making inter-state and inter-LGA comparison easier. If nationally representative data are collected, then inter-national comparisons also become possible using the very same rating model.

Our rating, like any rating, produces an order, it ranks the rated. For anti-FGM/C activists in general and the UNFPA-UNICEF Joint Programme on FGM/C in particular, the closer we get to total abandonment of FGM/C, the better. In terms of the rating, then, the higher the value obtained, the better = the closer the rated state or LGA is to abandonment of the harmful practice.

The rating results give us Ebonyi State as the (unexpected) "winner" – even if its lead over second-rated Lagos (expected to win, modern and cosmopolitan as it is) is not very important. Imo comes third. And the south-western states Oyo, Osun and Ekiti (in that order) bring up the rear.

[18] The rating can be applied to whole nations or to village communities, availability of data being the only precondition.

Rating results
States

Ebonyi State	59.0
Lagos	58.0
Imo	53.4
Sample total	*51.5*
Oyo	42.5
Osun	40.9
Ekiti	39.6

Condensing an amalgam of very disparate data, the rating's results – the mathematical values – have no direct real world meaning outside the rating. 100 is best and 0 is worst. So Ebonyi State, at 59.0, is significantly "better" in terms of FGM/C than Ekiti at 39.6, and Ebonyi State, Lagos and Imo are fairly close to each other as are Oyo, Osun and Ekiti. But you cannot say that Lagos is one and a half times better than Ekiti – though the mathematical calculation is correct, this statement would have little meaning.

So far, the rating has been dealt with as if it was a black box. How is it done?

The quantitative questionnaire contained 62 questions. The first twelve of these questions were demographic/established the respondents' background.
For the remaining 50 questions, to make them more manageable, let us assemble them. The four categories that the questions for the rating were grouped into are:

Knowledge of/participation in discussion about FGM/C;
Attitude and views of self;
Attitude and views of others;
Practice of cutting.

These categories provide us with the rating model's subindices. To obtain the subindices, the model needs to be fed with the "indicators" = answers to the following questions (numbers in parentheses refer to the questions' positions in the quantitative questionnaire):

Knowledge of/participation in discussion about FGM/C:

Percent (%) who know FGM/C (Q13)
% who say FGM/C is required by religion (Q18)
% who know one or more negative health consequence (Q24)
% who know two or more negative health consequence (Q24)
% who know three or more negative health consequence (Q24)
% who know one or more negative psychosocial/emotional consequence (Q26)
% who agree that cutting can cause death (Q38vi)
% who have discussed FGM/C with spouse (Q49i)
% who have discussed FGM/C with family (Q49ii)
% who have discussed FGM/C with friends (Q49iii)
% who have discussed FGM/C in public (Q49iv)

Attitude and views of self:

% who are glad to be cut (Q31/ a+f+g)
% who intend to cut daughter (Q35)
% who agree that cutting should continue (Q38ii)

% who agree that cutting reduces promiscuity (Q38iii)
% who agree that cutting is inhumane (Q38iv)
% who know ≥1 case of death resulting from cutting (Q46)
% who know ≥1 case of problems resulting from cutting (Q47)
% who stand up against FGM/C in the family (Q57)
% who stand up against FGM/C in public (Q59)

Attitude and views of others:

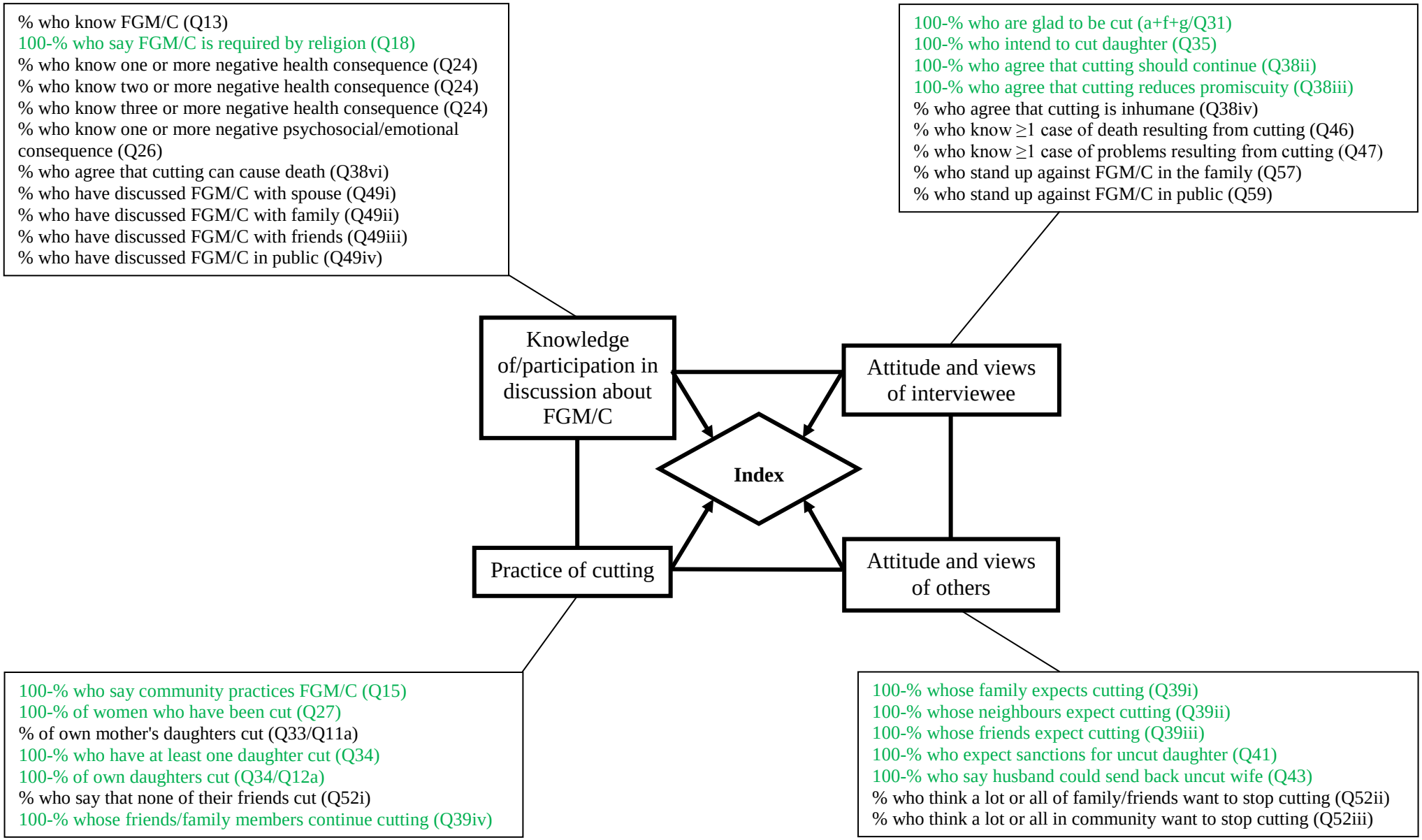
% whose family expects cutting (Q39i)
% whose neighbours expect cutting (Q39ii)
% whose friends expect cutting (Q39iii)
% who expect sanctions for uncut daughter (Q41)
% who say husband could send back uncut wife (Q43)
% who think a lot or all of family/friends want to stop cutting (Q52ii)
% who think a lot or all in community want to stop cutting (Q52iii)

Practice of cutting:

% who say community practices FGM/C (Q15)
% of women who have been cut (Q27)
% of own mother's daughters cut (Q33/Q11a)
% who have at least one daughter cut (Q34)
% of own daughters cut (Q34/Q12a)
% who say that none of their friends cut (Q52i)
% whose friends/family members continue cutting (Q39iv)

All of the indicators are expressed in percentages. The disparate/incomparable has thus become comparable. But some of the indicators are positive, some negative – "negative" meaning that a "yes" as an answer is an obstacle to FGM/C abandonment. For the negative (coloured green in the above overview), the simple operation of deducting the questionnaire results from 100% will "positivize" them and we can go on exploring the rating model.

A schematic drawing of our quest so far gives the following:


% who know FGM/C (Q13)
100-% who say FGM/C is required by religion (Q18)
% who know one or more negative health consequence (Q24)
% who know two or more negative health consequence (Q24)
% who know three or more negative health consequence (Q24)
% who know one or more negative psychosocial/emotional consequence (Q26)
% who agree that cutting can cause death (Q38vi)
% who have discussed FGM/C with spouse (Q49i)
% who have discussed FGM/C with family (Q49ii)
% who have discussed FGM/C with friends (Q49iii)
% who have discussed FGM/C in public (Q49iv)
100-% who are glad to be cut (a+f+g/Q31)
100-% who intend to cut daughter (Q35)
100-% who agree that cutting should continue (Q38ii)
100-% who agree that cutting reduces promiscuity (Q38iii)
% who agree that cutting is inhumane (Q38iv)
% who know ≥1 case of death resulting from cutting (Q46)
% who know ≥1 case of problems resulting from cutting (Q47)
% who stand up against FGM/C in the family (Q57)
% who stand up against FGM/C in public (Q59)
Knowledge of/participation in discussion about FGM/C
Attitude and views of interviewee
Index
Practice of cutting
Attitude and views of others
100-% who say community practices FGM/C (Q15)
100-% of women who have been cut (Q27)
% of own mother's daughters cut (Q33/Q11a)
100-% who have at least one daughter cut (Q34)
100-% of own daughters cut (Q34/Q12a)
% who say that none of their friends cut (Q52i)
100-% whose friends/family members continue cutting (Q39iv)
100-% whose family expects cutting (Q39i)
100-% whose neighbours expect cutting (Q39ii)
100-% whose friends expect cutting (Q39iii)
100-% who expect sanctions for uncut daughter (Q41)
100-% who say husband could send back uncut wife (Q43)
% who think a lot or all of family/friends want to stop cutting (Q52ii)
% who think a lot or all in community want to stop cutting (Q52iii)

We are almost there. The only preparatory question left to settle now is the relative importance of the subindices and of the questions making up each subindex.

Take an example: Under the subindex "Attitude and views of self", the percentage of respondents who intend to cut their daughter is considered more "important"/more pertinent for FGM/C abandonment than the percentage of female interviewees glad to be cut. Both are thought relevant (or they would not be included in the rating), but the first is deemed to carry more weight than the second.

So "weights" have been assigned to each indicator so that it is more or less important in making up the subindex it belongs to. And weights have also be assigned to each of the four subindices – here again, their "importance" for the overall index is thought to vary. The subindex "Practice of cutting" is, for example, considered to carry more weight than the subindex "Knowledge of/participation in discussion about FGM/C". For the weights assigned see the table in the annex.

The model/rating proposed here is of the simplest kind[19]. For each LGA and each state, it calculates the subindices, weighted averages of the indicators that make them up, and then the overall index as a weighted average of the four subindices thus obtained. On the basis of the 34 indicators, we thus obtain comparable values for each of the six states and each of the 37 LGAs, our FGM/C Index. More formally:

$$\textbf{Index}_{\text{FGM/C}} = \sum(SI_i * w_i),$$

$$\text{where } \textbf{SI} = \sum(a_j * w_j)$$

SI means Subindex
w means weight
with $1 \leq i \leq 4$ for the four subindices and with $1 \leq j \leq$ number of indicators chosen for each of the four subindices
a = answer value (or 100 minus answer value for the "negative" indicators)

The following table presents the rating results for the six states and the 37 Local Government Areas which participated in the baseline study.

[19] The model is entirely my responsibility. I have, in 2014, created a similar *Index of Readiness for Public Declaration of FGC abandonment* in Eritrea. Far away inspirations for the rating come from UNDP's yearly HDI (Human Development Index), from WEF's yearly Gender Gap Index and from GiroCredit's quarterly country risk rating that I put in place with colleagues at the beginning of the 1990s, all of which I have worked with a lot. An index, by definition, is an inadmissible simplification of reality – its only *raison d'être* is its usefulness.

LGA	state	SI 1 - Knowledge about FGM/C	SI 2 - Attitude-views of self	SI 3 - Attitude-views of others	SI 4 - Practice of cutting	overall index FGM/C
Ikwo	Ebonyi	61,3	64,9	90,7	65,5	71,0
Ezza South	Ebonyi	47,2	63,8	95,3	63,8	68,9
Ohaozara	Ebonyi	54,1	63,4	90,3	59,0	66,8
Shomolu	Lagos	45,2	57,9	71,4	66,4	62,7
Surulere	Lagos	38,0	56,1	72,2	69,1	62,5
Lagos island	Lagos	43,7	54,5	70,7	67,3	62,1
Ikorodu	Lagos	43,4	55,6	69,8	62,5	60,0
Ebonyi state		51,7	60,9	83,4	46,6	59,0
Ehime Mbano	Imo	36,4	60,9	76,8	56,2	58,8
Lagos state		40,7	53,0	69,8	59,8	58,0
Alimosho	Lagos	41,1	49,8	69,1	61,0	57,9
Ifako-Ijaiye	Lagos	38,6	56,9	68,2	59,1	57,6
Ideato North	Imo	46,2	54,4	73,2	53,8	57,5
Owerri Municipal	Imo	51,2	53,9	71,8	49,7	56,2
Ibadan North	Oyo	38,2	48,6	68,6	55,3	54,7
Imo state		43,7	52,4	71,4	46,9	53,4
Ihitte/Uboma	Imo	39,0	51,1	73,9	47,6	53,3
Ikole	Ekiti	40,7	45,6	69,8	50,3	52,8
sample total		41,4	49,7	68,2	46,3	51,5
Owerri West	Imo	40,2	51,6	71,3	44,1	51,5
Afikpo North	Ebonyi	52,8	64,4	77,2	29,0	50,9
Ola Oluwa	Osun	43,7	51,9	74,6	37,7	50,3
Akinyele	Oyo	43,9	48,5	68,0	40,4	49,2
Ebonyi	Ebonyi	44,3	55,6	74,8	32,3	48,8
Ojo	Lagos	37,3	48,9	68,8	37,7	47,3
Ifelodun	Osun	48,2	52,4	68,0	29,1	45,9
Ohaukwu	Ebonyi	47,4	51,1	72,9	24,4	44,8
Ado ekiti	Ekiti	36,8	41,2	59,4	40,4	44,7
Orlu	Imo	48,2	42,2	62,0	30,1	43,1
Oyo state		37,8	41,6	61,6	33,3	42,5
Ogbomosho South	Oyo	38,4	39,6	60,6	30,8	41,0
Osun state		41,7	43,1	63,0	26,5	40,9
Ido/osi	Ekiti	37,1	43,3	61,9	28,8	40,9
Ekiti state	Ekiti	36,3	37,1	56,7	31,7	39,6
Ife Central	Osun	40,1	42,5	61,4	24,9	39,5
Ede North	Osun	41,4	37,9	63,4	24,4	39,2
Oriade	Osun	41,8	38,5	59,7	23,0	37,9
Orolu	Osun	36,0	39,3	56,6	23,9	36,7
Oyo West	Oyo	37,2	33,6	48,0	24,8	34,1
Ibarapa North	Oyo	32,3	35,5	50,9	23,7	33,9
Ikere	Ekiti	32,0	29,7	53,6	22,9	33,2
Ekiti west	Ekiti	34,6	30,4	51,2	21,3	32,5
Kajola	Oyo	34,4	32,5	59,1	12,9	31,3
Ekiti south	Ekiti	34,4	28,7	42,4	21,2	30,0
LGA	**state**	**SI 1 - Knowledge about FGM/C**	**SI 2 - Attitude-views of self**	**SI 3 - Attitude-views of others**	**SI 4 - Practice of cutting**	**overall index FGM/C**

3.5 State overviews with short comments

The next twelve pages present, for each of the states participating in the baseline study, an FGM/C overview following the pattern of the overview discussed above. After each overview, there are short comments on rating results, prevalence rates, etc., as well as a table comparing various aspects of the study population, of importance for a social norms theorist.

This table included for each state at the bottom of the comments page will be dealt with in more detail in the following chapter 4, in the Discussion.

The order in which the six states are presented, corresponds to the results of the rating, with the best – the one closest to abandonment of FGM/C according to the rating – coming first.

FGM/C Overview Ebonyi State

FGM/C rate: 55.6%

Public Declarations

Official:
State law against FGM/C: **yes**
If yes: State law applied: **no**

Community declarations: n.a.

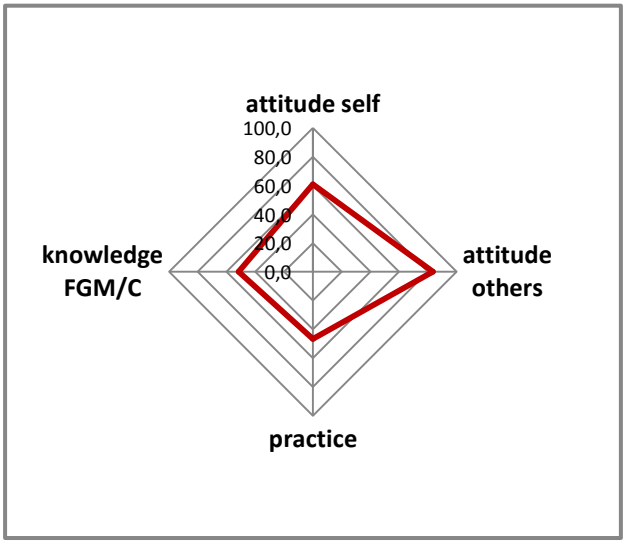
Traditional authorities: n.a.

Religious authorities: n.a.

Other influential people: n.a.

FGM/C Rating: 59.0

(best state in sample: 59.0
worst state in sample: 39.6
sample total: 51.5)



FGM/C supporters/FGM/C abandoners – willing/reluctant

"practice FGM/C" here means
"has at least one cut daughter"

	are for FGM/C	*don't know*	*are against FGM/C*
practice FGM/C	**17.8% Willing Practitioners**		**29.1% Reluctant Practitioners**
		3.6% Contemplators	
do not practice	**3.9% Reluctant Abandoners**		**45.5% Willing Abandoners**

In red: those most likely to be "converted" to abandonment

Communication About FGM/C

57.7% have discussed FGM/C with spouse
(sample average: 56.0%)
74.8% have discussed FGM/C with family
(sample average: 66.1%)
84.6% have discussed FGM/C with friends
(sample average: 72.9%)
45.2% have discussed FGM/C in public
(sample average: 35.8%)

Opinion leaders who raise the issue publicly: n.a.

Radio programmes on FGM/C:
(which radio? Regular or occasional?)
n.a.

Other media treating FGM/C
n.a.

Ebonyi State - comments

Ebonyi State has come out top in the rating, attaining a value of 59.0. In terms of the FGM/C rate, it comes third (behind the non-intervention state Lagos and the other south-eastern intervention state Imo) with 55.6% of female respondents cut.

The six LGAs range between 44.8 and 71.0 in the rating (standard deviation: 11.6, the highest value in the six states), and their FGM/C rates lie between 37.3% and 72.6% (standard deviation: 15.5). Ikwo's rating result of 71.0 is the highest amongst the 37 LGAs of the baseline study.

Note that the big "decrease" in prevalence rate from DHS 2013 (74.2%) is mathematically impossible in such a short time. Maybe FGM/C was defined differently by data collectors – the explanation of the miraculous decrease is a technical/statistical one, not a real world one.

Rating subindices: "Others" are no big worry in Ebonyi State. The subindex Attitude and views of others, at 83.4 is not far from the ideal 100. The subindex Attitude and views of self is lower, at 60.9, but still the best result amongst the six states, shortly before Lagos. Knowledge about FGM/C and participation in discussions is lower yet again, at 51.7, but there again, none of the other states has done better. The subindex Practice lags – at 46.6 it is clearly behind Lagos. Practice lags theory, it seems.

Part of the explanation could be the high number of reluctant practitioners – they make up a high 29.1% of respondents (contemplators a low 3.6%). Maybe they just need that little extra push …

The state has passed a law against FGM/C. As everywhere else, this law has not been applied.

Type of FGM/C: clitoridectomy around the naming ceremony of the 8th day after a girl's birth is less dominant here than in the other states. "At least 40% of cut girls in Ebonyi and Ikwo LGAs had the procedure performed when they were between the ages of 5 and 18"[20].

	Afikpo North	Ebonyi	Ezza South	Ikwo	Ohaozara	Ohaukwu	**Ebonyi Total**
"FGM/C at some time practiced in community"	95,7	73,3	87,8	85,7	89,6	88,1	**87,0**
one or more of mother's daughters cut	81,2	87,8	58,3	57	62,8	92,8	**73,1**
"FGM/C is required by culture"	66,7	59,6	76,3	52,5	77,1	80,9	**69,1**
% of female respondents cut	70,4	65,5	39,2	43,9	37,3	72,6	**55,6**
one or more of own daughters cut	69,2	69,8	30,5	23,2	37,2	82,2	**49,0**
"some family/friends still cut daughters"	37,3	17,0	1,2	12,1	2,6	37,3	**18,9**
"cutting should continue"	15,8	16,3	4,5	10,0	19,3	29,9	**16,4**
respondents intending to cut daughters in future	18,9	15,2	6,0	8,6	6,7	35,2	**15,8**
families expect respondents to cut daughters	28,4	17,4	0,7	8,5	4,1	31,3	**15,7**
neighbours expect respondents to cut daughters	20,1	7,9	0,7	8,0	3,6	21,5	**11,0**
friends expect respondents to cut daughters	16,1	10,0	1,4	7,6	3,6	19,1	**10,1**
"cutting girls is required by religion"	7,6	2,3	1,8	3,1	13,9	23,4	**9,3**
husband can send newlywed back if uncut	6,1	0,4	1,2	1,7	6,7	3,3	**3,3**
an uncut girl/woman or her family risks sanctions	1,6	2,7	1,6	1,7	0,2	6,1	**2,4**
rating results	49,9	47,3	66,6	68,2	64,6	43,9	**57,0**

[20] p.34 of the draft state report

FGM/C Overview Lagos

FGM/C rate: 44.8%

Public Declarations

Official:
State law against FGM/C: **no**
If yes: State law applied: n.a.

Community declarations:
n.a.

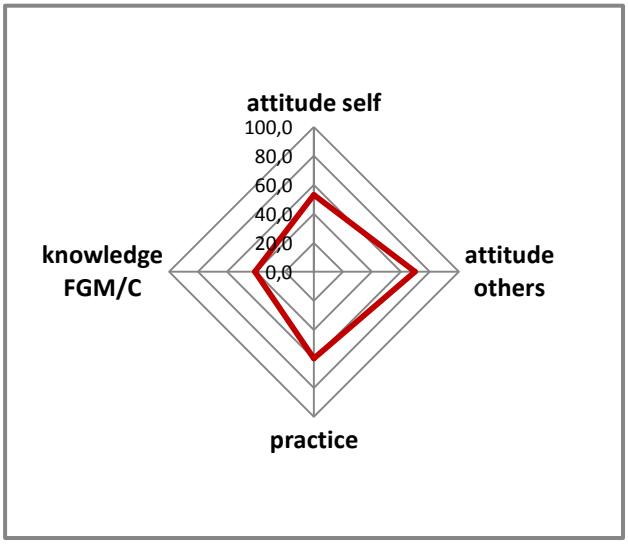
Traditional authorities:
n.a.

Religious authorities:
n.a.

Other influential people:
n.a.

FGM/C Rating: 58.0

(best state in sample: 59.0
worst state in sample: 39.6
sample total: 51.5)



FGM/C supporters/FGM/C abandoners – willing/reluctant

"practice FGM/C" here means
"has at least one cut daughter"

	are for FGM/C	*don't know*	*are against FGM/C*
practice FGM/C	**14.6% Willing Practitioners**		**11.8% Reluctant Practitioners**
		13.2% Contemplators	
do not practice	**12.6% Reluctant Abandoners**		**47.8% Willing Abandoners**

In red: those most likely to be "converted" to abandonment

Communication About FGM/C

50.1% have discussed FGM/C with spouse
(sample average: 56.0%)
60.0% have discussed FGM/C with family
(sample average: 66.1%)
70.3% have discussed FGM/C with friends
(sample average: 72.9%)
33.2% have discussed FGM/C in public
(sample average: 35.8%)

Opinion leaders who raise the issue publicly:
n.a.

Radio programmes on FGM/C:
n.a.

Other media treating FGM/C
n.a.

Lagos - comments

(Non-intervention state) Lagos has come a close second in the rating, attaining a value of 58.0. In terms of the FGM/C rate, it ranks best with "only" 44.8% of female respondents cut.

The seven LGAs range between 47.3 and 62.7 in the rating (standard deviation: 5.4), and their FGM/C rates lie between 20.9% and 51.6% (standard deviation: 11.5). Shomolu's 20.9% FGM/C rate is the lowest recorded in the 37 LGAs that took part in the baseline study.

Rating subindices: Like everywhere, the subindex "Attitude and views of others" has reached the best value: 69.8. But "Practice of cutting" comes a somewhat surprising second, at 59.8, a bit ahead of "Attitude and views of self" (53.0) while "Knowledge of/participation in discussion about FGM/C" is at a relatively low 40.7 (Ebonyi, Imo, Osun are higher). Note that the rating's laggard amongst Lagos's LGAs, Ojo, lags significantly only in one subindex: practice.

Reluctant practitioners make up 11.8% of respondents, contemplators a relatively high 13.2% (the highest value in our six states).

The state has not passed a law against FGM/C.

Type of FGM/C: clitoridectomy around the naming ceremony of the eighth day after a girl's birth largely dominates.

	Alimosho	Ifako-Ijaye	Ikorodu	Lagos Island	Ojo	Shomolu	Surulere	**Lagos Total**
one or more of mother's daughters cut	53,7	76	56,1	44,4	94,2	45	55,5	**61,4**
"FGM/C is required by culture"	58,7	62,7	59,5	40,8	47,0	42,2	53,7	**52,1**
% of female respondents cut	49,2	40,6	44,7	51,6	50,0	20,9	43,4	**44,8**
"FGM/C at some time practiced in community"	55,0	23,8	15,5	23,8	44,5	74,7	18,1	**40,3**
one or more of own daughters cut	25,2	33,5	30,9	22,5	68,3	19,9	16,9	**30,1**
"cutting should continue"	31,2	20,2	27,0	28,4	29,7	18,1	23,7	**26,8**
families expect respondents to cut daughters	29,2	32,3	22,5	23,7	25,4	16,5	21,0	**25,4**
"some family/friends still cut daughters"	23,9	20,3	27,7	26,3	14,5	17,9	21,2	**21,8**
respondents intending to cut daughters in future	25,9	13,8	20,0	20,8	21,0	13,0	17,8	**20,4**
"cutting girls is required by religion"	24,7	6,0	14,9	9,3	19,2	17,0	18,9	**18,2**
friends expect respondents to cut daughters	11,6	7,8	10,4	8,5	10,6	6,4	8,1	**9,7**
neighbours expect respondents to cut daughters	12,3	3,9	7,0	7,4	7,1	5,5	6,1	**8,2**
an uncut girl/woman or her family risks sanctions	3,9	7,6	10,8	6,6	4,9	6,0	6,8	**6,1**
husband can send newlywed back if uncut	2,4	8,6	7,9	0,6	8,9	1,6	3,9	**4,8**
rating results	55,5	54,0	57,9	60,3	45,2	60,6	59,3	**55,4**

N.B. These tables in the state sections have their order determined by the state level percentages. There are thus variations between the states depending on results.

Note that Lagos not only has the lowest FGM/C rate, but it also has the lowest percentage of people from an FGM/C background (defined as "one or more of mother's daughters cut) amongst the six baseline states. Still, 30.1% have had one or more daughters cut; 26.8% state that cutting should continue; and 20.4% say that they will cut their daughters in future.

FGM/C Overview Imo

FGM/C rate: 48.8%

Public Declarations

Official:
State law against FGM/C: **no**
If yes: State law applied: n.a.

Community declarations: 10 communities in Oguta

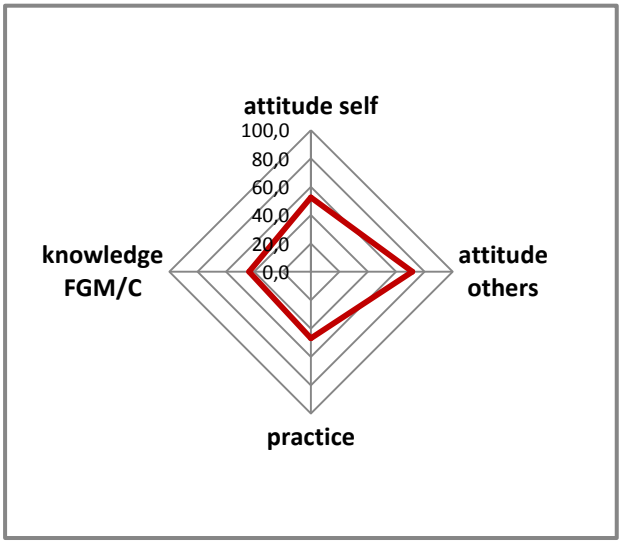
Traditional authorities: n.a.

Religious authorities: diocesenal conference of Anglican Church

Other influential people: n.a.

FGM/C Rating: 53.4

(best state in sample: 59.0
worst state in sample: 39.6
sample total: 51.5)



FGM/C supporters/FGM/C abandoners – willing/reluctant

"practice FGM/C" here means
"has at least one cut daughter"

	are for FGM/C	*don't know*	*are against FGM/C*
practice FGM/C	**22.4% Willing Practitioners**		**14.2% Reluctant Practitioners**
		9.3% Contemplators	
do not practice	**16.2% Reluctant Abandoners**		**38.0% Willing Abandoners**

In red: those most likely to be "converted" to abandonment

Communication About FGM/C

50.8% have discussed FGM/C with spouse
(sample average: 56.0%)
72.4% have discussed FGM/C with family
(sample average: 66.1%)
74.1% have discussed FGM/C with friends
(sample average: 72.9%)
35.0% have discussed FGM/C in public
(sample average: 35.8%)

Opinion leaders who raise the issue publicly:
Development Dynamics as part of VAPP bill;
August meetings have several times dealt with FGM/C

Radio programmes on FGM/C: Heartland (occasional, fairly often on VAPP bill), IBC Radio (occasional)

Other media treating FGM/C
n.a.

Imo - comments

Imo is third in the rating, with a value of 53.4. In terms of the FGM/C rate, it comes second (behind the non-intervention state Lagos and before rating winner Ebonyi) with 48.8%.

The six LGAs range between 43.1 and 58.8 in the rating (standard deviation: 5.7), and their FGM/C rates lie between 26.9% and 71.0% (standard deviation: 15.6).

Rating subindices: Imo's subindices largely reflect its overall position amongst the six baseline study states: "Attitude and views of others" 71.4; "Attitude and views of self" 52.4; "Knowledge of/participation in discussion about FGM/C" 43.7; "Practice of cutting" 46.9 – here Imo comes second, for once just before Ebonyi.

Reluctant practitioners make up 14.2% of respondents, contemplators 9.3%

The state has not passed a law against FGM/C (in fact it had passed a law, the VAPP bill, and then the law ran into difficulties for religious reasons not connected to FGM/C at all; an amended VAPP bill has been submitted).

Type of FGM/C: clitoridectomy around the naming ceremony of the eighth day after a girl's birth dominates. There is a second, minority type being practiced, usually termed "massage", though the practice has nothing benign: having applied herbal concoctions/Vaseline/Mentholatum/or hot water, the masseur or, usually, masseuse forcefully pushes back the clitoris to make it fall off/suppress it/push it back into the body. That the FGM/C rate which the baseline study found for Imo is significantly lower than that of the 2013 DHS could find part of its explanation in omission of this secondary type – it is seen by many as an alternative to FGM/C – there is no cutting involved.

	Ehime Mbano	Ideato north	Ihitte/Uboma	Orlu	Owerri Municipal	Owerri West	**Imo Total**
"FGM/C at some time practiced in community"	71,5	93,9	78,0	82,3	86,4	73,4	**81,7**
one or more of mother's daughters cut	47,2	70,5	76,9	72,8	72,4	81,1	**69,7**
% of female respondents cut	26,9	47,3	49,3	71,0	47,1	49,7	**48,8**
one or more of own daughters cut	40,3	21,8	46,0	56,2	36,1	47,2	**40,2**
"FGM/C is required by culture"	26,3	49,0	44,0	33,3	58,9	34,0	**40,1**
"some family/friends still cut daughters"	8,9	35,9	21,6	56,0	26,7	30,1	**30,6**
families expect respondents to cut daughters	8,2	27,8	21,7	50,9	30,3	21,4	**27,4**
"cutting should continue"	10,3	30,3	27,9	39,0	29,6	22,9	**27,1**
respondents intending to cut daughters in future	8,3	25,2	23,6	42,1	23,7	18,6	**24,1**
neighbours expect respondents to cut daughters	2,5	28,8	18,6	37,5	11,0	11,5	**19,3**
friends expect respondents to cut daughters	3,5	23,1	18,0	24,2	13,4	9,3	**15,9**
"cutting girls is required by religion"	1,8	11,1	10,3	4,6	19,3	17,6	**10,4**
an uncut girl/woman or her family risks sanctions	0,3	6,4	1,2	3,4	5,7	2,1	**3,4**
husband can send newlywed back if uncut	1,1	5,0	0,5	4,1	1,9	2,9	**2,7**
rating results	58,3	53,4	50,8	41,7	53,2	48,7	**51,0**

Note that only 40.1% see FGM/C as required by culture (the lowest result for the six states) and only 10.4% as required by religion (a close second behind Ebonyi at 9.3).

FGM/C Overview Oyo

FGM/C rate: 69.1%

Public Declarations

Official:
State law against FGM/C: **no**
If yes: State law applied: n.a.

Community declarations:
n.a.

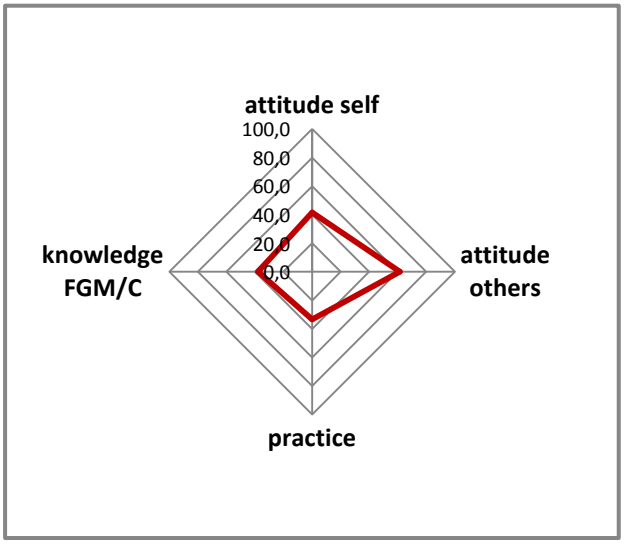
Traditional authorities:
n.a.

Religious authorities:
n.a.

Other influential people: a sort of *negative* public declaration was the governor's wife in 1999 having her granddaughter cut

FGM/C Rating: 42.5

(best state in sample: 59.0
worst state in sample: 39.6
sample total: 51.5)



FGM/C supporters/FGM/C abandoners – willing/reluctant

"practice FGM/C" here means
"has at least one cut daughter"

	are for FGM/C	*don't know*	*are against FGM/C*
practice FGM/C	**41.3% Willing Practitioners**		**14.7% Reluctant Practitioners**
		7.2% Contemplators	
do not practice	**14.5% Reluctant Abandoners**		**22.3% Willing Abandoners**

In red: those most likely to be "converted" to abandonment

Communication About FGM/C

62.1% have discussed FGM/C with spouse
(sample average: 56.0%)
64.6% have discussed FGM/C with family
(sample average: 66.1%)
71.6% have discussed FGM/C with friends
(sample average: 72.9%)
31.0% have discussed FGM/C in public
(sample average: 35.8%)

Opinion leaders who raise the issue publicly:
(list or n.a.)

Radio programmes on FGM/C: Flash FM (occasionally), Amuludun FM (occasionally)

Other media treating FGM/C
n.a.

Oyo - comments

Oyo has come fourth in the rating, attaining a value of 42.5. In terms of the FGM/C rate, its 69.1% also means fourth place. Oyo is the best of the second and worse group of states in the ranking, which are all situated in the Nigerian South-West.

The six LGAs range between 31.3 and 54.7 in the rating (standard deviation: 9.4), and their FGM/C rates lie between 48.2% and 98.1% (standard deviation: 19.1, the highest value amongst the six states). The 98.1% FGM/C rate is the highest recorded in any of the 37 LGAs that took part in the baseline study.

Rating subindices: The relative best here as elsewhere is the subindex "Attitude and views of others" at 61.6. "Attitude and views of self" (41.6) and "Knowledge of/participation in discussion about FGM/C" (37.8) range somewhere in the middle. And "Practice of cutting" at 33.3 brings up the rear. It is the 33.3 of the practice subindex that makes Oyo rank before Osun; it fared slightly worse than Osun in the three others.

Reluctant practitioners make up 14.7% of respondents, contemplators 7.2%.

The state has not passed a law against FGM/C.

Type of FGM/C: clitoridectomy around the naming ceremony of the eighth day after a girl's birth largely dominates.

	Akinyele	Ibadan North	Ibarapa North	Kajola	Ogbomosho South	Oyo West	**Oyo Total**
one or more of mother's daughters cut	85,7	67,9	86,6	90,9	86,6	89,9	**82,2**
"FGM/C at some time practiced in community"	49,8	81,7	89,3	97,7	86,0	76,2	**78,8**
"FGM/C is required by culture"	69,8	62,2	80,2	88,4	89,0	79,2	**78,0**
% of female respondents cut	64,3	48,2	84,7	98,1	74,7	86,1	**69,1**
one or more of own daughters cut	53,3	27,5	65,5	75,7	60,7	63,1	**58,3**
"cutting should continue"	35,4	35,5	59,2	60,2	50,7	61,0	**47,2**
"some family/friends still cut daughters"	34,7	22,0	66,9	71,6	36,8	68,8	**45,7**
families expect respondents to cut daughters	37,9	24,2	62,3	68,6	39,4	62,6	**45,4**
respondents intending to cut daughters in future	27,8	24,4	52,6	67,2	41,2	54,5	**41,4**
friends expect respondents to cut daughters	22,7	12,7	50,3	36,1	26,0	57,9	**29,8**
neighbours expect respondents to cut daughters	20,6	9,1	51,3	40,6	25,5	59,1	**29,4**
"cutting girls is required by religion"	22,0	30,9	40,1	11,9	38,8	43,0	**28,7**
an uncut girl/woman or her family risks sanctions	7,3	10,2	27,2	2,5	10,8	26,2	**11,9**
husband can send newlywed back if uncut	2,4	4,2	19,0	1,7	5,7	8,1	**5,4**
rating results	46,5	51,3	32,1	30,1	38,8	31,9	**40,5**

Note that FGM/C rates vary substantially between Ibadan North's "only" 48.2% and Kajola's 98.1% in the state's south-west. Not surprisingly, social norms seem a bit stronger in Oyo than the sample average, but there are still few sanctions. 41.4% of respondents intend to cut their daughters in future, 67.2% in Kajola.

FGM/C Overview Osun

FGM/C rate: 75.3%

Public Declarations

Official:
State law against FGM/C: **yes**
If yes: State law applied: **no**

Community declarations:
n.a.

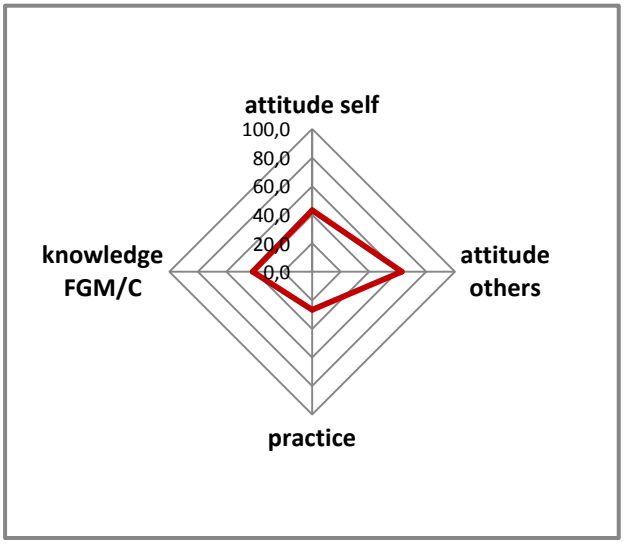
Traditional authorities: Iyalode of Osogbo, late Chief Bernice Alake Kolade J.P.

Religious authorities:
n.a.

Other influential people:
n.a.

FGM/C Rating: 40.9

(best state in sample: 59.0
worst state in sample: 39.6
sample total: 51.5)



FGM/C supporters/FGM/C abandoners – willing/reluctant

"practice FGM/C" here means
"has at least one cut daughter"

	are for FGM/C	*don't know*	*are against FGM/C*
practice FGM/C	**38.8% Willing Practitioners**		**20.3% Reluctant Practitioners**
		8.4% Contem plators	
do not practice	**10.5% Reluctant Abandoners**		**22.0% Willing Abandoners**

In red: those most likely to be "converted" to abandonment

Communication About FGM/C

76.4% have discussed FGM/C with spouse
(sample average: 56.0%)
77.0% have discussed FGM/C with family
(sample average: 66.1%)
74.4% have discussed FGM/C with friends
(sample average: 72.9%)
48.4% have discussed FGM/C in public
(sample average: 35.8%)

Opinion leaders who raise the issue publicly:
n.a.

Radio programmes on FGM/C: OSBC – one Monday per month (MoH programme on Mondays 5-5:30 p.m.), Radio 99, Gold FM, Ara Station, Orisun (all occasionally)

Other media treating FGM/C
n.a.

Osun - comments

Osun has come fifth in the rating, attaining a value of 40.9. In terms of the FGM/C rate, it comes last with 75.3% of female respondents cut.

The six LGAs range between 36.7 and 50.3 in the rating (standard deviation: 5.3, the lowest value amongst the six states), and their FGM/C rates lie between 66.8% and 87.6% (standard deviation: 8.2).

Rating subindices: Like in the other states, the others are the least problem – the subindex "Attitude and views of others" stands at 63.0. "Attitude and views of self" at 43.1 and "Knowledge of/participation in discussion about FGM/C" 41.7 are a bit above the overall result for Osun. It is the subindex "Practice of cutting" at 26.5 that pulls down the overall result – it is the worst for the six states, with relatively little variation from one LGA to another.

Reluctant practitioners in Osun make up a relatively high 20.3% of respondents, contemplators 8.4%.

The state has passed a law against FGM/C. As elsewhere, this law has so far not been applied.

Type of FGM/C: clitoridectomy around the naming ceremony of the eighth day after a girl's birth largely dominates.

	Ede North	Ife Central	Ifelodun	Ola Oluwa	Oriade	Orolu	**Osun Total**
one or more of mother's daughters cut	92,2	79,8	85,8	90,2	93,6	93,7	**88,5**
"FGM/C at some time practiced in community"	84,6	78,1	90,6	91,7	88,3	91,3	**86,5**
"FGM/C is required by culture"	88,7	73,2	89,1	45,9	82,6	88,1	**84,4**
% of female respondents cut	87,6	66,8	81,2	76,4	71,1	75,3	**75,3**
one or more of own daughters cut	68,3	67,9	61,7	50,7	66,7	67,0	**63,9**
"some family/friends still cut daughters"	52,2	63,5	38,3	35,6	65,4	58,0	**54,9**
families expect respondents to cut daughters	48,0	44,5	33,4	26,2	51,3	54,8	**44,3**
"cutting should continue"	59,5	43,6	30,2	25,5	54,3	44,6	**44,1**
respondents intending to cut daughters in future	53,9	42,7	28,2	27,7	51,4	46,9	**42,9**
friends expect respondents to cut daughters	37,8	22,1	25,6	20,6	35,7	43,9	**30,7**
"cutting girls is required by religion"	51,3	18,5	15,7	17,3	27,0	62,1	**30,5**
neighbours expect respondents to cut daughters	37,6	16,7	24,4	20,8	37,1	45,1	**29,7**
an uncut girl/woman or her family risks sanctions	5,7	13,6	4,2	10,0	12,6	18,4	**11,4**
husband can send newlywed back if uncut	1,6	3,6	1,7	3,9	11,4	8,6	**5,6**
rating results	37,2	38,5	43,9	47,0	35,6	34,4	**38,9**

FGM/C "context" is high at 88.5%. With 75.3% of female respondents cut, 63.9% have cut one or more of their daughters and 42.9% intend to cut their daughters in the future. Here as elsewhere there are hardly any sanctions. But empirical and normative expectations are stronger than in most other states. 54.9% of family/friends still cutting is the highest amongst the six states. 84.4% (only Ekiti comes close) think FGM/C is required by culture and 30.5% by religion.

FGM/C Overview Ekiti

FGM/C rate: 71.2%

Public Declarations

Official:
State law against FGM/C: **yes**
If yes: State law applied: **no**

Community declarations: n.a.

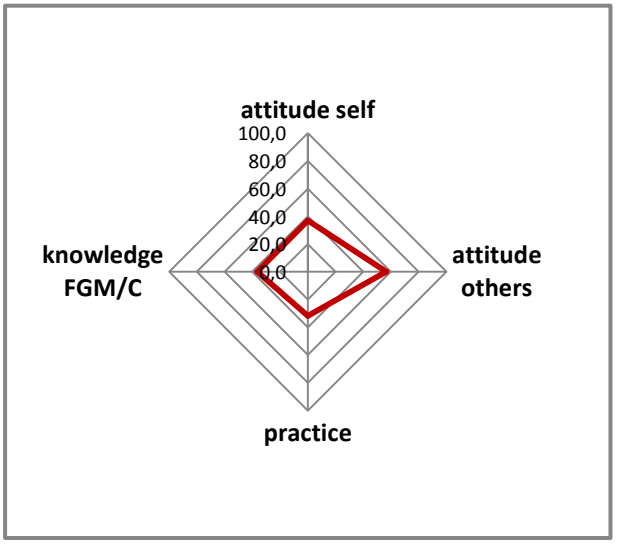
Traditional authorities: Chief Rufus Falodu, Saade of Ijero kingdom (one of the kingmakers)

Religious authorities: n.a.

Other influential people: former governor's wife Ms Bisi Adeleye-Fayemi

FGM/C Rating: 39.6

(best state in sample: 59.0
worst state in sample: 39.6
sample total: 51.5)



FGM/C supporters/FGM/C abandoners – willing/reluctant

"practice FGM/C" here means
"has at least one cut daughter"

	are for FGM/C	*don't know*	*are against FGM/C*
practice FGM/C	**43.7% Willing Practitioners**		**8.3% Reluctant Practitioners**
		7.9% Contemplators	
do not practice	**21.7% Reluctant Abandoners**		**18.5% Willing Abandoners**

In red: those most likely to be "converted" to abandonment

Communication About FGM/C

63.7% have discussed FGM/C with spouse
(sample average: 56.0%)
72.2% have discussed FGM/C with family
(sample average: 66.1%)
71.3% have discussed FGM/C with friends
(sample average: 72.9%)
34.4% have discussed FGM/C in public
(sample average: 35.8%)

Opinion leaders who raise the issue publicly:
(list or n.a.)

Radio programmes on FGM/C: Ekiti FM (occasional)

Other media treating FGM/C: Ekiti State Television (occasional)

Ekiti - comments

Ekiti has come last in the rating, attaining a value of 39.6. In terms of the FGM/C rate, it comes second last, before its neighbour Osun, with 71.2% of female respondents cut.

The six LGAs range between 30.0 and 52.8 in the rating (standard deviation: 8.8). The 30.0 of LGA Ekiti South is the lowest value amongst the 37 LGAs of the baseline study. Ekiti's six LGAs' FGM/C rates lie between 46.4% and 85.2% (standard deviation: also 8.7).

Rating subindices: The order of the subindices is the usual, but the values are low: "Attitude and views of others" 56.7, "Attitude and views of self" 37.1, "Knowledge of/participation in discussion about FGM/C" 36.3, "Practice of cutting" 31.7. Ekiti comes last in the first three of these subindices, and last but one (before Osun) in Practice.

Reluctant practitioners make up a low 8.3 of respondents, contemplators 7.9%. Respondents seem to be relatively secure in their attitudes and practice.

The state has passed a law against FGM/C. As elsewhere, this law has so far not been applied.

Type of FGM/C: clitoridectomy around the naming ceremony of the eighth day after a girl's birth is very much dominant in Ekiti.

	Ado-Ekiti	Ekiti South	Ekiti West	Ido-Osi	Ikere	Ikole	**Ekiti Total**
"FGM/C at some time practiced in community"	85,1	91,3	87,5	88,3	85,9	70,8	**84,8**
one or more of mother's daughters cut	81,3	88	89,3	87,3	90,3	61,7	**82,6**
"FGM/C is required by culture"	78,3	88,0	84,7	90,6	84,7	57,7	**80,6**
% of female respondents cut	68,1	82,3	85,2	65,8	79,5	46,4	**71,2**
"cutting should continue"	48,8	70,3	67,1	45,2	68,2	37,2	**55,2**
one or more of own daughters cut	33,8	64,5	65,3	65,0	64,9	42,5	**55,0**
families expect respondents to cut daughters	47,3	75,7	65,7	47,2	61,1	31,8	**53,9**
respondents intending to cut daughters in future	48,6	72,9	62,9	39,3	65,8	31,1	**52,8**
"some family/friends still cut daughters"	46,6	70,5	64,2	40,2	61,7	31,1	**51,7**
"cutting girls is required by religion"	34,3	56,1	54,5	29,1	44,4	36,1	**41,6**
friends expect respondents to cut daughters	30,0	65,5	52,4	25,6	45,3	25,2	**39,4**
neighbours expect respondents to cut daughters	29,1	62,8	51,7	21,9	43,4	26,0	**38,0**
an uncut girl/woman or her family risks sanctions	11,2	20,5	20,8	9,4	13,6	5,4	**13,3**
husband can send newlywed back if uncut	14,6	25,6	11,1	6,4	13,8	4,3	**12,9**
rating results	40,7	28,0	30,5	39,0	31,1	51,2	**37,3**

80.6% - a close second to Osun – believe that FGM/C is required by culture, 41.6% – more than in any other baseline study state – believe that it is required by religion. Slightly more than half of family and friends still cut their daughters (only Osun is slightly higher), 53.9% of families (only Osun slightly higher), 39.4% of friends (sample high) and 38.0% of neighbours (sample high) are said to expect respondents to cut their daughters. Sanctions are slightly higher than in the other baseline states.

4. Discussion. Social Norms and the baseline study

So what do we make of all this? The social norms theory and our baseline study are to guide us in our anti-FGM/C activities. What is their advice?

The FGM/C rating, based on an in-depth evaluation, provides us at one glance with an estimate of the severity of the problem in a state/LGA/community[21]. Looking at the five intervention states, we have noticed a rather clear separation into two groups: the three south-western baseline study participants Ekiti, Osun and Oyo are significantly worse off than the two south-eastern states Ebonyi State and Imo. So the south-western need for anti-FGM/C intervention is quite a bit more pronounced than the south-eastern one.

Our "control sample" Lagos – not an intervention state – ranges with the south-eastern states, in fact it was "beaten" – although not by much – in our rating by Ebonyi State. It came a close second. This certainly does not fit the image: modern, cosmopolitan Lagos trapped in atavistic customs. Looking a bit more closely, one can see that among the seven LGAs participating in the baseline study for Lagos, it is Ojo that has the worst rating results – and thus pulls down the Lagos state score. Without hardly any first-hand knowledge of Lagos and none at all of Ojo, but judging from population density[22], it looks less urban than other LGAs of Lagos City[23], so let us not draw conclusions about urban-rural similarities or discrepancies and cosmopolitan areas too fast.

Internationally, ethnicity is known to be the most important determining factor in matters of FGM/C practice, so there is a strong suspicion that this plays a role in Nigeria too[24]. But whether ethnicity plays a major role in the discrepancies between the three south-western and the two south-eastern states is a question that cannot be answered here – more in-depth research would be needed for this. Note that it is surprising that the part of Nigeria that has first come into close contact with "modernity", the Yoruba south-west, seems more attached nowadays to "ancestral" customs than the Igbo south-east that only came into contact with modernity quite some time later.

Social norms theory advocates great sensitivity to context. It is with some hesitation that conclusions are formulated for five states that are far apart[25] and subject to disparate socio-economic conditions. Fortunately, there is one very dominant form of FGM/C practiced in the five states – clitoridectomy; which in the great majority of cases is done to the baby girl around the 8th day after her birth, around the naming ceremony. In Imo, and also in Oyo, there is a secondary form of FGM/C – a "massage" of the clitoris of the baby girl that is meant to push back and diminish the clitoris or at best make it fall off. And in Ebonyi State – the only intervention state that the international consultant did not visit for research – there are some parts where FGM/C is practiced on girls above five years of age[26].

[21] We go far beyond the usual classification by FGM/C rate only (which, alone, was the reason of selection of the intervention states) – FGM/C rates were just one of the 34 indicators, albeit it has a great weight attached to it.
[22] Wikipedia's table "The 16 LGAs of Metropolitan Lagos" on https://en.wikipedia.org/wiki/Lagos shows the second lowest population density for Ojo – Ajeromi-Ifelodun's is almost 15 times higher.
[23] A remark in the state report goes in the same direction.
[24] Note that Lagos is a "Yoruba" city – though, of course, many other ethnic groups live there too.
[25] Ibadan and Owerri are 400 km apart as the crow flies.
[26] 40 per cent of cut girls in Ebonyi and Ikwo LGAs had FGM/C performed when between 5 and 18 years old. See state report.

So we know which of the states participating in the baseline study are the most urgent to deal with in terms of FGM/C. Unfortunately, the same does not hold true for LGAs as it was not all LGAs of the five states that took part. A certain number of LGAs[27] were chosen for statistical representativity on the state level, not for the importance of FGM/C there or for their future role in Joint Programme interventions. So they provide us with an idea of the range and variation of intra-state realities and we can calculate standard deviation from state averages at best (see comments to state overviews above). But they will not guide us in our anti-FGM/C activities – except in case of a lucky coincidence, if one of the LGAs of the baseline study is chosen for intervention activities. With these exceptions, they will also not be able to help us with below-state level impact measurement.

Who should we target in the states?

During the three weeks of interviews of the international consultant with experts in four of the five intervention states (in chronological order: Imo, Osun, Ekiti, Oyo), he was most surprised by the individualistic picture that was painted for him by most of the experts. By the great majority, FGM/C was presented to him as – nowadays – an entirely intimate practice: it was said to be entirely up to the parents and grandparents; and nobody else knows or needs to know. Of course: in some remote villages, it is said to be different, the community there still plays a role, as it had done everywhere, in the old days.

A diagram that seems to represent this can be found in an article by Adriane Martin Hilber et al.[28]

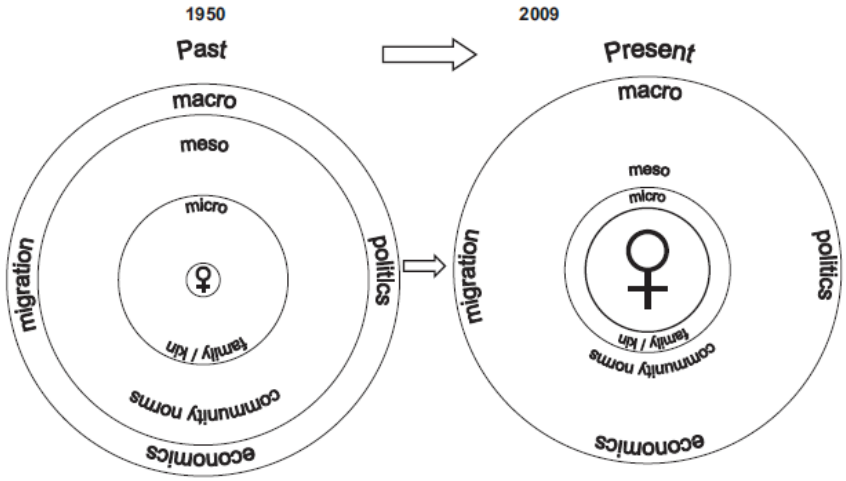


Fig. 2. Evolution of vaginal practices.

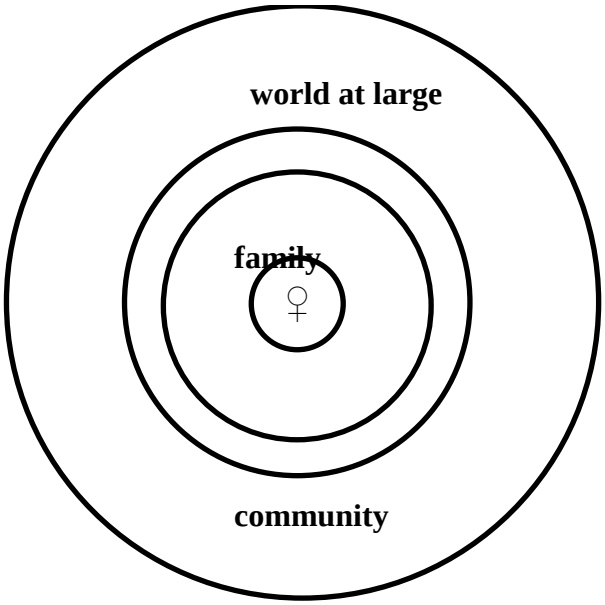
Think of the new-born girl's mother as the woman (♀) at the centre of the concentric circles that represent the different spheres that make up her world. There are four of them: the individual's individual sphere, the family sphere, the community and the rest of the world. Adriane Martin

[27] 6 each for the intervention states, 7 for Lagos. Note that for the qualitative data collection, purposive sampling was used, aiming to include high- and low-prevalence LGAs for focus group discussions and interviews. But that is neither representative nor is it enough to guide us for LGA selection.

[28] Adriane Martin Hilber, Elise Kenter, Shelagh Redmond, Sonja Merten, Brigitte Bagnol, Nicola Lowa, Ruth Garside, Vaginal practices as women's agency in Sub-Saharan Africa: A synthesis of meaning and motivation through meta-ethnography, Social Science & Medicine 74 (2012) p.1315

Hilber et al. found that the individual woman's sphere had expanded at the cost of the family and that the rest of the world had all but taken over the community sphere.

For the four provinces where the international consultant conducted research, and for matters of FGM/C, a slightly different diagram seems needed for the present day.



In comparison to traditional times, the family has maintained its importance while the world at large has become a lot more important – at the cost of the "community". The baby girl's mother's sphere has, in this scheme, not gained in size. This seems a fair representation of the urban world in Nigeria's south-west and south-east. For the rural areas, a representation of a young mother's world could be anywhere between Adriane Martin Hilber et al.'s drawing for 1950 and the new drawing for the urban present.

Who is, in matters of FGM/C, family? Besides the baby girl's mother, it includes first of all the two new-born girl's grandmothers, to a lesser extent the father and aunts, and to an even lesser extent grandfathers and uncles. Paternal grandmothers and, to a somewhat lesser extent, maternal grandmothers typically accompany the baby girl's mother through the first weeks or months of the baby's upbringing. They are thus in the best of positions possible to take care of the baby girl's clitoridectomy. As this is a patriarchal world, the husband is, of course, the family's head. No decision must be taken without at least consulting him. However, the husband does not necessarily know about his baby daughter's clitoridectomy – it is very much a "woman's thing".

In an urban setting, the community has nowadays much less weight than traditionally. This is by no means to say that urban Nigerians of the south-west and south-east are no longer attached to their village (town unions continue to be important) or their ethnic groups. But people take a lot more liberties with their own decisions; they seem to have emancipated themselves from the community's "tyranny" of olden days. A new-born baby girl's mother, in matters of FGM/C, will be subject to her mother-in-law's, her mother's and her husband's decisions and approval, but she will not nowadays have to go looking further than that.

And finally, there is the world at large. While the typical Igbo community, to take an example, was largely self-sufficient and highly autonomous in pre-colonial times, this no longer holds anywhere nowadays. Even the remotest areas are exposed to modern media (first of all the radio,

to some extent TV), modern-day communication (mobile telephones) and to present-day education. Also, "emigrants" (to Lagos, the Nigerian north, other parts of the country or abroad) have brought knowledge and more real vestiges of the world "out there" back to the remotest areas for quite some time now. And globalisation has gone a lot further than that in urban areas. So that, in the above diagrams, the "world at large" has significantly gained in importance – this certainly also holds for rural areas, albeit to a lesser extent.

Empirical expectations and the baseline study

People on the whole know that cutting continues. They do not know how many of the members of their community still cut their babies, because everything sexual tends to be taboo and it is, indeed, a very intimate thing: clitoridectomy, the removal of the clitoris. And it is not or hardly visible. But it is clear that cutting continues, that traditional "circumcisers" or traditional birth attendants and even health personnel continue to cut.

31.8% of respondents think that some of their family/friends still cut their girls (question 39iv).

And the percentage is similar – at 32.4% – if you look at question 52i that goes into a bit more detail, 12.3% of respondents believe that few of their friends and family continue cutting, 11.7% believe that a lot still cut their girls, and 8.4% believe that all their friends and family still cut.

Normative expectations with sanctions in the baseline study

There is no or little sanction for girls and women who were not cut. In the rating, the subindex "attitudes and views of others" that explores this aspect of FGM/C is by far the most positive – 68.2 is the value of this subindex for the sample total in comparison to values in the 40s for the other three subindices and 51.5 for the overall index.

Only 7.5% of respondents believe that an uncut girl/woman or her family would be sanctioned (question 41; no: 80.6%, don't know: 7.9%, no response: 4.0%))

And only 5.6% believe that the husband could send his newly wed back to her parents if he discovered that she was not cut (question 43; no: 75.6%, don't know: 15.5%, no response: 3.3%)

21.8% of respondents believe that cutting girls is required by their religion (question 18/not required 54.8%, don't know: 17.1%, no response: 6.2%); note that in this case; it is God who sanctions or the individual's conscience, not the community.

And who would know? If, as is the ideal, only the tip of the clitoris is removed, once the bleeding has stopped, or, for the "massage" in Imo, once the baby has stopped crying because the rather brutal handling of its clitoris called "massage" has stopped, there is little trace of the "operation" visible for a non-expert. And if the operation is not performed – who comes near enough to notice? Only people that are very close to the girl or woman concerned. And the men amongst them, in their great majority, are reputed not to care.

Normative expectations without or with few sanctions in the baseline study

Who wants eight days old girls to be cut? Who, do people think, wants them to cut their eight days old girls? Who is part of their reference group?

32.2% of respondents state that their families expect them to cut their daughters (question 39i) while friends (18.4%/question 39iii) and neighbours (17.8%/question 39ii) are thought to have much fewer expectations in that respect.

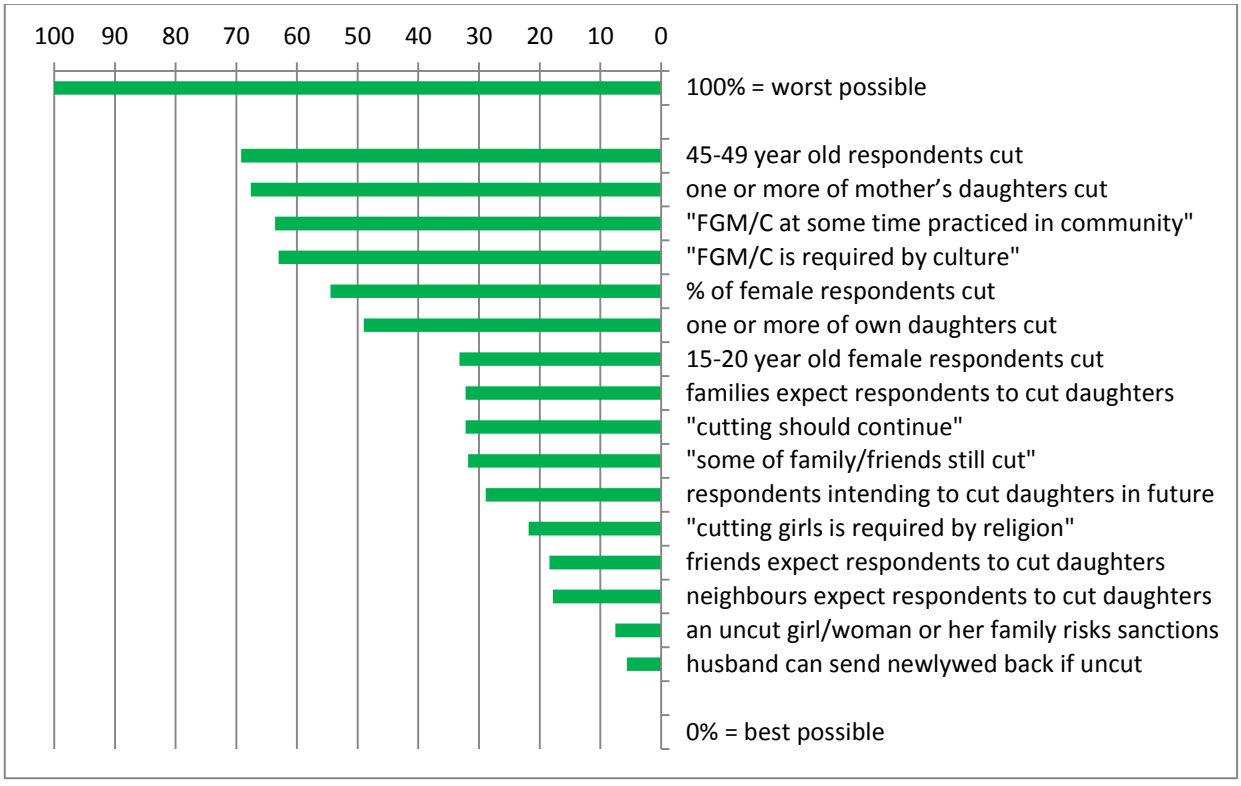
63.0% of respondents state that FGM/C is required by their culture (question 19/not required: 22.0%, don't know: 13.8%, no response: 1.2%)

Let us take a step back. Our baseline survey has looked at the five Nigerian states that are worst affected by FGM/C plus at Lagos. But even in these worst-affected states, the practice is by no means universal – far from it. Amongst our female respondents, about half have been cut and half not.
So when we try to put empirical and normative expectations into perspective, we must not take the entire states' populations as reference groups – the "cutting communities" are smaller than that.

Let us reconsider:

69.2% of 45-49 year old respondents have themselves been cut
67.6% of respondents state that one or more of their mother's daughters have been cut
63.6% of respondents state that FGM/C has at some time been practiced in their communities
54.5% of all female respondents have themselves been cut
49.0% of respondents have had one or more of their daughters cut
33.2% of 15-20 year old respondents have themselves been cut
32.2% of respondents are of the view that cutting should continue
28.9% of respondents intend to cut their daughters in the future

About two thirds of the people interviewed for our baseline study in the six states come from an FGM/C background, meaning that cutting was practiced in their family of origin. A bit more than half of all female interviewees were cut themselves. And the FGM/C rate has come down to almost exactly a third amongst the youngest female respondents, the 15 to 19 year olds.



The findings about empirical and normative expectations need to be seen before the background of these figures. Empirical expectations are pretty much in line with the figures we have for the FGM/C rate amongst the youngest age class. The same holds true for normative expectations: just short of a third of respondents state that their families expect them to cut their daughters. So far, it seems that empirical and normative expectations are not very strongly developed in the six

baseline study states. But this is contradicted by the almost two thirds – 63.0%! – of respondents who have stated that FGM/C is required by their culture.

5. Conclusion. A virtual community, with the grandmothers as guardians

There is no or little sanction for not cutting. People know that cutting continues, albeit only about a third tells us that it continues inside their families and amongst their friends. And people are not very clear about who in their families or communities expects them to cut their daughters. But the practice does continue – on a reduced scale, but nevertheless: one third of 15 to 19 year old girls cut is one third too much. 28.9% of interviewees stating that they intend to cut their daughters in future are 28.9% too many: close to a third of baby girls born in the near future in the six baseline study states are likely to undergo the inhumane and harmful practice of FGM/C.

Respondents seem to think that they and people around them are in their majority free to cut or not to cut, as they – individually or in tandem with their spouse – deem fit. People do not see many advantages in the practice[29] and they often know about its dangers and its harmfulness[30]. Yet quite a few – about half of those who come from an FGM/C background – continue cutting their own baby girls.

Yet the Nigerian society in the south-west and the south-east seems still quite some way off the society of monads where every lonely individual takes his or her own decisions. It looks, instead, as if we were faced with what one could call **a virtual community**. Virtual because it does not exist in real, its members neither meet nor talk, there is never reunions, and no contact.

From the interviews with experts conducted in four of the five intervention states, it very much looks like a community mainly made up of **grandmothers**[31]. It is they who make sure that the custom, the tradition continues, that what culture demands[32] is executed, that the necessary is done **to ensure submission**[33]**, propriety and decency**[34].

NB: It is our girls' and women's obedience and proper behaviour in all matters sexual that ensure our families' and our societies' wellbeing.

[29] In response to question 22, only 43.1% of interviewees saw a benefit, 29.5% explicitly stating that there was no benefit and a third (32.3%) don't knows.

[30] 46.1% agree that "female genital mutilation is a very harmful and inhumane practice" (question 38v) and 41.0% agree that "female genital mutilation can lead to death as a result of pain and severe bleeding" (question 38vi)

[31] In Senegambia, Shell Duncan et al. have found that FGM/C is a social norm that is a "woman's thing" in the sense that it serves the maintenance of the intra-women hierarchy and the submission of young vis-à-vis old women. See Bettina Shell-Duncan, Ylva Hernlund, Katherine Wander and Amadou Moreau, Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia. Summary Report, Seattle (Univ. of Washington) 2010.

[32] Remember that 63.0% of respondents say that FGM/C is required by their culture. See above.

[33] See, for example, the "classic" and excellent Sylvie Fainzang, Circoncision, excision et rapports de domination, Anthropologie et Sociétés, 1985, vol.9, no.1, pp.117-127

[34] See Elena Jirovsky, Contemporary Meanings of Female Circumcision/Female Genital Mutilation (FC/FGM) in Bobo-Dioulasso, Burkina Faso - Local Aspects of a Global Assemblage, PhD Dissertation in Philosophy, Cultural and Social Anthropology at the University of Vienna, 2014. Chapter 7 – "Narratives about sexuality: local norms and stereotypes of insatiable women, virginity, and sexual functionality" – is especially pertinent in this context.

6. **Recommendations**

6.1 General recommendations

Based on the above, the international consultant recommends to focus on communities and to address the whole community, including men (heads of family and "deciders")[35] – but most of all the grandmothers.

The grandmothers are the guardians of the tradition of cutting girls. In most cases their daughter or daughter-in-law is "powerless" to stop them from taking any decision regarding their grand-child. We "should always remember that the grandmothers mean well for their granddaughters. To avoid creating conflict within families, our interventions should be framed to show that the grandmother's motives are pure, but their methods can hurt the girls". So the question will be how we can achieve the same goal without hurting the girls"[36].

Before or during intervention, deploy radio, internet and other media to make FGM/C an issue that people think and talk about. And during intervention, make sure that people discuss about it amongst themselves as much as possible.

Go for a public declaration by the community, where possible. But the community needs to prepare this well – be careful not to do it too early – a public promise, if it is broken afterwards, can do more harm than good.

"We do not have a silver bullet"[37]. Each state, sometimes each community, needs to develop its own anti-FGM/C programme, well adapted to its socio-cultural conditions. This means to always pay attention to context. FGM/C is a sensitive issue. Deep-rooted beliefs and values are involved.

Working on the demand side (people who come with their girls to have them cut) will be more efficient than working on the supply side. Cutting a clitoris is not a very difficult operation, and even if the traditional circumciser abandons, somebody else can easily take her or his place. Because: "any willing to cut their daughter, (…) will find someone willing to oblige them (even if they do not have prior experience)."[38]

All grassroots activities must be known to try and improve people's lives – holistic approaches are to be put into practice wherever feasible. Ideally, anti-FGM/C activities are embedded in community improvement measures.

Community insiders are the best agents of change – they are much better suited for provoking sustainable, lasting change.

6.2 Specific recommendations

Good and best practices identified during the international consultant's field work in Nigeria's capital, the South-East and the South-West are the basis of these "specific" recommendations.

[35] "As the "heads of the families", once the fathers start paying close attention to their daughter's health, I believe that no one will tamper with their bodies." Benjamin Mbakwem, email of 3rd of August 2015
[36] Ibid.
[37] Ibid.
[38] Ibid.

We need to build on the existing – utilise and expand the excellent work that is already being done on the ground[39].

Specific recommendations for the national level

Adopt the FGM/C overview and the FGM/C rating as standards;

Frame the outlines of a modest but efficient FGM/C communication-lobbying-advocacy strategy for the national level[40];

Lobby/advocate the new Senate and House of Representatives for funds for activities against FGM/C[41];

Lobby/advocate for making the FGM/C part of the VAPP (Violence Against Persons Prohibition) Act as widely known as possible[42];

Create/raise awareness that FGM/C is a problem: 1) through radio programmes 2) through social media 3) through text messages on mobile phones; for this: 1) train relevant journalists, 2) employ a competent expert to reach the 40 million estimated social network users in Nigeria, and 3) get MTN, Airtel, Glo Mobile, Etisalat to send regular messages free of charge;

Creating/raising awareness includes celebration of International Anti-FGM/C day in a widely visible and audible manner and including FGM/C in the 16 Days of Activism to Eliminate Violence Against Women;

Lobby/advocate Federal and State governments plus the World Bank for **integration of FGM/C into** all Community and Social Development Project/**CSDP programmes** in states that have FGM/C rates above 10%; have relevant personnel trained by CSDP Osun's FGM/C specialist[43]; provide support for the first months of implementation;

Lobby/advocate relevant professional associations to take FGM/C (more) into account (TBAs/ community birth attendants, doctors, nurses, midwives, faith-based organisations, circumcisers, youths and women associations …)[44];

NB: Given far-reaching autonomy of Nigerian states vis-à-vis the federal state, and given the importance that anti-FGM/C activities be adapted to local context, the Joint Programme should privilege the state or LGA level above the federal level. Abuja-activities should be seen as creating a basis and supporting state-LGA-community level activities. This should be reflected in resource allocation: by far the most important part should go to activities in the five intervention states/the selected LGAs in these states.

[39] The original proposal – here reworked in form but not content – was submitted to UNICEF on 1 March 2015, before quantitative data were collected in the six baseline study states. Analysis of the quantitative data obtained since has not changed the recommendations.
[40] Possible lead: Dr Jude Ohanele of Development Dynamics, Owerri
[41] Lead: Ms Adenike Etta (Director Family Health at Federal Ministry of Health, FGM/C focal person at Ministry of Health) and LACVAW (The Legislative Advocacy Coalition on Violence Against Women)
[42] Logical lead: Ms Etta, Director Family Health at Federal Ministry of Health, FGM/C focal person at Ministry of Health; note that this suggestion has been changed following the passing of the law in May; the original proposal, on 1st of March 2015, went "Lobby/advocate for the VAPP (Violence Against Persons Prohibition) law (which includes some paragraphs about FGM/C)".
[43] Ms Aduke Obelawo, Project Officer, Information Education and Communication (PO IEC) at the Osun Agency for Community and Social Development Project (Osun CSDP); also Osun State Coordinator of The Inter-African Committee on traditional practices affecting the health of women and children (IAC)
[44] Lead: Ms Etta, Director Family Health at Federal Ministry of Health, FGM/C focal person at Ministry of Health for health-related issues, Federal Ministry of Women's Affairs and Social Development (MoWAs&SD) for women issues, etc.

Specific recommendations for the state level:

So as not to squander resources, first choose the LGAs which the Joint Programme is to concentrate on;

Clarify the roles of technical working committee presidents and members, explain that committee presidents and ministry focal people are to participate in the planning and will be the main responsible for coordinating activities and for monitoring them – but they will not be the Joint Programme's main actors;

Make use of available resource persons[45];

Publicise results of baseline study widely amongst anti-FGM/C activists;

Frame the outlines of an efficient FGM/C communication, lobbying, advocacy strategy for each state[46];

Lobby/advocate anti-FGM/C with modern leaders (governors down to community leaders/village chairmen), traditional leaders (ezes, obas, chiefs), religious leaders, women leaders and youth leaders – at the state, LGA and community level.

NB: "Insiders" – like the late Iyalode of Osogboland for traditional leaders' councils or Ms Adegoke for traditional birth attendants (TBAs) – tend to be the most convincing for their peers.

Create/raise awareness that FGM/C is a problem: 1) through radio programmes in the local language 2) through social media in the local language; for this: 1) train relevant radio journalists, 2) employ a competent expert to reach the social network users in the local language.

Specific recommendations for the community level (community is here meant in a broad sense – this can be the village or LGA, but also the community/traditional birth attendants, youths, CHEWs, etc.):

Develop **one** strategy per community (or one per cluster of communities);

Involve existing institutions/structures where possible to spread "the word": town unions, women and youths associations, August meetings in Imo state, religious communities, landlord associations – but perfunctory implication is not worth much, only convinced leaders/members can make a difference;

Focus on community sensitisation[47], leading up to community resolutions/public declarations, if possible;

Sensitise youths = those who will soon have their daughters cut – or not[48]; train youth croppers on FGM/C before they are sent to the field[49];

[45] e.g. Lady Ngumezi, Ms Obelawo, Ms Ilesanmi, Professor Onadeko, Ms Orenuga, all of the Inter-African Committee on traditional practices affecting the health of women and children (IAC), Ms Margaret Onah, Executive Director of SAFEHAVEN Development Initiative (SDI); Lady Agnes Ngumezi is the national IAC's vice president, Nigeria chapter (IAC) and in charge of the Imo section of IAC; Ms Aduke Obelawo is the IAC's Osun State Coordinator, Ms Yemi Ilesanmi is the Secretary of the IAC's Osun state chapter, Prof Modupe Onadeko is the IAC's national President, Ms Oyefunso Orenuga is the former (2005-11) IAC President.

[46] Consultant: Dr Jude Ohanele of Development Dynamics, Owerri

[47] Lead: Chief Malachy C. Uchegbu, executive co-ordinator of Better Community Life Initiative (BECOLIN), Owerri; consultant: Ms Onah of Safe Haven; the BECOLIN strategy overlaps with several of the above and below mentioned strategies/recommendations

[48] Lead: Mr Chigozie Benjamin Mbakwem, programme director of Community Youth & Development Initiatives (CYDI), Owerri, consultant: Ms Aladejare Abimbola, Executive Director of The New Generation Girls and Women Development Initiative (NIGAWD)

Sensitise women associations[50], focussing pregnant women, newly-weds and grandmothers (can someone take over the late Iyalode of Osogboland's grandmother association?[51]);

Community birth attendant sensitisation[52], community/traditional birth attendants (TBAs) being the main circumcisers in Nigeria;

Sensitise other health personnel: the organisational setup varies from one state to the other, but CHEWs play important roles everywhere on the grassroots level, then there are community health officers, officers in charge of health facilities, health assistants, health promotion officers, gender officers, etc.; sensitise the most pertinent amongst them and equip them to be agents of change at the community level;

Involve circumcisers, sensitise them – they must certainly not be excluded from dialogue and communication – and a turned-around circumciser can be one of the most convincing anti-FGM/C activists; but DON'T engage in large-scale retraining measures: they have not worked in the past, why should they work now?

Pay sufficient attention to monitoring and evaluation/**M&E** – base all Joint Programme M&E on baseline study indicators; do necessary training for this for coordinators/M&E people of the state and make it clear that the role of coordination and M&E is incompatible with doing activities (sensitisation etc.) at the grassroots level.

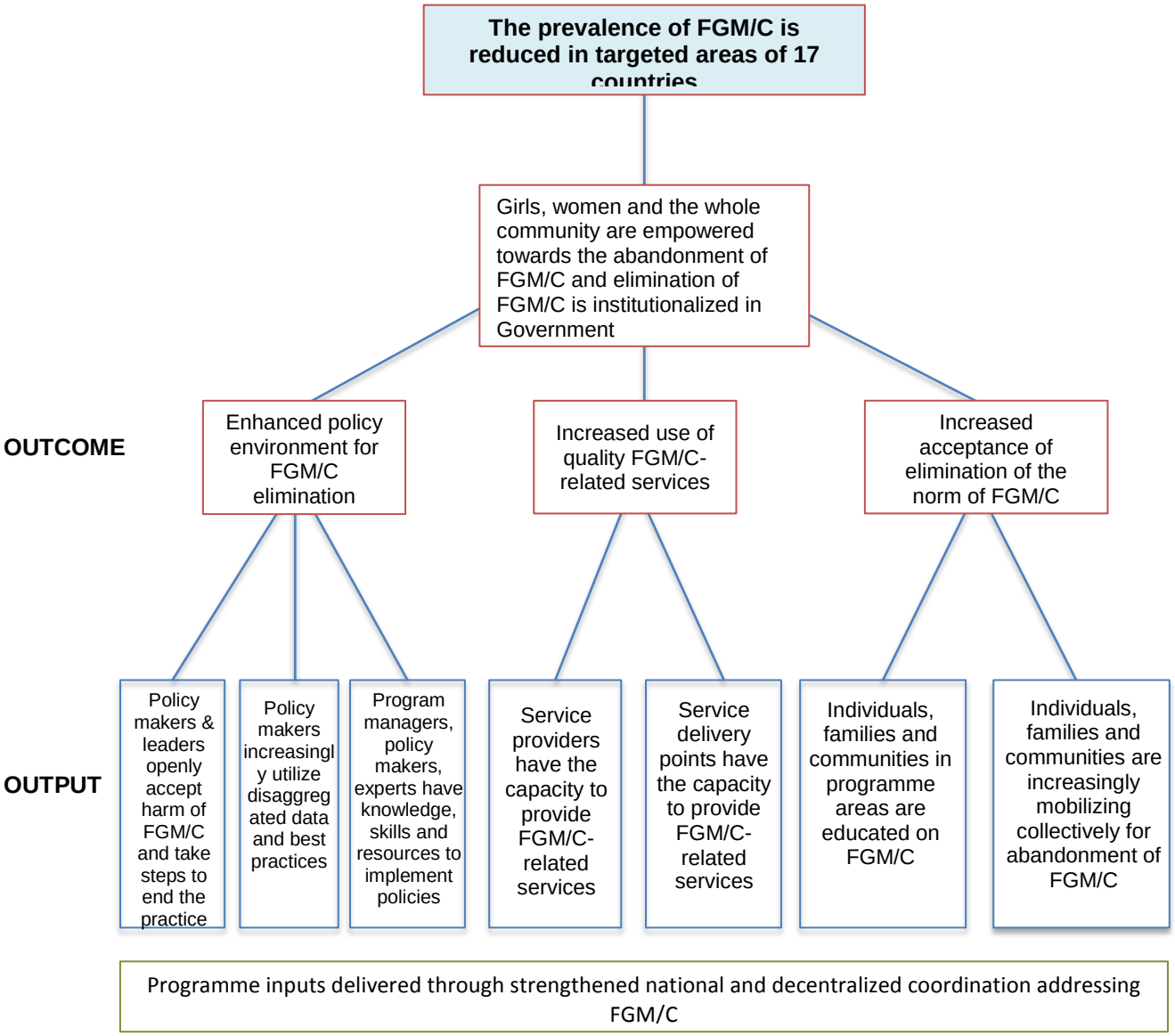
NB: By far the biggest part of resources should go to sensitisation.

6.3 Linking the recommendations and the 17 country-UNFPA-UNICEF Joint Programme against FGM/C "Accelerating Change"

Nigerian anti-FGM/C interventions – from the National Policy and Plan of Action against FGM/C[53] to state strategies/action plans (yet to be developed) and community activities – would gain from producing a results chain diagram along the lines of the Joint Programme's shown on the next page – a very simple schematic representation that helps clarity and understanding and should come in very useful for planning and strategising. Monitoring and evaluation would also benefit.

[49] Lead: Ms Rita Ilevbare, Executive Director of the Gender Relevance Initiative Promotion (GRIP) in Ado Ekiti
[50] Lead: Dr Ebunlomo M. Walker, Executive Director of Initiative for Integrated Community Welfare in Nigeria (IICWIN) in Ibadan, consultant: Ms Chibuzo L. Oriuwa, executive director of Forward Africa, Owerri office
[51] Maybe her friend Ms Obatayo of Hope Foundation in Ado Ekiti? Ms Adenike Adebowale Obatayo, Executive Director and founder of Hope Foundation; Ms Obatayo is also President of the Ekiti Branch of the National Council of Women's Societies
[52] Lead: Ms Muibat Lawal Adegoke, Chairperson of Association of Community Birth Attendants and Voluntary Health Workers of Nigeria, Oyo State chapter
[53] Federal Ministry of Health Abuja, 2013 – 2017. National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria, Abuja August 2014 (draft)

A 'Theory of Change' depiction of the programme logic of the Joint Programme, phase II[54]



Note that, where FGM/C abandonment is concerned, amongst the three strands of the results chain – 1) politics/administration/law, 2) service providers, and 3) individuals/families – we can do without the first two. Norms and practices can change from within society, without a law change and without the help of "services" – but we will never be able to do without the third, the communities – they will, or will not be, the abandoners. So the ultimate focus is always on them.

Reiterating: Close attention needs to be paid to people's beliefs and values. It is important to stress how fundamental values – an ethical and honourable way of life, aiming for fit and healthy adults and their offspring, striving for an improved material future – remain untouched. It should become clear that, in comparison with the old tradition, the norm change provides the community with a better way of loving their girls and women and ensuring all their families' prosperity.

[54] UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, Phase II - 2014-2017, Results-Based Management Framework and Plan, Draft, Updated January 2015, p.7

Annexes:

1. List of experts interviewed by the international consultant from 23/1/2015 to 25/2/2015
2. The international consultant's interview topics and questions for anti-FGM/C experts
3. FGM/C Rating (with details and weights) (excel document)
4. Baseline study Questionnaire
5. Federal VAPP bill 2015

Annex 1: List of experts interviewed by the international consultant – in chronological order – during his stay in Abuja and his field research in Nigeria (Imo, Osun, Ekiti and Oyo) from 23/1/2015 to 25/2/2015 (please forgive orthographic mistakes should that have happened):

Abuja – interviews 24/1/2015 -31/1/2015

Mr Kelvin Chukwuemea, coordinator Imo state, Joint Programme baseline study

Ms Maryam Enyiazu, Joint Programme focal person UNICEF

Ms Rachel Harvey, Chief of Child Protection at UNICEF

Ms Nkiru Igbokwe, Joint Programme focal person UNFPA

Ms Nkechi Onwukwe, Deputy Director of Women Affairs at Federal Ministry of Women's Affairs and Social Development plus two of her staff

Ms Adenike Etta, Director Family Health at Federal Ministry of Health, FGM/C focal person at Ministry of Health

Ms Olasunbo Odebode, Gender and Development Programme Officer at UNICEF Abuja

Mr Adebisi Adebayo Tunde, MICS specialist, statistician for Joint Programme baseline study

Ms Alheri Yusuf, Deputy Director of Research and Planning at Nursing and Midwifery Council of Nigeria (NMCN), Ms Ayoola Modupe, NMCN's representative at the Federal technical working group

Dr Chris Oworoyeguono Agboghoroma, Secretary General of Society of Obstetricians and Gynaecologists of Nigeria (SOGON)

Mr Taiwo Oyelade, FGM/C focal person at WHO

Ms Adekemi Ndieli, VAW focal person at UN Women

Owerri and Imo – interviews 2-6/2/2015

Dr Jude Ohanele of Development Dynamics, Owerri

Ms Meg Obi, Director of Women Affairs at MoWAs&SD Owerri

Ms Thecla, FGM/C focal point of MoH Owerri

Dr Emmanuel Emukah, Director Public Health/Primary Health Care of MoH Owerri

Dr Udeji, head of Reproductive Health of MoH Owerri

Lady Linda Mgbechi, teacher at School of Midwifery of MoH Owerri

His Royal Highness Eze Matthew Onweni, deputy chairman of Imo State Council of Ndi-Eze, Owerri

Ms Hajia Rakiya M. Ahmed, president of Imo chapter of Federation of Muslim Women's Associations in Nigeria (FOMWAN), Owerri

Dr Hyacinth O. Emele, chairman of Imo chapter of Nigerian Medical Association (NMA)

Dr Emily A. Nzeribe, president of Imo chapter of Medical Women's Association of Nigeria (MWAN) and coordinator of Society of Gynaecology & Obstetrics of Nigeria (SOGON) for Imo State, Owerri

Ms Elizabeth Njoku, staff of Aboh Mbaise Local Government Council and Community Woman Leader and president of the NGO Unity Women Association of Aboh Mbaise, Aboh Mbaise

Lady Agnes Ngumezi, vice president of The Inter-African Committee on traditional practices affecting the health of women and children, Nigeria chapter (IAC) and in charge of the Imo section of IAC, retired MoH FGM/C focal point, Owerri

Ms Chibuzo L. Oriuwa and Ms Ogechi Okehielam E., executive director respectively M&E officer of Forward Africa, Owerri office

Dr O. Anyaoha, sociology lecturer at Imo State University, Owerri

Chief Malachy C. Uchegbu, executive co-ordinator of Better Community Life Initiative (BECOLIN), Owerri

Mr Chigozie Benjamin Mbakwem, programme director of Community Youth & Development Initiatives (CYDI), Owerri

Dr Ngozi Izuagba, secretary of Anglican Diocese, teacher at Alvan Ikoku Federal College of Education, Owerri

Ms Anyiawu Mabel Chinwe, president of Imo state branch of Umuada Igbo Nigeria and in Diaspora, Owerri

Honourable Festus Nwaeke, village chairman, Amala

Ms Rose Catherine Nwigwe and Ms Chinyere Nwufo, president respectively FGM/C consultant of Friendly Environment & Human Development Foundation (FEHD Foundation), Owerri

Osogbo and Osun – interviews 8-11/2/2015

Ms Aduke Obelawo, Osun State Coordinator of The Inter-African Committee on traditional practices affecting the health of women and children (IAC), Desk Officer, UNICEF assisted, Child Protection at MoWAs&SD up till 2009, now Project Officer, Information Education and Communication (PO IEC) at the Osun Agency for Community and Social Development Project (Osun CSDP)

Ms Alhaja Suaibat Babalola Adubi, president of Osun chapter of Federation of Muslim Women's Associations in Nigeria (FOMWAN), accompanied by FOMWAN secretary, missioner and public relations manager

Ms Esther Bose Ademji, president of Brighter Future Initiative for Women & Children, Ede LGA, Osun

Ms Yemi Ilesanmi, Secretary of the Osun state chapter of The Inter-African Committee on traditional practices affecting the health of women and children (IAC), director at the state MoE

Mr Dare Adeoye, Legal Defence and Assistance Project, NGO, Osogbo

Ms Mary Adeyemi, Human Development Frontliners, NGO, Osogbo

Ms Funmi Adenuga, President of the Osun chapter of the National Association of Nigerian Nurses and Midwives (NANNM), reproductive health programme officer at state MoH, Osogbo

Prof Simi Odeyinka, Director; Dr Friday A. Ebdiyehi, senior research fellow; Ms O. A. Ayeni, senior assistant registrar; Dr Dolarpo Amole, senior research fellow; all at Bisi Adeleye-Fayemi Centre for Gender and Policy Studies, Obafemi Awolowo University, Ile-Ife

Secretary of the association of circumcisers and about a dozen members of that association of Ikire, Irewole LGA, accompanied by President of Community Development Council of Ikire

Members of the Akiri council (six in all, amongst them the secretary and the Eketa Iyalode) of (absent) Oba Olatunde Falabi, Ikire, Irewole LGA

Chief Abiola Ogundokun, National Patron and coordinator of circumcisers (NACIRDAN – National Circumcisers' Descendants Association of Nigeria), Iwo city, Iwo LGA

Ms Funmi Abokede, General Manager; Mr Adeyemo Ademola, M&E Manager; Mr. Akinsola Ogunsakin, Finance and Admin Manager; Sola Obajuwonlo, Project Officer Gender and vulnerable; Adedokun J.A., Admin Officer; Johnson Olabiyi, Project Officer, Management of Information System; Femi Akanni, Procurement Officer; all at CSDP/Osun state agency for Community and Social Development Project, Osogbo

Ms Hannah O. Mosadomi, Director of Women and Children Affairs; Ms Adiatu Basirat Temitayo, Gender Desk Officer; Mr Sunmola Oriowo, Director of the Child Development Department, at state Ministry of Women Affairs and Social Development (MoWAs&SD), Osogbo

Dr Kayode Ogunniyi, Director of Primary Health Care/Diseases Control; Ms Toyin Adelowokan, Gender and FGM/C Desk Officer; Dr Temitope Oladele, Permanent Secretary; all at Osun state Ministry of Health

Chief Bernice Alake Kolade JP, Iyalode of Osogboland

Abuja – interviews 13/2/2015

Ms Deborah Tabara, Ms Umma Rimi, Executive Programmes/UNFPA Project at Women's Rights Advancement and Protection Alternative (WRAPA)

Mr Chidimma Ezenwa Anyanwu, National Coordinator, Joint Programme baseline study

Imo interviews by telephone and email 14/2/2015ff

Ms Harriet Oleru, Executive Director Imo branch of Women in Nigeria Initiative for Gender Enhancement and Preservation

Lady Claribel Okpala, Concerned Group for Environment, Population, and Development in Nigeria (N-COGEP-P)

(Ado) Ekiti – interviews 16-17/2/2015

Ms Tayo Olatilu, Joint Programme and UNICEF focal officer at Ministry of Women Affairs, Social Development & Gender Empowerment (MoWAs)

Permanent Secretary of MoWAs, Princess Adekunbi Obaisi, Director and Deputy Director of Child Development, representative Director Social Welfare, other staff of Child Development department

Ms Juliet Adewanle Boluwatife, Director Child Development at MoWAs

Ms Funmi Ogunyemi, Ms Sola Adeluyi, Director resp. Deputy Director (and ministry's Gender focal point) of Women Affairs Department of MoWAs

Ms Akinleye Olukemi, Gender Desk Officer at Public Health Department of Ekiti's Ministry of Health (MoH), a public health nurse/member of NANNM, IAC focal person in Ekiti

Permanent Secretary of MoH, Ms Folakemi Olomojobi, Director of Public Health, Dr Oluwafemi

Ms Aladejare Abimbola, Executive Director of The New Generation Girls and Women Development Initiative (NIGAWD), member of the federal technical working committee FGM/C

Ms Adenike Adebowale Obatayo, Executive Director and founder of Hope Foundation and several of her staff, Ms Obatayo is also President of National Council of Women's Societies, Ekiti Branch

At Palace of Ado Ekiti's Oba: five Chiefs (amongst them the eldest) and Cabinet Secretary of Council of Ministers

Ms Rita Ilevbare, Executive Director of the Gender Relevance Initiative Promotion (GRIP), a human rights based charity

Chief Ms Omowaye Oso, Iyaloja (market women leader) of Ado Ekiti, of Ekiti State and President of the Association of Nigerian Market Women and Men

Chief Rufus Falodu, Saade of Ijero Kingdom, one of the kingmakers of Ijero and member of the council of Oba Owa Ajero of Ijero

Ibadan and Lagos – interviews 18-20/2/2015 resp. 20-21/2/2015

Ibadan:

Mr Oderinde Akinyele, Deputy Director of Child Welfare and focal point of Joint Programme for Oyo state, Ministry of Women Affairs

Ms O.Y. Fola-Kayode, Director of Child Welfare, Ministry of Women Affairs

Ms Yemisi Okunmadewa, officer at Primary Health Care & Disease Control Department and FGM/C Focal Person Ministry of Health

Dr Oluwaloyin Oyelakin, Director of Primary Health Care & Disease Control, Deputy Director of Public Health, other ministry staff, briefly also Permanent Secretary of Ministry of Health

Prof Modupe Onadeko, national President of The Inter-African Committee on traditional practices affecting the health of women and children (IAC)

Dr Ebunlomo M. Walker, Executive Director of Initiative for Integrated Community Welfare in Nigeria (IICWIN)

Pastor Sam ‘Leye Adefioye, Executive Director of RESTANCHOR plus one staff

Ms Muibat Lawal Adegoke, Chairperson of Association of Community Birth Attendants and Voluntary Health Workers of Nigeria, Oyo State chapter

Mr Oloola Kobomoje, head of the family of descendants of Baba Kobomoje, the foremost circumciser of Ibadan and Oyo state

Lagos:

Ms Oyefunso Orenuga, former (2005-11) President and member (1990-2011) of The Inter-African Committee on traditional practices affecting the health of women and children (IAC)

Ms Margaret Onah, Executive Director of SAFEHAVEN Development Initiative (SDI)

Annex 2: The international consultant’s interview topics and questions for anti-FGM/C experts

1. Anti-FGM/C activities past and present
Your institution’s/organisation’s anti-FGM/C activities past and present: description (approach/ strategy, actors, targets, activities, scope, finances), what has worked/works – what has not worked/does not work, and evaluation (of pertinence, effectiveness, efficiency and sustainability)
Other organisations’ anti-FGM/C activities past and present (as above)
Is there communication between different anti-FGM/C actors at the state level? Informally? Institutionalised? Is there coordination?
Evaluation of national level activities past and present (as above)

2. The practice
Type(s) of FGM/C
Who does the cutting? Is medical personnel involved?
At what age is the girl cut?
Consequences? Are the “victims” looked after properly? Is surgical repair often necessary?

3. Reasons behind it
What are the underlying reasons? What does a cut girl gain?
What are the reasons people give?
What are the real reasons?
Will an uncut girl find a husband?

4. Norm enforcement
Who enforces the custom? How?
What happens to a girl or woman who is not cut?
Who takes the decision to cut a girl?
In general: what is women’s position in society? Are they subdued and expected to be docile? Are they independent? Are they strong?

5. Who cuts and who doesn’t
Does everybody around have their girls cut?

Who has her/his daughter cut? (age, ethnic (sub)group, religion, educated/uneducated, rich/poor, urban/rural …)
And who does not?
Has the custom changed over the years? The way it is done? Do more or less people have their daughters cut nowadays?

6. Is it an issue?
Is FGM/C an issue for people here?
Is it discussed with the husband/wife? in the family? with friends? in the community?
Is FGM/C an issue in the media? on the radio?
How many people have been reached by sensitisation activities? Have anti-FGM/C activities had an impact on a relevant part of the population?

7. Positive role models and public declarations
Have there been people who have stopped cutting? Who? And what made them stop?
Are there people who are known to be against the practice?
Are there people who have stood up against the practice?
Have any public statements/public declarations been made against FGM/C? Any public promises of abandonment?

8. Social networks and community mobilisation
Who are the communities' opinion leaders?
Who are the guardians of tradition?
Are there personalities or associations or institutions in the communities predestined to deal with the question of FGM/C? Which?

9. Advocacy and lobbying
Have State and local authorities been sensitised and implicated?
Have traditional and religious leaders been sensitised and implicated?

10. Anti-FGM/C law
Is there an anti-FGM/C law in this state?
Is it being implemented?
Should it be implemented?
Is such a law a good thing?
Is implementation plausible?

11. Recommendations
What could and should be done to reduce and finally eradicate FGM/C?