



May 11, 2010

The Committee on the Rights of the Child

Re: Supplementary information on Nigeria scheduled for review by the Committee on the Rights of the Child during its 54th Session

Distinguished Committee Members:

This letter is intended to supplement the combined third and fourth periodic report submitted by the Federal Republic of Nigeria, which is scheduled to be reviewed by the Committee on the Rights of the Child (the Committee) during its 54th session. The Center for Reproductive Rights, (the Center) an international non-governmental organization, and Women Advocates Research and Documentation Centre (WARDC), a national non-governmental organization based in Nigeria, hope to further the work of the Committee by providing independent information concerning the rights protected under the Convention on the Rights of the Child (the Convention). This letter highlights several areas of concern regarding the status of the reproductive health and rights of girls and adolescents in Nigeria, with a focus on access to reproductive health services and information and freedom from gender-based violence.

Sexual and reproductive rights are fundamental to adolescents' rights to life, health, and equality and nondiscrimination and receive broad protection under the Convention. For example, Article 6 recognizes that "every child has the inherent right to life" and requires states to "ensure to the maximum extent possible the survival and development of the child."¹ Article 24 similarly recognizes the right "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health," and requires states to take appropriate measures "to develop... family planning and education services," "ensure appropriate pre-natal and post-natal health care for mothers," and take all appropriate measures to abolish practices harmful to children.² Moreover, Article 3(2) requires each state to "take all appropriate legislative and administrative measures" to ensure the protection and care of children, necessary for their well-being.³ Article 19 requires states to take actions to protect children from all forms of physical, mental, and sexual abuse⁴ and Article 34 aims to protect children from all forms of sexual abuse and exploitation.⁵ Finally, Article 17 requires states to ensure that children have access to a diverse range of information, including health-related information.⁶ Yet, despite these protections, the reproductive rights of girls and adolescents in Nigeria continue to be neglected and, at times, blatantly violated.

Approximately 53% of Nigeria's total population of over 140 million people⁷ is 19 years of age or younger and 20% of its population are adolescents between the ages of 10 and 19.⁸ Despite the great number of young people reaching reproductive maturity, preconceived notions about adolescent sexuality have led law and policy makers to largely ignore adolescents' specific sexual and reproductive health needs, rendering adolescents vulnerable to a host of health problems and harmful practices. Laws, policies, and programs specifically tailored to adolescents' sexual and

reproductive health needs are necessary to protect and promote their fundamental rights to life, health, self-determination, equality and nondiscrimination, and to be free from violence and harmful practices.

We wish to bring to the Committee's attention the following issues of concern, which directly impact their sexual and reproductive health and rights:

I. The Right to Reproductive Health Services (Articles 3(2), 6, 24)

When viewed together, the provisions in Articles 6, 3(2), and 24, highlighted above, obligate governments to ensure adolescents' access to sexual and reproductive health services. In the absence of these services, adolescent girls may experience unwanted pregnancies, possibly resulting in death or serious and permanent injury due to the girls' physical immaturity and the lack of adequate maternal health care, or they may turn to unsafe illegal abortions which could also result in complications or death. Lack of family planning information and services can also result in increased rates of sexually transmitted infections (STIs) and HIV among young people. This is particularly true for girls and young women, who are especially vulnerable to HIV due to physiological differences and entrenched gender inequalities.⁹

The Committee has regularly expressed concern in its Concluding Observations regarding adolescents' limited access to sexual and reproductive health services and asked states to increase access to such services.¹⁰ It has also frequently drawn attention to high rates of maternal mortality affecting adolescents,¹¹ highlighting "the impact that punitive legislation regarding abortion"¹² and "the lack of access by teenagers to reproductive health education and services" can have on those rates.¹³ In the Committee's 2005 Concluding Observations on Nigeria, it expressed concern that "insufficient attention has been given to adolescent health issues by the State Party, including ... reproductive health concerns."¹⁴ It recommended that the Nigerian government "formulate adolescent health policies and programmes with a particular focus on the prevention of sexually transmitted infections (STIs), especially through reproductive health education"¹⁵ The Committee further urged the government to strengthen "reproductive health counselling and make [it] known and accessible to adolescents."¹⁶

An increase in health funding, particularly for sexual and reproductive health, could facilitate much needed access to sexual and reproductive health services. However, to date, the Nigerian government has failed to provide adequate funding for the country's health sector, which negatively impacts adolescents' sexual and reproductive health. The government recently allocated approximately 4.0% of its proposed 2010 budget, or approximately 162 billion Nigerian Naira (approximately USD \$1.07 billion), to the Federal Ministry of Health's budget.¹⁷ This represents an increase of approximately 7 billion Nigerian Naira (approximately USD \$47 million), from the previous year—2009—in which the Health Ministry was allocated approximately 155 billion Naira.¹⁸ However, this allocation still falls short of the 2001 commitment made by African heads of state and the government of the Organisation of African Unity (now the African Union) to allocate at least 15% of their annual national budgets to health.¹⁹ Furthermore, the problems associated with Nigeria's inadequate funding allocation for public health are compounded by corruption and lack of transparency at all levels of government and the health sector.²⁰ Without sufficient funding, the Nigerian government will be unable to adequately address the sexual and reproductive health issues of women and girls in the country.

A. Reproductive Health Education and Information and Access to Family Planning Information and Services

The Committee has confirmed that states have an obligation to “ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours.”²¹ In evaluating state compliance with the Convention, the Committee has specifically recognized a state’s duty to ensure access to sexual and reproductive health education and repeatedly recommended that states strengthen their programs for adolescents to combat adolescent pregnancy and the spread of HIV and STIs.²² Further, the Committee has recommended that all adolescents be given “access to sexual and reproductive information,”²³ adding that “[a]dolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs.”²⁴

In its current periodic report to the Committee, the Nigerian government indicates that it has adopted policies and programmes to promote adolescent health through the creation of a “National Policy on Adolescent Health and Development” in 2006,²⁵ and the adoption and promotion of the “Adolescent Reproductive Health Guidelines.”²⁶ While the adoption of adolescent health policies and programmes that provide reproductive health education is in keeping with the Committee’s 2005 Concluding Observation on Nigeria,²⁷ the steps taken to implement this 2006 policy are unclear. Similarly, the government does not indicate in its current report how it is promoting sexuality education. Although the Federal Ministry of Health developed the Family Life and HIV Education curriculum, it is not clear to what extent it has been integrated into the school curricula of the different states.

The Committee has regularly expressed concern regarding limited access to family planning services and low levels of contraceptive use among adolescents, and has recommended that states make family planning services more widely available.²⁸ In its Concluding Observations on Nigeria, the Committee expressed concern at “the high proportion of teenage pregnancies.”²⁹ However, adolescents in Nigeria continue to lack access to information and services. The 2008 National Demographic Health Survey [2008 NDHS] found that among women age 15 to 49, girls between 15 and 19 were the least likely to know of a contraceptive method.³⁰ It also found that only 9.5% of women and 19.5% of men age 15-19 used a condom during their first sexual encounter.³¹ Lack of government funding for and information regarding the full range of contraceptive methods creates substantial barriers to adolescents’ access to contraceptives.³² Lack of access to contraceptives, in turn, contributes to unwanted pregnancies and unsafe abortions³³ and increases the incidence of STIs, including HIV, among adolescents.

B. HIV/AIDS Treatment and Prevention

HIV prevention, treatment, care, and support are key components of sexual and reproductive health. In Nigeria, however, knowledge of HIV risk factors and prevention measures is low and comprehension of transmission and prevention routes is especially dismal. Young women are particularly vulnerable to HIV infection compared to young men – 2.3% of women aged 15-24 are HIV positive, compared to just 0.8% of men of that age range.³⁴ Only 28.2% of women and 38.7% of men know that the risk of mother-to-child transmission can be reduced by taking certain drugs during pregnancy.³⁵

Efforts aimed at preventing the spread of HIV in Nigeria have centered on “sexual abstinence, mutually faithful monogamy between HIV-negative partners, and condom use for people not

practicing abstinence,”³⁶ but the 2008 NDHS reveals that adolescents’ knowledge of these methods of prevention is limited.³⁷ The NDHS found that less than half of adolescent women and less than two thirds of adolescent men are aware that using condoms can prevent HIV transmission.³⁸ In addition, adolescent women were consistently less knowledgeable about HIV prevention methods than their male counterparts³⁹ and less than 20% of adolescent women had a comprehensive knowledge of HIV/AIDS.⁴⁰

In addition to taking steps to prevent the spread of HIV, the government of Nigeria must take further steps to ensure access to effective treatment. According to the World Health Organization (WHO), as of 2007 less than 10% of all HIV-positive pregnant women in Nigeria received antiretroviral drugs (ARVs) to help prevent mother-to-child transmission⁴¹ and, as of December 2008, only 12% of children with HIV received ARVs.⁴²

C. Unsafe Abortion

Nigeria’s abortion laws are among the most restrictive in the world, criminalizing abortion except to save the pregnant woman’s life.⁴³ Even this exception is frequently not realized in practice. Absent this sole exception, anyone who aids or compels a woman to have an abortion, women who procure an abortion, and those who supply any material used to procure an abortion, are subject to terms of fourteen, seven, and three years of imprisonment, respectively.⁴⁴ The omission of a health, rape or incest exception in Nigeria’s abortion law directly contravenes the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, which Nigeria has ratified, which mandates states to ensure women’s access to abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental or physical health or life of the pregnant woman or in cases of severe fetal anomaly.⁴⁵ The failure to provide for a health exception under the law is also at odds with decisions and concluding observations issued by treaty-monitoring bodies. For example, in *K.L. v. Peru*, the Human Rights Committee found that compelling a woman to continue a pregnancy that posed risks to her health and life was a violation of the right to be free from cruel, inhuman, or degrading treatment or punishment.⁴⁶ Similarly, the omission of a rape or incest exception directly contradicts the Human Rights Committee’s General Comment 28, which emphasizes the need for access to safe abortion for women who have become pregnant as a result of rape.⁴⁷

An estimated 456,000 unsafe abortions take place annually in Nigeria,⁴⁸ and many women and adolescents have been seriously injured or died as a result of unsafe abortions. According to the Nigerian government’s submission to the Committee on the Elimination of all Forms of Discrimination against Women, unsafe abortions lead to approximately 34,000 maternal deaths each year.⁴⁹ A 2002 study found that “about half of the . . . Nigerian women who die from unsafe abortions each year are adolescents.”⁵⁰ For each woman who dies, it is estimated that another 30 women are injured or disabled by unsafe abortion.⁵¹

The law has a disproportionate impact on poor and young women who cannot afford the cost of a safe abortion in Nigeria or to travel abroad to obtain access to safe services.⁵² One study found that while 66% of Nigerian women who are not considered poor access abortion through medically trained professionals in health centers, only 44% of their poor counterparts are able to do the same.⁵³ These women frequently turn to clandestine abortions, often in unsanitary conditions at the hands of untrained practitioners, greatly increasing the risk of abortion-related complications and death. As the government acknowledged in its sixth periodic report to CEDAW, “[l]ow income women and girls who cannot afford the high cost of abortion or who are ignorant of the dangers of unsafe procedures utilized by unqualified individuals, stand very high risks of [losing] their lives.”⁵⁴

The Committee on the Elimination of Discrimination against Women (CEDAW) recently recommended that Nigeria “assess the impact of its abortion law on the maternal mortality rate and to give consideration to its reform or modification.”⁵⁵ The government has already acknowledged that “[o]f the main causes of maternal mortality, unsafe abortion is the single most preventable cause of death.”⁵⁶ Increasing access to safe abortion services through law and policy reform would undoubtedly serve to reduce Nigeria’s maternal mortality rate, the second highest in the world.⁵⁷ Recognizing this link between restrictive abortion laws and maternal mortality rates, Health Ministers at the 2009 First Extra Ordinary Assembly of the Health Ministers from the Economic Community Of West African States (ECOWAS), which includes Nigeria, released a communiqué identifying unsafe abortion as a main cause of maternal mortality and urged states to consider reforming their abortion laws as a means of reducing these preventable deaths in the sub-region.

D. Maternal Mortality and Morbidity

The Committee has repeatedly confirmed that states have an obligation to immediately take action to reduce preventable maternal mortality and morbidity. For instance, the Committee has emphasized that adolescent girls should be given information regarding the harms of early pregnancy⁵⁸ and recommended that states “take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices.”⁵⁹ Additionally, the Committee has urged states to address high maternal mortality rates by improving infrastructure,⁶⁰ and decriminalizing abortion in cases of rape and incest.⁶¹ With respect to Nigeria, the Committee has emphasized that it was “gravely concerned at the alarmingly high rate of . . . maternal mortality” in the country,⁶² and recommended that Nigeria improve its healthcare infrastructure to, among other things, reduce maternal mortality.⁶³

While the Committee has called for prompt and direct action to reduce maternal mortality rates, the Nigerian government has not taken adequate action. According to a recent Lancet study, Nigeria has the second highest number of maternal deaths in the world, accounting for more than 10% of maternal deaths worldwide.⁶⁴ The study further showed that Nigeria’s maternal mortality ratio has substantially increased between 1990 and 2008.⁶⁵ Although in its recent report to the Committee, the government stated that the maternal mortality rate is “estimated to be 800/100,000 live births,”⁶⁶ a recent UNICEF report put Nigeria’s maternal mortality rate at approximately 1,100 maternal deaths per 100,000 live births.⁶⁷ The UNICEF report further states that a woman in Nigeria has a 1-in-18 lifetime risk of dying in childbirth or from pregnancy-related causes and that Nigeria accounts for one of every nine maternal deaths worldwide.⁶⁸

The 2008 NDHS has confirmed that pregnant adolescent girls face severe medical risks. Over 75% of all births to adolescents under age 20 took place at home,⁶⁹ a skilled healthcare provider attended less than 25% of births to adolescents,⁷⁰ and the maternal mortality rate for adolescents 15-19 was 0.822.⁷¹ According to the NDHS, “[t]eenage pregnancy is a major health concern because of its association with higher morbidity and mortality”; approximately 23 percent of adolescents in Nigeria have begun childbearing.⁷²

In a fact-finding report on maternal mortality in Nigeria, CRR and WARDC documented the financial, infrastructural, and institutional obstacles that prevent access to maternal healthcare needed to prevent maternal deaths.⁷³ Financial barriers include a system of user fees that prevents impoverished women from accessing antenatal and intra-partum care.⁷⁴ Women who do receive maternity-related healthcare risk being detained if they are unable to pay later.⁷⁵ This practice, in

turn, leads women to avoid care if they are unable to afford it, or to endanger themselves by leaving the hospital before treatment has ended to avoid the hospital fees.⁷⁶

Another financial barrier relates to the practice of compulsory spousal blood donation. Although the Nigerian policy on blood donation requires that all donations be voluntary, our report findings revealed that pregnant women who attempt to access maternal healthcare services at many public or government hospitals are often required to bring their husbands to donate blood. While patients may sometimes opt out of this blood donation requirement by paying a fee, this option is not always made known and has a discriminatory impact on the poor who may prefer to pay—but be unable to afford—a fee in lieu of blood donation.

Compulsory spousal blood donation can have multiple negative consequences on pregnant women who are unable or unwilling to compel their husbands to donate blood, including husbands' refusal to permit their wives to access antenatal, intra-partum, and postnatal services and women's exposure to domestic violence if they attempt to compel their husbands to donate blood. The blood-donation requirement also disadvantages pregnant women who are unmarried, including those who may have become pregnant due to sexual violence, or whose husbands become ill, abandon them, or pass away during the course of the pregnancy. These women have no option but to pay the fee in lieu of blood donation, which can be as high as NGN 11,000 (over USD 90), according to a member of the nursing staff at Lagos University Teaching Hospital. The discriminatory effects this fee has on poor and single women include diminished access to reproductive health services, inferior care, and worse health outcomes.⁷⁷

In addition to financial barriers, there is a general shortage of skilled health workers, which leads to long waiting periods and inadequate maternal health care, causing increased mortality and further violating Nigerian women's and girls' rights to life and health, among other rights.⁷⁸

II. Harmful Traditional Practices and Violence against Young Girls and Adolescents (Articles 19, 24 and 34)

Article 19 of the Convention provides that states must take all appropriate measures to protect the child against all forms of abuse and violence.⁷⁹ Additionally, Article 34 obliges states to take all appropriate measures to protect the child against all forms of exploitation and sexual abuse,⁸⁰ and Article 24 calls for states to “recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.”⁸¹ Despite these explicit protections in the Convention, young girls and adolescents continue to experience harmful traditional practices and violence, such as early marriage, sexual violence in schools and female genital mutilation (FGM).

A. Early Marriage

According to the 2008 NDHS, approximately 39% of women aged 20-24 in 2008 were married by the time they turned 18,⁸² and nearly 30% of surveyed girls age 15-19 had already been married.⁸³ In some regions of Nigeria, most notably the North, nearly half of all girls are married by age 15.⁸⁴ Early marriages create grave health risks for young women in Nigeria; because they may often become pregnant shortly after marriage, their early marriages expose them to high rates of fistula and maternal mortality.⁸⁵

The Committee has expressed concern that “early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS.”⁸⁶ In spite of the multiple risks early marriage can pose, Nigeria's marriage laws do not adequately protect

young women. While the Child Rights Act passed in 2003 sets the minimum age for marriage at 18, Nigeria's federal system allows states to amend or not enforce federal legislation if the law is contrary to local traditions and religions.⁸⁷ In its second periodic report to the Committee, Nigeria explained that the "age of marriage is a highly controversial issue and it varies from place to place," ranging from 16 to 18 in the south, to as low as 14 in the northern states.⁸⁸ In the north-central states, the age of marriage for girls is "between the second and third menstruation."⁸⁹ As of 2007, less than half of all states – 15 states in total – had formally domesticated the Child Rights Act.⁹⁰

Early marriage and childbearing also interferes with girls' right to education. As the 2008 NDHS found, "childbearing during the teenage years frequently has adverse social consequences, particularly regarding educational attainment, because women who become mothers in their teens are more likely to curtail their education."⁹¹ Although a few states, such as Bauchi and Kano, have passed legislation prohibiting the withdrawal of girls from school due to early marriage,⁹² the implementation and enforcement of these laws has been limited.

As recently as April 2010, women's groups in Nigeria drew public attention to a 49-year-old senator, formerly a state governor, for marrying a girl they believed to be 13 years old.⁹³ According to press reports, the senator went "to Egypt to procure a 13-year old girl as bride for a sum of \$100,000 . . . [she] is his fourth wife, a replacement for an earlier 15-year old who had to be divorced so the Egyptian child bride could take her place."⁹⁴ The senator denied the allegations but stated that even if he had done so, he still would not have broken any law since the Child Rights Act's has not been promulgated into law in his home state of Zamfara, where applicable religious laws permit marriage before the age of 18. However, the senator's marriage was contracted in the Federal Capital Territory, which is where he resides, and the Child Rights Act – including the minimum marrying age of 18 – is the applicable law in that jurisdiction.⁹⁵ Although the Nigerian senate has ordered an investigation, the situation further confirms the weakness of the existing legislative framework on early marriage.

B. Sexual Violence in Schools

Sexual violence against adolescents and young girls is a serious problem throughout Nigeria, especially within the country's school system. This problem is compounded by the fact that sexual abuse is an underreported crime.⁹⁶ According to one recent survey, only 12.7% of women rape victims in Nigeria reported their rapes to the police.⁹⁷ What little information does exist, however, indicates that sexual abuse and violence against children is a widespread threat to the full development of many Nigerian youth.

According to one survey, 52% of Nigerian children have reported experiencing some form of sexual abuse.⁹⁸ Other surveys indicate that rape is common in schools, and frequently committed by teachers. For instance, a 2006 study that surveyed a nationally representative sample of adult Nigerians found that, among rape victim respondents, 15.2% of rapes were reported to have been committed at a work place or school;⁹⁹ the same study found that 17% of rapes were committed by a schoolmate, co-worker, teacher, or other person with authority over the victim.¹⁰⁰ Furthermore, several reports have indicated that girls are often pressured to have sexual relations with their instructors in exchange for better evaluations,¹⁰¹ and that these illicit exchanges are increasingly taking place at virtually every level of schooling.¹⁰² Additionally, fear of social stigma and inappropriate responses by police discourage reporting of sexual violence.¹⁰³ According to the aforementioned 2006 study, 39.5% of rape victims who do report the crime are often "dissatisfied with the police handling of their complaint."¹⁰⁴ A key reason cited for their dissatisfaction was that the police demanded a bribe to investigate the crime.¹⁰⁵

Sexual violence against young people has severe negative physical and psychological consequences. Sexual abuse and harassment in schools is viewed as a common rationale for why parents keep their girls out of school, and has also been linked with female underperformance.¹⁰⁶ In addition, rape and sexual abuse in school may lead young women and girls to suffer psychological trauma, unwanted pregnancy, and unsafe abortion,¹⁰⁷ violating the girls' rights to life, health and to be free from violence.

In its 2005 Concluding Observations to Nigeria, the Committee expressed deep concern about the levels of violence and sexual abuse against young women and children¹⁰⁸ and recommended that the government carry out public education campaigns and “take effective measures for the prevention of violent acts committed within the family, in schools and by the police and other State agents, making sure that perpetrators of these violent acts are brought to justice, putting an end to the practice of impunity.”¹⁰⁹ Although in its most recent report to the Committee, the Nigerian government highlights its passage of the Child Rights Act, which criminalizes the sexual abuse and exploitation of children,¹¹⁰ there is no indication of the law's effectiveness or any other program to reduce sexual violence in Nigerian schools. In addition, there are currently no state or federal laws protecting girls against sexual harassment in Nigeria.

C. Female Genital Mutilation

FGM has been linked to obstetric complications and increased risk of death, both at the time of delivery and post-partum.¹¹¹ FGM can cause obstructed labor which can result in obstetric fistula (a hole either between the rectum and vagina or between the bladder and vagina).¹¹² The resulting leakage of feces and/or urine caused by obstetric fistula can devastate the lives of women who are heavily stigmatized and often shunned by their husbands, families, and communities.¹¹³

The Committee has emphasized the need to eliminate FGM and other practices harmful to the health of young women.¹¹⁴ In response to Nigeria's last report in 2005, the Committee expressed its concern that FGM continued without legal restriction¹¹⁵ and recommended that the Nigerian government, “as a matter of urgency, take all necessary measures to eradicate all [harmful] traditional practices[,] . . . adopt federal legislation prohibiting such practices and encourage further legal changes at the State level, in particular, female genital mutilation.”¹¹⁶ Likewise, during the 2006 Day of the African Child, the Chairperson of the African Union Commission stressed that FGM was a form of violence against girls and called on member states to “make a solemn commitment to eliminate the practice and help the millions of children who continue to be victims of such devastating practices.”¹¹⁷

Although eleven Nigerian states have passed legislation banning FGM,¹¹⁸ the practice remains unrestricted in many other states and at the federal level.¹¹⁹ Even in those states where legislation prohibiting FGM exists, the penalty for offenders is often minimal and implementation of the law has been slow. According to the 2008 NDHS, 21.7% of the female adolescents aged 15-19 surveyed had undergone some form of FGM.¹²⁰ The vast majority of girls who are subjected to FGM are cut before the age of one.¹²¹ An additional concern is the “medicalization” of FGM, which could undermine efforts to stop the practice. NDHS data suggests that increasing awareness of the health risks posed by FGM has not led parents to abandon the practice; instead, many of them turn to medical professionals to perform the procedure.¹²² Despite the perceived safety benefits of having medical professionals perform FGM, long-term health risks persist after the procedure and WHO, UNFPA, and UNICEF have recommended that medical professionals should not perform the procedure.¹²³

In light of the information provided above, we hope the Committee will consider raising the following questions to the government of Nigeria:

1. What concrete steps has the government taken to implement its 2006 National Policy on Adolescent Health and Development?
2. What governmental efforts have been made to ensure that comprehensive, evidence-based sexual and reproductive health information reaches all children despite their grade level or lack of formal education? What steps is the government taking to implement the Federal Ministry of Health's Family Life and HIV Education curriculum into the school curricula of the different states?
3. What measures are being taken to ensure that adolescent women, who are especially vulnerable to HIV infection, are receiving accurate and comprehensive information regarding HIV prevention and treatment? What sexual and reproductive health education programs are available specifically for girls and adolescent women? What specific sexual and reproductive health education and HIV prevention programs are available to out-of-school adolescents, including married adolescents and those living on the streets? How much funding is dedicated to such programs?
4. Are integrated service programs being developed to ensure access to comprehensive sexual and reproductive health services which address both the need for contraception and STI and HIV prevention? What steps are being taken to ensure access to contraceptives, emergency contraceptives and post-exposure prophylaxis, all essential to combat Nigeria's high rates of maternal mortality and early pregnancy?
5. What measures has the government taken to ensure the recruitment, training and retention of youth-friendly health workers, who are essential to improving access to adequate health services?
6. What are the specific provisions of the government's "National Policy on Female Genital Mutilation" of 2005, which is mentioned in its report to the Committee? Is the federal government taking any other concrete steps to end FGM in states where it is not already banned? What is being done to address the needs of girls and women who have already undergone FGM, including their mental and reproductive health care needs?
7. How is the government enforcing the Child Rights Act of 2003 in states and regions, particularly in the North, where child marriage is a common practice? Outside of legal reforms, how effective have the government's programs been to eliminate child marriage? What steps is the government taking to ensure that adolescent girls are not denied their right to education due to early marriage?
8. How will the government ensure the effectiveness of its programs to combat sexual abuse and harassment in schools and training centers? How will it enforce the Child Rights Act and other laws to reduce sexual abuse in Nigerian schools? What will the government do to ensure that police appropriately respond to, and collect data regarding, incidents of sexual abuse? Have structures been set up for providing services for victims of these abuses? How many girls and women have benefited from these services since 2005?

9. What specific actions has the Nigerian government taken to ensure nationwide access to maternal healthcare before, during, and after labor? For example, has the government considered eliminating user fees for maternal and child healthcare services? How have these steps reduced the incidence of maternal mortality where they have been implemented?
10. In light of the CEDAW Committee recommendation that Nigeria should study the impact of its restrictive abortion law with a view towards changing it, what has Nigeria done to review its abortion law and safeguard the lives of women and girls from unsafe abortions? What changes in national legislation does the government plan to undertake to harmonise its abortion laws with international human rights standards? Is the government taking the necessary measures to ensure proper post-abortion care for adolescents who have abortions?

We hope the Committee will also urge the government of Nigeria to adopt the following recommendations:

- Increase the amount of health-related funding to reflect the government's commitment to allocate at least 15% of the national budget to health.
 - Ensure adequate funding for sexual and reproductive health services for adolescents.
 - Provide funding support for sexual and reproductive health education programs for all children, including those with little to no formal education and those in the poorest economic classes. Ensure that sexual and reproductive health education programs utilize scientifically accurate information and utilize the focused characteristics of programs that have been found to be effective.
 - Institute continuous and permanent training programs for reproductive healthcare providers that include training on the provision of adolescent or youth friendly services.
 - Increase adolescent access to skilled medical birth attendants to reduce labor complications such as prolonged labor and obstetric fistula.
- Improve access to family planning services for all adolescents, including a full range of contraceptive methods.
 - Ensure that all children and adolescents receive timely, accurate, evidence-based information regarding family planning and contraceptives.
 - Improve HIV/AIDS education and awareness with the goal of increasing the proportion of adolescents with a comprehensive knowledge of the disease.
- Take all affirmative and tangible steps to ending child marriage.
 - Target specific areas of the country, especially the Northern regions, with a full range of individualized legal, outreach, and educational tools to overcome ingrained child marriage practices.

- Undertake previously recommended reforms and infrastructure improvements to reduce the high rates of adolescent maternal mortality.
- Reduce incidence of unsafe abortion among adolescents, which is one of the primary causes of maternal mortality.
 - Reform existing abortion laws to bring them into conformity with international human rights standards.
 - Ensure that young women who develop abortion-related complications receive appropriate healthcare and are not additionally victimized by health care providers and the criminal justice system.
- Undertake all appropriate measures to reduce and eliminate FGM from Nigeria.
 - Expand and enforce legal restrictions on FGM, particularly in states where the practice is not already banned.
 - Initiate educational programs to inform members of the public, particularly among groups with a high incidence of FGM, about the long-term health consequences of the practice.
- Enact tangible programs and policies to reduce the incidence of sexual abuse in Nigerian schools.
 - Ensure proper data collection of known occurrences of sexual abuse in schools.
 - Demand appropriate police and government responses to instances of sexual abuse in schools.

There remains a significant gap between the provisions of the Convention and the reality of adolescents' sexual and reproductive health and lives in Nigeria. We appreciate the active interest that the Committee has taken in these issues and the strong Concluding Observations the Committee has issued to governments in the past, stressing the need to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Nigerian government's compliance with the provisions of the Convention. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,



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Abiola Akiyode-Afolabi
Executive Director
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¹ Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 6, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC].

² *Id.* at art. 24.

³ *Id.* at art. 3(2).

⁴ *Id.* at art. 19.

⁵ *Id.* at art. 34.

⁶ *Id.* at art. 17.

⁷ NATIONAL POPULATION COMMISSION, FEDERAL REPUBLIC OF NIGERIA [NIGERIA], AND ICF MACRO, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 2008 3 (2009) [hereinafter NDHS 2008].

⁸ *Id.* at 12.

⁹ UNAIDS, AIDS EPIDEMIC UPDATE 2009 21–22 (December 2009), *available at* http://data.unaids.org/pub/Report/2009/jc1700_epi_update_2009_en.pdf.

¹⁰ *See e.g., Concluding Observations of the Committee on the Rights of the Child: Benin*, (21st Sess.), para. 25, U.N. Doc. CRC/C/15/Add.106 (1999); *Concluding Observations of the Committee on the Rights of the Child: Cambodia*, (24th Sess.), para. 52–53, U.N. Doc. CRC/C/15/Add.128 (2000) [hereinafter CRC, *Concluding Observations: Cambodia*]; *Concluding Observations of the Committee on the Rights of the Child: Mexico* (22nd Sess.), para. 27, U.N. Doc. CRC/C/15/Add.112 (1999); *Concluding Observations of the Committee on the Rights of the Child: Colombia*, (25th Sess.), para. 48, U.N. Doc. CRC/C/15/Add.137 (2000) [hereinafter CRC, *Concluding Observations: Colombia*].

¹¹ *See e.g., Concluding Observations of the Committee on the Rights of the Child: Chad*, (21st Sess.), para. 30, U.N. Doc. CRC/C/15/Add.107 (1999) [hereinafter CRC, *Concluding Observations: Chad*]; *Concluding Observations of the Committee on the Rights of the Child: Dominican Republic*, (26th Sess.), para. 37, U.N. Doc. CRC/C/15/Add.150 (2001) [hereinafter CRC, *Concluding Observations: Dominican Republic*]; *Concluding Observations of the Committee on the Rights of the Child: Peru*, (23rd Sess.), para. 24, U.N. Doc. CRC/C/15/Add.120 (2000).

¹² CRC, *Concluding Observations: Chad*, *supra* note 11, at para. 30; *see also*, CRC, *Concluding Observations: Colombia*, *supra* note 10, at para. 48; *Concluding Observations of the Committee on the Rights of the Child: Guatemala*, (27th Sess.), para. 40, U.N. Doc. CRC/C/15/Add.154 (2001).

¹³ *Concluding Observations of the Committee on the Rights of the Child: Guinea*, (20th Sess.), para. 27, U.N. Doc. CRC/C/15/Add.100 (1999); *see also*, CRC, *Concluding Observations: Cambodia*, *supra* note 10, at para. 52; *Concluding Observations of the Committee on the Rights of the Child: Dominican Republic*, *supra* note 11, at para. 37.

¹⁴ *Concluding Observations of the Committee on the Rights of the Child: Nigeria*, (38th Sess.), para. 50, U.N. Doc. CRC/C/15/Add.257 (2005) [hereinafter CRC, *Concluding Observations: Nigeria* (2005)].

¹⁵ *Id.* at para. 51(a).

¹⁶ *Id.* at para. 51(b).

¹⁷ FEDERAL GOVERNMENT OF NIGERIA, 2010 BUDGET PROPOSAL (MINISTRY OF HEALTH), *available at* <http://mail.budgetoffice.gov.ng/2010%20budget%20messeage/HEALTH.pdf> (last visited May 6, 2010); *see also* NairaBrain, *Nigeria 2010 Budget Breakdown*, NAIRABRAIN NEWS, *available at* <http://nairabrain.com/2009/11/25/nigeria-2010-budget-breakdown/> (last visited May 10, 2010).

¹⁸ The Health Ministry was allocated exactly 154, 567, 493, 157 Naira in 2009. FEDERAL GOVERNMENT OF NIGERIA, 2009 APPROPRIATIONS (MINISTRY OF HEALTH) *available at* <http://www.budgetoffice.gov.ng/pdf%202009/Min%20of%20Health.pdf>

¹⁹ ORGANISATION OF AFRICAN UNITY, ABUJA DECLARATION ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, 5 at para. 26, Doc. OAU/SPS/Abuja/3 (2001), *available at* http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

²⁰ CENTER FOR REPRODUCTIVE RIGHTS, *BROKEN PROMISES: HUMAN RIGHTS, ACCOUNTABILITY AND MATERNAL DEATH IN NIGERIA* 20–25 (2008) [hereinafter *BROKEN PROMISES*].

²¹ Committee on the Rights of the Child, *General Comment 4: Adolescent health and development*, (33rd Sess.), para. 26, U.N. Doc. CRC/GC/2003/4 (2003) [hereinafter CRC, *General Comment 4*].

²² *See Concluding Observations of the Committee on the Rights of the Child: Argentina*, (8th Sess.), para. 19, U.N. Doc. CRC/C/15/Add.35 (1995); *Concluding Observations of the Committee on the Rights of the Child: Egypt*, (26th Sess.), para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); *Concluding Observations of the Committee on the Rights of the Child: Georgia*, (24th Sess.), para. 47, U.N. Doc. CRC/C/15/Add.124

(2000) [hereinafter CRC, *Concluding Observations: Georgia*]; *Concluding Observations of the Committee on the Rights of the Child: Latvia*, (26th Sess.), paras. 39-40, U.N. Doc. CRC/C/15/Add.142 (2001) [hereinafter CRC, *Concluding Observations: Latvia*]; *Concluding Observations of the Committee on the Rights of the Child: Russian Federations*, (22nd Sess.), para. 48, U.N. Doc. CRC/C/15/Add.110 (1999) [hereinafter CRC, *Concluding Observations: Russian Federations*].

²³ CRC, *General Comment 4*, *supra* note 21, at para. 28.

²⁴ *Id.* at para. 31.

²⁵ Committee on the Rights of the Child, *Consideration of reports submitted by States parties under article 44 of the Convention, Third and fourth periodic report of States parties due in 2008, Nigeria*, 85, U.N. Doc. CRC/C/NGA/3-4 (Jan. 5, 2009) [hereinafter *CRC Consideration of reports, Nigeria* (2009)].

²⁶ *Id.* at 91.

²⁷ CRC, *Concluding Observations: Nigeria* (2005), *supra* note 14, at para. 51.

²⁸ See CRC, *Concluding Observations: Russian Federations*, *supra* note 22, at para. 48; CRC, *Concluding Observations: Georgia*, *supra* note 22, at para. 47; CRC, *Concluding Observations: Latvia*, *supra* note 22, at paras. 39-40.

²⁹ CRC, *Concluding Observations: Nigeria* (2005), *supra* note 14, at para. 50.

³⁰ NDHS 2008, *supra* note 7, at 64-65.

³¹ *Id.* at 227.

³² BROKEN PROMISES, *supra* note 20, at 30-35.

³³ *Id.* at 50.

³⁴ UNICEF, *At a glance: Nigeria – Statistics*, (Feb. 26, 2004), http://www.unicef.org/infobycountry/nigeria_statistics.html.

³⁵ NDHS 2008, *supra* note 7, at 204.

³⁶ *Id.* at 199.

³⁷ *Id.* at 200.

³⁸ *Id.* at 200.

³⁹ *Id.* at 200.

⁴⁰ *Id.* at 201. Comprehensive knowledge is defined in the 2008 NDHS as having the knowledge that “consistent use of condoms during sexual intercourse and having just one HIV negative and faithful partner can reduce the chances of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission and prevention.”

⁴¹ WORLD HEALTH ORGANIZATION, UNAIDS & UNICEF, EPIDEMIOLOGICAL FACT SHEET ON HIV AND AIDS: CORE DATA ON EPIDEMIOLOGY AND RESPONSE: NIGERIA 14 (Oct. 2008).

⁴² *Id.* at 142.

⁴³ See Criminal Code Act, (Revised ed. 1990) Cap. 77, ch. 25, art. 297 (Nigeria), available at <http://www.nigeria-law.org/Criminal%20Code%20Act-PartV.htm#Chapter%2025> [hereinafter Nigeria Criminal Code].

⁴⁴ See *id.* at arts. 228-230; see also Penal Code (Northern States) Federal Provisions Act, (Revised ed. 1990) Cap. 345, art. 235, (Nigeria). The Criminal Code and Penal Code apply in the Southern and Northern parts of the country, respectively.

⁴⁵ Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14(2)(c) (The Protocol states that states parties shall take all appropriate measures to “protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.” Nigeria has ratified the protocol.)

⁴⁶ Human Rights Committee, *K.L. v. Peru*, Comm. No. 1153/2003, §6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

⁴⁷ Human Rights Committee, *General Comment 28: Equality of rights between men and women (Article 3)*, (68th Sess.), para. 11, U.N. Doc. CCPR/C/21/Rev/1/Add/10 (2000).

⁴⁸ Andrew Walker, *Saving Nigerians from risky abortions*, BBC NEWS, Apr. 7, 2008, available at <http://news.bbc.co.uk/2/hi/africa/7328830.stm> [hereinafter Walker, *Saving Nigerians from risky abortions*].

⁴⁹ Committee on the Elimination of Discrimination against Women, *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against*

Women, Sixth periodic report of States parties, Nigeria, 82, U.N. Doc. CEDAW/C/NGA/6 (2006) [hereinafter *CEDAW consideration of reports, Nigeria* (2006)].

⁵⁰ DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID), DFID'S POLICY POSITION ON SAFE AND UNSAFE ABORTION 3 (2009), available at <http://www.dfid.gov.uk/Documents/publications/Safe-and-Unsafe-Abortion.pdf>.

⁵¹ Onwuka Nzeshi, *Abortion Law Blamed for High Maternal Death*, THIS DAY, May 28, 2008, available at <http://allafrica.com/stories/200805280992.html>.

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⁵³ Guttmacher Institute, *In Brief: Facts on Unwanted Pregnancy and Induced Abortion in Nigeria*, (2006) at 1, available at http://www.guttmacher.org/pubs/2006/07/13/FB_Nigeria.pdf.

⁵⁴ *CEDAW consideration of reports, Nigeria* (2006), *supra* note 49, at 81.

⁵⁵ *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Nigeria*, (41st Sess.), para. 337, U.N. Doc. CEDAW/C/NGA/CO/6 (2005).

⁵⁶ *CEDAW consideration of reports, Nigeria* (2006), *supra* note 49, at 82.

⁵⁷ Institute for Health Metrics and Evaluation, *21 Countries with the Most Maternal Deaths, 2008*, available at http://www.healthmetricsandevaluation.org/resources/news/2010/maternal_deaths_fall_0410.html (last visited May 10, 2010) [hereinafter IHME, *Most Maternal Deaths*].

⁵⁸ CRC, *General Comment 4*, *supra* note 21, at para. 28.

⁵⁹ *Id.* at para. 31.

⁶⁰ *Concluding Observations of the Committee on the Rights of the Child: Sao Tome and Principe*, (36th Sess.), para. 45, U.N. Doc. CRC/C/15/Add.235 (2004).

⁶¹ *Concluding Observations of the Committee on the Rights of the Child: Kenya*, (44th Sess.), para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007).

⁶² CRC, *Concluding Observations: Nigeria* (2005), *supra* note 14, at para. 48.

⁶³ *Id.* at para. 49(b).

⁶⁴ See IHME, *Most Maternal Deaths*, *supra* note 57.

⁶⁵ Margaret C. Hogan, et al., *Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5*, LANCET, April 12, 2010, at 10, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960518-1/abstract>.

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⁶⁷ UNICEF, THE STATE OF THE WORLD'S CHILDREN 2009 148 (December 2008), available at <http://www.unicef.org/sowc09/docs/SOWC09-FullReport-EN.pdf>.

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⁷⁰ *Id.* at 134.

⁷¹ *Id.* at 237.

⁷² *Id.* at 60.

⁷³ BROKEN PROMISES, *supra* note 20, at 39.

⁷⁴ *Id.* at 40.

⁷⁵ *Id.* at 41.

⁷⁶ *Id.*

⁷⁷ *Id.* at 9 & 44-45.

⁷⁸ *Id.* at 47-48.

⁷⁹ CRC, *supra* note 1, at art. 19.

⁸⁰ *Id.* at art. 34.

⁸¹ *Id.* at art. 24.

⁸² NDHS 2008, *supra* note 7, at 94.

⁸³ *Id.* The percentage of girls aged 15-19 who had been married was calculated by subtracting from 100% the 70.6% of girls aged 15-19 who reported being "never married".

⁸⁴ Ramita Navi, *Broken Lives: Nigeria's child brides who end up on the streets*, THE TIMES (LONDON), Nov. 8, 2008, available at <http://www.timesonline.co.uk/tol/news/world/africa/article5248224.ece> [hereinafter Navi, *Broken Lives*].

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- ⁸⁶ CRC, *General Comment 4*, *supra* note 21, at para. 20.
- ⁸⁷ Navi, *Broken Lives*, *supra* note 84.
- ⁸⁸ Committee on the Rights of the Child, *Consideration of reports submitted by States parties under Article 44 of the Convention, Second periodic reports of States parties due in 1998: Nigeria*, para. 46, U.N. Doc. CRC/C/70/Add.24 (2003).
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- ⁹⁰ UNICEF, *Information Sheet: The Child's Rights Act*, 2007, at 3, available at http://www.unicef.org/wcaro/WCARO_Nigeria_Factsheets_CRA.pdf.
- ⁹¹ NDHS 2008, *supra* note 7, at 60.
- ⁹² Prohibition of Withdrawal of Girls from School for Marriage Law of Bauchi, Borno, Gombe and Kano States, Nigeria; see CRC *Consideration of reports, Nigeria* (2009), *supra* note 25, at 35.
- ⁹³ Nigerian senator Sani denies marrying girl of 13, BBC NEWS, April 30, 2010, available at <http://news.bbc.co.uk/2/hi/africa/8651043.stm>.
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- ¹⁰⁹ *Id.* at para. 45.
- ¹¹⁰ CRC *Consideration of reports: Nigeria* (2009), *supra* note 25, at 73.
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