Contributions to Nigeria's national anti-FGM/C strategy

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UNFPA-UNICEF Joint Programme on FGM/C – Nigerian baseline study

In a nutshell

Make the proposed FGM/C overview and the FGM/C rating into standards;

Deploy radio, internet and other media to make FGM/C an issue that Nigerians think and discuss about;

Make the FGM/C part of the VAPP bill widely known, pass state laws where they are not yet in place, make state laws against FGM/C widely known and make it known that these laws will be implemented in future;

Create a lean but high-capacity agency for coordination of FGM/C activities, with headquarters in Abuja and affiliates in states where planned or ongoing activities so require; main tasks of this agency will be to rule on standards for M&E and to broker information;

Nigeria's education needs FGM/C mainstreaming; this includes professional training where pertinent, e.g. training of medical personnel – also to stop medicalisation;

The overhead (maintenance of the anti-FMG/C apparatus including M&E and research) must not consume more than a small part of resources available for anti-FGM/C activities – by far the biggest part of resources needs to be dedicated to on the ground activities;

All grassroots activities must be known to try and improve people's lives – holistic approaches are to be put into practice wherever feasible; members of targeted communities do not need to be told what to do but need to discuss amongst themselves, deliberate and decide on changing what no longer holds true and can be improved by adopting new norms;

Continue focussing on naming ceremony clitoridectomy, Nigeria's quantitatively dominating type of FGM/C. The current UNFPA-UNICEF Joint Programme should build on good and best practices and expand on them in the five states selected in the country's south-west and south-east. In future or if additional financial means become available, experiences from this programme could be extended further in the intervention zones and beyond;

Add a new front against infibulation – though by far less common, its consequences are much more severe; target well to reach the minorities concerned;

Kaduna and Jigawa will need close attention also – DHS 2013 has found the practice expanding there; widely practiced *yankan gishiri* will need adaptation of campaigning from elsewhere;

Whenever money is or becomes available – build on existing strengths; lots of anti-FGM/C activities have been undertaken in the past, though they are usually little talked about; some of them work – it is generally very advantageous to follow good and best practices that have proven their worth, expand them while adapting them to changed context.

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Introduction

The UNFPA-UNICEF Joint Programme on FGM/C will, hopefully, do ground-breaking work against FGM/C in the five Nigerian states targeted. Some activities have started in 2014, but with the baseline study's practical phase unfortunately delayed, the real take-off is for 2015. The programme is to last at least until end of 2017.

Nigeria has made a big step forward in 2015 when passing the VAPP bill. This is the kind of support we need from our top policy makers to go for FGM/C abandonment. Now we want the policy makers to "mainstream the commitment to end FGM/C throughout Government".

Nigeria is too big and – more importantly – too diverse to have Abuja direct anti-FGM/C activities on the ground. Programmes ought to be invented, planned and put into practice on a state or local level. Abuja needs to play a coordinating and accompanying role (support with PR, with donor contacts and with knowhow; research; networking; exchange of information) while its part in implementation will be very limited.

To maximise impact, the apparatus put in place should be lean and efficient – on the state and national level, and even leaner on the federal level. Committees with membership extending to everybody in the least involved are expensive and little effectual. Coordination, steering and advice are ideally left to small groups of committed experts. The large anti-FGM/C working groups put in place in (some parts of) Nigeria recently seem well fitted to the spreading of information and to gaining adherence of all institutions, even those only little involved. But they are unlikely to get down to working on the ground – and should not try to.

Each state should develop its own anti-FGM/C programme, well adapted to its socio-cultural conditions. In which states anti-FGM/C interventions on a major scale will happen will, however, have to be decided on the federal level, depending amongst others on available financing.

In Nigeria, information about FGM/C is not easy to come by. Even where plenty of anti-FGM/C activities have been conducted in the past, they have typically been little talked or written about. Fact-finding missions will thus be necessary as a first step – to create or rather assemble the knowledge base for strategising and planning. On the basis of the international consultant's experience in four Joint Programme intervention states in February 2015, an absolute minimum of one week per state seems necessary, two weeks would yield better results. A combination of external eyes with insider eyes would be ideal for such a mission. If (like in the present case) only an outsider is sent, then the quality of the information gathered will depend very much on the local "guides". Maybe one guide from a state ministry (most likely MoH or MoWA) plus one guide from civil society (the IAC has been on the ground the longest in most cases but there are also a few dynamic young organisations) would be ideal.

Quantitative research has an important role to play in anti-FGM/C activities. Though a nationwide in depth-study would be ideal, finances for such an endeavour may be difficult to come by. In that case, research should be focused on intervention zones. On the basis of the experiences gained with the Joint Programme baseline study, improved and condensed questionnaires could be used in states/LGAs/communities where interventions are planned. A strong argument could be made for leaving the striving for representativity, even on the state level, to Demographic and Health Surveys, and to focus additional research on where anti-FGM/C activities are to actually happen. Baseline studies, mid-time evaluations and post-intervention research can then measure impact – donors like to know that their money is well spent and strategising and planning becomes a lot easier if you have evidence-based knowledge about what has worked and what has not worked in the past.

The modest contributions to Nigeria's national anti-FGM/C strategy that follow have the following points of reference:

> 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);
>
> UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, Phase II - 2014-2017, Results-Based Management Framework and Plan, Draft, New York, Update of January 2015 (see the extracts in Annex 1 and 2);
>
> The Social Norms theory (see the short summary in the international consultant's final consultancy report of August 2015);

And last but certainly not least:

> The international consultant's field research in Nigeria from 23 January 2015 to 25 February 2015 that took him, in that order, to Abuja, Imo, Osun, Ekiti, Oyo, and briefly to Lagos (see the list of people met in Annex 3).

Preliminary remark 1: Context

For all anti-FGM/C activities, social norms theory recommends utmost attention to context[1]. This "context" includes the socio-economic environment, the culture, the values and beliefs of the community at stake. If (financially) possible, holistic interventions are much preferable because more effective – for the targeted community the practice of cutting is no isolated feat, it is embedded into life, and the community's interest lies in improving life all-round, not just one little aspect of it. So in order to well and "really" communicate about FGM/C, it may be necessary to also talk about violence against girls and women, about gender, about reproductive health, about health, about nutrition and thus about food consumption and production and thus social, economic and maybe even (local) political matters that go far beyond the harmful practice of cutting little girls' sexes. Not to speak of moral, religious, or spiritual matters connected with the practice.

Being attentive to the real world we are dealing with in all its complexities also means paying attention to the different varieties of FGM/C. One size does not fit all. Clitoris "massage", infibulation and clitoridectomy have to be dealt with in entirely different ways. Very often, people do not put the different kinds of FGM/C into one category. In Imo, for example, FGM/C tends to mean clitoridectomy – and "massaging" the baby girl's clitoris is seen as something totally different – maybe with the same objective, to get rid of that disturbance called clitoris, but resorting to "massage" is often seen as "abandonment of FGM/C[2]. Under such conditions, insisting at the grassroots level on the WHO and UN definition that all the different varieties all belong together in the one category "FGM/C" may be counterproductive.

Besides the "what is done", "how it's done" is also important. Cutting as part of initiation rites of girls, marking their passage into womanhood, is clearly a different matter from cutting an eight day-old baby girl; cutting an individual girl or an individual (maybe pregnant) woman has very

[1] Whenever possible, try to avoid the term "circumcision" except for the cutting of the prepuce of the clitoris and for boys' circumcision. The word means "to cut around" and in the very big majority of cases this is not what happens – instead, something is cut out, is cut off (and sometimes even sewn closed afterwards). Also the term tends to imply that FGM/C is a harmless as boy's circumcision – which is only true if only the prepuce of the clitoris is cut off. **However**, on the ground, "circumcision" is in most cases the term to use – people don't know the term "FGM/C" or are not at ease with it.

[2] In Eritrea, where the dominant ethnic group, the Tigrinya, practice clitoridectomy while the Hedareb, Afar, Bilen, Saho, Tigre etc. infibulate, for these latter groups, "stopping FGM/C" often means replacing infibulation by clitoridectomy.

different implications from cutting girls as part of a big public ceremony with the whole community afterwards celebrating with the cut girls.

Each variety of FGM/C calls for its own adequate approach.

Respecting our vis-à-vis, respecting the "target" community is of the utmost importance. The best agitators and agents of change usually come from inside the community – strangers are less trusted, especially for such intimate matters that deal with the sex of girls and women. Those who intimately know the way of life of the concerned, including the local traditions, customs and habits, are in a much better position than outsiders – whites are the worst possible activists in most grassroots settings, "they know nothing about our culture here", or, worse, "they once again want to impose their ways", but people from the state capital or some other faraway place often are in no better a position, they may even be termed "whites" for the occasion, meaning that their views and culture have nothing much to do with the local one, despite their speaking the same language.

Community insiders, if committed to the cause, are much better suited for provoking sustainable; lasting change. They will need support from the world out there, but once the original impetus has come from outside, those interested will usually make themselves known – in the interest of efficiency, they should be entrusted with as much of the sensitisation and communication work as possible.

Preliminary remark 2: Selection of intervention zones

The Joint Programme has chosen a simple method for the selection of its five Nigerian intervention states: it looked at the DHS 2013 and there took the five states with the highest FGM/C rates for the 15 to 49 year olds, the internationally most-used measure for FGM/C, deeming them the "most concerned", the "most in need".

Other selection criteria could be used in future:

Staying close to the method of the Joint Programme, one could examine the FGM/C rates for the younger girls instead of the rates of those that are 15 and older. Table 18.6 of DHS 2013 provides data for the 0 to 14 year olds in five year-age brackets. Jigawa in Nigeria's North West has the highest values here for 0-4 year olds, 52.5% while its overall value for 0-14 year olds, at 46.4%, is slightly lower than Ekiti's rate of 47.8%. Kano also ranks high in this respect, with 44.4% of 0-14 year olds cut and 43.6% of 0-4 year olds.

Or one could take a more dynamic view and compare the rates of the 15 to 49 year olds of table 18.2 in DHS 2013with those of the young girls – and then either go for the states where progress has been most significant so as to quickly eradicate the cutting of girls entirely – or go for the states where least progress is visible, where the reduction in cutting rates from the "old" to the young is least pronounced, seen that they seem stuck in their old and harmful habits. There are also cases, Jigawa and Kano, where prevalence amongst the young is higher than amongst the older (39.4% for the 15-49 year olds in Jigawa, 40.9% for the same age bracket in Kano), indicating that the practice has been on the increase over the past 15 years.

A qualitatively different selection criterion would be to choose by the type of FGM/C. It could easily be argued that infibulation needs eradication more urgently than hymenectomy or clitoris "massage", even if the latter is done in a rather brutal way. In comparison to other types, infibulation – even in cases where the operation itself goes well – certainly has the most drastic consequences on the girl's future life.

Infibulation will need another kind of intervention. In no Nigerian state is it the dominant form of FGM/C. In Nasarawa 22.3 of all women who have been cut, have been infibulated. Kaduna

with 21.1% and Bayelsa with 20.1% are the only two other states where more than a fifth of cut women have suffered infibulation. If we calculate from table 18.2 of DHS 2013, then Kaduna has the highest rate of infibulated women between ages 15 and 49 – 5.3%. Abia follows with 4.3%, then come Bayelsa with 3.3% and Delta with 3.0%. Such a thinly spread practice will need another kind of campaign, with a more careful targeting, circumscribing/researching first of all where the infibulating communities reside.

Another selection criterion, qualitatively very different, is to rely on good and best practices: There are approaches that have worked and work and that are known to work. Let us continue with them, extend them to areas of similar culture/traditions/practices, if possible, though always adapting them to the specific local context.

You could build Nigeria's national strategy on and around any one of these selection criteria. The international consultant's personal feeling is that a combination would work best. Do something specifically against infibulation + go and work where it matters most, taking a dynamic view of the urgency of intervention + build on known good and best practices.

For the last point, hope is that the Joint Programme will build on existing strengths in its five intervention states. This will further refine existing good and best practices or help to invent new ones so that soon, others will be inspired by our approaches and will adapt our good and best practices to their target communities' specific needs and context.

An FGM/C Rating to measure the urgency of intervention

One of the products of the baseline study is a rating developed on the basis of the data collected by means of the quantitative survey. 34 variables were grouped into four subindices – Attitude and views of the respondents, Attitude and views of the "others", the Practice of cutting and Knowledge about FGM/C and participation in discussions about it. The four subindices, each within a range of zero to one hundred, together make up the overall index/rating – itself lying between a worst possible 0 and a best possible 100. This one resulting value is to give us a broad-based, profound, yet simple evaluation of the seriousness of FGM/C in a state. Please see the international consultant's final consultancy report of August 2015 for a full explanation of the rating.

Have a look at the results for the six states that participated in the baseline study – the five intervention states plus Lagos as a sort of control sample (SI stands for subindex):

Rating	Ebonyi	Ekiti	Imo	Lagos	Osun	Oyo	sample total
SI A - Knowledge of/participation in discussion about FGM/C	51,7	36,3	43,7	40,7	41,7	37,8	41,4
SI B - Attitude and views of self	60,9	37,1	52,4	53,0	43,1	41,6	49,7
SI C - Attitude and views of others	83,4	56,7	71,4	69,8	63,0	61,6	68,2
SI D - Practice of cutting	46,6	31,7	46,9	59,8	26,5	33,3	46,3
FGM/C Rating	**59,0**	**39,6**	**53,4**	**58,0**	**40,9**	**42,5**	**51,5**

Ebonyi State surprisingly came out top, beating Lagos by a bit and its fellow south-eastern state Imo a bit more clearly. Then rank, after something of a gap, the south-western states Oyo, Osun and Ekiti (in that order). We could, for example, decide to distribute available time, money and energy according to the rating results – Ekiti, being the worst touched by FGM/C, would benefit from more attention than the others, Ebonyi State, seen as the best off, would get less attention.

Let us turn to the rating itself. The table only gives us results for the six states and the sample total. But the rating has also given us results for the LGAs that participated in the baseline study. It could give us results for a single village or a whole nation or for all of Western Africa. Once we have the knowledge, meaning once we have collected the data, the rating model would give us a result for any clearly defined community, be it small or large – and it makes the small and the large comparable.

This rating could be trend-setting. The international consultant has, in 2014, created a similar *Index of Readiness for Public Declaration of FGM/C abandonment* in Eritrea, geared to their specific needs of knowing whether communities are ready for public declarations. But no other rating has so far been developed in an FGM/C context.

Note that the rating is not yet written in stone (that would be the case only if it was accepted as an international standard for inter-national comparisons), so that modifications could – and should – be made. Thirty four variables may be a bit much. Maybe some of the weights seem wrong. FGM/C specialists that understand a bit about mathematics and statistics should get together and discuss this.

Note also that the rating would be an excellent means for measuring impact. For this, baseline studies and after-intervention research would have to be conducted, asking all the questions that feed into our rating.

Standardised one page-community overviews in matters of FGM/C

In a similar vein, I would like to propose another standardisation. Any community – from the very big to the very small – could have its most relevant facts about FGM/C presented on one page – like you see on the following page.

The template has there been filled in for the entire six states that participated in the Joint Programme's baseline study, Ebonyi State, Ekiti, Imo, Lagos, Osun, and Oyo.

The one page-overview could also be done for a single village, an LGA, it has been done for the six baseline study states individually, and it could be done for the whole of Nigeria (some information would have to be summarised if dealing with such big communities, for example the left hand top quarter on public declarations or the bottom right hand information about media dealing with FGM/C).

Donors would love it. And anybody interested in the subject in the concerned area must be happy to have such concise and comparable information, focusing on all that is considered important by our state of the art Social Norms Theory.

You'll find on that one page:

- top centre, just under the title, the "old" FGM/C rate;
- top left: whether there is a law against the harmful practice, whether public promises/public declarations of FGM/C abandonment have been made by entire communities, whether influential people, traditional or religious or other authorities have spoken out publicly against the practice;
- top right: the rating result for the community and a radar chart representing the rating's four subindices;
- bottom left: a table willing vs. reluctant practitioners, contemplators, willing vs. reluctant abandoners; reluctant practitioners and contemplators may prove the most likely to be "converted" to abandonment;
- bottom right: all there is to know about communication about FGM/C: how much community members have already discussed the issue, how often it is raised by the media, etc.

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

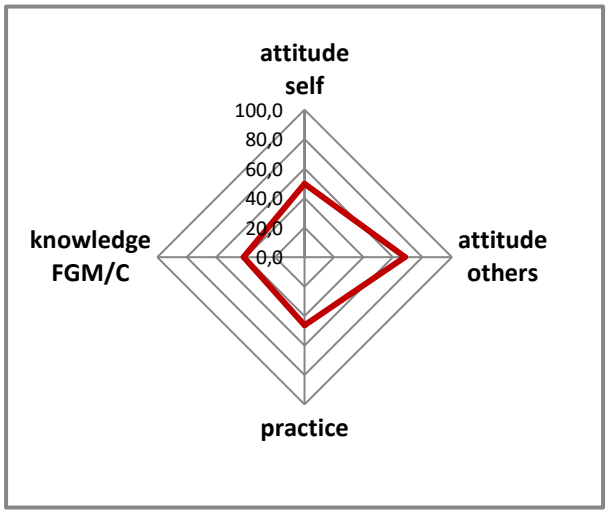
Traditional authorities: Iyalode of Osogbo/Osun, late Chief Bernice Alake Kolade J.P., Chief Rufus Falodu, Saade of Ijero kingdom/Ekiti (one of the kingmakers)

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% Contem plators	
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

The two tools – the FGM/C rating and the FGM/C overview – will make the planning and the strategising a lot easier – on the national as well as on the state level.

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) **– some comments**

Overall, the document is very pertinent and modern in approach, with FGM/C from the very start well framed as a question of girls' and women's rights.

Here are **three general points** before turning to more specific comments.

In the international consultant's eyes, a major improvement that would render Nigeria's anti-FGM/C activities much more performant concerns the apparatus itself. Committees are usually good at deliberating and at deciding. For doing, they need an executive branch. The document puts in place an organization that could be compared to the United Nations without Ban Ki-moon or rather without the United Nations Secretariat. Nigeria's anti-FGM/C apparatus would gain much if equipped with a **General Secretariat** or a Permanent Secretariat. However you'd call it, it should be a small agency, lean enough to be efficient and versatile – but institutionally well anchored i.e. equipped with clout. This also means sufficient financing from the state. The agency's head, the Permanent Secretary or Secretary-General, should rank as high as possible in state hierarchy. To prevent confusion of roles from the very outset, this agency's statutes should prohibit undertaking any grassroots activity whatsoever. The agency is to be coordinator, arbiter, lobbyist, and information broker – not at all implementer.

The document has been produced (with much assistance from outside) by the Ministry of Health. So it is natural that MoH concerns are in the foreground. But the question needs to be put at the very outset – and the document does not do so, it rather vacillates between a yes and a no: Do we want Nigeria's anti-FGM/C apparatus to be **anchored** in the Ministry of Health or do we want it to be more transdisciplinary, more intersectoral than that? The question is of great import, and there is no ready answer for it. Strategic considerations need to be taken into account – people who know the intricacies of Nigeria's politics and administration will decide. Anchoring the agency at the federal Presidency (possible state affiliates maybe at the Governor's Office) might mean higher visibility and more clout because of proximity to the big men. On the other hand, most institutional knowledge is presently concentrated in the Ministry of Health – and though such personnel would be most likely to be appointed Secretary-General and to other posts of the new agency wherever it is anchored, removing it from the health ministry may lead to a loss of feeling of ownership at the most concerned ministry and thus hinder the new agency's success from the start. Whatever decision is taken, the document should be as clear as possible about it.

The Plan of Action, which acts as the National Policy's draft **budget**, strangely does not add it all up. If I am not mistaken[3], the sum comes to 1.8bn naira[4] – 9m USD at current exchange rates. That is no little affair – best of luck! For available financial means, prioritisation will be essential. Dissipation of money and energy must be avoided at all cost – trying to do too much with too few means at one's disposal may end up in not achieving anything at all. **Concentrating** on less and doing it well (maybe also choosing where success is most likely – so that good publicity will make the word spread), **doing less and doing it well will have more impact**.

[3] There is a typo on p.46 – I have taken 5,00,000 to mean 500,000; also there is a figure missing on top of p.59

[4] 1,790,131,200 to be exact; integration of FGM/C into modules of school curricula does not seem to be provided for by the budget; conversion into USD at middle rate of 198.97 naira for 1 USD valid on 25 July 2015 according to http://themoneyconverter.com/

Specific comments

It may be a good idea to make a results chain **drawing** – this would make the logical coherence of the National FGM/C Elimination Plan more apparent. Inspiration from this may be taken from Annexes 1 and 2 where the Joint Programme New York has drawn its results chain, calling it theory of change diagram for the first drawing[5].

National Response to FGM/C (pp.13f): The list does not do justice to what has been done and what is being done against FGM/C in Nigeria. During the international consultant's three week field trip in Imo, Osun, Ekiti, Oyo and Lagos, he came across wonderful anti-FGM/C work (see below where concrete recommendations are made). A more appreciative presentation seems called for – even though much remains to be done, there is no question about that.

P.15: While the (short) Guiding Principles do not mention health at all, the Policy Goal (also p.15) frames the question almost entirely as a health issue. See the comments above about where to anchor Nigeria's anti-FGM/C agency.

Policy objectives and targets (pp.16f): Objective 1 "To reduce the prevalence of female genital mutilation in Nigeria" is the **impact**/goal, and **not a mere objective**. In logical structure it is thus superior to the other objectives.

Target 3 of objective 1 "Reduce proportion of women and girls undergoing FGM from 30% as reported in 2008 NDHS to less than 5% by 2017" makes the goal concrete. It is, unfortunately, **mathematically impossible**. Such a decrease is not in reach. And we already know, pretty much, what the FGM/C rate will be in 2017: In 2008, the overall rate was 29.6%, in 2013 it was 24.8%, and in 2017 it will be 22.5% - all you need to do to get there is to take the 45-49 year olds, the oldest age class (35.8% of whom are cut), out of the 2013 DHS calculation, and you add the 10-14 year old girls of that same DHS 2013 (17.8% of whom are cut)[6].

Almost everyone is cut at a very young age – of course, for an entirely exact result we'd have to know how many adolescent girls will have been cut by 2017 – but they won't be many, so the result won't change much. So we more or less[7] know the 2017 prevalence rate already – it will be about 22.5%.

A **meaningful target/indicator** should be referring to the girls who are going to be cut between now and 2017. Taking the 15.9% of the 0-4 year olds of DHS 2013 as a starting point/baseline, we could for example want to target halving this to 7.9%, or be more ambitious and try reducing it to 5%.

Target 5 of Objective 1 needs to be adapted – as the Joint Programme baseline results show, medicalisation in 2015 is far from having vanished from Nigeria.

Target 2 of Objective 2 "Reduce the proportion of women who support continuation of FGM from 22% to less than 2% by 2017" seems overambitious by far. DHS 2013 found 23.1% of women opting for continued cutting.

Target 1 of Objective 3, the federal VAPP bill, has been reached on time (2015). Somewhere amongst the targets of Objective 3, mention should be made of the application of the law(s).

[5] Note that this is not the Nigerian but the entire Joint Programme's results chain – thus "The prevalence of FGM/C is reduced in targeted areas of 17 countries" as impact/goal. Nigeria and Yemen have in 2014 been added to the programme as the 16th and 17th country, to participate in the second phase 2014-17.

[6] The calculation is a bit rough. I have no information as to the weight of the 10-14 year olds in overall society, so I have been assuming a growth rate between 15-19 and 10-14 that equals the growth rate between 20-24 year olds and 15-19 year olds in DHS 2013. Also, migration and other developments may slightly change the picture.

[7] Quality of data collection may also change. The Joint Programme baseline data collection yielded results that in some cases substantially differed from DHS 2013.

As for the **Implementation Strategies** (pp.18f), number 3 "Awareness creation and Sensitization" and number 6 "Behavioural Change Communication" should be put together. Number 4 "Educational Empowerment" could be considered a part of 3. And number 5, "Capacity Building", mostly comes in support of 3. So there is a hierarchy amongst these strategies.

Strategy number 7, "Skills Acquisition" has not worked in the past (it has been tried over and again, also within a substantial World Bank programme) – why should it work in the future? Cutting a clitoris is not a very difficult operation, and even if the traditional circumciser abandons, someone else can easily take her or his place. So **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.

Strategy 8 "**Male Involvement**" is important. Though FGM/C is a "women's thing", it is done "for men". The Joint Programme baseline study has revealed that they are the main "deciders" in matters of FGM/C – and this is true although they are often not even aware or informed – since the man is the head of the family, it is in the last resort he who decides – routine decisions may not need to be submitted to him. The most important targets of our sensitisation should, however, be the **grandmothers**, at least in Nigeria's South-East and the South-West. They are the ones carrying the social norm (see the international consultant's final consultancy report), they are the ones who, as members of a virtual community, are the guardians of the tradition of cutting girls.

Institutional Roles and Responsibilities (pp.20-30): there is a quite a bit of overlap between advisory and technical committees.

Research (p.31): The fifth and last priority should be underlined: **best practices** need to be identified, researched, knowledge about them spread wide and far.

Monitoring and Evaluation (pp.31f): to aim for M&E everywhere & always (well "periodically," but what it means is continually) may be overambitious. Setting standards (the first paragraph mentions the development of indicators for the NHMIS) may be much more achievable – and a very important first step (see above for suggestions for the rating and the one page-survey).

If, to conclude this section about the Nigerian National FGM/C Policy Draft, the document is examined with the eyes of the Joint Programme requirements (see Annexes 1 and 2[8]), then a fundamental similarity of approach can be diagnosed with all the elements essentially in place. The Joint Programme's diagram and table are probably more appetising, more easily digestible ways of presenting a complex issue, but content is essentially similar. Note that the Joint Programme has divided the FGM/C issue in three: 1) politico-administrative support including the law, 2) service provision, and 3) norm change by individuals, families and communities. In combination, these three are to effect a reduction of prevalence and eventually the elimination of the harmful practice altogether.

As a final remark it should be noted that, where FGM/C abandonment is concerned, amongst these three – politics/administration/law, service providers, 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 abandoners.

Getting concrete with the recommendations

The following recommendations are based on good and best practices identified during the international consultant's field work in Nigeria's capital and in the Nigerian South-East and South-

[8] [8] taken from: 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 resp. pp.13f

West[9]. Quantitative data were collected in the six baseline study states after this. For analysis and interpretation of these quantitative data see the international consultant's final consultancy report of August 2015 and the six state reports written by the state consultants.

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[10];

Lobby/advocate the new Senate and House of Representatives for funds for activities against FGM/C[11];

Lobby/advocate for making the FGM/C part of the VAPP (Violence Against Persons Prohibition) Act as widely known as possible[12];

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[13]; 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 …)[14];

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.

[9] 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.
[10] Possible lead: Dr Jude Ohanele of Development Dynamics, Owerri
[11] 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)
[12] 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)".
[13] 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)
[14] 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[15];

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[16];

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[17], leading up to community resolutions/public declarations, if possible;

Sensitise youths = those who will soon have their daughters cut – or not[18]; train youth croppers on FGM/C before they are sent to the field[19];

[15] 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.

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

[17] 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

[18] 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[20], focussing pregnant women, newly-weds and grandmothers (can someone take over the late Iyalode of Osogboland's grandmother association?[21]);

Community birth attendant sensitisation[22], 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;

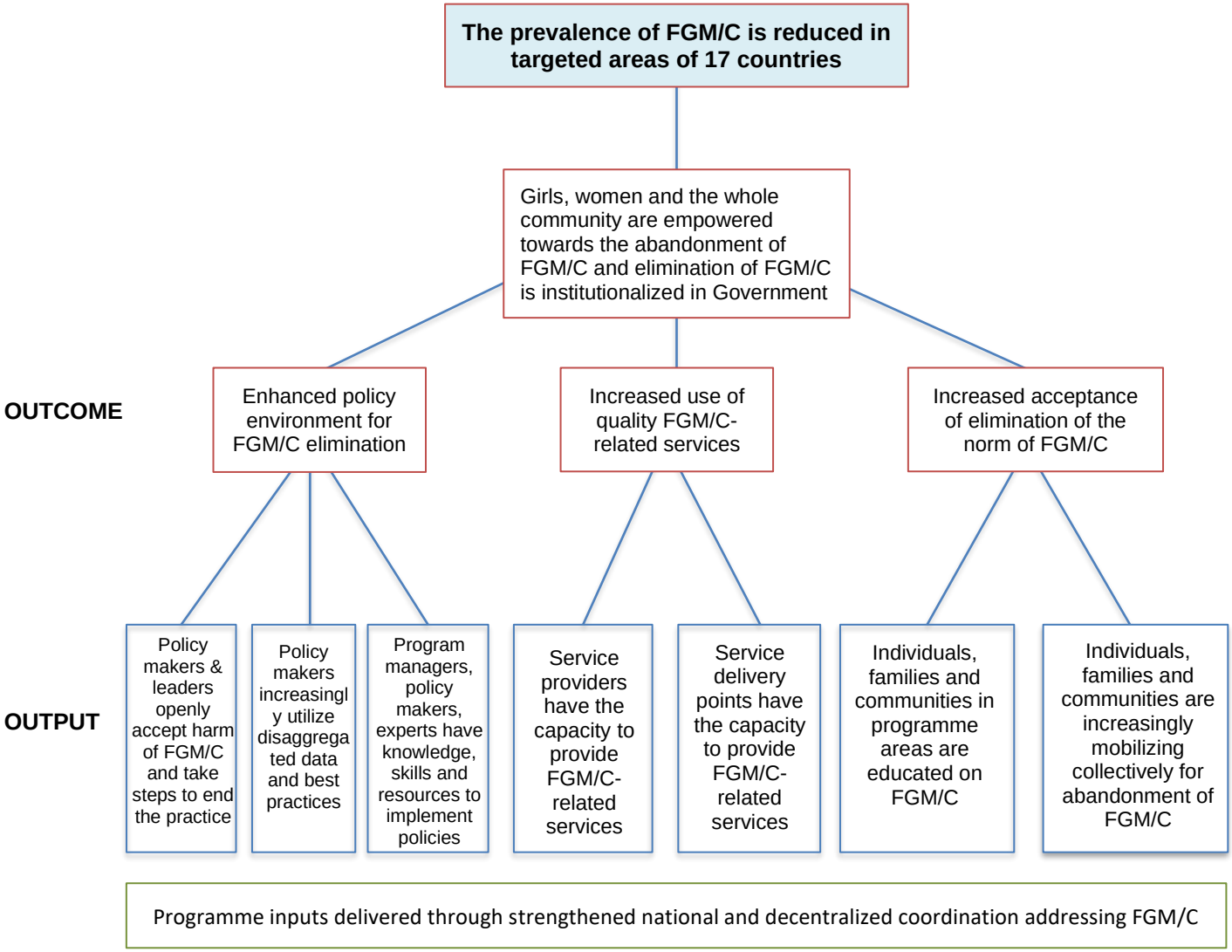
Involve circumcisers, sensitise them – they must certainly not be excluded from dialogue and communication – and a turned-around circumciser can be one of the most convincing anti-FGM/C activists; but DON'T engage in large-scale retraining measures: they have not worked in the past, why should they work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

[19] Lead: Ms Rita Ilevbare, Executive Director of the Gender Relevance Initiative Promotion (GRIP) in Ado Ekiti
[20] 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
[21] 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
[22] Lead: Ms Muibat Lawal Adegoke, Chairperson of Association of Community Birth Attendants and Voluntary Health Workers of Nigeria, Oyo State chapter

Annex 1: A "Theory of Change" depiction of the programme logic of the Joint Programme, phase II[23]



[23] 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

Annex 2: Joint Programme, phase 2, Result chain – goal, outcomes, outputs and indicators[24]

The result chain and specific indicators

Goal	**Prevalence of FGM/C is reduced in targeted areas of 17 countries by the end of 2017 in line with UNGA Resolution 69/150** **INDICATORS** **1. 40% decrease in prevalence among girls 0-14 years in at least 5 countries** **2. One country declaring total abandonment by the end of 2017**

Outcome 1	**Indicators**
Programme countries enact legal and policy frameworks for eliminating FGM/C which are appropriately resourced and implemented (in line with AU and UN Resolutions)	1. Number of countries implementing a comprehensive legal and policy framework to address FGM/C
	2. Number of countries with budget line to implement legislation and policies to eliminate FGM/C
Outputs	**Indicators**
1.1 Policy makers mainstream the commitment to end FGM/C throughout Government	a. Number of public policy statements (including bills, policies, plans of action) on record by policy makers, politicians, and traditional leaders at national and decentralized levels
1.2 Policy makers increasingly utilize disaggregated data and best practices to enforce law and implement evidence based programmes to progressively eliminate FGM/C	a. Number of Joint Programme reports available and disseminated to policy makers and leaders on evidence, policy, costing related to programmes (including disaggregated data analysis) b. Number of cases of enforcement of the FGM/C law (sub-indicators: # of Arrests, # Cases brought to court, # convictions and sanctions)
1.3 Program managers and experts have capacity to implement the national and decentralized policies to end FGM/C in a coordinated way	a. Number of programme managers and experts trained in evidenced based programming on FGM/C b. Number per month of national and decentralized coordination meetings that address efforts to eliminate FGM/C (or other responsible committees)
Outcome 2	**Indicators**
Service providers provide timely, appropriate and quality services to girls and women at risk of or having experienced FGM/C in select districts in programme countries	1. Number of girls and women receiving services related to FGM/C prevention or response

[24] 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, pp.13f

Outputs	Indicators
2.1 Service providers have the capacity to provide FGM/C-related services	a. Number of service delivery points with at least 1 provider trained by the Joint Programme a. Prevention services b. Protection services c. Provision of care services
2.2 Service delivery points have the capacity to provide FGM/C-related services	a. Number of service delivery points that are applying tools (curricula, modules, guidance, guidelines supervision/case management forms) developed by the Joint Programme b. Number of management information systems reporting FGM/C related indicators to national databases

Outcome 3	Indicators
A majority of individuals, families and communities in programme areas accept the norm of eliminating FGM/C	1. Number of communities making public declarations of abandonment of FGM/C
	2. Degree of shift in the social norm upholding FGM/C in programme areas (composite indicator composed of: 1. % of individuals not supporting continuation, 2. % of individuals who believe others will cut and 3. % of individuals who believe they will be sanctioned if they do not cut.)

Outputs	Indicators
3.1 Individuals, families and communities in programme areas are increasingly educated about the harms and norms related to FGM/C and alternatives the practice	a. Proportion of population [girls/boys/women/men] in targeted areas who participate regularly in educational dialogues promoting abandonment of FGM/C in school, out of school, in adult learning programmes
3.2 Individuals, families and communities are increasingly mobilizing collectively to abandon FGM/C	a. Number per month of community-to-community outreach events in programme areas to expand the abandonment of FGM/C b. Number per month of outreach events conducted by service providers in the community about prevention, protection and care services c. Number and types of media coverage of FGM/C elimination efforts d. Number of consensus-building activities with traditional, religious and community leaders towards organizing a public declaration

Annex 3: List of people met – in chronological order – by the international consultant in Abuja and during his field research in Imo, Osun, Ekiti and Oyo from 23/1/2015 to 25/2/2015 (please forgive orthographic mistakes should they 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, FGC 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 FGC 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 FGC 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)