CENTER FOR REPRODUCTIVE RIGHTS

WOMEN ADVOCATES RESEARCH AND DOCUMENTATION CENTRE

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Report on Nigeria's Compliance with its Human Rights Obligations in the Area of Women's Reproductive and Sexual Health

Submitted by:

Center for Reproductive Rights, New York, U.S.A.

Women Advocates Research and Documentation Centre, Nigeria

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In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center for Reproductive Rights (the Center), a non-profit legal advocacy organization dedicated to promoting and defending women's reproductive rights worldwide, and Women Advocates Research and Documentation Centre (WARDC), a national non-governmental organization based in Nigeria, present this submission as non-governmental stakeholders. This submission aims to supplement the report of the government of Nigeria, scheduled for review by the Human Rights Council during its 17th session.

I. Introduction

International human rights law requires that states parties protect the reproductive and sexual health rights of women and girls. Nigeria is a party to multiple human rights treaties that protect these rights;[1] however, it has failed to meet many of its treaty obligations with respect to sexual and reproductive rights. The Center and WARDC urge the Human Rights Council to closely examine the following issues with respect to Nigeria: 1) access to quality maternal health care and family planning services and information; 2) access to safe abortion and post-abortion care services; 3) inadequate HIV treatment and prevention; 3) sexual and physical violence against women and girls; and 4) the harmful practices of early marriage and female genital mutilation.

II. Key Issues

A. Normative and Institutional Framework

In its 2004 and 2008 concluding observations, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) called upon Nigeria to domesticate the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[2] Various states parties further underlined the need for domestication of CEDAW in their recommendations pursuant to Nigeria's 2009 Universal Period Review.[3] The African Commission on Human and People's Rights has echoed the concerns about the absence of "concrete legislation at the national level" despite Nigeria's ratification of regional and international human rights treaties on the rights of women.[4] Nigeria has yet to domesticate CEDAW; opposition about traditional gender roles and reproductive rights hinders the adoption of a bill to domesticate the CEDAW Convention.[5]

B. Right to Reproductive Health Services and Information

1. Maternal Health

In 2008, the CEDAW Committee expressed concern over the "very high maternal mortality rate" in Nigeria and regretted that there had "been no progress in reducing the maternal mortality rate" since Nigeria's 2004 periodic report. The CEDAW Committee noted that there was insufficient access to health care services for women and girls, and called upon the state to improve access to affordable health services.[6] The Committee on the Rights of the Child (CRC Committee) has echoed concerns about high rates of maternal mortality,[7] and the African Commission on Human and People's Rights has expressed concern about high rates of maternal mortality, especially in the Northern region.[8] Despite the Committees' concerns and recommendations, Nigeria continues to have one of the ten highest maternal mortality ratios (MMR) in the world, with 630

maternal deaths per 100,000 live births.[9] Nigeria's 2010 MMR remains substantially higher than it was in 1990.[10] Nigeria has the second-highest number of maternal deaths globally.[11]

The high rate of maternal mortality results in part from poor quality and insufficient access to antenatal care. More than one third of Nigerian women do not receive any antenatal care, with rural and poor women the least likely to receive antenatal care.[12] Nearly 40% of Nigerian women give birth with no skilled-birth attendant,[13] and only 11% of the poorest Nigerian woman had a skilled-birth attendant present at their labor.[14]

Government efforts to improve maternal health have been ineffective.[15] The Midwives Services Scheme (MSS) was launched in December 2009 to mobilize midwives in rural communities, but results from the first year were uneven geographically.[16] The health care facilities in the Northeast and Southeast saw no improvement in MMR during the first year.[17] The program faces challenges navigating between federal, state and local authorities, insufficient government commitment and maintaining sufficient qualified personnel.[18]

Access to reproductive health and rights receive broad protection under human rights treaties. Art 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[19] The Committee on Economic, Social and Cultural Rights (ESCR Committee) has explicitly confirmed that "[t]he realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[20] Further, the ESCR Committee has asserted that states parties are required to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning . . . emergency obstetric services and access to information, as well as to resources necessary to act on that information."[21] States parties to CEDAW also have an obligation to ensure women have access to appropriate services, including "granting free services where necessary."[22] The CEDAW Committee has reiterated that this duty includes taking appropriate budgetary and economic measures to ensure women can realize their right to health care. The Committee has specifically noted that high fees are a financial barrier to health care that violates women's right to health care.[23]

Nigeria, however, has not met the obligation to ensure access to affordable health care. Nigerian women who attempt to access public or private health services face financial and practical barriers.[24] The system of user fees[25] prevents low income women from receiving antenatal and intra-partum care. Women have been physically detained if they are unable to pay.[26] Further, while Nigerian policy requires that blood donation be voluntary, compulsory spousal blood donation continues to present obstacles to health care. Nearly all Lagos-area public hospitals require husbands of antenatal patients to donate blood.[27] Those who cannot afford to pay user fees and whose spouses refuse to donate blood, or who cannot because they are unmarried, are denied care.[28]

2. Access to Family Planning Information and Services

Family planning services and information are critical to reduce maternal mortality. Without contraceptive services, women may experience unwanted pregnancies, and may seek unsafe

abortions[29] that can result in complications or death.[30] Insufficient access to contraceptives affects women's right to control their fertility, to decide whether to have children and the number and spacing of children, and to protect themselves against sexually transmitted infections (STIs).[31]

The CEDAW Committee has repeatedly urged the Nigerian government to increase access to family planning health care services. It has called upon Nigeria "to increase access to affordable means of family planning for women and men,"[32] advised it "to improve the availability and affordability of sexual and reproductive health services, including family planning information and services,"[33] and recommended that Nigeria adopt "measures to increase knowledge of and access to, affordable contraceptive methods, so that women and men can make informed choices about the number and spacing of children."[34] However, in a recent survey of Nigerian experts asked to rank the family planning program's effectiveness, the program scored only 34%.[35] While the government has recently announced increased funding for family planning services,[36] the family planning program faces challenges of misinformation, supply and training. In some states, resistance to contraceptives stems from the fear caused by misinformation that it might render users infertile.[37]

Apart from lack of education, clinics report difficulty maintaining supplies of the preferred forms of contraceptives.[38] In rural areas, where women have to travel great distances to the nearest health care facility, the contraceptive injection, which will last for several months, is the most preferred, but clinics report shortages.[39] Over the course of six-months in 2011, less than half of Nigerian contraceptive Service Delivery Points (SDPs) report never having been out of stock of one or more modern contraceptive methods,[40] and a UNAIDS survey indicates that "most contraceptives are approaching a state of undersupply or are in a state of undersupply at stores and SDPs."[41] Cost is a further barrier to access. Only 7% of Nigerian women report obtaining contraceptives for free.[42] Of those women who reported the cost of contraceptives, the median paid 119 Naira (or approximately USD 0.76), which considering almost 100 million people in Nigeria live on less than a dollar a day is very high.[43]

While the use of modern contraceptives has increased globally, Nigeria has seen little improvement in contraceptive use.[44] Only 14% of Nigerian women use any form of contraception,[45] and fewer than 10% of married women use modern contraception.[46] Among unmarried, sexually active women, only 33% use modern contraception.[47] Usage rates drop dramatically amongst poor and rural women.[48] Access to reproductive health services is especially difficult for adolescents.[49] Despite high rates of adolescent pregnancy,[50] the health care system has had a "tepid and ineffective" response to the needs of young people.[51] Although 47% of Nigerian women give birth by age 20,[52] staff at health care facilities are less likely to discuss family planning services with women ages 15 to 19, than with women ages 20 to 39.[53]

Low rates of contraceptive use, however, are not indicative of demand. More than one quarter of Nigerian women between the ages of 15 and 49 have an unmet need for effective contraception.[54] Among married women, unmet need is 20%,[55] and estimates of unmet need among unmarried women range from one third to one half.[56] The high rate of unmet need leads to a high occurrence of unplanned and unwanted pregnancies.[57] Eleven percent of all pregnancies are mistimed or unwanted,[58] and one-third of Nigerian women have had an unplanned

pregnancy.[59] While Nigeria's report for its 2009 Universal Periodic Review was silent on its commitment to ensuring access to contraceptives,[60] Nigeria's 2011 submission to the Africa Commission, noted the government's commitment to improve contraceptive prevalence, citing the 2005 National Policy on Population for Sustainable Development's goal of increasing contraceptive prevalence rates by two points per year.[61] Despite this commitment, Nigeria has seen little improvement in contraceptive use.[62] Improved access to contraception, subsidization of services and counseling to aid women in choosing methods would mitigate the rates of unplanned pregnancies.[63]

Access to reproductive health services includes making information and education available. The provision of "education and access to information concerning the main health problems in the community" is one of the obligations of states parties to the ICESCR.[64] The ESCR Committee has stated that "accessibility includes the right to seek, receive and impart information and ideas concerning health issues."[65] The Committee has specifically indicated that states parties are required to undertake measures to ensure access to reproductive health information[66] and must remove barriers to sexual and reproductive health education and information. [67] In its 2010 Concluding Observations on Nigeria, the CRC Committee recommended that the government "[i]ntroduce sex education for boys and girls in the school curricula and undertake sensitization programs at community level on reproductive health and rights."[68] However, only 13% of women obtain information on family planning from schools or community leaders.[69] Nigeria has implemented sexuality education programs in Lagos and Abuja states,[70] but most Nigerian schools do not teach family planning or sexuality education, even though it is included in school curricula.[71] Further, parents and other stakeholders frequently withhold information on reproductive health and sexuality from adolescents due to traditional and socio-cultural beliefs.[72]

3. Access to Abortion and Post-Abortion Care and Unsafe Abortion

Despite recommendations from treaty monitoring bodies to reform and modify its restrictive abortion laws,[73] Nigeria continues to criminalize abortion except to save a woman's life.[74] Outside of this narrow exception, women who procure an abortion, persons who aid an abortion and persons who supply any material used to procure an abortion are subject to imprisonment.[75] Although the Human Rights Committee has underscored the importance of access to abortion in cases of rape,[76] the Nigerian abortion law provides no exception for rape, nor does it provide for exceptions for incest or health.[77]

The high rate of unwanted and unplanned pregnancies increases the number of abortions and exposure to unsafe abortion—nearly half of all unplanned Nigerian pregnancies end in abortion.[78] One in seven Nigerian women ages 15 to 49 have tried to obtain an abortion, either from "unqualified practitioners or by qualified ones working under substandard medical conditions."[79] The restrictive abortion law means most abortions are clandestine and "very frequently unsafe."[80] As a result, one quarter of all Nigerian women who have had an abortion report moderate or severe complications,[81] and two thirds of women who have an unsafe abortion experience serious health consequences.[82] Even where a woman obtains a legal abortion at a health care facility, inadequate staffing, training and equipment expose women to unnecessary risks.[83] Among those who have an abortion performed by a physician, a large number sought hospital care, indicating that the performing physician was not well-trained in abortion services.[84] Few general practitioners receive training to perform abortions. [85] In its 2006

report to the CEDAW Committee, the Nigerian government estimated that 34,000 women die annually from unsafe abortions.[86] The Human Rights Committee has acknowledged the direct connection between unsafe abortion and high maternal mortality and now requires reporting states to inform the Committee of measures taken to prevent unwanted pregnancies and to ensure women do not "undergo life threatening clandestine abortions."[87]

Nigeria's abortion law also discriminates against poor, rural and young women who cannot afford the cost of a safe abortion.. Because poor and rural women are less likely to have an abortion performed by a skilled practitioner, they experience severe health consequences at higher rates.[88] The burden on poor women is compounded by the large fees for post-abortion treatment.[89] In a country where about 70% on less than USD 1 a day, the average post-abortion patient pays USD 95 for treatment.[90]

4. Services for Sexually Transmitted Infections, Including HIV/AIDS

ICESCR obliges states parties to protect the right to enjoyment of the highest attainment standard of physical and mental health.[91] It explicitly states that this obligation includes taking steps necessary to prevent, treat and control epidemic diseases.[92]

Approximately 4% of the Nigerian population is living with HIV.[93] Women constitute nearly 60% of persons over 15 years-old living with HIV. [94] Between 2001 and 2009, the number of women living with HIV increased by more than 20%.[95] The CEDAW Committee has expressed concern about high rates of HIV/AIDS among Nigerian women and girls,[96] and recommendations from Nigeria's 2009 Universal Period Review reiterated this concern.[97]

Despite the disproportionate rates among women, only 23% of women have a comprehensive knowledge of HIV/AIDS, including prevention.[98] The CEDAW Committee has recommended Nigeria implement policies and programs to combat HIV/AIDS and campaigns to enhance women's knowledge of health issues, with a special focus on STIs and HIV/AIDS.[99] The CRC Committee has further highlighted the need for education and information on HIV/AIDS, recommending that the government "strengthen awareness of HIV/AIDS prevention among adolescents, including through sex education in school . . . and other public awareness campaigns."[100] However, Nigeria's programs to address the HIV/AIDS epidemic have an inadequate gender-based approach,[101] and "minimal progress has been made in addressing the human rights and legal issues surrounding HIV/AIDS."[102]

Beyond prevention, the government must focus on treatment of those living with HIV. In multiple Concluding Observations, the Human Rights Committee has urged states parties to ensure access to adequate antiretroviral treatment.[103] However, of the 3.4 million Nigerians living with HIV,[104] only 26% of adults needing treatment receive antiretroviral therapy,[105] and only 7% of children who need treatment receive it.[106] Further, discrimination and stigmatization of people living with HIV/AIDS is a continuing problem in Nigeria. Workplace stigma and discrimination are persistent.[107] A 2011 nationwide survey found that amongst women, less than 10% have an accepting attitude toward persons with HIV/AIDS.[108] Discrimination against persons with HIV/AIDS violates international human rights. Multiple UN treaty monitoring bodies have reiterated the importance of preventing discrimination against persons with

HIV/AIDS, and have specifically expressed concern about discrimination against women living with HIV/AIDS.[109]

C. Right to Be Free from Discrimination, Including Gender-Based Violence

1. Physical and Sexual Violence against Women

Physical and sexual violence against women and girls is a persistent problem in Nigeria. Twenty-eight percent of women experience physical violence after the age of 15.[110] Although reports indicate only 6 to 9% of women have been victims of sexual violence,[111] the actual rate of victimization is much higher given under-reporting. In Lagos state, only one in five victims reported the offense to the police.[112] A large number of those abused are victimized by their intimate partner. The 2008 Nigeria: Demographic and Health Survey found that 18% of all Nigerian women had experienced physical or sexual violence at the hands of their husband or partner within the previous twelve months.[113]

Rape and sexual violence often go unpunished because of social stigma placed on the victim.[114] Where victims do attempt to bring charges against their aggressor, they face laws that are inadequate and outdated.[115] For example, the Penal Law, applicable in the North, defines rape in a way that limits recourse for women and girls who are raped by a foreign object or who were penetrated orally or anally.[116] Under the Criminal Code, charges of rape of a girl under 13 years old must be brought within two months of the rape.[117] Differences in federal, state, Sharia and customary legal systems also undermine a woman's ability to seek redress.[118] The Federal Constitution does not specifically prohibit rape, and the Northern Penal Code and the Southern Criminal Code set out different definitions of rape and different punishments, creating discrepancies within the country.[119] The Criminal Code defines rape as "carnal knowledge" without consent, implying any type of penetration; thus, women in the South have greater protection than their Northern counterparts.[120] Further, some laws make redress practically impossible: Sharia law requires a witness to the rape.[121]

Of those women who reported experiencing sexual violence, over 40% were abused for the first time before age 19.[122] Reports indicate that sexual violence is common in schools.[123] The opportunity for sexual favors is regarded by male teachers as "a privilege of their position."[124] Some teachers in training are taught that sexual abuse is normal.[125] Sexual violence in public institutions is not limited to schools. Amnesty International reports there is impunity for state actors, including police officers and other members of the security forces, especially the military, who commit rape and other sexual violence.[126]

Despite the high rates of physical and sexual abuse, Nigeria has not complied with the CEDAW Committee's recommendation to "enact comprehensive legislation on all forms of violence against women, including domestic violence."[127] The Elimination of Violence in Society Bill,[128] proposed in 2006, which targets social violence especially against vulnerable groups like women and children,[129] and the Violence Against Persons (Prohibition) Bill, proposed in 2011, which criminalizes physical and sexual violence against women and girls at the national level,[130] have not been enacted by the Federal legislature.[131]

2. Early Marriage

The Convention on the Rights of the Child (CRC) imposes on states parties the obligation to abolish practices detrimental to the health of children,[132] including early marriage.[133] Early marriage violates autonomy and jeopardizes girls' rights to health and education.[134]

In its 2010 observations on Nigeria, the CRC Committee expressed concerns about the "extremely high prevalence of early marriages among girls in the northern states," and urged the state to "take prompt measures to address the practice of early marriages in the northern states."[135] Nigeria has failed to address these rates in the intervening years.[136] Although Nigeria passed the Child Rights Act, which sets 18 as the minimum age for marriage and imposes criminal sanctions,[137] it has only been promulgated in 24 of the 36 states.[138] All but one of the Northern states, where early marriage rates are significantly higher, have failed to pass or enforce the law.[139] Forty percent of Nigerian women are married or live with a man, and are considered married, before the age of 18.[140] Among the poorest households this rate skyrockets to 68%.[141] In the North, more than half of girls are married by 16 and bear their first child within a year of marriage.[142]

Early marriage creates significant health and developmental risks for girls. Complications from pregnancy and child birth are the primary causes of death among girls ages 15 to19 in developing countries.[143] Beyond the immediate health risks, marriage is often the reason girls drop out of school.[144] "Child marriage robs girls of their girlhood, entrenching them and their future families in poverty, limiting their life choices, and generating high development costs for communities."[145]

3. Female Genital Mutilation

Nigeria's obligations under the CRC include abolishing the practice of female genital mutilation or cutting (FGM).[146] The African Commission on Human and People's Rights has expressed concern about the absence of legislation prohibiting FGM, and has recommended that the state adopt such legislation at the federal level.[147] While a number of states in the country have implemented laws banning FGM,[148] implementation and enforcement have been a challenge,[149] and there is no federal law banning or criminalizing the practice. The WHO estimates that 29.6% of all Nigerian women have undergone FGM.[150] In the Southeast and Southwest the rates skyrocket, 50.4% and 60.7% of females are victims of FGM respectively.[151]

Not only is FGM a violation of human rights,[152] but it also poses serious health risks. FGM can lead to infertility, childbirth complications and stillbirth, among other long-term health consequences.[153] Research indicates that FGM decreases a girl's lifespan and the associated health care costs can be a serious financial burden.[154]

III. Cooperation with Human Rights Mechanisms

The Center and WARDC commend the Nigerian government's collaboration with United Nations bodies, including UNAIDS[155] and United Nations Population Fund (UNFPA),[156] but they remain concerned about the failure to implement recommendations made repeatedly by the CEDAW Committee, the CRC Committee and other treaty monitoring bodies.

Nigeria has ratified seven of the major international human rights instruments,[157] but has not yet fully incorporated its international obligations into domestic law. The CEDAW Committee has repeatedly noted with concern the failure to domesticate CEDAW, a concern echoed in Nigeria's 2009 Universal Period Review.[158] The CRC Committee has expressed concern that federal, state and local legislation does not fully comply with the provisions and principles of the CRC.[159] While the CRC Committee has welcomed the passage of the Child Rights Act by the federal legislature, it has urged the government to ensure those states that have not adopted the Act do so.[160]

In its 2009 report to the Universal Period Review, the Nigeria government stated its commitment to ratify, sign or domesticate outstanding United Nations human rights instruments and protocols.[161] However, Nigeria has not fulfilled this pledge. It has yet to ratify several international human rights treaties, including the International Convention on the Protection of all Migrant Workers and their Families, the Convention on the Rights of Persons with Disabilities and the International Convention for the Protection of All Persons from Enforced Disappearance.[162] The CEDAW Committee and the Committee on the Elimination of Racial Discrimination have called upon the Nigerian government to ratify these conventions.[163]

IV. Best Practices

The Center and WARDC acknowledge that the Nigerian government has taken some steps to reduce maternal mortality, including the provisions of commodities aimed at managing obstetric hemorrhage, pre-eclampsia and eclampsia, and the distribution of midwifery kits.[164]

The Center and WARDC welcome the October 2012 "Saving One Million Lives" initiative that aims to expand primary health care access for women and children,[165] and look forward to seeing how the program will be implemented. We further anticipate expansion of the MSS aimed to mobilize midwives in rural communities.[166]

V. Questions

Taking into account the CEDAW and the CRC Committee's recommendations and the recommendations from Nigeria's previous Universal Periodic Review, we respectfully suggest the following questions during the dialogue with the Nigerian government:

1. What concrete measures does the government propose to reduce the high maternal mortality rate in accordance with the CEDAW Committee's 2008 and 2004 concluding observations? Does the government intend to allocate more resources to the health sector as recommended by the CEDAW Committee in its 2008 concluding observations and the CRC Committee in its 2010 concluding observations? What steps has the government

taken to eliminate financial barriers, including compulsory spousal blood donation, to maternal health services?

2. What steps is the government taking to ensure access, especially among adolescents, to sexual health services and affordable contraceptive methods in keeping with recommendations by the CRC Committee in its 2010 concluding observations and obligations as described by the ESCR Committee's General Comment 14?

3. What steps will the government take to improve access to safe and legal abortion and reduce the number of unsafe abortions as recommended by the CEDAW Committee in its 2008 concluding observations and the CRC Committee in its 2010 concluding observations? How will the government address the disproportionate rates of unsafe abortion among poor women?

4. How is the government addressing the 2009 Universal Period Review Recommendation and the CEDAW Committee's 2008 concern about disproportionate impact of HIV/AIDS on women and girls? What efforts are underway to improve knowledge about HIV/AIDS and access to prevention and treatment in fulfillment of obligations under the ICESCR?

5. What measures are been taken to address the CRC Committee's 2010 concluding observations' concern that child marriage be reduced, especially in the North? Are steps being taken to implement the Child Rights Act in Northern states as recommended by the CRC Committee in 2010?

6. What steps are being taken to implement legislation to protect women from gender-based violence in accord with the CEDAW Committee's 2008 recommendation? How is the government addressing the high rate of sexual violence in schools?

7. What measures are being taken to end the practice of FGM as recommended by the CRC Committee in 2010? What health care services are being provided to women who have already undergone FGM?

VI. Recommendations

We respectfully suggest the Human Rights Council consider making the following recommendations:

1) Nigeria should domesticate the Convention on the Elimination of all Forms of Discrimination against Women in compliance with recommendations from the 2009 Universal Period Review, the 2004 and 2008 CEDAW Committee recommendations and the 2010 CRC Committee Recommendations.

2) Nigeria should address its high maternal mortality rate, including by allocating adequate resources and improving the health infrastructure, particularly at the primary level, as mandated by the recommendation of the CRC and CEDAW Committees.

3) The government should consider the impact of its abortion law on the country's maternal mortality rate as recommended by the CEDAW Committee in 2004 and 2008

and the CRC Committee's recommendation in 2010, and take adequate steps to improve access to safe and legal abortion.

4) The government should undertake effective and sustainable measures to increase knowledge of, and access to contraceptive methods, in accordance with the CEDAW Committee's recommendations in 2008 and the ESCR Committee's General Comment Number 14.

5) Nigeria should undertake to follow the CRC and CEDAW Committees' recommendations to take concrete steps to prevent further spread of HIV/AIDS and ensure women and girls receive complete and accurate information about prevention and treatment.

6) Nigeria should implement the African Commission and the CRC Committee's recommendations to undertake measures to end traditional harmful practices, including the practice of early marriage and FGM.

7) Nigeria should follow the CEDAW Committee's recommendations and implement legislation prohibiting gender-based violence, and should adopt policies to prevent sexual violence, especially in schools.

We hope this information is useful during the Universal Period Review of the Nigerian government's compliance with its human rights violations.

If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

Onyema Afulukwe

Onyema Afulukwe
Legal Adviser for Africa
Center for Reproductive Rights

Abiola Akiyode-Afolabi
Executive Director
WARDC

[1] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 2979, G.A. Res. 34/189, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 2, 1981) (ratified by Nigeria June 13, 1985) [hereinafter CEDAW]; International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (accession by Nigeria on July 29, 1993) [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights [hereinafter ICESCR], *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) (accession by Nigeria on July 29, 1993) [hereinafter ICESCR]; African Charter on Human and People's Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (ratified by Nigeria on June 22, 1983).
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[4] African Commission on Human and People's Rights (ACHPR), *Concluding Observations and Recommendations on the Third Periodic Report of the Federal Republic of Nigeria* (44th Ordinary Sess.), para. 23 (2008).
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