Globalization: Is African Women's Reproductive Health Getting Better or Worse? The Nigerian Experience

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***Abstract:*-Beyond the economy; information and communication technology; politics; and even cultural differences between nations human reproduction in Africa has much implications for women's participation in the process of globalization which is created and shaped by both gender. Accounting for social change in any human society implies a recognition of some relatively stable social and cultural elements. African women's participation in the process of globalization is, to a large extent determined by their traditional sex role and their reproductive health especially because child bearing remains a vital function of the women. At the same time, globalization is expected to help improve the general well-being of men and women as global citizens. Hence the gate-keeping role of the government of any nation in the process of globalization is critical. This paper examines and assesses the efforts of the Nigerian government towards ensuring the reproductive health of women and girls by tapping into global best practices; and ensuring women's active participation in the process of globalization. It uses the qualitative method, to analyse some indicators in the key reproductive health related policies, documents and practices in Nigeria against the recommendations of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and other key international and regional instruments to which Nigerian is signatory. It evaluates the level and quality of implementation of these instruments and documents in order to ascertain the effects of the government's effort at enhancing Nigerian women's reproductive health and ensuring their valued contribution to the globalization process. The analysis reveals the negative effect of the lack of domestication of CEDAW on women's reproductive rights and reproductive health; a wide gap between existing policies and their implementation; and the resultant generally poor outcome of Nigerian women's reproductive health especially in the rural areas. In conclusion, the paper argues for a genuine domestication of international best practices in addressing the socio-cultural constraints to women's reproductive rights in Nigeria so as to achieve the desired women's reproductive health and increase their chances of actively contributing to the process of globalization from their little corners of the world no matter how remote.**

***Key Words:* Globalization; Nigerian government; Women's reproductive health; Reproductive rights; Reproductive health related policies.**

I. INTRODUCTION

Over the years, theories of global inequality and of the direction of global social change, have focused largely on the economy; information and communication technology; politics; and sometimes, on the cultural differences between nations with very little attention given to the process of reproduction and its implication for globalization. Men and women collectively create and shape globalization, a form of social change. Accounting for social change in any human society implies a recognition of some relatively stable social and cultural elements. Hence, African women's participation in the process of globalization is, to a large extent determined by their traditional sex role of child bearing and its implication for their reproductive health.

The central place of reproduction in African families is indubitable. Although the method of human reproduction in Nigeria is largely sexual between female and male, the physiological implication of the process is disproportionately borne by both sexes. Females bear the brunt of it. This partly explains why illness and death from poor sexual and reproductive health (RH) constitute part of the top ten estimated causes of death in low and medium income countries of the world in 2016(World Health Organization [WHO] 2018).The 2015 estimate for maternal mortality in Nigeria is 814 per 100,000 live births (CIA Factbook 2018). Nigeria was ranked fourth globally after such other African countries as Sierra Leone, Central African Republic, and Chad despite all her endowments. Nigeria also has the third highest infant mortality rate globally (CIA Factbook 2018).It is trite to state that concerns of RH include medical and non-medical conditions and that the latter provides the much-needed enabling environment for RH to thrive.

There have been several efforts aimed at ensuring healthy reproduction globally. For instance, the 1974 World Population Conference in Bucharest; and the 1984 International Conference on Population in Mexico City. The former offered the world its first template for integrating population issues into economic and social development while the latter recognised the need for wider access to family planning (FP). The efforts climaxed in the International Conference on Population and Development (ICPD) in Cairo 1994.The poor state of global RH occupied a central place at the ICPD and the conference underscored the direct links between RH and human rights (UNFPA 2005). It brought to the fore the rights of women and girls, and the

need to empower them to control their fertility. The conference thus came up with the following definition of RH:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life … the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice… and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth (ICPD PoA, 7:2).

Implicit in the definition above, are among others:

1. Sexual health including the prevention and management of sexually transmitted and reproductive tract infections.
2. Reproductive rights (RR) including the choice of spouse; elimination of harmful traditional practices (HTPs) and violence in relation to RH.
3. Family Planning (FP) information and services.
4. Maternal health and Safe motherhood.
5. Prevention and treatment of infertility and sexual dysfunction.

Giddens (2013) defines globalization as the ‘growing interdependence between different peoples, regions and countries in the world as social and economic relationships come to stretch worldwide. Ideally, Nigeria as part of the global community is expected to share in the global desire for improved RH and the general well-being of women and men as global citizens. Doing so demonstrates not only a recognition of the relationship between globalization and RH and RR, but also a positive step at ensuring the active participation of its citizens in the global process. This gate-keeping role of the government of any nation is critical to the process of globalization. This paper seeks to: find out and document attempts by the Nigerian State to adapt or domesticate some of the global and regional instruments that are designed to promote women’s RH; assess their level of implementation; and evaluate the effects of these efforts on the RH and RR of Nigerian women and adolescent girls as global citizens.

II. NIGERIA AND SOME GLOBAL INSTRUMENTS THAT GUARANTEE WOMEN’S RH AND RR

Some of the critical international instruments that have direct bearing on women’s RH include:the International Bill of Rights; the World Population Plan of Action (adopted at the 1974 World Population Conference); the adopted Recommendation for the Further Implementation of the Plan of Action at the 1984 International Conference on Population; the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) that was adopted by the UN General Assembly on Dec. 18 1979; the 1993 Vienna Declaration; the 46thand 47th World Health Assemblies (WHA) held in 1993 and 1994 respectively; the ICPD; the 1995 Beijing Declaration and Platform for Action; the Millennium Development Goals of the year 2000; and the 2015 Sustainable Development Goals. In addition to these are key regional instruments like the African Union Solemn Declaration, and The Protocol. These instruments are intrinsically related and aimed solely at achieving reproductive well-being of all.

Although Nigeria officially recognizes and professes her commitment to all of these global treaties and consensus documents, primary focus will be on the efforts so far made by the Nigerian State towards the realization of some of the provisions of CEDAW which she ratified on June 13, 1985.

Aside from space, priority is given to CEDAW in this paper for the following reasons among others: (1) CEDAW is the most comprehensive and specific international declaration on gender equality and the advancement of women hence, it is sometimes referred to as ‘the international bill of rights for women’; (2) it addresses women’s RH and RR even in marriage and the family; (3) CEDAW advocates for "a proper understanding of maternity as a social function’ (article 5); (4) it equally defines what constitutes discrimination against women and recognizes the impact of cultural factors on gender relations and women’s RR; and (5) CEDAW gives special consideration to rural women most of whom contribute in no small measure to sustaining their families by engaging in various forms of work in the non-monetized sectors of the economy.

Part one of CEDAW comprises the first six articles that deal with different aspects of discrimination and ways to guarantee basic human rights and fundamental freedoms of women. It urges State parties to do this through their national constitutions and other appropriate legislative and legal measures including temporary ones‘to accelerate equality for women’. The most critical step towards realizing the desired gender equality and the enjoyment of all the economic, social and political rights embedded in CEDAW is therefore, its domestication. It is not enough to ratify the convention. Adequate legislative framework, institutions and procedures that will promote and fulfill its provisions and prevent its violation by both state and non-state actors will enable citizens to enjoy these rights.

However, despite the provision for close monitoring of its implementation, and forty years after ratification, Nigeria’s CEDAW bill is still before the National Assembly. In fact, the bill has generated a lot of questions due largely to the fact that the Nigerian government has done very little to educate her citizens on the content of the convention. Most Nigerian women and even government officials perceive the bill as one that encourages abortion because RH is often erroneously equated with women's right to abortion. Whereas, a successful domestication should ideally incorporate traditional best

practices including natural method of FP and child spacing, as well as address social and cultural issues that bring about unwanted pregnancies and abortion in modern times.

III. REPRODUCTIVE RIGHTS AND ELIMINATION OF HTPS AND GENDER VIOLENCE AGAINST WOMEN

Gender based sexual assault and exploitation perpetuated by men against women and girls is rife. In recognition of the close link between unequal gender relations and women's RH and as a follow-up to CEDAW, the General Recommendation 24 (adopted by the Committee on the Elimination of Discrimination against Women on May 4, 1999), addresses issues of gender and women's RH; women's access to RH information, education and services; prevention of unwanted pregnancy; health service providers' respect for women's RR; adolescent RR;etc.

In 1993, the 46th WHA adopted a resolution: WHA46.18 which expressed serious concerns about persistent gender inequalities and harmful traditional practices (HTPs) against women and the girl child. The 47th WHA of 1994 moved a step further to adopt a specific resolution: WHA 47.10 against HTPs. It urged all member States (including Nigeria) to:

1. Assess the extent to which HTPs against children and women's health constitute a social and public health problem in communities.
2. Establish national policies, programmes, and legal instruments that will effectively abolish female genital mutilation (FGM), child bearing before biological and social maturity, and other harmful practices affecting the health of women and children.
3. Collaborate with national non-governmental organizations (NGOs) active in the area of RH to fight abuses of RR and to encourage establishment of such RH/RR focused NGOs where they do not exist (Source: www.unhcr.ch/html: March 24, 2017).

Nigeria has fared pretty well in these areas by conducting various nation wide studies on female genital mutilation (FGM). These studies partly informed the formulation of some of her RH related policies especially the one on FGM[1] which was replaced by the Violence against Persons Prohibition Act (VAPP) of 2015. In addition to prohibiting FGM and other forms of HTPs and violence in both private and public spheres, the VAPP Act of 2015 and the 2008 adopted Implementation Framework and Plan of Action for implementing the National Policy on Gender have hardly translated to improved RH and RR of Nigerian women and adolescent girls, as sexual violence remains a national problem.Even law enforcement personnel have been accused of sexually violating female victims of *Bokko Haram* and herdsmen attacks. Sadly, the VAPP was enacted only at the Federal level and so expectedly, only had effect in the federal capital territory until very recently when about four: (Lagos, Anambra, Ebonyi and Oyo) out of the thirty-six states of the federation passed it.

As argued by Tomaševski (1998:549) 'the burden of exposing and opposing denials of human rights cannot be left to the victims alone. If it is, the very *human* in human rights is at stake'. For every right, government is expected to demonstrate three levels of obligations: (1) to respect the right; (2) to protect the right; and (3) to fulfill the right. Thus, domestication of CEDAW is central to ensuring women's RH in Nigeria as it will provide a legal framework against which women can demand their RR and put an end to the current impunity of crimes against their human rights.

Article 16 of the convention draws attention to marriage and family relations and asserts the equal rights and obligations of women and men with regard to: choice of spouse, parenthood, personal rights and command over property. Consistent with this provision and that of article 10, a few States in Nigeria, including Bauchi and Edo made deliberate effort to pass laws prohibiting forced marriage and the marriage of girls below 18 years, while Cross River State government passed an unprecedented bill in May 2007:'The Right of Female to Own and Inherit Property Bill' in line with the provisions of article 13(a) of CEDAW. The Act did not only prohibit all minors and young women (aged 18-20) from getting married until they are 21 years, it also provides for women in the State to inherit property from their parents and husbands under legally contracted marriages (Inyang 2007). Even though history has shown that laws alone are incapable of changing social behaviour, they certainly play a positive role in any human organization especially if supported by appropriate institutions and procedures to guarantee their enforcement. The recently discovered traditional practice of 'money marriage'[2] in a community in Cross River state is however, quite ironical. The practice of 'money marriage' denies the girls and women their dignity as human beings, let alone any'right to own property' and casts doubt on the level of implementation of the much applauded law eleven years after it was enacted.

Additionally, article 6 of CEDAW obliged governments 'to suppress all forms of traffic in women and exploitation of prostitution of women.' In spite of the goodwill and support from development partners, NGOs, religious bodies, and government to check this odious crime against humanity, the problem persists. This is largely due to poor leadership andthe high rate of youth unemployment and widespread absolute and relative poverty in the face of so much affluence. Thus, thousands of young Nigerian girls are still trafficked into other

[1]The National Policy and Plan of Action on Elimination of Female Genital Mutilation in Nigeria, 2002

[2]'Money marriage' is a practice among the Obanliku where girls are forced into marriage to meet the immediate material needs of their families (seeChannels News of 4th May, 2018 for details of the practice).

countries and sold to a life of sexual slavery.

The WHA resolution equally challenged the WHO to strengthen technical support to member States so that with other UN agencies and concerned organisations, national, regional and global strategies for the abolition of HTPs can be established (UNHCR 1997). Apart from the creation of the National Agency for the Prohibition of Trafficking in Persons (NAPTIP) by the federal government, much of the technical assistance by the UN agencies in the area of RH related HTPs in Nigeria has been quite limited to funding of surveys and other forms of research that reveal the extent and nature of the problem. They also provide incentives to interested groups and organisations to encourage them to sponsor relevant bills most of which are hardly ever enforced. Besides, law alone cannot change social behaviour. The various NGOs and civil society organizations (CSOs) interested in this area need to be encouraged and empowered in the fight against the cultural practice of early and forced marriages and sexual relationships[3] to combat the dangers of HTPs to women's health.

IV. MATERNAL HEALTH AND SAFE MOTHERHOOD

CEDAWencourages governments to ensure access to pregnancy, delivery and post-delivery health services. It urges State parties to grant free services and adequate nutrition to pregnant and lactating women where necessary, and to give special consideration to the peculiar needs of women at the grassroots. It also encourages free maternal health services where necessary (article 12).The Nigerian reality of very high MMR makes this provision imperative. Yet, the Federal Government has failed to enforce this at the tertiary health facilities (HFs) that fall directly under the federal ministry of health (FMOH). Only very few States like Rivers, Kano, Adamawa, Lagos and Borno attempted enforcing free maternal health services including free caesarean section (CS) in secondary HFs beginning only in the current democratic dispensation.Even this has not been without its challenges as some of the designated secondary HFs of the State governments lack the capacity to sustain such free services while most primary health care (PHC) facilities of the local governments barely survive on the little revenue generated from clients.

The World-bank-funded Nigeria State Health Investment Project (NSHIP) was started in 2011 with three pilot states of Adamawa, Nasarawa and On do. The project aimed at ensuring a universal health coverage (UHC) comprehensively for sexual, reproductive, maternal and newborn health care. Ondo state under their immediate past governor, Mimiko, a medical doctor, was acclaimed even by the World bank for achieving over 75percent reduction in maternal mortality by 2016 through her 'domesticated' '*Agbebiye* programme' (Muanya 2016). The programme was an incentive-oriented referral strategy for increasing facility delivery. Laudable as it is, it is cash based and highly dependent on external aid thus, rendering its sustainability questionable. Besides, not much attention has so far been given to ensuring adequate personnel and equipment to cope with the increase in patronage. Even the health facilities (HFs) themselves need sufficient attention.

The Federal government and the Nursing and Midwifery Council of Nigeria ironically limit the number of midwives and nurses in circulation by regulating the number that graduate annually. This practice restricts access to skilled delivery in HFs which has remained a major challenge to rural communities especially in northern Nigeria. The most recent 2013 national demographic and health survey (NDHS) reports 38percent as the total births assisted by a skilled provider nationally, and only 23percent in rural areas. Thirty-six percent of deliveries took place in a HF, and only 22percent in the rural areas. Facility-based births least occur in the north western zone (12%) and most in the south eastern zone (78%) (NPC & ICF 2014).

Moreover, the Federal Ministry of Health formulated a very comprehensive National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for All Nigerians, 2001. The policy provides the much-desired enabling environment for appropriate action, impetus and guidance to national and local initiatives in all areas of RH in the country. However, a close look at one of the five strategies: 'equitable access to quality health services', against the back-drop of the health reforms of both past and present administrations, one wonders if the interest of the poor was taken into consideration in the process as demanded by CEDAW.

Before its review in 2004, the 1988 National Health Policy assigned PHC to the Local government authorities (LGA); secondary health care facilities (general and cottage hospitals), to State governments; and tertiary (teaching and specialist hospitals) to the Federal government on the assumption that this process will enhance health care delivery and ensure health for all in spite of the private and faith-based health facilities that are highly indispensable. All of these tiers of government have however failed to prioritize health care delivery in the country due largely to poor coordination, poor budgetary allocation and lack of transparency. The situation is worse at the PHC level which paradoxically, is the nearest to the people. The tertiary health facilities that are more remote from the ordinary Nigerians generally receive more attention in terms of resource allocation, staff remuneration, physical upgrade and supplies. For example, towards the end of Obasanjo's tenure in 2006/2007, the Federal government carried out an extensive renovation of eight of the fourteen teaching hospitals nationwide and got them fitted with some state-of-the-art medical equipment accessible only to the rich despite the growing poverty in Nigeria. A recent online report

[3]Examples of this are the 'sira culture' among the Ogoni and the 'Kusam' among the Izere where first daughters are prevented from getting married until they have had one or two children for their own patrilineage.

by the World Poverty Clock (2018) alleged that almost half of Nigeria's population live in 'extreme poverty' as at May 2018 and that six of its citizens allegedly 'become extremely poor every minute'. The report presents Nigeria as the country with the largest number of people living in extreme poverty as at May 2018 despite all its supposed efforts at achieving the defunct MDGs and the current SDGs. Nigeria ironically took over from India despite the huge population difference between both countries.[4]

The Nigerian government reformulated her previous population policy of 1988 in 2004[5], to make it ICPD compliant and demonstrate her desire to protect and promote the RR of her female and male citizens.The policy does not only recognise women's disadvantaged position in all aspects of their socio-cultural life in Nigeria, but rightly identifies social, political and economic determinants of women's RH (NPPSD 2014). Thus, treating women's RH concerns in a comprehensive and inclusive manner and recognising the need for the general advancement and empowerment of women in Nigeria and for male involvement in sexual and RH.

However, despite the fact that the 2004 population policy devoted the whole of its sixth chapter to the institutional framework needed for the coordination and implementation of the policy, actual realisation of the provisions of this policy remains a major challenge, fourteen years after it was launched. Some of the major obstacles to its realisation are: the budgeting priorities of government; poor funding; and weak political will (Shiffman 2007). For instance, as important as population census is to development planning, Nigeria has never succeeded in implementing the constitutional requirement of conducting it every ten years. A major implication of irregular census is non-availability of adequate and up-to-date information needed for planning and effectively participating on the global stage.

Furthermore, in recognition of the global commitment to UHC and the 2015 SDGs, Nigeria introduced a new and comprehensive National Health Policy in 2016 to facilitate the country's implementation of some of the global declarations mentioned above to meet emerging health challenges and thus, realize her desire for the health and well-being of all Nigerians. This can largely be said to be merely on paper so far because despite WHO's recommendation that governments worldwide should devote a minimum of 15percent of their budgets to health and 10 percent of this to maternal health, and the 2001 'Abuja Declaration', government at all levels in Nigeria falls short of this practice. In fact, Nigeria has never given up to 6percent in the succeeding 17years. The highest so far is 5.95percent in 2012 and it is less than 4percent of the 2018 budget which is far less than what Nigerians spend on medical tourism every year. It is therefore not surprising that WHO once ranked Nigeria's health care delivery 187th of 190 countries (WHO 2000). Moreover, Nigeria was reported to have spent less than $35 U.S. per person annually on health care (WHO 2000) as far back as in the 1990s when the Nigerian currency had a higher value. Another major challenge is the gap between allocated resources and actual funds released despite constitutional provisions that support such allocations. Besides, the systemic corruption in the system renders the limited funds available highly susceptible to mismanagement and embezzlement.

Also, the national health insurance scheme (NHIS) initiated by the Federal government is urban and middle class oriented and only a tiny proportion of Nigeria's population, mostly civil servants, are enrolled in it. Even though more than50percent of Nigerians reside in rural areas where most especially women, earn below $2 U.S a day and are generally less educated. The 2013 NDHS for instance, reported 91percent of births to mothers with more than secondary education in health facilities and uneducated mothers only 11percent. Also, the rivalry between health care providers and the health maintenance organisations (HMOs) tends to lend credence to the perception of the scheme as another avenue for enriching the political class.

Furthermore, Article 11(2) of CEDAW urges State parties to take appropriate measures to guarantee pregnant women's right to maternity leave; protection of health and safety at work; and provide necessary support social services to enable 'parents to combine family obligations with work responsibilities and participation in public life…'(Article 11(2c). This was reiterated by the global Baby Friendly Initiative of 1990. Yet, a request presented to the 2005 National Political Reform Conference to increase maternity leave from 3 to 6 months in the public sector to enable nursing mothers respect the fundamental human right of every child to optimal breastfeeding for at least six months was rejected by the Federal government. It promised instead to establish *crèches* in government offices nationwide. The current minister for health announced thirteen years after(at the 107th International Labour Conference in Geneva in June 2018), the extension of maternity leave from 3 to 4 months. A change which is yet to reflect in the existing 2004 Labour Act. Private organizations are however, not compelled to grant even the shortest maternity leave. Worse still, some private firms restrict their female staff from getting pregnant in their first few years of service in violation of article 11(2)(a) of CEDAW. It is however worthy of note that a 10-day paternity leave in the first 2 months of the baby's delivery is enjoyed by male civil servants in Lagos state.

Article 4 of CEDAW seeks an end to discrimination against all women irrespective of their marital status. Yet, discrimination against unmarried women subsists in Nigeria with impunity especially in private sector employment and even among landlords in the north who deny unmarried

[4]The population of India at her last census in 2011 was 1,210,854,977 with an annual population growth percentage of 1.15% in 2016 (World bank). While that of Nigeria was 140.431,790 at her 2006 census with an annual growth of 2.6% (World bank)

[5]Nigeria's 2004 national population policy, the National Policy on Population for Sustainable Development(NPPSD)

women their right to rent any property of their choice anywhere in Nigeria.

V. NIGERIA AND THE REGIONAL INSTRUMENTS THAT GUARANTEE WOMEN'S RH

Nigeria is signatory to the AU Solemn Declaration on Gender Equality in Africa; The Protocol on the Rights of Women in Africa(both of which are critical to the advancement of African women's RH and RR); and other regional declarations on health care delivery including the Ouagadougou Declaration on Primary Health Care and the Abuja Declaration.

All the Heads of States and Government committed themselves to the AU Solemn Declaration at the Third Ordinary Session of the Assembly in Addis Ababa on July 6, 2004and adopted nine areas of agreement which include:

1. Acceleration of gender specific measures aimed at combating HIV/AIDS.
2. Advocacy for reinforcement of legal mechanism for the protection of women's rights and for ending impunity.
3. Ensuring the active promotion and protection of human rights for women.
4. Actively promoting the implementation of legislation to guarantee women's land, property and inheritance rights.
5. Adopting specific measures to ensure Education for All especially in rural areas.
6. Ensuring that The Protocol entered into force by 2005.

Former president Thabo Mbeki of South Africa once observed that the principle of gender equality was already contained in the Constitutive Act of the AU as passed by the National Parliaments of AU Member States and that any Member State that fails to apply it is, in fact, breaking its own national law and the law of the Union (Teriba 2005).

Although the AU Member States agreed to report on recorded progress in the area of gender mainstreaming annually, very little has been done in Nigeria to translate these to tangible results. The level of implementation of the 2006 National Gender Policy that is Nigeria's major attempt at mainstreaming gender in the various organs of government leaves much to be desired. The Nigerian government until very recently (following the passage of the Administration of Criminal Justice Act 2015 in 2017)failed to take practical and legal steps to check the menace of women's human rights abuses.

The Protocol entered into force on November 25, 2005 and provides a wide range of sexual and RR protection relevant to the experiences of African women and went beyond the provisions of the African Charter on Human and People's Rights to request states to guarantee and promote women's RR. Specifically, the Protocol requested states to:

- Provide adequate, affordable, and accessible health services to women;
- Establish and strengthen prenatal, delivery, and postnatal health and nutritional services for women during pregnancy and while breast feeding;
- Prohibit all medical and scientific experiments on women without their informed consent;
- Guarantee women's right to consent to marriage;
- Set the minimum age of marriage at 18 years;
- Ensure equal rights for women in marriage;
- Protect women against all forms of violence during armed conflict and consider such acts war crimes;
- Enact and enforce laws prohibiting all forms of violence against women, including unwanted or forced sex; and
- Reform laws and practices that discriminate against women (Source: CRR 2018:3).

While this protocol has been lauded by many international RR activists for containing a number of 'global firsts', it has largely been only on paper particularly in relation to violence against women and children in the ongoing security challenges in the north and in other parts of Nigeria

The Protocol specifically directed State parties to enact laws against HTPs, yet less than 50percent of states in Nigeria have legislated against female genital cutting, among them, Bayelsa, Cross Rivers, Edo, Ogun, Osun and Rivers. Ironically, most rural dwellers (including those that perpetuate this HTP) are not aware of these legislations nor the consequences of breaking them.Ideally, regional agreements should have more impact on local human rights, since they are less likely to be regarded as an imposition by outsiders than global ones (CRR 2018) but this has not been the case with Nigeria.

VI. CONCLUSION

The analysis demonstrates the essence of reproduction in the life of the average Nigerian woman and the importance of CEDAW and other key global and regional instruments in guaranteeing women's RR and RH. It equally reveals some of the negative effects of the failure of government to domesticate CEDAW on women's RR and RH. The existing gulf between government policies (that address issues of women's RH in piecemeal)and their implementation contributes significantly to the generally poor outcome of Nigerian women's RH especially in the rural areas where much HTPs against women and girls go unchecked.

A genuine domestication of international best practices will go a long way in ensuring maternal health and safe motherhood. It is both imperative and compelling in order to comprehensively address the socio-cultural constraints to the desired RH for women nationally and invariably, increase their chances for active participation in the process of globalization from their little corners of the world no matter

how remote, through their various economic, social and political activities.

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