

The Conflict in Northeast Nigeria's



Impact on the Sexual and Reproductive Rights of Women and Girls

Acknowledgements

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Recommendations

The government of Nigeria should take immediate steps to comply with international and regional human rights obligations regarding access to maternal health care services, abortion, and other related SRHR services for survivors of sexual violence to ensure women and girls affected by conflict-related violence can access comprehensive medical and support services, including psychosocial support.

The government should put in place measures to prevent and respond to sexual and gender-based violence, including ensuring that human rights sensitivity trainings are provided to IDP camp managers and to security personnel before deployment to conflict-affected areas, IDP camps, and host communities.

The government and other key stakeholders should ensure that there are functioning mechanisms to monitor, investigate, and punish sexual violence and other SRH violations by state and nonstate actors, even in the IDP camps and host communities, and that these mechanisms are able to confer meaningful and effective remedies and reparations on a basis of nondiscrimination.

The international community, including relevant organizations and agencies from the United Nations, African Union, and Economic Community of West African States, should call for a broad and robust understanding of accountability, which is participatory and transparent, to ensure effective and adequate access to justice.

Stakeholders including humanitarian providers and development partners should support the government in rebuilding, staffing, and restocking health facilities to mitigate the high levels of preventable maternal deaths due to poor quality of care. They should also ensure access to comprehensive SRHR services, including psychosocial counselling and support.

They should apply a human-rights-based approach to their policies and programs to ensure that the provision of sexual and reproductive health information and services is fully integrated into their humanitarian response, and that services are available, accessible, acceptable, and of good quality.

They should fund and enable the provision of lifesaving sexual and reproductive health services outlined in the MISP where not yet available in conflict-affected parts of Nigeria and ensure a timely transition from the MISP to comprehensive SRH services when applicable.

Humanitarian workers should ensure that their design, implementation, and evaluation of humanitarian programming and responses include the meaningful participation and inclusion of women, girls, and other affected populations.

Human rights and civil society

organizations, including the National Human Rights Commission, should prioritize the provision of technical support to stakeholders to increase awareness and the application of a human-rights-based approach to all humanitarian interventions.

All stakeholders should immediately prioritize the collection of disaggregated data on SRHR violations and services impacting women and girls affected by the conflict.

I. Background

CONFLICT AND HUMAN RIGHTS

Human rights and conflict intersect in multifaceted and dynamic ways.¹ Human rights laws, comprising both rights and obligations, provide guidance on how states should act in order to protect, promote, and fulfill the fundamental rights and freedoms of individuals and groups of people.²

During conflict, states, as well as other parties to the conflict, continue to have obligations to protect the rights and freedoms of all people directly or indirectly affected by the conflict.³

Conflicts (including armed conflicts) lead to immense negative impacts on the lives of millions of people through serious repercussions, including violations of rights and freedoms.⁴ In 2018, an estimated 34 million women of reproductive age, at least 5 million of whom were pregnant, were in need of humanitarian health assistance, due to conflict. While there continues to be a need for more reliable data on maternal mortality in conflict and displacement settings, there is little doubt that conflict exacerbates maternal mortality and morbidity.⁵ A recent study noted that conflict countries have had consistently



Women attend an FGD on sexual and reproductive health care services at an IDP Camp, 2018.
Photo Credit: Carey Wagner for the Center for Reproductive Rights.

higher maternal mortality rates than non-conflict countries for the past 30 years, and these gaps persist.⁶ In addition, women and girls affected by conflict are particularly vulnerable to sexual and gender-based violence (SGBV), including rape; sexually

transmitted infections, such as HIV/AIDS; sex trafficking and slavery; early and forced marriage; and forced and unintended pregnancy.⁷

These women, along with all women and girls living in conflict settings, therefore

urgently require sexual and reproductive health (SRH) services, including obstetric care, antenatal care, contraceptives, safe abortion and post-abortion care, and psychosocial counseling for trauma.⁸ In the context of conflict, however, delivery and access to these services are affected due to devastated and disintegrated health infrastructure and health facilities that are inaccessible and unable to provide reproductive health care services and information.⁹ They are also affected by political resistance, which has negatively influenced funding and programming efforts geared toward meeting the SRHR needs of women and girls affected by conflict.¹⁰

Boko Haram, (directly translated to “western education is forbidden”), an extremist jihadist group that is active in the Northern region of the country ... perceives a democratic means of governing as secular and therefore untenable, and has continued an insurgency for more than a decade.

In 2014, Boko Haram orchestrated an unprecedented attack on a government secondary school in Chibok town in the Northeast, forcibly removing and kidnapping 276 girls, which led to the global Bring Back Our Girls campaign.

For more marginalized populations, including people living in poverty, those with lower levels of education, and those living in rural areas, access to reproductive and maternal health services is several times worse in conflict countries than it is in non-conflict countries.¹¹

The breakdown of state infrastructure in conflict settings exacerbates preexisting systemic inequalities and patterns of discrimination that negatively affect women and girls. Women and girls may face discrimination due to their legal status, and are at an increased risk of being subject to discrimination and other human rights violations when seeking reproductive health care.¹²

CONTEXTUAL ANALYSIS OF BOKO HARAM INSURGENCY IN NORTHEAST NIGERIA

Nigeria is one of Africa's most populous countries, with a population of at least 200 million. It is also one of the most geographically and ethnically diverse countries on the continent.¹³ Northeast Nigeria is one of its geopolitical regions and comprises six states: Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe. The region has a total estimated population of just over 26 million people, as of 2016.¹⁴

The Northeast region extends from Lake Chad in the North to the Mambilla Plateau in the Taraba State (in the South). It borders the Nigeria-Cameroon boundary to the east and shares a state boundary with other Nigerian states including Kano and Kaduna to its West.¹⁵ The region occupies the Sahel-Savannabelt which lies south of the Sahara Desert, “the area most affected by desertification and land degradation,” and encompasses a total of 112 of the 774 statutorily recognized local government areas (LGAs) in Nigeria.¹⁶

Nigeria, which has been characterized by political instability and economic hardship since the 1980s, is affected by several conflicts over the sharing of proceeds from

exploitation of natural resources, as well as from differences over ethnic, religious, and political ideology.¹⁷ These, along with the lack of basic services and access to education and employment provided by the government, lie at the root of deep frustration among its inhabitants.¹⁸

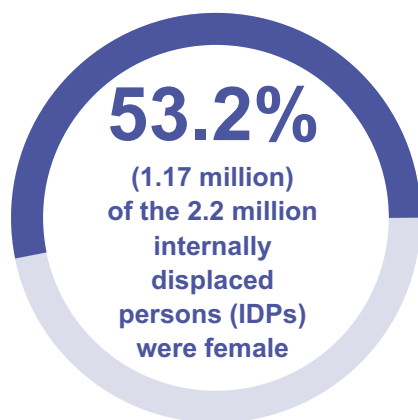
Boko Haram, (directly translated to “western education is forbidden”), an extremist jihadist group that is active in the Northern region of the country, found footing in this setting after forming in Maiduguri, the capital city of Borno State, in 2002.¹⁹

Boko Haram perceives a democratic means of governing as secular and therefore untenable,²⁰ and has continued an insurgency for more than a decade.²¹ The violence commenced in Bauchi State in July 2009 and spread to other states in Northern Nigeria, leaving thousands dead, including members of Nigerian law enforcement.²²

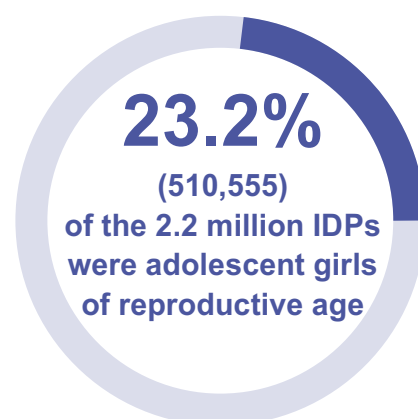
In the years that followed, attacks by Boko Haram, in Northeast Nigeria and other parts of the country, included bombings, mass shootings, executions, and abductions of women and adolescent girls. These attacks increased in number and frequency²³ until May 2013, when Goodluck Jonathan, the Nigerian president at the time declared a state of emergency in the states of Borno, Yobe, and Adamawa.²⁴ But in 2014, Boko Haram orchestrated an unprecedented attack on a government secondary school in Chibok town in the Northeast, forcibly removing and kidnapping 276 girls,²⁵ which led to the global Bring Back Our Girls campaign.

Evidently, in spite of the declaration of a state of emergency, attacks by the Boko Haram continued to increase steadily until 2015, when the Nigerian military, in coordination with Cameroon, Chad, and Niger, solidified its campaign against the group and recaptured much of the territory that it had earlier taken over.²⁶ President Muhammadu Buhari announced, in 2016, that Boko Haram had been defeated when the Nigerian military conquered one of the group's last remaining strongholds. Still, during 2017, Boko Haram began to regain momentum, winning a string

Between 2009 and 2016, ...



and ...



**7,000 women and
girls were abducted.**

of battles against the Nigerian army; continuing to attack civilians, including women and girls; and establishing new strongholds in Borno and Taraba States.

The group has also made efforts to reinvent itself in order to gain civilian support — for example, by providing services, including Islamic education, health care, and small loans to farmers²⁷ — in the absence of adequate government support. It has been reported that these factors make it unlikely that Nigeria will see an end to the conflict with Boko Haram in the near future.²⁸

IMPACT OF BOKO HARAM INSURGENCY ON VULNERABLE POPULATIONS

The Boko Haram insurgency has directly affected people mostly in Borno, Yobe, and Adamawa States, but other states in Nigeria and neighboring countries have also been affected.²⁹ Across West Africa's Lake Chad region, which encompasses Chad, Niger, Cameroon, and Nigeria, millions of families have had their children abducted, killed, and used as suicide bombers. Their villages have been left without basic services, such as electricity, clean water, health care, and schools — or have been completely burned to the ground.³⁰

Between 2009 and 2016, “more than 2.2 million people have been internally displaced, 20,000 civilians killed, and as many as 7,000 women and girls abducted.”³¹

Around 1.17 million of the internally displaced persons (IDPs) were female, and among them were 510,555 adolescent girls of reproductive age.³²

As of 2018, about 37,000 people had been killed and 2.4 million displaced.³³ Since Boko Haram's abduction of 276 Chibok schoolgirls in 2014 and the resulting Bring Back Our Girls campaign, the group has not relented: It has kidnapped thousands more women,

girls, men, and boys, “forcing the men and boys to join its ranks, and selling or sharing the girls and women as ‘wives’ or sex slaves.”³⁴

The 2019 abductions of schoolgirls in Dapchik underscore the ongoing threat to women and girl's sexual and reproductive health and rights (SRHR) in this conflict, as well as the lack of preparedness for and prioritization of SRH services.

As the conflict spread, “nearly two million people, the overwhelming majority of whom were women” were forced to flee their homes. A majority of these women — many of whom witnessed the killing of their husbands and sons, and the abduction of their daughters,³⁵ along with thousands of other women — live with their children as refugees in neighboring countries or as IDPs in government-run camps where food is scarce, health care is dismal, and impunity for human rights violations abounds. In these camps, resorting to “survival sex” in exchange for food, money, or permission to leave the camp is widely reported.³⁶

It is reported that the Boko Haram insurgency has caused an estimated damage of over USD 8 billion to infrastructure across Northeast Nigeria, with Borno State being the most affected and Maiduguri, its capital, being home to a majority of people displaced as a result of the conflict.³⁷

II. Objectives and Methodology

OBJECTIVES

As part of an effort to understand how human rights obligations and principles might benefit women and girls affected by the conflict in practice, in 2018 the Center for Reproductive Rights (the Center),³⁸ in partnership with the Legal Defence and Assistance Project (LEDAP),³⁹ launched a human rights documentation and advocacy project to study the impact of the Boko Haram conflict on the reproductive health and rights of women and girls in Nigeria.

In 2017, the Center had published a briefing paper that analysed existing international legal standards relevant to the protection of SRHR of women and girls affected by conflict.⁴⁰ The paper focused on international human rights obligations, including economic, social, and cultural rights, which continue to apply during situations of armed conflict. It also highlighted key human rights principles that should guide humanitarian service in conflict settings.

A critical aim of this project is to assess how the application of human rights legal frameworks and principles might address the current challenges in accessing SRH services and seeking accountability for SRHR violations for women and girls affected by the conflict.



Mothers share stories of their maternal health care experiences with interviewers at an IDP camp, 2018.
Photo Credit: Carey Wagner for the Center for Reproductive Rights.

METHODOLOGY

The Center and LEDAP staff undertook field-based human rights documentation interviews in two phases, with a focus on Borno, Adamawa, and Yobe, the core affected states, as well as Abuja, the Federal Capital Territory where the humanitarian coordination efforts are headquartered. The first phase took place in February 2018, with a focus on Adamawa and Abuja. The second phase occurred in July 2019 and focused on Borno, the epicenter of the conflict, and on Yobe and Abuja.

Significant information was gathered through over 150 one-on-one interviews and focus group discussions (FGDs) with over 250 women and girls who had experienced conflict-related SRHR violations, mostly directly but also indirectly, in IDP camps and host communities.

Interviewees were from Fufore Camp, Damare Camp, Malkwai IDP Camp, and

the Malkwai Host Community in Yola, Adamawa State; from Dalori Camp, CAN Centre, Farm Centre, the Kaleri Host Community, and EYN Wulari Camp in Maiduguri, Borno State; from host communities in Nainawa, Malari, Potiskum, Damagwu, and Kali in Yobe State; and from Durumi Camp in Abuja.

Over 75 in-person interviews were also conducted with over 100 federal and state government officials, United Nations agencies, humanitarian providers, representatives of national human rights institutions and human rights civil society organizations, health care providers, and members of communities hosting IDPs.

Interviewers had the requisite training and experience to undertake these interviews, including experience working with survivors of SGBV, on SRHR violations, and in conflict-related trauma. The methodology for the interviews and documentation complied with internationally recognized guidelines for human rights fact-finding missions and reports such as the Lund-

London Guidelines on International Human Rights Fact-Finding Visits and Reports by Non-Governmental Organizations. Questionnaires contained predetermined questions tailored to various categories of interviewees, ranging from affected populations to humanitarian providers, and were designed to ensure validity, sensitivity, and objectivity.

Interviewers undertook comprehensive measures prior to, during, and after the interviews to prioritize the safety of interviewees, particularly IDPs and those in host communities, and maintain sensitivity to their situation, including carefully choosing interview locations, dates, times, and length. They also took detailed steps to ensure that consent was informed and voluntary prior to, during, and after the interviews, including by providing reliable interpretation in local languages where needed, and providing continuous assurances throughout the interviews that interviewees were entitled to refrain from responding to any question and could end the interview at any time.

Interviewers made extensive and careful effort in identification and choice of interviewees to prevent retraumatization, revictimization, or exploitation. Interviewers also provided information about referrals to appropriate support service providers and experts, including counselors, health care providers, and law enforcement where feasible.

A critical aim of this project is to assess how the application of human rights legal frameworks and principles might address the current challenges in accessing SRH services and seeking accountability for SRHR violations for women and girls affected by the conflict.



Residents of an IDP camp at an FGD on gender-based violence with interviewers, 2018.
Photo Credit: Carey Wagner for the Center for Reproductive Rights.

III. Effects of the Conflict in Northeast Nigeria on Sexual and Reproductive Rights

An overview of the findings indicate high levels of sexual exploitation of IDPs and a correlated increase in HIV transmission rates; a wide range of inadequacies in the provision of SRH services, such as contraception, abortion, SRH trauma-related psychosocial counseling; evidence of preventable maternal injuries and deaths; inadequate financing and coordination of acute and protracted humanitarian response and concerns about financial and technical capacity to undertake recovery efforts; overlooked linkages between access to shelter, food, and education for children, and susceptibility to SRHR violations, among other violations; and a lack of accountability mechanisms.

SEXUAL AND GENDER-BASED VIOLENCE, SEXUAL EXPLOITATION, AND FORCED MARRIAGE

The findings suggest a significantly high incidence of recurring SGBV, forced and child marriage, and sexual exploitation in exchange for food, water, feminine hygiene products, and lifesaving medicines occur with impunity in IDP camps and host communities in Borno, Adamawa, Yobe, and Abuja. Serious concerns exist about the prevalence of HIV transmission due to sexual abuse and exploitation.

One woman summed up her experience in an IDP camp with these haunting words: “I’ve been raped so many times I can’t even remember.” In one-on-one interviews and FGDs, some interviewees who had been in camps staffed by fellow IDPs spoke about being prevented from reporting rape or seeking SRH services by other female IDPs who warned them that they would be labelled as “a troublemaker” and evicted from the camp. And an interviewee in an FGD recounted the experience of a woman whose husband left the camp to run an errand and never came back. Instead of investigating his disappearance, male camp leaders (also IDPs) tried to demand sexual favours in exchange for access to food. When she

Many had been raped by the group and lost their pregnancies as a result. Those who did not, ultimately gave birth without any skilled attendance while camped out on roads, while seeking shelter underneath trees, in abandoned buildings, and in military detention centers. Many suffered severe maternal injuries, and others died.

refused, they forced her out of the camp, leaving her without a place to live.

Yet another interviewee shared the experience of a 12-year-old girl who was sexually exploited by a camp manager in charge of distributing food ration cards. The girl was afraid to go to the camp’s mobile court because the manager had told her that “anyone seen going to the mobile court will be locked up and is no longer good for marriage.”⁴¹

The interviewees, including IDPs, humanitarian care providers, and government officials, also spoke about the far-reaching impact of the prevalence of sexual violence on adolescent girls’ education, noting that one of the reasons most girls are kept away from school was to reduce their exposure to abduction and sexual violence by Boko Haram and other perpetrators. A humanitarian care provider in corroborating the severe levels of sexual violence and exploitation in the camps concluded: “Many things happen to young girls in the IDP Camps. They conceal it because they don’t want other people to know what had happened to them.”⁴²

There are also increased levels of child and forced marriage among IDPs as a survival measure and evidence of affected women and girls being forced into transactional sex and, in some instances, sex work for survival.

Interviewees and FGD participants raised concerns about increased levels of child marriage among IDPs due to lack of economic resources and because families mistakenly perceive marriage as a way to protect girls from other forms of violence, including sexual violence.⁴³ Many of the women interviewed said many girls in the area were married off before the age of 18. Some were married off as early as 9 years old, and there were also multiple reports of forced and early marriages.

The parents of one young woman in a host community in Adamawa forced her to marry a much older man when she was younger than 18 because they thought it

would keep her from being abducted by Boko Haram. During a one-on-one interview, the woman shared her experience of being abused and abandoned with her two children and of living in a host community without adequate shelter. She and her parents had fled Gwaza to Madagali in Adamawa State for safety, but when they heard that Boko Haram was also coming there, they married her off to a man who was about 50. After she gave birth to two children, the man would not provide for them and she and the children would often go hungry.

Another interviewee from Yobe recounted the sexual violence she and her 2-year-old daughter experienced while fleeing Boko Haram, her daughter’s death following the experience, and her subsequent dependence on sex work to survive in the host community she now lives in due to the absence of food and other means of survival. After the group set her village on fire, killed her father, and caused the rest of her family to scatter in separate directions, she fled with her 2-year-old daughter: “I followed some people and we ran together to a village. There was no food to eat, no water to drink, we used to drink cow water—water that animals take—that’s what we drank to survive; the food, anything you see, you eat. Then, the other people [the villagers] started using the advantage. Sometimes they will come to you; if they did not sleep with you, then they won’t give you what to eat. And we don’t have [any] option.”

She went on to tell a story of unimaginable loss: “See that my daughter, before she even died, one man, big man no be say na small man [not a small man], he sleep with [raped] a 2-year-old baby. No hospital, no treatment. I went somewhere to look for water to drink, before I come back she faint. One woman was telling me what happened. ... I shouted, I say ‘what!’ and she said I should calm down and be patient so they don’t hear our voice or they can pursue us. I said patient for what? A 2-year-old baby? I carried my baby, I wanted to leave that night. Is it not better for somebody to just go — to face the death once and for all?”

Her daughter died, and she subsequently left the village. To survive, she lives with a former sex worker who provides her, and many other women who fled the conflict, shelter in exchange for engaging in sex work. Her clients, she said, are often the soldiers fighting to end the conflict.

MATERNAL HEALTH

There is evidence of significant disparities in access to maternal health care services, including skilled birth attendants and essential medicines, for conflict-affected populations; there is also a dearth of supporting mechanisms and processes to ensure accountability for violations.

Interviewees in all the interview locations spoke about their experiences of fleeing invasion by Boko Haram while pregnant. Many had been raped by the group and lost their pregnancies as a result. Those who did not, ultimately gave birth without any skilled attendance while camped out on roads, while seeking shelter underneath trees, in abandoned buildings, and in military detention centers. Many suffered severe maternal injuries, and others died.

Findings indicate that access to maternal care remained a key barrier for the women who eventually made it to IDP camps and host communities. Many had become pregnant several times as IDPs, partly due to a lack of access to contraception and partly due to a perceived pressure to bear children, particularly for those in plural or polygamous marriages whose husbands had children from other wives. While some women in IDP camps had access to free antenatal health care services, they reported that they were required to pay out of pocket for medications and typically did not have enough food to eat to sustain nursing after delivery, leaving their newborns without adequate nutrition because they could not afford baby formula.

In multiple FGDs in Adamawa, Borno, and Abuja, women who had given birth in IDP camps noted that they had access to

antenatal care, but they expressed misgivings about the delivery and postnatal care services. They reported that post-delivery overnight stays were not permitted unless one gave birth at night (in the case of an IDP camp in Adamawa) and that they were subjected to mistreatment and abuse (IDP camps in Borno). For instance, interviewees in an IDP camp in Maiduguri recounted nurses scolding them loudly for requesting timely services and telling them that because the services were free, they had no choice but to wait. One interviewee said she was in labor for four days and was left unattended by the IDP camps clinic's nurse for most of that time until a different nurse, who was nicer, took over duty.

One woman, who participated in both a one-on-one interview and an FGD at Fufore IDP camp in Adamawa, carrying her sister's son in her arms, recounted the events that led up to her sister's death: she was certain that the pregnancy had been uneventful, and her sister had attended all of her antenatal care appointments. Her sister was not ill and had gone to the IDP camps clinic as soon as she went into labor. She received care and delivered her son safely but was discharged immediately after delivery because it was not a night-time delivery and there were not enough beds. She returned to her tent and died that night.⁴⁴ The interviewee was not given any information on what caused the death of her sister.

Women who were IDPs in a host community nearby had additional challenges, reporting that those who go into labor at night have no option but to give birth in their tents because the health care facility does not operate 24 hours per day.

There were also disparities in accessing health care services, including reproductive health care, between IDPs in formal camps and those in host communities or those who had chosen to remain in camps after the government attempted to relocate them. For example, IDPs in Damare Camp in Adamawa indicated that there was no health clinic or water source in the camp,

and women and girls risked exposure to sexual and physical violence while walking to a water source outside the camp.

Pregnant and recently pregnant interviewees at IDP camps in Maiduguri observed that some pregnant women and girls had been exposed to sexual and physical violence and arbitrary arrests while walking to the clinic in the closest town to seek maternity care. This had caused a chilling effect, discouraging other pregnant women and girls from attempting to obtain skilled attendance during delivery.

IDPs from Durumi Camp in Abuja shared that they had given birth in their tents and that those who sought out care at a health clinic in the city, which had been mandated to provide maternity care to IDPs, had been detained in the facility for their inability to pay. They recounted stories of women who were detained until their bills had been fully paid. In one of those stories, a woman died while she was detained, and the hospital would not release her body to her fellow IDPs until they raised the money to pay the bill.

COMPREHENSIVE ABORTION CARE

Interviewees from all the IDP camps and host communities, as well as the humanitarian service providers who attend to them, were reluctant to speak about their experiences with abortion due to its criminalization. According to the penal code of Nigeria, abortion is a criminal offense. A woman who has an abortion or allows one to be procured for her can be imprisoned for seven years, and any person who provides an abortion faces imprisonment for 14 years, except when the abortion is performed to save the life of the mother.⁴⁵ The women were similarly reluctant to speak about personal experiences with seeking post-abortion care (PAC) due to the stigma and legal restrictions surrounding abortion. As one humanitarian service provider stated, “there's a culture of keeping quiet in cases like that. ... the fear and intimidation that has



A resident of an IDP camp flashes a smile at a session to discuss access to reproductive health services, 2018.
Photo Credit: Carey Wagner for the Center for Reproductive Rights.

been created, the stigmatization, these are things that affect the young women and the girls in the camps.” Yet the providers readily acknowledged that women and girls who become pregnant due to rape and sexual exploitation are forced to seek out unsafe abortion if they do not want to carry their pregnancies to term. “Yes, many of them use very crude means of aborting the pregnancy,” one said.

Interviews with both international and

national humanitarian service providers who have assisted with the establishment of health facilities and provision of health services in IDP camps and host communities in Nigeria revealed that the facilities play a substantial role in providing SRH services to affected populations within and outside of IDP camps and host communities. This is carried out in coordination with the government, either in existing government health facilities or in their own newly-constructed clinics. While these humanitarian service providers, during the first phase of interviews in Abuja and Adamawa, noted that they provide the Minimum Initial Service Package (MISP)⁴⁶ to women and girls in need of SRH services, this did not include abortion services, even for survivors of SGBV or sexual slavery. When pressed about the implications of this, given the widespread deliberate abduction, rape, and forced pregnancy of women, the humanitarian providers noted that they would typically refer them to local

providers if they requested abortion care. They did not know the outcome of the referrals. Some representatives of local Non-Governmental Organizations (NGOs) indicated that a funding policy by the U.S. government, known as the global gag rule,⁴⁷ had posed restrictions on their capacity to advocate for or provide abortion services.

The humanitarian care providers also cited Nigeria's aforementioned restrictive abortion law, which permits the procedure only if necessary to save the life of the woman, and some raised concerns about this legal barrier: "How can we mitigate high maternal mortality if the [abortion] law is not reviewed?" asked one interviewee. "We need to reform our present abortion law," another interviewee noted.

During the second phase of interviews, some of the humanitarian service providers in Maiduguri, the epicenter of the conflict, indicated that they had moved beyond MISP to providing comprehensive reproductive health services when presented with women who are victims of rape or forced pregnancy, or when they are in need of emergency obstetrics care due to an unsafe abortion.

LACK OF ACCOUNTABILITY MECHANISMS AND JUSTICE FOR SEXUAL AND REPRODUCTIVE RIGHTS VIOLATIONS

Ensuring accountability and the provision of SRH information and services is central not only to an effective humanitarian response but also for fulfilling fundamental human rights obligations. Yet a pervasive sense of lack of accountability for SRH violations was evident in interviews with all categories of stakeholders. Interviewees in the IDP camps and host communities recounted the severe sexual violence they were subjected to when their villages and homes were attacked by Boko Haram. Several women and girls, including pregnant women, were

raped, more often than not in the presence of their children, and many contracted HIV after these experiences.⁴⁸ Though they suggested they were more focused on survival in the IDP camps than on the likelihood of ultimately securing justice for what happened to them before they got there, they acknowledged that those who had been subjected to sexual violence in the camps were still unlikely to obtain justice.

A visually impaired young woman who was separated from her mother and brothers while fleeing Boko Haram and had resided in Bama IDP Camp told us she ultimately learned her family was at Dalori IDP Camp, so she relocated there. She recalled being raped when she had gone to get some drinking water with her younger brother at a stream near the Dalori Camp. Although the perpetrator was ultimately identified and taken to the police, she did not know what became of him and whether he was ever prosecuted because her IDP status and restrictions on the movement of IDPs precluded her and her family from following up on the matter with the police.

Another woman, also displaced and living in an IDP camp, was similarly raped and had recognized and identified her rapist; she explained that she was denied justice because under the penal code, corroboration by a male witness is required.

The interviewees in the IDP camps also expressed reservations about the government's commitment to ensuring SRH services to women and girls affected by the conflict, but felt they lacked agency to address this directly. NGO representatives who were interviewed made similar observations. One interviewee from an NGO noted, "Government needs to prioritize SRHR. [We] can't compel government; we can only tell them the situation through data gathering." Another called for the government to "look into finding a way to address the mental health challenges that people face as a result of the conflict they encountered, whether as a form of trauma or sexual violence."

We also interviewed humanitarian service

providers about the obstacles to ensuring that services are provided in an equitable manner and that there was accountability when violations occur. They highlighted challenges in retaining enough staff to reach affected populations due to insecurity posed by the conflict. Some noted that they relied on volunteers to provide services to populations in hard-to-reach locations. They further shared concern about access, noting that over one million people in need have yet to receive any humanitarian services in Northeast Nigeria. They observed that so far in the humanitarian response, there had been inadequate investment in addressing the root causes of the crisis and that this failure had resulted in a very protracted conflict without an end in sight. They also highlighted existing gaps in the humanitarian coordination efforts brought on by underfunding and lack of political will and expressed concerns about sustaining the future efforts.

Interviewees from government agencies noted that the government was committed to reducing the impact of the conflict on affected populations but conceded that there were several shortcomings in the government's response to the SRH needs of survivors.⁴⁹ There was a recognition that the provision of SRH services was not a priority and that inadequate funds had been allocated for these services. They further acknowledged that state and nonstate actors have yet to be held accountable, despite allegations and evidence of exploitative sexual encounters between affected populations (including minors) and some members of the military.

The findings indicate that a diverse set of interviewees—including humanitarian providers, UN agencies, NGO networks, and the affected women and girls—noted a widespread lack of, or inadequate access to, SRH services, including skilled birth attendants and essential medicines. These are in addition to ongoing human rights violations, and a dearth of supporting mechanisms and processes to ensure accountability for violations.

IV. Legal Framework

The SRHR of women and girls affected by conflict are protected by multiple, complementary bodies of law: national laws; regional human rights laws, and international laws, including international humanitarian law (IHL) and international human rights law (IHRL).⁵⁰ In Nigeria, these multiple bodies of law intersect to form a framework that is applicable in the protection of the SRHR of women and girls affected by the conflict. This brief focuses on the protections of SRHR offered by Nigeria's national laws, Africa's regional human rights laws, IHL, and IHRL.

The Maputo Protocol enshrines protection of women from all forms of violence, particularly sexual and verbal violence; and protection and respect of women's rights to health and reproductive health in Article 14 (1), including the right to control one's fertility and choose preferred means of contraception.



A young woman at an IDP host community, smiles as she reflects on her memories of a better time with her father and younger brother who were lost in the conflict, 2018. Photo Credit: Carey Wagner for the Center for Reproductive Rights.

APPLICABLE NATIONAL, REGIONAL, AND INTERNATIONAL LEGAL FRAMEWORK

National law, specifically the Nigerian Constitution, guarantees the right to life and prohibits the intentional deprivation of a person's life except on enumerated grounds. It protects the right to dignity and forbids subjecting any person to torture, or inhuman or degrading treatment. The Constitution also forbids the deprivation of a person's right to personal liberty unless based on a procedure permitted by law or in line with the instances listed in the constitution.⁵¹ The constitution further prohibits discrimination against any person solely on grounds of sex, place of origin, and circumstances of birth, among other delineated grounds, and provides for "adequate medical and health facilities for all persons."⁵² To ensure that these constitutional human rights provisions are operational, the National Health Policy and Strategy to Achieve Health for all Nigerians outlines plans that include improving equitable access to reproductive health services and ensuring that materials required to provide such services are

available.⁵³ Likewise, the National Health Act prohibits the refusal of emergency treatment to a person for any reason and further classifies reproductive health services as essential service.⁵⁴

Regional human rights laws that have been ratified by the Nigerian government include the African Charter on Human and Peoples' Rights (the African Charter),⁵⁵ the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) and the African Charter on the Rights and Welfare of the Child (the African Children's Charter). The African Charter provides for the following, which underlie women's and girls' reproductive rights: the right to life;⁵⁶ the right to health;⁵⁷ respect for dignity;⁵⁸ and protection from cruel, inhuman, and degrading treatment.⁵⁹ The African Charter provides that these rights and freedoms shall be enjoyed by all, on a nondiscriminatory basis, irrespective of race, ethnic group, color, sex, language, national and social origin, economic status, birth, or other status.⁶⁰ It also requires states to "ensure the protection of the rights of the woman."⁶¹

The Maputo Protocol enshrines protection of women from all forms of violence, particularly sexual and verbal violence;⁶² and protection and respect of women's rights to health and reproductive health in Article 14 (1), including the right to control one's fertility and choose preferred means of contraception. It also outlines women's right to receive information on health, including on HIV. Article 14 (2) requires the state to provide access to comprehensive SRHR services and information to all women, including on specific issues such as prenatal, delivery, and post-natal care. In the same vein, it guarantees access to safe medical abortion, including 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.”⁶³ Specifically, for situations of conflict and for women and girls affected by conflict, the Maputo Protocol emphasizes women's right to peaceful existence⁶⁴ and states' obligations to protect women “against all forms of violence, rape and other forms of sexual exploitation” during armed conflict.⁶⁵ The African Children's Charter requires states to “take all appropriate

The African Children's Charter requires states to “take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child...” and enshrines the rights to life and health. It also emphasizes the state's duty to take care of children and protect their rights during armed conflict.

measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child...”⁶⁶ and enshrines the rights to life and health.⁶⁷ It also emphasizes the state's duty to take care of children and protect their rights during armed conflict.⁶⁸

The African Charter has been domesticated into law in Nigeria by virtue of the African Charter on Human and Peoples' Rights (Enforcement and Ratification) Act of 1983. Regarding those that are not yet domesticated, the obligation of compliance that accompanies ratification of a treaty persists.

IHL is applicable only in times of armed conflict, including both international armed conflict and noninternational armed conflict, and binds all parties to an armed conflict, including nonstate armed groups.⁶⁹ IHL allows for no derogation or reservation.⁷⁰ In addition, many, but not all, of the customary international law rules, including those rules related to fundamental guarantees, such as the right to be protected from torture, or from cruel or degrading treatment, apply to both international armed conflict (IAC) and noninternational armed conflict (NIAC) and hence, nonstate armed groups.⁷¹ The situation in Nigeria has been determined to be a noninternational armed conflict for the purposes of the application of IHL.⁷²

Customary IHL Rule 134 related to NIAC notes that while common Article 3 of the Geneva Conventions and Additional Protocol II do not contain a general rule stating that the specific needs of women must be respected, they refer to specific aspects of this rule by requiring respect for the person and honor of each person. They prohibit violence to life, health, and physical and mental well-being, and prohibit outrages upon personal dignity, including humiliating and degrading treatment, rape, enforced prostitution, and any form of indecent assault. They also require the separation of women and men in detention.⁷³

Recognizing their specific needs and the vulnerabilities they face in conflict, however, IHL affords women additional specific protections and rights.⁷⁴ Additional Protocol I requires that parties to an armed conflict treat pregnant women and nursing mothers with particular care, including with respect to medical assistance.⁷⁵ Rule 134 of Customary IHL requires that the specific protection, health and assistance needs of women affected by armed conflict, regardless of whether they are combatants, fighters, civilians or hors de combat, must be respected; IHL standards are referenced to support this rule.⁷⁶ The International Committee of the Red Cross (ICRC) has interpreted this norm as encompassing “medical, psychological and social assistance,” including trauma treatment and counseling.⁷⁷ The breadth of this responsibility is also recognized in the ICRC Commentary (2016), which notes that the special protection and care afforded to women must take into account “the distinct set of needs of and particular physical and psychological risks facing women, including those arising from social structures.” It requires “equal respect, protection and care based on all the needs of women.”⁷⁸

Customary IHL also prohibits sexual violence against any person, regardless of sex.⁷⁹ The range of prohibited acts include rape and enforced prostitution, sexual slavery, forced pregnancy, forced sterilisation, forced public nudity or stripping, mutilation of sexual organs, forced marriage, forced inspections for virginity, sexual exploitation (such as obtaining sexual services in return for food or protection), forced abortions, and sex trafficking.⁸⁰ The aforementioned ICRC Commentary (2016) further notes that “there is a growing acknowledgement that women, men, girls and boys are affected by armed conflict in different ways” and “[s]ensitivity to the individual's inherent status, capacities and needs, including how these differ among men and women due to social, economic, cultural and political

structures in society, contributes to the understanding of humane treatment under common Article 3.”⁸¹

The complementary and mutually reinforcing protection of IHRL (see below) and IHL has been expressly recognized by international and regional courts and tribunals.⁸² Human rights law instruments, documents, and case law support strengthen and clarify analogous principles of IHL.⁸³

IHRL is applicable in Nigeria's case. Nigeria has ratified several international human rights treaties, such as the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Optional Protocol on the Elimination of all Forms of Discrimination against Women (OP-CEDAW); UN Convention on the Rights of the Child (CRC); Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (OPAC); UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); and Convention on the Rights of Persons with Disabilities (CRPD). These treaties also enshrine rights and obligations that underlie access to and enjoyment of women's and girls' reproductive rights, even in conflict settings.

The CRC recognizes that every child has the inherent right to life⁸⁴ and the right to the enjoy the highest attainable standard of health, which includes access to health facilities and services.⁸⁵ It charges states with ensuring the protection of children against torture or other cruel, inhuman, or degrading treatment or punishment⁸⁶ and ensuring their access to information, especially that which is aimed at the promotion of the child's well-being and physical and mental health. The CAT focuses entirely on states' obligation to



A young woman and her child share a joyful moment of bonding at an IDP Camp, 2018.
Photo Credit: Carey Wagner for the Center for Reproductive Rights.

protect people from and to prevent all forms of torture and cruel, inhuman or degrading treatment (TCIDT) within their jurisdictions, on the basis that humans have inherent dignity and are therefore entitled to such protection.⁸⁷ The ICCPR mandates the same.⁸⁸ It also accords everyone the right to seek, receive, and impart information and ideas of all kinds;⁸⁹ this would include information on health and reproductive health.

The ICESCR, whose focus is socioeconomic rights, recognizes everyone's right to access and enjoy the highest attainable standard of health, both physical and mental. It also mandates states to take specific steps necessary to achieve, among other things, “the healthy development of the child.”⁹⁰ It highlights state responsibility to ensure the equal right of men and women to access and enjoy all of the rights it enshrines.⁹¹ Minimum core obligations with respect to economic, social, and cultural rights are not subject to resource availability and are nonderogable.⁹² This means that states are required to “prioritize the realization of

people's basic economic, social and cultural rights....”⁹³ and therefore “satisfy, at the very least, minimum essential levels of each of the rights....”⁹⁴

The CEDAW declares that discrimination against women violates respect for human dignity. It mandates states to take “all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning,”⁹⁵ including for women in rural or remote areas.⁹⁶

The CEDAW Committee, in its General Comment 30, has provided guidance on obligations under that Convention in situations of armed conflict, recommending that state parties:

[e]nsure that sexual and reproductive health care includes access to sexual and reproductive health and rights information; psychosocial support; family planning services, including emergency contraception; maternal health services, including antenatal

*care, skilled delivery services, prevention of vertical transmission and emergency obstetric care; safe abortion services; post-abortion care; prevention and treatment of HIV/AIDS and other sexually transmitted infections, including post-exposure prophylaxis; and care to treat injuries such as fistula arising from sexual violence, complications of delivery or other reproductive health complications, among others.*⁹⁷

The CEDAW Committee has called on states to give priority to the provision of these SRH services, including safe abortion services, noting with concern the effects of armed conflict on SRHR and maternal mortality.⁹⁸ It has also noted that instead of suspending rights protections, states should “adopt strategies and take measures addressed to the particular needs of women in ... states of emergency.”⁹⁹

The CEDAW and CESCRC committees have noted that refugees, stateless persons, asylum seekers, and undocumented migrants are in a situation of vulnerability due to their legal status, which requires the state to take additional steps to ensure their access to affordable and quality sexual and reproductive information, goods, and health care.¹⁰⁰

Guidance from these committees posits that realizing SRHR in humanitarian settings requires, among other things:¹⁰¹

- > Ensuring available, accessible, adequate, and quality services without discrimination.
- > Ensuring that those who seek services are able to make informed and autonomous decisions, without spousal, parental, or third-party consent.
- > Establishing systems for maintaining privacy and confidentiality.
- > Access to justice and effective remedies when individual rights are violated.

Implications for the Sexual and Reproductive Rights of Women and Girls in Conflict

International and regional legal and political bodies charged with interpreting these treaties and laws have affirmed that fundamental human rights obligations, including SRHR, continue to apply during situations of armed conflict, subject only to certain limitations.^{102, 103, 104} As such, Nigeria is bound by its obligations under human rights law in its responses to SRHR violations emerging from the ongoing conflict as discussed below.¹⁰⁵

Maternal Health

Nigeria must ensure that IDP women and girls have the maternal health services they need in line with the legal obligations discussed above. The CEDAW Committee has recommended that states ensure maternal health services, among other services, for women and girls affected by conflict.¹⁰⁶ Human rights law obligates states to eliminate preventable maternal mortality and morbidity, including by ensuring access to adequate pre- and post-natal care, emergency obstetric services, and skilled birth attendants, free from discrimination, coercion, and violence.¹⁰⁷

The Inter-Agency Working Group on Reproductive Health in Crises (IAWG), an authoritative source for SRH in crises,

recommends that at the health center level, closest to women and girls, basic emergency obstetric and newborn care must be provided as part of maternal health care. This must be accompanied by “a well-coordinated system to identify obstetric complications and ensure their immediate management and/or referral to a hospital” with comprehensive emergency obstetric care. Where health centers are not available, the IAWG recommends the distribution of “clean, safe delivery and newborn care kits to all visibly pregnant women.”¹⁰⁸

Noting the effects of armed conflict on SRHR and maternal mortality, the CEDAW Committee has recommended that states prioritize access to maternal health care services regardless of where women reside.¹⁰⁹ The obligation to ensure reproductive and maternal health is comparable to a minimum core or minimum essential obligation with which states must comply at all times.¹¹⁰

Human rights bodies have repeatedly raised concerns about maternal mortality levels, particularly in Northeast Nigeria, and urged the government to take action.¹¹¹ However, the conflict has only exacerbated these underlying issues, and the government does not appear to have prioritized addressing maternal mortality or other inadequacies in maternal health services to these populations. Special Rapporteurs, or independent experts, visiting Nigeria observed “limited” access to services, including ... sexual and reproductive health services.¹¹² These observations align with the findings on maternal health that were made during the interviews, which revealed unaddressed inadequacies, including discrepancies in access to skilled care or free maternal care services for pregnant IDPs, lack of respectable and dignified care exemplified by mistreatment, abuse, and detention of IDPs for inability to pay hospital bills, and resultant maternal mortalities and morbidities.

Comprehensive Abortion Services and Contraceptive Information And Services

It is critical to ensure cross-sector collaboration by government institutions; humanitarian agencies; relevant subregional, regional, and UN mechanisms; states hosting refugees; and donor states and foundations to prioritize SRHR

Following from the legal framework on abortion under national, regional, and international law, at a minimum, Nigeria must ensure that abortion is both legal and accessible when a woman's life or health is at risk, in cases of rape and incest, and in cases of severe or fatal fetal anomalies.¹¹³ It is also obligated to provide humane, quality post-abortion care to women, regardless of whether abortion is legal.¹¹⁴

As part of its minimum but essential international obligations under the right to health, Nigeria must also take steps to prevent unsafe abortion and to “repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine individual's or particular group's access to sexual and reproductive health facilities, services, goods and information.”¹¹⁵

The former UN High Commissioner for Human Rights, Zeid Ra'ad Hussein has strongly urged the “most compassionate possible interpretation” of Nigeria's national abortion laws to include legal abortion care in cases of rape and to preserve the health of the woman. Regional human rights bodies have also called on the Nigerian government to bring its laws in line with its regional commitments to safe abortion.¹¹⁷

In terms of programming for delivery of comprehensive abortion services in conflict setting, the IAWG recognizes that first-line comprehensive abortion care can be safely

The fact that abortion remains criminalized in Nigeria fuels stigma and hampers provision of access to abortion, even by humanitarian service providers who have adapted to the prevailing legal and social contexts by generally not programming for nor providing abortion services.



A woman in an IDP Camp in Borno shows interviewers her living quarters, 2019. Photo Credit: Ikechukwu Udeh for the Center for Reproductive Rights and LEDAP.

provided by nurses, midwives, and other trained health care providers without dependence on less accessible higher-cadre professionals, such as obstetricians/ gynecologists and surgeons. It recommends that technical support to qualified medical personnel already providing abortion services should be continuous and that distribution of information and commodities for safe medication abortion must be sustained as it is fundamental to reducing harm from unsafe abortion.¹¹⁸

Nigeria is also obligated to ensure access to contraceptive information and services for all individuals— including adolescents and youth.¹¹⁹ Noting the increased risk of sexual violence in conflict, the CEDAW Committee has called on states to ensure access to contraception, including emergency contraception, in these settings.¹²⁰

The African Commission, which interprets the African Charter, has called on states to remove obstacles faced by women, particularly in situations of conflict, who want access to contraception and safe abortion services.¹²¹ The IAWG calls for access to contraception for adolescents, in their diversity, including those who are “married, unmarried, with disabilities, in-school and out of school.” Yet, according to a recent national survey, contraceptive use is

generally low, and as low as 3% among married women in Northeast Nigeria.¹²²

The findings of this study, including the aforementioned reports, underscore the government's failure to provide effective and adequate access to safe abortion and contraceptive services for many women and girls affected by the conflict. As was earlier highlighted, the fact that abortion remains criminalized in Nigeria fuels stigma and hampers provision of access to abortion, even by humanitarian service providers who have adapted to the prevailing legal and social contexts by generally not programming for nor providing abortion services. As a consequence, women and girls who fall pregnant under circumstances that should allow them eligibility for access to abortion—e.g., through rape and sexual exploitation—are unable to access any information on safe abortion and are mostly left with no choice but to seek unsafe abortion if they do not want to or cannot carry their pregnancies. All this is despite the fact that in Northeast Nigeria, there are acknowledged widespread deliberate abductions, sexual slavery, rape, and forced pregnancy of women and girls. This raises serious concerns about the deficient prioritization and funding of these services by the government as well as by humanitarian service providers.

SEXUAL AND GENDER-BASED VIOLENCE AND RELATED VIOLATIONS

Under its regional and international human rights commitments, as discussed above, Nigeria is obligated to ensure that women and girls who have suffered SGBV are provided with immediate access to appropriate medical and psychosocial care, and to allow humanitarian organizations to provide such care when Nigeria is unable to.¹²³ UN Security Council Resolution 2349 called on Nigeria to provide “rapid access for survivors of abduction and sexual violence to specialised medical and psychosocial services” and community reintegration to prevent stigmatization and persecution.

Nigeria is also bound by IHL to provide care for women and girls who are survivors of SGBV, including rape, as these women and girls fall within the protections provided for the wounded and sick in armed conflict situations.¹²⁴ Similarly to the above, “at minimum, IHL establishes an obligation to provide medical care and attention to victims of sexual violence.”¹²⁵ The ICRC notes that this is an obligation of means; states, including Nigeria, must therefore make their “best efforts” to fulfill this obligation, including by permitting humanitarian organizations to assist, especially in cases when they are unable to fulfill it, through deployment of their own means.¹²⁶

However, despite the well-publicized plight of women and girls affected by the conflict with Boko Haram, little assistance is available, particularly for those living outside camps.¹²⁷ Moreover, in certain instances, the government has deliberately prevented women and girls from accessing SRH services. Human rights reports indicate that Nigerian government forces have detained women and girls suspected of being “Boko Haram wives” and subsequently denied them essential maternal and obstetric health care while in detention.¹²⁸ While the Nigerian

government has noted its attempts to rehabilitate and reintegrate the girls they have released from captivity, it has not addressed whether any measures have been taken to ensure that these girls have access to sexual and reproductive health and services.¹²⁹

Nigeria is bound by the provisions of the Maputo Protocol, which states that abortion should be permitted in situations of rape, incest, and sexual assault.¹³⁰ The denial of safe abortion care to survivors of rape violates the rights to health and privacy and could amount to a violation of the prohibition on ill-treatment.¹³¹

The UN Secretary-General has called for humanitarian responses to include access to emergency contraception for pregnancies resulting from rape.¹³² Special Rapporteurs have urged that Nigeria should “[e]nsure that survivors of sexual violence who seek assistance have access to comprehensive clinical services, including emergency contraception and post-exposure prophylaxis to prevent HIV infection, and authorization from the authorities for termination of pregnancy for those wishing to do so.”¹³³

The Guidelines on Combating Sexual Violence and its Consequences in Africa also require Nigeria to provide SGBV survivors with medical services to mitigate and/or remedy the consequences of the violence, including, but not limited to, access to contraception (including emergency contraception), medical abortion, and post-abortion care. The IAWG recommends that this be done in safe spaces in health facilities that allow for confidential care; these spaces should be designed to receive survivors and provide them with the appropriate clinical care, as well as any relevant referrals.¹³⁴

The findings in this study, of recurring rape; forced and child marriage; sexual exploitation, including of adolescents, in exchange for accessing food, water, feminine hygiene products, and lifesaving commodities, are clear indications that the

government is failing to protect IDPs affected by the Boko Haram conflict, from SGBV. This, coupled with serious concerns about the high prevalence of HIV transmission due to the aforementioned forms of SGBV and documented deaths as a result of SGBV, suggests that the government is not ensuring access to SRH services for those at risk of or for those who survive SGBV. This is the case to date.

LACK OF ACCOUNTABILITY MECHANISMS AND JUSTICE

The inadequate provision of sexual and reproductive health services and prevalence of sexual violence and forced marriage impair or nullify the enjoyment of a range of human rights, including but not limited to the rights to life, health, liberty and security of person, nondiscrimination, equal protection and equality in the family, dignity, and freedom from torture and cruel, inhuman, or degrading treatment.^{135, 136}

To comply with its international and regional human rights obligations, as discussed above, Nigeria must ensure access to abortion to survivors of sexual violence and prevent the detention of IDPs in health care facilities following delivery. Further, Nigeria must ensure that state actors do not inflict sexual violence or other outrages upon women's and girls' dignity, and must investigate and prosecute those responsible for violations.^{137, 138} Nigeria must also exercise due diligence to ensure that women and girls, including refugees and IDPs, in conflict settings are protected from SGBV, including child marriage and sexual exploitation, carried out by third parties.^{139, 140} Moreover, Nigeria is obligated to provide survivors with immediate access to medical services and accountability mechanisms for SGBV in all displacement settings.¹⁴¹

States are the primary duty-bearers of IHRL. Consequently, the human rights obligations, both positive and negative, apply to Nigeria, as a whole, independent of

any division of responsibility or internal structure.¹⁴² These obligations include the duty to investigate alleged violations of IHRL and hold those responsible to account, including in the case of human rights violations amounting to crimes, by prosecuting and punishing the perpetrators. While IHRL is generally thought to apply only to states, this view is evolving, particularly where nonstate actors, as in the case of Boko Haram in Nigeria, “exercise some degree of control over a given territory and population.”¹⁴³

Many women and girls continue to be abused by Boko Haram. Those still in captivity face sexual violence, sexual slavery, forced marriages, and forced pregnancy, among other violations. In 2017, the CEDAW Committee raised concerns that a significant number of girls who were abducted by Boko Haram in Borno State in 2014 had not been rescued and that they continue to be subjected to rape, sexual slavery, forced marriage, and impregnation.¹⁴⁴

A 2017 report of the Special Rapporteur on the human rights of IDPs described “an epidemic of exploitation and abuse,” noting that “sexual exploitation and sexual violence, including demands for transactional sex to access food and nonfood items, are commonplace” and that these “violations have been exacerbated by a lack of adequate assistance to IDPs in host communities and camps.”

In addition to failing to protect women and girls from abduction, the Nigerian government has not provided effective accountability mechanisms. A joint report by the UN Special Rapporteurs on health, children, and contemporary forms of slavery noted that “[a]ccess to remedies for victims of the insurgency, including of sexual and gender-based violence, is almost nonexistent” due to interrelated and mutually reinforcing factors. These include “resistance to reporting for fear of stigma, ostracism and reprisals, ignorance of entitlements and avenues to them, mistrust of authorities, a context of entrenched discrimination and stereotypes, and lack of training and sensitivity of public officials, including law enforcement officers, among others.”¹⁴⁵ The African Commission has urged Nigeria to meet its regional human rights obligations, including by thoroughly investigating and bringing perpetrators of these gross human rights violations to justice.¹⁴⁶

Even when women and girls are able to evade or escape Boko Haram, many of them have been subjected to sexual abuse and exploitation or have been among the increasing number of cases of child, forced, or coerced marriages in displacement settings.¹⁴⁷ A 2017 report by the UN Secretary-General describes incidents of rape, sexual violence, and sexual exploitation carried out by security guards, camp officials, the Civilian Joint Task Force, and other officers of the Nigerian security forces.¹⁴⁸ A 2017 report of the Special Rapporteur on the human rights of IDPs described “an epidemic of exploitation and abuse,” noting that “sexual exploitation and sexual violence, including demands for transactional sex to access food and nonfood items, are commonplace” and that these “violations have been exacerbated by a lack of adequate assistance to IDPs in host communities and camps.”¹⁴⁹

International and regional human rights bodies have urged Nigeria to investigate, prosecute, and punish perpetrators of

alleged sexual exploitation, including “transactional sex” in IDP camps.¹⁵⁰ The Special Rapporteur on IDPs noted that in some camps, “food distribution was under the authority of males, creating the conditions for sexual abuse due to scarcity of food,” and in other instances, distance and lack of lighting in bathing areas made women and girls vulnerable to sexual abuse.¹⁵¹

The findings of this study do not vary from the above. As underlined, “a pervasive sense of lack of accountability for SRH violations was evident in interviews with all categories of stakeholders.” Engagement of government, with data indicating why it should prioritize provision of SRHR services as well as mental health support for survivors of SRHR violations, has not led to any action. Instead, the government of Nigeria has acted adversely in admittedly deprioritising these services and consequently allocating inadequate funds for their delivery. Under the prevalent insecurity and instability, humanitarian service providers struggle with retaining enough staff to deploy and fill in the gaps left by government, including in reaching affected populations in remote and unsafe areas.

Furthermore, reports of women and girls, including pregnant women, being raped, more often than not in the presence of their children, are not addressed. These women and girls still feel that they are unlikely to obtain justice. Whereas IDP status and restrictions on the movement of IDPs preclude survivors from following up on accountability processes, there has been no action from government authorities to address this. This lack of action is also apparent with the government's acknowledgement that state actors, including members of the military, and nonstate actors have yet to be held accountable for exploitative sexual encounters against conflict-affected populations.

The government's failure to respond to these violations has raised concerns that it has not prioritized its obligation to protect women and girls from SGBV or to hold those responsible accountable for their crimes.¹⁵²

V. Conclusion

The findings affirm the role and potential impact of operationalizing human rights obligations and principles in ensuring SRH services and accountability for the range of SRHR violations experienced by women and girls affected by the conflict in Northeast Nigeria. Interviewees' experiences illustrate the challenges and barriers to accessing SRH services and accountability mechanisms.

In line with the Nigeria-specific recommendations that have been made by regional and international human rights experts and bodies, it is critical to ensure cross-sector collaboration by government institutions; humanitarian agencies; relevant subregional, regional, and UN mechanisms; states hosting refugees; and donor states and foundations to prioritize SRHR, including access to maternal health care, contraception, safe abortion care, post-abortion services, and remedies for violations in these settings.

Ensuring the provision of comprehensive sexual and reproductive health information and services, as well as accountability for sexual violence, is central to an effective humanitarian response as well as to the fulfillment of fundamental human rights obligations.

ENDNOTES

- 1 Georg E. Frerks, Human Rights Violations and Temporary Conflict: An Inquiry into Causes and Remedies in Ineke, , pp. 67, 68 (Boerefin Ed Human Rights and Conflict: Essays in Honor of Bas de Gaay Fortman, 2012).
- 2 United Nations High Commissioner for Human Rights, International Legal Protection of Human Rights in Armed Conflict, p. 5 (2011), available at https://www.ohchr.org/Documents/Publications/HR_in_armed_conflict.pdf [hereinafter Legal Protection of Human Rights].
- 3 Legal Protection of Human Rights, p. 11.
- 4 Legal Protection of Human Rights, p. 1.
- 5 See, e.g., Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Rep. of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General, para. 43, UN Doc. A/68/297 (August 9, 2013) (by Anand Grover); Therese McGinn, Sara Casey, Susan Purdin, & Mendy Marsh, Reproductive Health for conflict-affected people: Policies, research and programmes 45 OVERSEAS DEVELOPMENT INSTITUTE HUMANITARIAN PRACTICE NETWORK, pp. 10-11 (April 2004); see also Kayla McGowan, Closing the Gaps of Maternal Health in Conflict and Crises, MATERNAL HEALTH TASK FORCE BLOG (December 15, 2016), <https://www.mhtf.org/2016/12/15/closingthe-gaps-of-maternal-health-in-conflict-and-crisis>.
- 6 Akseer N, Wright J, Tasic H et al. Women, children and adolescents in conflict countries: an assessment of inequalities in intervention coverage and survival. BMJ GLOBAL HEALTH 2020, available at <https://gh.bmj.com/content/bmjgh/5/1/e002214.full.pdf>
- 7 Dyan Mazurana, 'The gendered impact of conflict and peace keeping in Africa' in ACCORD, Conflict Trends, Issue 2 (ACCORD 2013). See also, Health Cluster, Gender-based violence in health emergencies, available at <https://www.who.int/health-cluster/about/work/other-collaborations/gender-based-violence/en/>, last accessed on June 2, 2020.
- 8 United Nations Population Fund (UNFPA), State of World Population 2015: Shelter from the Storm, A Transformative Agenda for Women and Girls in a Crisis-Prone World (2015), available at <http://www.unfpa.org/sites/default/files/sowp/do>wnloads/State_of_World_Population_2015_EN.pdf [hereinafter UNFPA, State of World Population 2015]. And World Health Organization (WHO), World Report on Violence and Health, 147-174 (2002), available at http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf. And Committee on Economic, Social and Cultural Rights (CESCR Committee), General Comment No. 22 (2016) on the Right to sexual and reproductive health, para. 5, UN Doc. E/C.12/GC/22 (2016) [hereinafter CESCR Committee, Gen. Comment No. 22].
- 9 Center for Reproductive Rights, Factsheet: Sexual and Reproductive Health and Rights in Conflict (September 2017), available at https://www.reproductiverights.org/sites/crr.civicaactions.net/files/documents/GLP_GA_SRHR_FS_0817_Final_Web.pdf [hereinafter Sexual and Reproductive Health and Rights in Conflict] and Carmen Márquez Carrasco et al, Human Rights Violations in Conflict Settings, p. 171 (2014), available at <http://www.fp7-frame.eu/wp-content/uploads/2016/08/08-Deliverable-10.1.pdf>
- 10 Shirin Heidari et al, Sexual and reproductive health and rights in humanitarian crises at ICPD25+ and beyond: consolidating gains to ensure access to services for all, Sexual and Reproductive Health Matters (2019), 27:1, 343-345, DOI: 10.1080/26410397.2019.1676513
- 11 Akseer N, Wright J, Tasic H et al. Women, children and adolescents in conflict countries: an assessment of inequalities in intervention coverage and survival. BMJ Global Health (2020), available at
- 12 Committee on the Elimination of Discrimination against Women General Comment No 30: Women in conflict, prevention, conflict and post conflict 1 (47th Session, 2010) CEDAW/C/GC/30 (2013) [hereinafter referred to as CEDAW Committee General Recommendation 30].
- 13 Internal Displacement Monitoring Centre. Nigeria: Fragmented response to internal displacement amid Boko Haram attacks and flood season. Oslo: Norwegian Refugee Council (2013).
- 14 NBS 2016.
- 15 United Nations Development Programme, National Human Development Report 2018, Achieving Human Development in Northeast Nigeria, p. 4 (2018) available at <https://reliefweb.int/report/nigeria/fragmented-response-internal-displacement-amid-boko-haram-attacks-and-flood-season> [hereinafter referred to as National Human Development Report 2018].

- 16 National Human Development Report 2018, pp. 4 & 13.
- 17 National Human Development Report 2018, p. 14.
- 18 National Human Development Report 2018, pp. 4 & 16.
- 19 Internal Displacement Monitoring Center; Fragmented response to internal displacement amid Boko Haram attacks and flood season and Pérouse de Montclos M-A, Nigeria's interminable insurgency? Addressing the Boko Haram crisis. London, UK: Chatham House, The Royal Institute of International Affairs (2014), available at <https://www.prio.org/Publications/Publication/?x=7481> [hereinafter referred to as Pérouse de Montclos M-A, Nigeria's interminable insurgency? Addressing the Boko Haram crisis]
- 20 Pérouse de Montclos M-A, Nigeria's interminable insurgency? Addressing the Boko Haram crisis
- 21 UNDP, Lucky Musonda, Achieving human development in North-East Nigeria will require addressing root causes of the crisis, available at <https://www.ng.undp.org/content/nigeria/en/home/presscenter/articles/achieving-human-development-in-north-east-nigeria-will-require-a.html>
- 22 Reinert M et al. Boko Haram: Islamism, politics, security and the state in Nigeria, Vol. 2, West African Politics and Society Series. Leiden, Netherlands: African Studies Centre, Institut Français de Recherche en Afrique (2014), pp. 237–45, available at <https://openaccess.leidenuniv.nl/handle/1887/23853> [hereinafter referred to as Reinert M et al, Boko Haram: Islamism, politics, security and the state in Nigeria].
- 23 Reinert M et al, Boko Haram: Islamism, politics, security and the state in Nigeria, pp. 237–45.
- 24 Id.
- 25 Al Jazeera, Fidelis Mbah, Nigeria's Chibok schoolgirls: Five years on, 112 still missing (April 14, 2019) available at <https://www.aljazeera.com/news/2019/04/nigeria-chibok-school-girls-years-112-missing-190413192517739.html>, last accessed on June 1, 2020.
- 26 Omar Mahmood and Christian Nduibuisi, "Factional Dynamics within Boko Haram," Institute of Security Studies (July 6, 2018), available at <https://issafrica.org/research/books-and-other-publications/factional-dynamics-within-boko-haram> [hereinafter referred to as Factional Dynamics within Boko Haram].
- 27 Factional Dynamics within Boko Haram. And International Crisis Group, Nigeria: Growing Insecurity on Multiple Fronts (July 20, 2017) available at <https://www.crisisgroup.org/africa/west-africa/nigeria/nigeria-growing-insecurity-multiple-fronts>, last accessed on June 1, 2020.
- 28 International Crisis Group, Returning from the Land of Jihad: The Fate of Women Associated with Boko Haram, Report 275 / Africa (May 21, 2019) available at <https://www.crisisgroup.org/africa/west-africa/nigeria/275-returning-land-jihad-fate-women-associated-boko-haram> last accessed on June 1, 2020.
- 29 ACAPS. Northeast Nigeria: Secondary Data Review: Conflict – Adamawa, Borno, Gombe, and Yobe states (August 24, 2015) available at <https://reliefweb.int/report/nigeria/northeast-nigeria-secondary-data-review-conflict-adamawa-borno-gombe-and-yobe-states> last accessed on June 1, 2020.
- 30 UNICEF USA, Children in Conflict: Boko Haram Crisis, available at <https://www.unicefusa.org/mission/emergencies/conflict/boko-haram-crisis>, last accessed on June 1, 2020.
- 31 UNFPA, Adolescent Girls in Disaster & Conflict: Interventions for Improving Access to Sexual And Reproductive Health Services 42 (2016), available at https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-Adolescent_Girls_in_Disaster_Conflict-Web.pdf
- 32 Id.
- 33 Council on Foreign Relations, John Campbell and Asch Harwood, Boko Haram's Deadly Impact (August 20, 2018), available at <https://www.cfr.org/article/boko-harams-deadly-impact> last accessed on June 1, 2020
- 34 International Crisis Group, Nnamdi Obasi, Nigeria's Faltering Response Emboldens Boko Haram (January 31, 2015) available at <https://www.crisisgroup.org/africa/west-africa/nigeria/nigeria-s-faltering-response-emboldens-boko-haram>. Last accessed in June 2020.
- 35 Interviewees from IDP camps and host communities in Borno, Adamawa, Yobe and Abuja (FCT) recounted details of these killings and abductions during interviews that the Center and LEDAP conducted between February 2018 and June 2019.
- 36 International Crisis Group, Ayo Obe, To Defeat Boko Haram, Nigeria Must Get Women on Board (December 12 2016) available at <https://www.crisisgroup.org/africa/west-africa/nigeria/defeat-boko-haram-nigeria-must-get-women-board>, International Crisis Group,
- Nnamdi Obasi, Nigeria's Faltering Response Emboldens Boko Haram (January 31, 2015), available at <https://www.crisisgroup.org/africa/west-africa/nigeria/nigeria-s-faltering-response-emboldens-boko-haram>.
- 37 UNDP, Lucky Musonda, Achieving human development in North-East Nigeria will require addressing root causes of the crisis – Achim Steiner available at <https://www.ng.undp.org/content/nigeria/en/home/presscenter/articles/achieving-human-development-in-north-east-nigeria-will-require-a.html>, last accessed on June 1, 2020.
- 38 The Center for Reproductive Rights (the Center), with headquarters in New York, and offices in Nairobi, Kathmandu, Bogota, Geneva, and Washington, D.C., uses international, regional, and constitutional law to secure women's reproductive rights.
- 39 For this project, the Center partnered with the Legal Defence and Assistance Project (LEDAP) (<http://ledapnigeria.org>). The Center's strategy of partnering with national-level organizations ensures ownership, sustainability, and legitimacy of goals and outcomes.
- 40 Center for Reproductive Rights . Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict. (2017), available at <https://www.reproductiverights.org/document/briefing-paper-ensuring-sexual-and-reproductive-health-and-rights>[hereinafter referred to as Center for Reproductive Rights , Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict]
- 41 In the Nigerian context where sociocultural values privilege, marriage, and virginity, coupled with the inadequacies in accessing SRH services, she feared the stigma and reprisal that she might encounter if she sought SRH services or justice.
- 42 Interview with humanitarian providers in Abuja, July 24, 2018.
- 43 United Nations High Commissioner for Human Rights (OHCHR), Human Rights Council, Preventing and Eliminating Child, Early and Forced Marriage, para. 20, UN Doc. A/HRC/26/22, 26th Session (2014), available at https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/26/22
- 44 The World Health Organization has confirmed that almost 50% of all postnatal maternal deaths happen within 24 hours after delivery and in its technical guidelines recommends that women who have gone through uncomplicated vaginal delivery remain in the health facility for at least 24 hours after childbirth.
- 45 Sources: Sections 228 and 289 of Criminal Code Act (1916) Cap. (C38) Laws of the Federation of Nigeria 2004 (nb: Although the

- Criminal Code Act does not apply throughout Nigeria except with respect to federal offenses, individual states have their criminal codes with provisions similar to the Criminal Code Act.)
- 46 "...a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis." – <https://cdn.iawg.rgyn.io/documents/minimum-initial-service-package-misp-advocacy-sheet.pdf?mtime=20200303202343&focal=n one>
- 47 Under this policy, nongovernmental organizations (NGOs) incorporated outside the United States and receiving U.S. global health assistance funds for grants or cooperative agreements are prohibited from using this money or any of their own funds from any other sources to perform or actively promote abortion as "a method of family planning." The prohibition includes providing referrals and counseling for women seeking an abortion as "a method of family planning" or advocacy to make abortion safe and legal as "a method of family planning." – https://www.reproductiverights.org/sites/default/files/documents/GLP-GGR-FS-0118-Web_2.pdf
- 48 Interviews with IDPs from Borno and Yobe in Maiduguri, Borno, June 2019.
- 49 Interviews with federal ministries of justice, women affairs, health, and education in Abuja in February 2018 and June 2019.
- 50 Center for Reproductive Rights, Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict, p. 13
- 51 The Constitution of the Federal Republic of Nigeria, 1999, Sections 1, 33, 34, 25, 39, and 42.
- 52 Id, Section 17 (3) (d).
- 53 National Health Policy of 1998, 2004, and 2016.
- 54 The National Health Act, Section 45.
- 55 See, ACHPR, Ratification Table: African Charter on Human and Peoples' Rights, available at <https://www.achpr.org/ratificationtable?id=49>, last accessed on June 2, 2020. and ACERWC, Ratifications Table, available at <https://www.acerwc.africa/ratifications-table/> last accessed on June 2, 2020
- 56 African Charter on Human and Peoples' Rights, adopted June 27, 1981, art. 4, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (entered into force October 21, 1986) [hereinafter African Charter].
- 57 African Charter, Article 16.
- 58 African Charter, Article 5.
- 59 African Charter, Article 5.
- 60 African Charter, Article 2.
- 61 African Charter, Article 18 (3).
- 62 African Charter, Article 3 (4).
- 63 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003, art. 5(b), CAB/LEG/66.6 (2000) (entered into force November 25, 2005) [hereinafter Maputo Protocol].
- 64 Maputo Protocol, Article 10.
- 65 Maputo Protocol, Article 11.
- 66 Maputo Protocol, Article 21.
- 67 African Charter, Articles 5 (1), 14.
- 68 African Charter, Article 22.
- 69 '... Under Article 3 common to the Geneva Conventions of 12 August 1949, non-international armed conflicts are armed conflicts in which one or more non-State armed groups are involved. Depending on the situation, hostilities may occur between governmental armed forces and non-State armed groups or between such groups only. ... Non-governmental groups involved in the conflict must be considered as "parties to the conflict", meaning that they possess organized armed forces. This means for example that these forces have to be under a certain command structure and have the capacity to sustain military operations. Additional Protocol II to the Geneva Convention of 12 August 1949 develops and supplements common Article 3 without modifying its existing conditions of application, by introducing a requirement of territorial control. It provides that non-governmental parties must exercise such territorial control "as to enable them to carry out sustained and concerted military operations and to implement this Protocol". Additional Protocol II expressly applies only to armed conflicts between State armed forces and dissident armed forces or other organised armed groups. Contrary to common Article 3, the Protocol does not apply to armed conflicts occurring only between non-State armed groups.' from ICRC Case Book : <https://casebook.icrc.org/glossary/non-international-armed-conflict> See also (1) Customary IHL Rules, Chapter 32, p. 299; (2) Prosecutor v Sam Hinga Norman (Case No. SCSL-2004-14-AR72(E)) Decision on Preliminary Motion Based on Lack of Jurisdiction (Child Recruitment), Decision of May 31, 2004, at para 22, in which the Appeals Chamber of the Sierra Leone Special Court held that: "it is well settled that all parties to an armed conflict, whether states or nonstate actors, are bound by international humanitarian law, even though only states may become parties to international treaties." [https://sierralii.org/sl/judgment/special-court/2004/18](https://sierralii.org/sl/judgment/special-court/2004/18;); (3) Updated European Union Guidelines on promoting compliance with international humanitarian law (IHL) (2009/C/303/06), December 15, 2009, available at [https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52009XG1215\(01\)&from=EN](https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52009XG1215(01)&from=EN)
- 70 ICRC, Customary International Law Database, Introduction to Fundamental Guarantees, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_intofugu
- 71 See Rules 87-105, Rules on Fundamental Guarantees https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter32
- 72 RULAC, Non-International Armed Conflicts in Nigeria, available at <http://www.rulac.org/browse/conflicts/non-international-armed-conflict-in-nigeria>, last accessed on June 2, 2020.
- 73 ICRC Customary IHL Rule 134, available at https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter39_rule134, last accessed on June 2, 2020.
- 74 Id.
- 75 Geneva Convention I, art. 12; Protocol Additional to the Geneva Conventions of August 12, 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I) (8 June 1977), Art. 8(a), available at <https://ihl-databases.icrc.org/ihl/INTRO/470>, last accessed on June 3, 2020.
- 76 ICRC Customary IHL Rule 134, available at https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_cha_chapter39_rule134, last accessed on June 2, 2020.
- 77 ICRC, 2016 commentary art. 12, paras. 1429-30.
- 78 ICRC, 2016 commentary art. 12, paras. 1429-30.
- 79 ICRC Customary IHL Database Rule 93; see also Protocol I (Art. 75 (2)(b) and Protocol II Article 4 (2)(e)- https://ihl-databases.icrc.org/customary-ihl/eng/print/v1_rul_rule93
- 80 ICRC 2016 Commentary.
- 81 ICRC Customary IHL, Rule 34 ; ICRC, 2016 Commentary, article 12, paras 1429-30.
- 82 ICRC, Humanitarian Law, HR Law and Refugee Law—the Three Pillars, available at

- <https://www.icrc.org/en/doc/resources/documents/statement/6t7g86.htm>; OHCHR Report on HR in Conflict, International Legal Protection of Human Rights in Armed Conflict, , HR/PUB/11/01, p. 118 (2011), available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjBjeKClpAhX7DmMBHfUABHwQFjAAegQIAhAB&url=https%3A%2F%2Fwww.ohchr.org%2Fdocuments%2Fpublications%2Fhr_in_armed_conflict.pdf&usg=AOvVaw3Zpu8zbitNCB4jiUEo2Qwx3 last accessed on June 3, 2020
- 83 ICRC; Jean-Marie Henckaerts et al, Customary International Humanitarian Law, Rules, Vol. 1, part V, chapter 32 (2009) available at <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwix8LKczuTpAhUkAWMBHWF4D-4QFjAAegQIAhAB&url=https%3A%2F%2Fwww.icrc.org%2Fen%2Fdoc%2Fassets%2Ffiles%2Fother%2Fcustomary-international-humanitarian-law-i-icrc-eng.pdf&usg=AOvVaw2SG0k06NvPrhWhnzZ0AHsx> See also generally, Vienna Convention on the Law of Treaties, Article 31 (3) (c), in the interpretation of a treaty 'there shall be taken into account...any relevant rules of international law applicable in the relations between the parties.'
- 84 Convention on the Rights of the Child, adopted November 20, 1989, art. 6, G.A. Res. 44/25, annex, UN GAOR, 44th Session, Supp. No. 49, UN Doc. A/44/49 (1989) (entered into force September 2, 1990) [hereinafter CRC].
- 85 CRC, Article 24 (1).
- 86 CRC, Article 31.
- 87 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted December 10, 1984, art. 2, art 16, G.A. Res. 39/46, UN GAOR, 39th Session, Supp. No. 51, UN Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (entered into force June 26, 1987) available at <https://www.ohchr.org/en/professionalinterest/pages/cat.aspx> [hereinafter CAT].
- 88 International Covenant on Civil and Political Rights, adopted December 16, 1966, art. 10 (1), art 7, G.A. Res. 2200A (XXI), UN GAOR, 21st Session, Supp. No. 16, UN Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force March 23, 1976) [hereinafter ICCPR].
- 89 ICCPR, Article 19 (1) and (2).
- 90 ICPPR, Article 12 (1) and (2).
- 91 ICCPR, Article 3.
- 92 ICESCR General comment 12.
- 93 Kirsteen Shields, The Minimum Core Obligations of Economic, Social, and Cultural Rights: The Rights to Health and Education (2017), available at https://www.researchgate.net/publication/323787361_The_Minimum_Core_Obligations_of_Economic_Social_and_Cultural_Rights_The_Rights_to_Health_and_Education
- 94 Amrei Müller, The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law, An Analysis of Health Related Issues in Non-international Armed Conflicts Nottingham Studies on Human Studies, Vol. 2 (2013), available at <https://brill.com/view/title/22972>
- 95 Convention on the Elimination of All Forms of Discrimination against Women, adopted December 18, 1979, art. 121, G.A. Res. 34/180, UN GAOR, 34th Session, Supp. No. 46, at 193, UN Doc. A/34/46 (1980), U.N.T.S. 13 (entered into force September 3, 1981) [hereinafter CEDAW].
- 96 CEDAW, Article 14 (b).
- 97 Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations (47th Session, 2010) para. 52(c), CEDAW/C/GC/30 (2013) available at <https://www.refworld.org/docid/5268d2064.html> [hereinafter CEDAW Committee General Recommendation 30]. Notably, the CEDAW Committee's guidance does not condition the provision of safe abortion services to circumstances in which abortion services are legal.
- 98 CEDAW Committee, Gen. Recommendation No. 30, CEDAW Committee, Concluding Observations: Central African Republic, para. 40(b), UN Doc. CEDAW/C/CAF/CO/1-5 (2014).; See also, CEDAW Committee, Concluding Observations: Democratic Republic of the Congo, paras. 35-36, UN Doc. CEDAW/C/COD/CO/5 (2006).
- 99 CEDAW Committee, Gen. Recommendation No. 28, para. 11.
- 100 CESCR Committee, Concluding Observations: Czech Republic, UN Doc. E/C.12/CZE/CO/2 (2014).; CESCR Committee, Concluding Observations: Slovakia, UN Doc. E/C.12/SVK/CO/3 (2019).; CEDAW Committee, Concluding Observations: Lithuania, UN Doc. CEDAW/C/LTU/CO/4 (2008).; Convention on the Elimination of All Forms of Racial Discrimination, adopted December 21, 1965, G.A. Res. 2106, Annex, 20 UN GAOR Supp. (No. 14) at 47, UN Doc. A/6014 (1966), 660 U.N.T.S. 195 (entered into force January 4, 1969).
- 101 CEDAW Committee, Gen. Recommendation No. 30.; CEDAW Committee, Gen. Recommendation No. 33.
- 102 States cannot derogate from certain jus cogens norms, such as the prohibitions on torture, genocide, and slavery, even during situations of armed conflict. Where derogations are permitted, the measures taken cannot involve discrimination based solely on prohibited grounds, which include sex. At the regional level, the African Charter of Human and Peoples' Rights does not permit any grounds for derogation.
- 103 Committee on Economic, Social and Cultural Rights, General Comment No. 14, The right to the highest attainable standard of health (Art. 12), UN Doc. E/C.12/2000/4 (2000).
- 104 African Charter for Human and Peoples' Rights, adopted June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (entered into force October 21, 1986).
- 105 Boko Haram also has obligations toward women and girls affected by the conflict (primarily under international humanitarian law, but increasingly under human rights law), but the focus of this discussion is on the state's obligations.
- 106 Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, UN Doc CEDAW/C/GC/30 (2013).
- 107 Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), adopted at the 20th session, UN Doc. A/54/38/Rev.1, chap. 1 (1999); Committee on Economic, Social and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, UN Doc. E/C.12/GC/22 (2016); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [Maputo Protocol].
- 108 <https://iawgfieldmanual.com/manual/mnh>
- 109 CEDAW Committee, Gen. Recommendation No. 30, para 52 (c) and (e)
- 110 Committee on Economic, Social and Cultural Rights, General Comment No. 14, The right to the highest attainable standard of health (Art. 12), UN Doc. E/C.12/2000/4 (2000).
- 111 African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 3rd Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on

- Human and Peoples' Rights (2005 – 2008), adopted at the 44th Ordinary Session held from November 10 to November 24, 2008, in Abuja, Nigeria.
- 112 End of visit statement of the Special Rapporteur on extrajudicial, summary, or arbitrary executions on her visit to Nigeria, September 2, 2019, available at <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24934&LangID=E>
- 113 Committee on the Elimination of Discrimination against Women, Concluding Observations: Nigeria, UN Doc. CEDAW/C/NGA/CO/7-8 (2017); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [Maputo Protocol].
- 114 Committee on Economic, Social and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, UN Doc. E/C.12/GC/22 (2016).
- 115 Committee on Economic, Social and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, UN Doc. E/C.12/GC/22 (2016).
- 116 OHCHR. UN rights chief urges concerted action to tackle Boko Haram's 'extensive and far-reaching' abuses [Internet]; July 1, 2015 [cited September 26, 2018]. Available from: <http://www.ohchr.org/EN/NewsStories/Pages/BokoHaramHumanRightsViolations.aspx>.
- 117 African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011 – 2014), adopted at the 57th Ordinary Session held from November 4 to November 18, 2015, in Banjul, The Gambia. Available from http://www.achpr.org/files/sessions/57th/conn-obs/5th-2011-2014/concluding_observations_nigeria_5th_sr_eng.pdf.
- 118 <https://iawgfieldmanual.com/manual/cac>
- 119 Committee on Economic, Social and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, UN Doc. E/C.12/GC/22 (2016); Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), adopted at the 20th session, UN Doc. A/54/38/Rev.1, chap. 1 (1999); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [Maputo Protocol].
- 120 Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on women in conflict prevention, conflict, and post-conflict situations, UN Doc CEDAW/C/GC/30 (2013).
- 121 African Commission on Human and Peoples' Rights (ACHPR), General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted at its 55th Ordinary Session held from April 28 to May 12, 2014, in Luanda, Angola (2017). Available from <http://www.achpr.org/instruments/general-comment-two-rights-women>.
- 122 National Population Commission [Nigeria] and ICF International. Nigerian Demographic Health Survey 2013. Rockville, Maryland, USA: available at <https://dhsprogram.com/pubs/pdf/fr293/fr293.pdf>.
- 123 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [Maputo Protocol]; Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, UN Doc CEDAW/C/GC/30 (2013).
- 124 Stéphane Kolanowski, Protection of Women under International Humanitarian Law, Report of ICRC-EUISS Colloquium on Women and War 21 (September 30, 2014), available at https://www.icrc.org/en/download/file/8598/icrc_report_women_and_war.pdf.
- 125 Center for Reproductive Rights, Briefing Paper: Ensuring Sexual and Reproductive Health and Rights of Women and Girls Affected by Conflict, https://reproductiverights.org/sites/default/files/documents/ga_bp_conflictnrcris_2017_07_25.pdf, pp. 23-24.
- 126 ICRC, 2016 commentary on the First Geneva Convention, art. 12, para. 1379;
- 127 Human Rights Council, Report of the Special Rapporteur on the human rights of internally displaced persons on his mission to Nigeria, UN Doc. A/HRC/35/27/Add.1 (2017).
- 128 Amnesty International. They Betrayed Us: Women Who Survived Boko Haram Raped, Starved and Detained in Nigeria. Amnesty International; 2018. Available from <https://www.amnesty.org/download/Document/s/AFR4484152018ENGLISH.PDF>.
- 129 African Commission on Human and Peoples' Rights, Federal Republic of Nigeria's 6th Periodic Country Report on the Implementation of the African Charter on Human and Peoples' Rights in Nigeria (2015 – 2016), considered at the 62nd Ordinary Session held from April 25 to May 9, 2018, in Banjul, The Gambia.
- 130 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [Maputo Protocol].
- 131 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [Maputo Protocol]; Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, UN Doc CEDAW/C/GC/30 (2013).
- 132 UN Security Council, Report of the Secretary-General on Sexual Violence in Conflict, UN Doc. S/2013/149 (2013).
- 133 Human Rights Council, Report of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences on their joint visit to Nigeria, UN Doc. A/HRC/32/32/Add.2 (2016).
- 134 <https://iawgfieldmanual.com/manual/gbv>
- 135 Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), adopted at the 20th session, UN Doc. A/54/38/Rev.1, chap. 1 (1999).
- 136 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [Maputo Protocol].
- 137 Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, UN Doc CEDAW/C/GC/30 (2013).
- 138 African Commission on Human and Peoples' Rights (ACHPR), General Comment No. 4 on the Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading

- Punishment or Treatment (Article 5), adopted at the 21st Extra-Ordinary Session of the ACHPR, held from February 23 to March 4, 2017 in Banjul, The Gambia. Available from <http://www.achpr.org/instruments/general-comment-right-to-redress>.
- 139 African Commission on Human and Peoples' Rights (ACHPR), General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted at its 55th Ordinary Session held from April 28 to May 12, 2014 in Luanda, Angola. Available from <http://www.achpr.org/instruments/general-comment-two-rights-women>.
- 140 African Commission on Human and Peoples' Rights, Resolution 369 on the Situation of Internally Displaced Persons in Africa, ACHPR/Res. 369 (LX) (2017).
- 141 Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, UN Doc CEDAW/C/GC/30 (2013).
- 142 OHCHR, International Legal Protection of Human Rights in Armed Conflict, at 22, https://www.ohchr.org/Documents/Publications/HR_in_armed_conflict.pdf
- 143 OHCHR, International Legal Protection of Human Rights in Armed Conflict, at 25, https://www.ohchr.org/Documents/Publications/HR_in_armed_conflict.pdf; See also CEDAW Comm., General Recommendation No. 30, para. 16, The Optional Protocol to the Children's Rights Convention on the involvement of children in armed conflict specifically imposes some degree of obligation on armed groups-CRC OP Art 4 CRC//C/15/Add.153; The Security Council has also called on nonstate actors to a conflict to respect IHL and IHRL, UNSCR 1564 (2004) <http://unscr.com/en/resolutions/1564>; There are also examples where nonstate actors have agreed to respect human rights standards-OHCHR, International Legal Protection of Human Rights in Armed Conflict, at 26, https://www.ohchr.org/Documents/Publications/HR_in_armed_conflict.pdf; In addition, gross violations of human rights could entail individual criminal responsibility, including by members of nonstate armed groups. IHRL norms around extraterritoriality as well as the obligations of nonstate actors continue to evolve, including on accountability for sexual violence in conflict, See, e.g. UN Security Council Resolution 1894 (2009); UN Security Council, Report of the Secretary-General on Conflict-related Sexual Violence, UN Doc. S/2015/203 (March 23, 2015); UN Human Rights Council, Report of the Independent International Commission of Inquiry on the Syrian Arab Republic, UN Doc. A/HRC/19/69 (February 22, 2012). See generally International Legal Protection of Human Rights in Armed Conflict, at 23-27 (collecting evidence of UN practice with regard to human rights obligations of nonstate actors); Remarks of Zainab Bangura, Special Representative of the Secretary-General on Sexual Violence in Conflict to the UN Security Council, UN Doc. S.PV.7560 (November 16, 2015), http://www.un.org/ga/search/view_doc.asp?symbol=S/PV.7560&referer=/english/&Lang=E
- 144 Committee on the Elimination of Discrimination against Women, Concluding Observations: Nigeria, UN Doc. CEDAW/C/NGA/CO/7-8 (2017).
- 145 Human Rights Council, Report of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences on their joint visit to Nigeria, UN Doc. A/HRC/32/32/Add.2 (2016).
- 146 African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011 – 2014), adopted at the 57th Ordinary Session held from November 4 to November 18, 2015, in Banjul, The Gambia. Available from http://www.achpr.org/files/sessions/57th/conc-obs/5th-2011-2014/concluding_observations_nigeria_5th_sr_eng.pdf.
- 147 Human Rights Council, Report of the Special Rapporteur on the human rights of internally displaced persons on his mission to Nigeria, UN Doc. A/HRC/35/27/Add.1 (2017); Human Rights Council, Report of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences on their joint visit to Nigeria, UN Doc. A/HRC/32/32/Add.2 (2016).
- 148 UN Security Council, Report of the Secretary-General on children and armed conflict in Nigeria, UN Doc. S/2017/304 (2017).
- 149 Human Rights Council, Report of the Special Rapporteur on the human rights of internally displaced persons on his mission to Nigeria, UN Doc. A/HRC/35/27/Add.1 (2017).
- 150 Committee on the Elimination of Discrimination against Women, Concluding Observations: Nigeria, UN Doc. CEDAW/C/NGA/CO/7-8 (2017); African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011 – 2014), adopted at the 57th Ordinary Session held from November 4 to November 18, 2015, in Banjul, The Gambia. Available from http://www.achpr.org/files/sessions/57th/conc-obs/5th-2011-2014/concluding_observations_nigeria_5th_sr_eng.pdf.
- 151 Human Rights Council, Report of the Special Rapporteur on the human rights of internally displaced persons on his mission to Nigeria, UN Doc. A/HRC/35/27/Add.1 (2017).
- 152 Human Rights Council, Report of the Special Rapporteur on the human rights of internally displaced persons on his mission to Nigeria, UN Doc. A/HRC/35/27/Add.1 (2017); Committee on the Elimination of Discrimination against Women, Concluding Observations: Nigeria, UN Doc. CEDAW/C/NGA/CO/7-8 (2017).

PHOTO CREDIT

Front Cover: Women at an IDP host community in Adamawa gather for an FGD with interviewers from the Center for Reproductive Rights and LEDAP, 2018. Photo Credit: Carey Wagner for the Center for Reproductive Rights.

Right: A young woman at an IDP Camp in Borno having just shared her story during a one-on-one interview, 2019. Photo Credit: Ikechukwu Udeh for the Center for Reproductive Rights and LEDAP.

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**The Conflict in Northeast Nigeria's
Impact on the Sexual and
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