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Women of the World:

Laws and Policies Affecting Their Reproductive Lives



Francophone Africa

The Center for Reproductive Law and Policy
Groupe de recherche femmes et lois au Sénégal (GREFELS)

**WOMEN OF THE WORLD: LAWS AND POLICIES
AFFECTING THEIR REPRODUCTIVE LIVES
FRANCOPHONE AFRICA**

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Table of Contents

GLOSSARY 11

LIST OF INTERNATIONAL AND REGIONAL DOCUMENTS CITED 13

FOREWORD 14

I. INTRODUCTION 15

2. BENIN 24

Statistics 24

I. Introduction 26

II. Setting the Stage: The Legal and Political Framework 26

A. The Structure of Government 26

1. Executive Branch

2. Legislative Branch

3. Judicial Branch

B. Sources of Law 28

1. International Sources of Law

2. Domestic Sources of Law

III. Examining Reproductive Health and Rights 28

A. Health Laws and Policies 28

1. Objectives of the Health Policy

2. Infrastructure of Health Services

3. Cost of Health Services

4. Regulation of Health Care Providers

5. Patients' Rights

B. Population and Family Planning 32

1. The Population and Family Planning Policy

2. Government Delivery of Family Planning Services

3. Services Provided by NGOs and the Private Sector

C. Contraception 33

1. Prevalence

2. Legal Status of Contraceptives

3. Regulation of Information on Contraception

D. Abortion 34

1. Prevalence

2. Legal Status of Abortion

3. Requirements for Obtaining a Legal Abortion

4. Policies Related to Abortion

5. Penalties for Abortion

6. Regulation of Information on Abortion

E. Sterilization 34

F. Female Circumcision/Female Genital Mutilation 34

1. Prevalence

2. Laws to Prevent FC/FGM

3. Policies to Prevent FC/FGM

G. HIV/AIDS and other STIs 35

1. Prevalence

2. Laws Related to HIV/AIDS

3. Laws Related to other STIs

4. Programs Related to Prevention and Treatment of HIV/AIDS

IV. Understanding the Exercise of Reproductive

Rights: Women's Legal Status 35

A. Legal Guarantees of Gender Equality/Non-Discrimination 36

B. Rights within Marriage 36

1. Marriage Law

2. Divorce and Custody Law

C. Economic and Social Rights 37

1. Property Rights

2. Labor Rights

3. Access to Credit

4. Access to Education

D. Right to Physical Integrity 38

1. Rape

2. Domestic Violence

3. Sexual Harassment

V. Focusing on the Rights of a Special Group:

Female Minors and Adolescents 39

A. Reproductive Health of Female Minors and Adolescents 39

B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents 40

C. Marriage of Female Minors and Adolescents 40

D. Education for Female Minors and Adolescents 40

E. Sexuality Education for Female Minors and Adolescents 40

F. Sexual Offenses against Female Minors and Adolescents 41

3. BURKINA FASO 44

Statistics 44

I. Introduction 46

II. Setting the Stage: The Legal and Political Framework 46

A. The Structure of Government	46	A. Legal Guarantees of Gender Equality/Non-Discrimination	57
1. Executive Branch		B. Rights within Marriage	57
2. Legislative Branch		1. Marriage Law	
3. Judicial Branch		2. Divorce and Custody Law	
B. Sources of Law	47	C. Economic and Social Rights	58
1. International Sources of Law		1. Property Rights	
2. Domestic Sources of Law		2. Labor Rights	
III. Examining Reproductive Health and Rights	48	3. Access to Credit	
A. Health Laws and Policies	48	4. Access to Education	
1. Objectives of the Health Policy		D. Right to Physical Integrity	59
2. Infrastructure of Health Services		1. Rape	
3. Cost of Health Services		2. Domestic Violence	
4. Regulation of Health Care Providers		3. Sexual Harassment	
5. Patients' Rights		V. Focusing on the Rights of a Special Group:	
B. Population and Family Planning	51	Female Minors and Adolescents	60
1. The Population Policy		A. Reproductive Health of Female Minors and Adolescents	60
2. The Family Planning Policy		B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents	60
3. Government Delivery of Family Planning Services		C. Marriage of Female Minors and Adolescents	60
4. Services provided by NGOs and the Private Sector		D. Education for Female Minors and Adolescents	61
C. Contraception	53	E. Sexuality Education for Female Minors and Adolescents	61
1. Prevalence		F. Sexual Offenses against Female Minors and Adolescents	61
2. Legal Status of Contraceptives			
3. Regulation of Medical Technology		4. CAMEROON	66
4. Regulation of Information on Contraception		Statistics	66
D. Abortion	54	I. Introduction	68
1. Prevalence		II. Setting the Stage: The Legal and Political Framework	68
2. Legal Status of Abortion		A. The Structure of Government	68
3. Requirements for Obtaining a Legal Abortion		1. Executive Branch	
4. Policies Related to Abortion		2. Legislative Branch	
5. Penalties for Abortion		3. Judicial Branch	
6. Regulation of Information on Abortion		B. Sources of Law	69
E. Sterilization	55	1. International Sources of Law	
F. Female Circumcision/Female Genital Mutilation	55	2. Domestic Sources of Law	
1. Prevalence		III. Examining Reproductive Health and Rights	70
2. Laws to Prevent FC/FGM		A. Health Laws and Policies	70
3. Policies to Prevent FC/FGM		1. Objectives of the Health Policy	
G. HIV/AIDS and other STIs	56	2. Infrastructure of Health Services	
1. Prevalence		3. Cost of Health Services	
2. Laws Related to HIV/AIDS			
3. Laws Related to other STIs			
4. Programs Related to Prevention and Treatment of HIV/AIDS and other STIs			
IV. Understanding the Exercise of Reproductive Rights: Women's Legal Status	56		

4. <i>Regulation of Health Care Providers</i>			
5. <i>Patients' Rights</i>			
B. Population and Family Planning	74		
1. <i>The Population Policy</i>			
2. <i>The Family Planning Policy and Government Delivery of Family Planning Services</i>			
3. <i>Services Provided by NGOs and the Private Sector</i>			
C. Contraception	75		
1. <i>Prevalence</i>			
2. <i>Legal Status of Contraceptives</i>			
3. <i>Regulation of Information on Contraception</i>			
D. Abortion	76		
1. <i>Legal Status of Abortion</i>			
2. <i>Requirements for Obtaining a Legal Abortion</i>			
3. <i>Policies Related to Abortion</i>			
4. <i>Penalties for Abortion</i>			
5. <i>Regulation of Information on Abortion</i>			
E. Sterilization	77		
F. Female Circumcision/Female Genital Mutilation	77		
1. <i>Prevalence</i>			
2. <i>Laws to Prevent FC/FGM</i>			
3. <i>Policies to Prevent FC/FGM</i>			
G. HIV/AIDS and other STIs	77		
1. <i>Prevalence</i>			
2. <i>Laws Related to HIV/AIDS</i>			
3. <i>Laws Related to other STIs</i>			
4. <i>Programs Related to Prevention and Treatment of HIV/AIDS and other STIs</i>			
IV. Understanding the Exercise of Reproductive Rights: Women's Legal Status	78		
A. Legal Guarantees of Gender Equality/Non-Discrimination	78		
B. Rights within Marriage	78		
1. <i>Marriage Law</i>			
2. <i>Divorce and Custody Law</i>			
C. Economic and Social Rights	80		
1. <i>Property Rights</i>			
2. <i>Labor Rights</i>			
3. <i>Access to Credit</i>			
4. <i>Access to Education</i>			
D. Right to Physical Integrity	81		
1. <i>Rape</i>			
2. <i>Incest</i>			
3. <i>Domestic Violence</i>			
4. <i>Sexual Harassment</i>			
V. Focusing on the Rights of a Special Group: Female Minors and Adolescents	82		
A. Reproductive Health of Female Minors and Adolescents	82		
B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents	82		
C. Marriage of Female Minors and Adolescents	82		
D. Education for Female Minors and Adolescents	83		
E. Sexuality Education for Female Minors and Adolescents	84		
F. Sexual Offenses against Female Minors and Adolescents	84		
5. CHAD	89		
Statistics	89		
I. Introduction	91		
II. Setting the Stage: The Legal and Political Framework	91		
A. The Structure of Government	91		
1. <i>Executive Branch</i>			
2. <i>Legislative Branch</i>			
3. <i>Judicial Branch</i>			
B. Sources of Law	93		
1. <i>International Sources of Law</i>			
2. <i>Domestic Sources of Law</i>			
III. Examining Reproductive Health and Rights	94		
A. Health Laws and Policies	94		
1. <i>Objectives of the Health Policy</i>			
2. <i>Infrastructure of Health Services</i>			
3. <i>Cost of Health Services</i>			
4. <i>Regulation of Health Care Providers</i>			
4. <i>Patients' Rights</i>			
B. Population and Family Planning	97		
1. <i>The Population and Family Planning Policy</i>			
2. <i>Government Delivery of Family Planning Services</i>			
3. <i>Services Provided by NGOs and the Private Sector</i>			
C. Contraception	99		
1. <i>Prevalence</i>			
2. <i>Legal Status of Contraceptives</i>			
3. <i>Regulation of Information on Contraception</i>			
D. Abortion	100		
1. <i>Prevalence</i>			
2. <i>Legal Status of Abortion</i>			
3. <i>Requirements for Obtaining a Legal Abortion</i>			
4. <i>Policies Related to Abortion</i>			

5. <i>Penalties for Abortion</i>		I. Introduction	113
6. <i>Regulation of Information on Abortion</i>		II. Setting the Stage: The Legal and Political Framework	113
E. Sterilization	100	A. The Structure of Government	113
F. Female Circumcision/Female Genital Mutilation	101	1. <i>Executive Branch</i>	
1. <i>Prevalence</i>		2. <i>Legislative Branch</i>	
2. <i>Laws to Prevent FC/FGM</i>		3. <i>Judicial Branch</i>	
3. <i>Policies to Prevent FC/FGM</i>		B. Sources of Law	115
4. <i>Additional Efforts to Prevent FC/FGM</i>		1. <i>International Sources of Law</i>	
G. HIV/AIDS and other STIs	101	2. <i>Domestic Sources of Law</i>	
1. <i>Prevalence</i>		III. Examining Reproductive Health and Rights	115
2. <i>Laws Related to HIV/AIDS</i>		A. Health Laws and Policies	115
3. <i>Laws Related to other STIs</i>		1. <i>Objectives of the Health Policy</i>	
4. <i>Programs Related to Prevention and Treatment of HIV/AIDS</i>		2. <i>Infrastructure of Health Services</i>	
IV. Understanding the Exercise of Reproductive Rights: Women's Legal Status	102	3. <i>Cost of Health Services</i>	
A. Legal Guarantees of Gender Equality/Non-Discrimination	103	4. <i>Regulation of Health Care Providers</i>	
B. Rights within Marriage	103	5. <i>Patients' Rights</i>	
1. <i>Marriage Law</i>		B. Population and Family Planning	119
2. <i>Divorce and Custody Law</i>		1. <i>The Population and Family Planning Policy</i>	
C. Economic and Social Rights	103	2. <i>Government Delivery of Family Planning Services</i>	
1. <i>Property Rights</i>		3. <i>Services Provided by NGOs and the Private Sector</i>	
2. <i>Labor Rights</i>		C. Contraception	121
3. <i>Access to Credit</i>		1. <i>Prevalence</i>	
4. <i>Access to Education</i>		2. <i>Legal Status of Contraceptives</i>	
D. Right to Physical Integrity	105	3. <i>Regulation of Information on Contraception</i>	
1. <i>Rape</i>		D. Abortion	121
2. <i>Domestic Violence</i>		1. <i>Prevalence</i>	
3. <i>Sexual Harassment</i>		2. <i>Legal Status of Abortion</i>	
V. Focusing on the Rights of a Special Group: Female Minors and Adolescents	106	3. <i>Requirements for Obtaining a Legal Abortion</i>	
A. Reproductive Health of Female Minors and Adolescents	106	4. <i>Policies Related to Abortion</i>	
B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents	106	5. <i>Penalties for Abortion</i>	
C. Marriage of Female Minors and Adolescents	106	6. <i>Regulation of Information on Abortion</i>	
D. Education for Female Minors and Adolescents	107	E. Sterilization	122
E. Sexuality Education for Female Minors and Adolescents	107	F. Female Circumcision/Female Genital Mutilation	122
F. Sexual Offenses against Female Minors and Adolescents	107	1. <i>Prevalence</i>	
6. CÔTE D'IVOIRE	111	2. <i>Laws to Prevent FC/FGM</i>	
Statistics	111	3. <i>Policies to Prevent FC/FGM</i>	
		G. HIV/AIDS and other STIs	123
		1. <i>Prevalence</i>	
		2. <i>Laws Related to HIV/AIDS</i>	
		3. <i>Laws Related to other STIs</i>	
		4. <i>Programs Related to Prevention and Treatment of HIV/AIDS and other STIs</i>	

IV. Understanding the Exercise of Reproductive Rights: Women's Legal Status	124
A. Legal Guarantees of Gender Equality/Non-Discrimination	124
B. Rights within Marriage	124
1. <i>Marriage Law</i>	
2. <i>Divorce and Custody Law</i>	
C. Economic and Social Rights	125
1. <i>Property Rights</i>	
2. <i>Labor Rights</i>	
3. <i>Access to Credit</i>	
4. <i>Access to Education</i>	
D. Right to Physical Integrity	127
1. <i>Rape</i>	
2. <i>Indecent Assault</i>	
3. <i>Domestic Violence</i>	
4. <i>Sexual Harassment</i>	

V. Focusing on the Rights of a Special Group: Female Minors and Adolescents	128
A. Reproductive Health of Female Minors and Adolescents	128
B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents	128
C. Marriage of Female Minors and Adolescents	128
D. Education for Female Minors and Adolescents	129
E. Sexuality Education for Female Minors and Adolescents	129
F. Sexual Offenses against Female Minors and Adolescents	129

7. MALI **133**

Statistics	133
I. Introduction	135
II. Setting the Stage: The Legal and Political Framework	135
A. The Structure of Government	135
1. <i>Executive Branch</i>	
2. <i>Legislative Branch</i>	
3. <i>Judicial Branch</i>	
B. Sources of Law	135
1. <i>International Sources of Law</i>	
2. <i>Domestic Sources of Law</i>	
III. Examining Reproductive Health and Rights	137
A. Health Laws and Policies	138
1. <i>Objectives of the Health Policy</i>	

2. <i>Infrastructure of Health Services</i>	
3. <i>Financing the Health Sector</i>	
4. <i>Regulation of Health Care Providers</i>	
5. <i>Patients' Rights</i>	
B. Population and Family Planning	141
1. <i>The Population and Family Planning Policy</i>	
2. <i>Government Delivery of Family Planning Services</i>	
3. <i>Services Provided by NGOs and the Private Sector</i>	
C. Contraception	142
1. <i>Prevalence</i>	
2. <i>Legal Status of Contraceptives</i>	
3. <i>Regulation of Information on Contraception</i>	
D. Abortion	143
1. <i>Prevalence</i>	
2. <i>Legal Status of Abortion</i>	
3. <i>Requirements for Obtaining a Legal Abortion</i>	
4. <i>Policies Related to Abortion</i>	
5. <i>Penalties for Abortion</i>	
6. <i>Regulation of Information on Abortion</i>	
E. Sterilization	144
F. Female Circumcision/Female Genital Mutilation	144
1. <i>Prevalence</i>	
2. <i>Laws to Prevent FC/FGM</i>	
3. <i>Policies to Prevent FC/FGM</i>	
G. HIV/AIDS and other STIs	145
1. <i>Prevalence</i>	
2. <i>Laws Related to HIV/AIDS</i>	
3. <i>Laws Related to other STIs</i>	
4. <i>Programs Related to Prevention and Treatment of HIV/AIDS</i>	

IV. Understanding the Exercise of Reproductive Rights: Women's Legal Status	146
A. Legal Guarantees of Gender Equality/Non-Discrimination	146
B. Rights within Marriage	146
1. <i>Marriage Law</i>	
2. <i>Divorce and Custody Law</i>	
C. Economic and Social Rights	147
1. <i>Property Rights</i>	
2. <i>Labor Rights</i>	
3. <i>Access to Credit</i>	
4. <i>Access to Education</i>	
D. Right to Physical Integrity	148
1. <i>Rape</i>	
2. <i>Indecent Assault</i>	

3. <i>Kidnapping</i>		D. Abortion	164
4. <i>Domestic Violence</i>		1. <i>Prevalence</i>	
5. <i>Sexual Harassment</i>		2. <i>Legal Status of Abortion</i>	
V. Focusing on the Rights of a Special Group:		3. <i>Requirements for Obtaining a Legal Abortion</i>	
Female Minors and Adolescents	149	4. <i>Policies Related to Abortion</i>	
A. Reproductive Health of Female Minors and Adolescents	149	5. <i>Penalties for Abortion</i>	
B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents	149	6. <i>Regulation of Information on Abortion</i>	
C. Marriage of Female Minors and Adolescents	149	E. Sterilization	165
D. Education for Female Minors and Adolescents	150	F. Female Circumcision/Female Genital Mutilation	165
E. Sexuality Education for Female Minors and Adolescents	150	1. <i>Prevalence</i>	
F. Sexual Offenses against Female Minors and Adolescents	150	2. <i>Laws to Prevent FC/FGM</i>	
8. SENEGAL	155	3. <i>Policies to Prevent FC/FGM</i>	
Statistics	155	4. <i>Additional Efforts to Prevent FC/FGM</i>	
I. Introduction	157	G. HIV/AIDS and other STIs	166
II. Setting the Stage: The Legal and Political Framework	157	1. <i>Prevalence</i>	
A. The Structure of Government	157	2. <i>Laws Related to HIV/AIDS</i>	
1. <i>Executive Branch</i>		3. <i>Laws Related to other STIs</i>	
2. <i>Legislative Branch</i>		4. <i>Programs Related to Prevention and Treatment of HIV/AIDS and other STIs</i>	
3. <i>Judicial Branch</i>		IV. Understanding the Exercise of Reproductive Rights: Women's Legal Status	167
B. Sources of Law	158	A. Legal Guarantees of Gender Equality/Non-Discrimination	167
1. <i>International Sources of Law</i>		B. Rights within Marriage	167
2. <i>Domestic Sources of Law</i>		1. <i>Marriage Law</i>	
III. Examining Reproductive Health and Rights	159	2. <i>Divorce and Custody Law</i>	
A. Health Laws and Policies	159	C. Economic and Social Rights	168
1. <i>Objectives of the Health Policy</i>		1. <i>Property Rights</i>	
2. <i>Infrastructure of Health Services</i>		2. <i>Labor Rights</i>	
3. <i>Cost of Health Services</i>		3. <i>Access to Credit</i>	
4. <i>Regulation of Health Care Providers</i>		4. <i>Access to Education</i>	
5. <i>Patients' Rights</i>		D. Right to Physical Integrity	170
B. Population and Family Planning	162	1. <i>Rape</i>	
1. <i>The Population Policy</i>		2. <i>Domestic Violence</i>	
2. <i>The Family Planning Policy</i>		3. <i>Sexual Harassment</i>	
3. <i>Government Delivery of Family Planning Services</i>		V. Focusing on the Rights of a Special Group: Female Minors and Adolescents	171
4. <i>Services Provided by NGOs and the Private Sector</i>		A. Reproductive Health of Female Minors and Adolescents	171
C. Contraception	164	B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents	171
1. <i>Prevalence</i>		C. Marriage of Female Minors and Adolescents	171
2. <i>Legal Status of Contraceptives</i>		D. Education for Female Minors and Adolescents	172
3. <i>Regulation of Information on Contraception</i>		E. Sexuality Education for Female Minors and Adolescents	172

F. Sexual Offenses against Female Minors and Adolescents	172
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**9. REGIONAL TRENDS
IN REPRODUCTIVE RIGHTS 176**

I. Setting the Stage: The Legal and Political Framework 176

A. The Structure of National Governments	177
1. Executive Branch	
2. Legislative Branch	
3. Judicial Branch	
B. The Role of Women in Government	178
C. Sources of Law	178
1. International Sources of Law	
2. Domestic Sources of Law	

II. Examining Reproductive Health and Rights 178

A. Health Laws and Policies	178
1. Objectives of the Health Policy	
2. Infrastructure of Health Services	
3. Private Sector	
4. Cost of Health Services	
5. Regulation of Health Care Providers	
6. Patients' Rights	
B. Population and Family Planning	182
1. Population and Family Planning Policy	
2. Government Delivery of Family Planning Services	
3. Services Provided by NGOs and the Private Sector	
C. Contraception	185
1. Types of Contraceptives Available and Rates of Prevalence	
2. Cost of Family Planning Methods and Services	
3. Legal Status of Contraceptives	
4. Regulation of Information on Contraception	
D. Abortion	186
1. Legal Status of Abortion	
2. Requirements for Obtaining a Legal Abortion	
3. Policies Related to Abortion	
4. Regulation of Information on Abortion	
E. Sterilization	187
F. Female Circumcision/Female Genital Mutilation	188
1. Definition of FC/FGM	
2. Laws to Prevent FC/FGM	
3. Policies to Prevent FC/FGM	
G. HIV/AIDS and other STIs	189
1. Prevalence	

2. Laws Related to HIV/AIDS and other STIs
3. Programs Related to Prevention and Treatment of HIV/AIDS and other STIs

III. Understanding the Exercise of Reproductive Rights: Women's Legal Status 190

A. Rights within Marriage	190
1. Legal Age of First Marriage	
2. Consent to Marriage	
3. Types of Marriage	
4. Bride-price	
5. Pecuniary Effects of Marriage	
6. Personal Effects of Marriage	
B. Divorce and Custody Law	192
1. Types of Divorce	
2. Effects of Divorce	
C. Economic and Social Rights	193
1. Property Rights	
2. Labor Rights	
3. Access to Credit	
4. Access to Education	
D. Right to Physical Integrity	195
1. Rape	
2. Domestic Violence	
3. Sexual Harassment	

IV. Focusing on the Rights of a Special Group: Female Minors and Adolescents 196

A. Reproductive Health of Female Minors and Adolescents	196
B. Female Circumcision/Female Genital Mutilation of Female Minors and Adolescents	197
C. Marriage of Female Minors and Adolescents	197
D. Sexuality Education for Female Minors and Adolescents	198
E. Sexual Offenses against Female Minors and Adolescents	198

V. Conclusion 200

Glossary of Legal Terms

Civil Liability (*responsabilité civile*): Any obligation that may be enforced through a civil action (as opposed to a criminal prosecution) in a court of law. Generally refers to a duty to compensate another for injury or other loss.

Criminal Liability (*responsabilité pénale*): Obligation to face criminal charges for legal infractions and to submit to penalties prescribed by law.

Afflictive Penalty (*peine afflictive*): Type of criminal punishment, which may include death, imprisonment for life or for a term, or criminal detention (for political crimes) for life or for a term.

Defamatory Penalty (*peine infamante*): Penalty involving loss of civil rights and/or banishment.

Eligible to inherit (*successible*):

1. To be named in a will as an heir or otherwise entitled to inherit property of a deceased person.
2. To be a potential heir to the estate of a person who is still living.
3. To be entitled to inherit property of a deceased person, but not yet decided on whether or not to accept the inheritance.

Codification (*codification*):

1. Action of making a code, of bringing together legal texts relating to a particular area of law.
2. A legal code, the result of the process of codifying the law.
3. A legal system founded on codified law.

Marriage by Coemption (*mariage par coemption*): The fictitious sale of a bride by her father or her family to her husband.

Court of First Instance

1. (*tribunal de première instance*): Generic name for courts of original jurisdiction, the decisions of which may be challenged in a Court of Appeal.
2. (*tribunal de Grande Instance*): Court of original jurisdiction usually located at the district level, the decisions of which may be challenged by a Court of Appeal. It is composed of a president and judges, sitting on a panel (or individually in exceptional circumstances). It has exclusive competence in certain civil matters determined by law (e.g. marriage, divorce, affiliation, marital regimes, etc.), and over all matters that are not by statute expressly assigned

to other courts by reason of the subject matter or the amount of money in question.

Assize Court (*cour d'assises*): Criminal court with periodic sittings occurring successively in each jurisdiction. The Assize Court hears only cases pertaining to serious crimes and related correctional offenses. It is composed of three professional judges (one of which serves as president) and of nine citizens selected at random from a jury list at the beginning of each sitting.

Court of Appeal (*cour d'appel*): A court that hears appeals against decisions rendered in the Court of First Instance, with the power to overturn a Court of First Instance decision.

Paternal Rights (*puissance paternelle*): Set of rights belonging to a father over the person and belongings of his minor children.

Marital Rights (*puissance maritale*): Various legal privileges that give a husband a number of rights over his wife.

Parental Authority (*autorité parentale*): Set of rights belonging to parents over the person and belongings of their minor children.

Primogeniture (*primogéniture*):

1. The state of being the oldest among several children of the same parents.
2. The source of advantages, particularly in matters of succession, enjoyed by the eldest son.

Separation of Property (*séparation des biens*): Marital property system in which each spouse maintains the rights to administer, enjoy, and freely dispose of his or her personal property.

Community Property (*communauté de biens*): Marital property system in which all or part of the property of the spouses forms a single unit that must be divided between the spouses or among their heirs at the dissolution of the marriage.

Organic Law (*loi organique*): A law that completes a constitutional provision by outlining in detail the powers of public institutions. Organic laws may be adopted only by special procedures.

Order or Executive Order (*ordonnance*): A regulation issued by the executive branch that has the same force as a legislative act (law) by virtue of an express provision of the constitution.

Decree (*décret*): A generic term referring to a category of administrative rulings issued unilaterally by the President of the Republic or the Prime Minister. Decrees may either be regulations, when their provisions are general and impersonal, or non-regulations, when they concern one or several individual judicial situations. The procedures for a decree's adoption vary according to whether it has been developed in the Council of Ministers, the Council of State, or otherwise.

Violence (*violence*):

1. An unauthorized constraint, an act of force rendered illegal by the threat it poses to peace and liberty, by the brutality with which it is carried out, and /or by the intimidation and fear that results for the victim(s).
2. An act of aggression that threatens the physical integrity of the person against whom it is directed. The term "violence" refers not only to those acts causing physical harm, but also to those that result in psychological damage, even in the absence of physical contact with the victim.

Assault (*voie de fait*): Violence towards a person that does not constitute physical wounding (e.g. spitting in a person's face or slamming the door on someone).

Crime (*crime*): An infraction punishable by imprisonment or criminal detention (for political crimes) for a period of 10 or more years.

Offense or Misdemeanor (*délit*): Considered less serious than crimes and more serious than minor offenses. They are punishable by correctional penalties (prison or fine) and generally prosecuted in the court of corrections (*tribunal correctionnel*).

Minor Offense (*contravention*): Usually a strict-liability offense (intent need not be proven), punishable by fines and/or by the suspension or limitation of certain privileges, such as owning a weapon or driving a vehicle. Contraventions are minor offenses, adjudicated in the lowest criminal courts.

State of Necessity (*état de nécessité*): A circumstance that may be raised as a defense by one charged with intentionally causing harm to another. Intentional harm is not punishable when it is necessary to avert more serious harm to oneself or another.

Indecent Assault (*attentat à la pudeur*): Offensive, physical act committed intentionally upon the person of an individual of either sex. Such an act is deemed indecent assault where: (1) it is accompanied by violence or (2) in the absence of vio-

lence, it is committed against a person below a certain age.

Usufruct (*usufruit*): A real property right of limited duration that confers on its holder the use and enjoyment of any type of goods belonging to another, provided that the source is preserved.

Executory Judgement (*décision à caractère exécutoire*): A judicial decision capable of being enforced, either because it is not or no longer susceptible to a suspension of enforcement, or because it is a provisional remedy, which may be carried out prior to a final judicial decision.

Mandatory Grounds for Divorce (*cause péremptoire de divorce*): Judges are required by law to grant a divorce when adequate proof of these grounds is presented.

Optional Grounds for Divorce (*cause facultative de divorce*): Judges are permitted, but not obligated, to grant a divorce when proof of these grounds is presented.

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Foreword

I am delighted to present *Women of the World: Laws and Policies Affecting Their Reproductive Lives, Francophone Africa*. This book is unique in that it is one of the first comprehensive reviews of laws and policies related to reproductive health and rights in Francophone Africa. Since information regarding this region is often difficult to find, we hope that this publication will contribute to identifying the many challenges that the international community needs to overcome in order to achieve women's reproductive health and rights. Read in conjunction with our 1997 report covering Anglophone Africa, these two reports succeed in providing an overview of relevant laws and policies in sub-Saharan Africa. While we regret the division of our Africa reports into two volumes based on colonial linguistic patterns, we view such a division as being reflective of the different legal traditions of the sub-regions of Africa. Nonetheless, our future work in Africa will take a more holistic and broad view of this diverse continent. To facilitate the achievement of such an overarching perspective, we have published this book in both French and English.

Like *Women of the World: Laws and Policies Affecting Their Reproductive Lives, Anglophone Africa*, this publication is the result of almost two years of productive collaboration between different women's rights organizations. The Center for Reproductive Law and Policy and the Groupe de recherche femmes et lois au Sénégal (GREFELS), our regional coordinator, worked closely with national-level organizations in each of the countries profiled in this book. We continue in our collaborations with women's rights organization around the world as we forge ahead to complete future global reports on Eastern and Central Europe, East and Southeast Asia, the Middle East and North Africa, and South Asia. However, even as we complete upcoming regional legal and policy reviews, we continue the process of updating the information from previous reports.

In undertaking all legal and policy research, we seek to enhance knowledge regarding the range of formal laws and policies that affect the actions of billions of women and men around the globe. By making such information widely available, we hope to promote worldwide legal and policy advocacy to advance reproductive health and the status of women. Our goal is a world in which women and men are equal.

Anika Rahman
Director, International Program
The Center for Reproductive Law and Policy
November 1999

1. Introduction

Reproductive rights are internationally recognized as critical both to advancing women's human rights and to promoting development. In recent years, governments from all over the world have acknowledged and pledged to advance reproductive rights to an unprecedented degree. Governmental commitments at major international conferences, such as the five-year review of the International Conference on Population and Development (New York, 1999), the Fourth World Conference on Women (Beijing, 1995), the International Conference on Population and Development (Cairo, 1994), and the World Conference on Human Rights (Vienna, 1993) have created a global momentum for translating women's interests into nationally and internationally recognized rights. But for governmental and non-governmental organizations (NGOs) to work toward reforming laws and policies and implementing the mandates of these international conferences, they must be informed about the current state of laws and policies affecting reproductive rights at the national and regional levels.

A rights-based approach to reproductive interests promotes a woman's inherent dignity and worth as a human being.¹ Within the global human rights framework, reproductive rights encompass a broad range of internationally recognized political, economic, social, and cultural rights, at both the individual and the collective levels. But if the commitment to reproductive choice is to mean anything in practice, it is essential that we understand the laws and policies that affect the reproductive lives of women. These laws and policies are key factors affecting women's reproductive choices and their legal, economic, and social situations. Awareness of these issues is crucial to advocates seeking to promote national and regional legislative reforms that would enhance protection of women's rights and their reproductive health. Moreover, this knowledge may assist in the formulation of effective government policies by providing information on the different aspects of women's reproductive lives. The objective of this report is to ensure that women's concerns are reflected in future legal and policy efforts.

Laws are essential tools by which to promote women's reproductive health, facilitate their access to health services, and protect their human rights as users of such services. However, laws can also restrict women's access to the full enjoyment of reproductive health. For example, laws may limit an individual's choice of contraceptive methods, impose penalties on health providers who treat women suffering from abortion complications, and discriminate against specific groups, such as

adolescents, by denying them full access to reproductive health services. Laws that discriminate against women or that subordinate them to their spouses in marriage undermine the right to reproductive self-determination and serve to legitimize unequal relations between men and women. The absence of laws or procedures to enforce existing laws may also have a negative effect on the reproductive lives of women and men. For example, the absence of laws regulating the relationship between health care providers and users of reproductive health services may contribute to arbitrary decision making, which may affect the rights and interests of both parties.

Reproductive health policies are of special importance because they reflect a government's political positions and perspectives on health and women's rights. The role of women in the arena of a national reproductive health agenda varies among countries. Some governments treat women as central actors in the promotion of reproductive health. Others view women as a means by which to implement demographic goals set by different economic and cultural imperatives. Moreover, public policies can either facilitate global access to reproductive well-being or exclude specific groups by establishing economic barriers to health services. In the latter situation, women who are the poorest, the least educated, and the least empowered are hurt the most. Furthermore, the absence of reproductive health and family planning policies in some countries demonstrates the need for greater effort to ensure that governments fulfill the commitments they assumed at the international conferences

of New York, Beijing, Cairo, and Vienna.

This report sets forth national laws and policies in key areas of reproductive health and women's empowerment in seven Francophone countries in sub-Saharan Africa: Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Mali, and Senegal. This introduction seeks to provide a general background to the Francophone region of sub-Saharan Africa, the nations profiled in this report, and the information presented on each country. The following section provides an overview of the region and places a special emphasis on the legal system and on the principal regional indicators of women's status and reproductive health. A review of the characteristics shared by the seven profiled countries follows. Finally, this chapter concludes with a description of the content of each of the country chapters.

I. An Overview of the Francophone Region

Francophone sub-Saharan Africa represents the African nations that were colonized by France or Belgium. It is comprised of Benin, Burkina Faso, Burundi,² Cameroon, Central African Republic, Chad, Comoros, Congo-Brazzaville, Côte d'Ivoire, Democratic Republic of Congo (formerly Zaire), Djibouti, Gabon, Guinea, Madagascar, Mali, Mauritania, Mauritius, Niger, Reunion, Rwanda, Senegal, Seychelles, and Togo. However, it is important to recognize that the development of "French-speaking" Africa is an artificial creation, imposed upon the African continent at the Berlin Conference in 1884–1885.³ These borders were later adopted by almost all of the African states, following their independence, and later reaffirmed at the founding of the Organization of African Unity (OAU) in 1963.⁴ Because these divisions have no inherent basis, it is not always helpful to examine the French-speaking African countries in isolation from the other countries of sub-Saharan Africa. Rather, important indicators of economic and social development of the sub-Saharan region as a whole provide a helpful lens through which to view the Francophone region.

A. COMMON DEVELOPMENT INDICATORS

The population of sub-Saharan Africa is comprised of 612 million people, representing 10.5% of the global population.⁵ Women represent 50.5% of the total population.⁶ The regional gross national product (GNP) for sub-Saharan Africa is approximately U.S.\$311 billion, 1% of the world GNP.⁷ While economic growth in sub-Saharan Africa in 1997 was strong, estimated at around 4.6%,⁸ 40% of the population still lives on

less than U.S.\$1 per day.⁹ Those most vulnerable to poverty live in rural areas, in large households that are often headed by women.¹⁰ The World Bank estimates that, faced with the current population growth rate of 2.8% per year, the region will require economic growth between 5 to 8% to reduce the number of poor.¹¹

At a 1999 conference on human rights in Africa, the OAU Secretary-General noted that the continent's huge external debt and the consequences of structural adjustment policies (SAPs) are preventing the establishment of an entrenched human rights regime.¹² SAPs place an emphasis on private sector development in return for loans for debt servicing. SAPs, introduced to the continent by the International Monetary Fund and the World Bank in the early 1980s, have had an adverse impact on women; social welfare measures are being cut¹³ and it is increasingly difficult for governments to allocate sufficient funds for population, reproductive health, and related programs.¹⁴ Women are also suffering in the labor sector as a result of SAPs. In the area of agriculture, where 75% of women work,¹⁵ they must contend with increased costs for inputs due to the removal of subsidies.¹⁶ Moreover, women are gradually being forced out of the informal job sector, where they make up the majority of workers, because they cannot compete against men who are increasingly entering the informal sector due to job cutbacks in the formal sector.¹⁷ SAPs are also decreasing the availability of health care, previously offered by the state, by privatizing services as part of pro-market reforms. By 1989, 37 African countries had signed SAP agreements.¹⁸

B. REPRODUCTIVE HEALTH PROBLEMS

During the 1970s, concern about the state of health of mothers and children worldwide helped define national health strategies in sub-Saharan Africa. High maternal and infant mortality rates and increasing rates of disease and disabilities encouraged nations to reevaluate their health care systems. At the International Conference on Primary Health, held in 1978 in Alma-Ata, USSR, the Ministers of Health from 134 countries embraced the goal of health for all by the year 2000 and identified primary health care as the key to attaining this target.¹⁹ Primary health care was defined as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford."²⁰ Following this Conference, the World Health Assembly launched the Global Health Strategy based on a concept of localized health care that focuses on primary health care. The strategy was an unusual "global plan of action" in that it began at the national level and worked through regions to the

global level. The health policies of all of the countries featured in this report are based on the concept of primary health care for all, with an emphasis on the health of the mother and child.

In 1987, the Ministers of Health of African countries, with the support of the World Health Organization (WHO) and UNICEF, launched the Bamako Initiative, reaffirming the region's commitment to the Alma-Ata Declaration.²¹ Like the Alma-Ata Declaration, the Bamako Initiative aims to make primary health care universally accessible to the entire population in sub-Saharan Africa by increasing grass-roots participation, encouraging decentralized health care, and promoting essential drugs. At a March 1999 progress-review meeting, the Initiative was touted as one of the most important approaches to health promotion, particularly for mothers and children. It was noted that, since 1987, there has been an increased use of preventative and curative services in the countries that have adopted the Bamako Initiative. At the end of the review, the participants called on governments to develop a strong basic national framework for providing health services, including HIV/AIDS treatment, maternal and neo-natal health care, and programs to address malnutrition.²²

However, it was not until 1994 that increased attention was paid to the issue of reproductive health and rights. The International Conference on Population and Development (ICPD) was the first United Nations population conference to endorse the concept of "reproductive rights." Representatives from over 180 nations met in Cairo and agreed to the centrality of women in all discussions of population and development. One of the singular accomplishments of the ICPD Programme of Action is its support for a "new comprehensive concept of reproductive health."²³ The Programme of Action is also notable for its endorsement of a range of human rights. The document not only recommends that national population policies respect international human rights norms, it also endorses a host of rights — such as the right to development, the right to health, the right to health care, the right to education, and the right to decide the number and spacing of children — that are applicable to a broad range of development policies.

The countries of sub-Saharan Africa are working to implement these international and regional programs into their national health care systems. Nevertheless, much remains to be done. The governments of sub-Saharan Africa spend, on average, 2.7% of their total gross domestic product (GDP) on health expenditure, services, and use, compared to a world average of 5.4%.²⁴ Furthermore, even though most sub-Saharan African nations have participated in and adopted the plans of actions recommended at recent international conferences, women's reproductive health situation in the region is relatively low

compared with other regions in the world. Although only one-tenth of the world's women lives in sub-Saharan Africa, this region accounts for 40% of all pregnancy-related deaths worldwide. Every two and a half minutes, one woman in sub-Saharan Africa dies from a pregnancy-related cause.²⁵

Pregnancy and childbirth are the leading causes of death, disease, and disability among women of reproductive age in sub-Saharan Africa, where the average rate of maternal mortality is 975 for every 100,000 live births, the highest rate in the world.²⁶ Access to maternal health care is very limited in most African countries, as demonstrated by the percentage of women whose births are attended by a trained birth attendant. In Chad, skilled health staff attend only 15% of births; in the Central African Republic, Kenya, Côte d'Ivoire, and Ghana, the average is 45%; and in South Africa, the rate is 82%, the highest in the region.²⁷

While maternal mortality is a serious health concern for African women, it is crucial that women's reproductive health be viewed broadly to encompass an array of issues that assure the health of a woman's reproductive system. This holistic understanding of reproductive health was embraced by the ICPD, which reaffirmed the "right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children."²⁸ Access to contraception and safe abortions; protection from and treatment for sexually transmissible infections (STIs), human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS); and laws and policies which protect women from harmful traditional practices and sexual violence, are all components of reproductive health and are essential to any effort to reduce maternal mortality in the region.

According to the United Nations Population Fund (UNFPA), there is a low level of family planning in Africa that is resulting in unwanted pregnancies and unsafe abortions.²⁹ The average number of children per African woman is 5.5.³⁰ Multiple pregnancies per woman are attributable to several factors, including the low status of women, which prevents them from being able to control the number of children they would like to have. Contraceptive use in sub-Saharan Africa — at 16%,³¹ with only 20% of married women using contraception — is the lowest in the world.³² The prevalence of modern methods — oral contraceptives, intrauterine devices, hormone implants and injections, and sterilization — is consistently lower. Governments, international donor agencies, and medical providers often limit contraceptive choice through restrictive policies and attitudes toward women seeking reproductive health care. Even when available, contraceptives often require spousal consent, and are rarely available to unmarried women, particular-

ly adolescents.

There is an estimate of 3,740,000 unsafe abortions performed each year in sub-Saharan Africa, amounting to 26 unsafe abortions per 1,000 women of reproductive age.³³ Unsafe and illegal abortions are a major cause of maternal deaths in African countries. It has been estimated that approximately 13% of maternal deaths in the region can be attributed to unsafe abortions.³⁴ The major reasons that women seek unsafe abortions are: lack of information and access to contraceptives and family planning services; contraceptive failure; sexual abuse; incest; rape; and socio-economic reasons such as the stigma attached to a young woman having a child out of wedlock, or the lack of economic means to raise another child. Another important reason is the illegal status or limited availability of abortions in many African countries. Adolescents are disproportionately affected by this reality, since up to 70% of women who die from abortion complications are under age 20.³⁵ One third of the total worldwide deaths from unsafe abortion occur in Africa, equaling an estimated 680 deaths per 100,000 procedures.³⁶

The HIV/AIDS epidemic in sub-Saharan Africa, described by UNAIDS as in "emergency status," is one of the most serious health problems facing the region. There are an estimated 11.2 AIDS cases per 100,000 people in sub-Saharan Africa.³⁷ In 1998, seven out of 10 people newly infected with HIV lived in sub-Saharan Africa.³⁸ Of all AIDS deaths since the epidemic started, 83% have been in this region.³⁹ In the Central African Republic, Côte d'Ivoire, Djibouti, and Kenya, at least one in 10 adults are HIV-infected.⁴⁰ In general, Western and Central Africa, where the majority of Francophone African countries are located, are less affected by HIV/AIDS than Southern or Eastern Africa.⁴¹

Since HIV infection in sub-Saharan Africa is transmitted predominately through heterosexual intercourse, the HIV/AIDS epidemic has had a particularly adverse impact on women.⁴² In fact, women are more likely to be infected with HIV than to pass it on to their male partners.⁴³ It is estimated that six million women in sub-Saharan Africa are HIV positive and over 50% of new HIV infections in Africa occur in women.⁴⁴ This trend is even more acute among girls, sometimes at a rate three times greater than boys in the same age group.⁴⁵ This age gap in infection rates indicates that young girls are often getting infected through sex with older men. Transmission through blood transfusion accounts for up to 10% of infections.⁴⁶

Unfortunately, the HIV/AIDS epidemic has not spared children. In 1998, nine out of 10 children under 15 newly infected with HIV lived in sub-Saharan Africa.⁴⁷ Mother-to-child transmission is also an increasing problem, with as many

as one million children in sub-Saharan African infected prior to or during birth.⁴⁸ Moreover, a growing number of children live in AIDS-affected households or are attempting to survive after the death of their mother, or both parents, to AIDS. At least 95% of all AIDS orphans are African.⁴⁹

Research has shown that the presence of other STIs can increase the risk of contracting HIV/AIDS. STIs are very common in African countries, and women bear the brunt of the infections.⁵⁰ Biologically, women are more susceptible to STIs than men, because their reproductive systems expose a greater surface area during intercourse.⁵¹ This vulnerability is compounded by their social status, which often prevents them from practicing safe sex using barrier methods, such as condoms. Recent statistics for Africa indicate that an individual's risk of contracting a curable STI is one in four, the highest in the world.⁵² This rate is even more problematic when considered in conjunction with the fact that most women infected with an STI do not receive medical treatment. If untreated, STIs can lead to infertility and cervical cancer. Reasons for lack of treatment include: the fact that many STIs are asymptomatic in women; embarrassment or shame; lack of finances; and limited access to health care, particularly reproductive health care.

Assault and sexual violence at the hands of partners or others threatens the reproductive security of African women and undermines their self-esteem. Levels of domestic violence against women are reaching alarming proportions. South Africa is one of few African countries that has enacted legislation outlawing domestic violence and marital rape.⁵³ Furthermore, the prevalence of civil and regional wars in sub-Saharan Africa creates an additional threat to women. In 1998, 14 African states were involved in armed conflict.⁵⁴ This is of particular concern to women because rape is increasingly used as a weapon of war.

Moreover, some traditional practices threaten the reproductive health of African women. Female circumcision/female genital mutilation (FC/FGM) is practiced throughout much of the region, although there are different levels of prevalence. Currently, the practice exists in 28 sub-Saharan countries: in Mali, 94% of women are circumcised; by contrast, 5% of women in the Democratic Republic of Congo undergo the procedure and 20% in Senegal.⁵⁵ FC/FGM can result in both immediate and long-term complications, including severe pain and prolonged bleeding, chronic pelvic infections, excessive growth of scar tissue and serious psychological harm. The effects of FC/FGM are not limited to physiological harm; studies suggest that circumcised women experience a loss of self-esteem and self-identity.⁵⁶

Adolescents face all of the issues addressed above. However,

the problem is more acute where governments and policy makers do not recognize the particular needs of adolescents, as distinguished from children and from older women. Early sexual activity, marriage, and childbearing are common among adolescent African girls, and may result in serious reproductive health problems. Initiation of sexual intercourse, as part of or apart from marriage, by age 20 occurs among 83% of all women in sub-Saharan Africa.⁵⁷ In 1997, 134 per 1,000 girls between the ages of 15-19 had at least one child.⁵⁸

Adolescents in sub-Saharan Africa also report a high level of unwanted pregnancies. These rates range from around 35% in Côte d'Ivoire to about 65% in Ghana.⁵⁹ This high rate of unwanted pregnancies results in an elevated demand for abortions, which, given that abortion is illegal or unavailable in the majority of African countries,⁶⁰ means that adolescents may resort to clandestine, unsafe abortions.⁶¹ Adolescents who carry pregnancies to term face significant health risks associated with early childbearing including hemorrhage, anemia, malnutrition, delayed or obstructed labor, low birth weight, and death for the mother or infant.⁶² Children born to adolescent mothers are more likely to be premature, of low birth weight, and suffer the consequences of retarded fetal growth.⁶³

C. WOMEN'S SOCIO-ECONOMIC STATUS

The relationship between women's empowerment and reproductive health is often mutually reinforcing. Where women have opportunities for education, employment, and career development, they are more likely to take control of their reproductive lives. Therefore, reproductive health should be examined within the wider context of women's legal and social status.

African women continue to face many obstacles, particularly in the areas of employment, education, and physical integrity. The disadvantages faced by women in the labor market and salary discrimination exacerbate women's inferior status in African societies. In Africa, the percentage of women in the labor force (42%) is greater than that in other regions.⁶⁴ However, 75% of all women in the work force are employed in the agriculture sector.⁶⁵ In its 1989 report, *Sub-Saharan Africa: From Crisis to Sustainable Growth*, the World Bank described the plight of African women: "Women's farm labor has increased but goes unpaid; in industry and trade women have been confined to small-scale operations in the informal sector.... Women are also handicapped in access to formal sector jobs by their lower educational attainments, and those who succeed are placed in lower-grade, lower-paid jobs. Lower income prejudices their ability to provide for their children's welfare."⁶⁶ Despite their strong participation in the economic sector,

women's income represents only 36.2% of the total earned income.⁶⁷

Other important indicators of women's status are their education levels and their participation in government. Statistical indicators show that women generally do not have the same access to education as men in Africa. Only 40% of young women have attended any secondary schooling in sub-Saharan Africa.⁶⁸ Female adult literacy has improved greatly in the last 15 years, increasing 17%; however, it is still low at 47%.⁶⁹ While overall participation by women in national parliaments is low, at 10.3%, five African countries are among the top 15 in the world in terms of percentage of women in government.⁷⁰

While many indicators relevant to the status of reproductive health and women's rights are common among the countries of sub-Saharan Africa, for the purposes of this report, we will consider the reproductive laws and policies of Francophone sub-Saharan Africa in isolation. Francophone sub-Saharan Africa is often considered a distinct region not only because of the geographic proximity of many of the states which comprise it, but because these nations share a common legal and political history. Moreover, for the purpose of a comparative analysis, the laws and policies of these nations have developed differently from their Anglophone African counterparts.

II. Features of the Selected Nations

This study focuses on seven Francophone countries that offer a broad perspective of the region's legal, political, and social structures. In addition, we chose countries from both Central and West Africa to demonstrate that Francophone Africa is not, as commonly perceived, synonymous with West Africa, but rather is a 'geographical fiction' within sub-Saharan Africa.

The seven countries analyzed in this report represent 44% of the population of Francophone sub-Saharan Africa.⁷¹ Côte d'Ivoire, with 14.6 million inhabitants,⁷² has the largest population of the nations surveyed.⁷³ Benin, with 5.7 million people,⁷⁴ has the lowest number of people.⁷⁵ The World Bank characterizes all of the nations described in this report as "low-income" countries. Côte d'Ivoire's per capita gross domestic product (GDP) of U.S. \$690⁷⁶ is the highest of the selected countries, while Burkina Faso and Chad both have the lowest per capita GDP of U.S. \$240.⁷⁷

All seven profiled countries currently have democratically elected governments. However, their political histories since independence can be broadly characterized into two groups. Cameroon, Côte d'Ivoire, and Senegal adopted their current constitutions several decades ago. While these countries have

experienced relative stability since their independence, they have only permitted a legal and vibrant political opposition within the last decade, and each has had only two presidents since its independence. By contrast, Benin, Burkina Faso, Chad, and Mali adopted their current constitutions within the last 10 years. These countries have experienced more turbulent pasts, and have all been governed by military government for a period of time since their independence.

Islam, Christianity, and traditional faiths are the principle religions practiced in Francophone Africa, though religious predominance varies among the countries in the region. In Senegal, 94% of the population practice Islam; in Côte d'Ivoire, 65% practice traditional religions; and in Cameroon, 53% practice Christianity.

A. SHARED LEGAL TRADITION

All Francophone African nations share the same legal tradition, distinguishing them from the Anglophone African countries. In particular, the legal system of the Anglophone African countries is based on the English common law system.⁷⁸ This system stems from principles and rules of action that derive their authority solely from usage and custom or court judgments and decrees. By contrast, the legal tradition of Francophone African countries derives from the sixth century Roman civil law, known as *Corpus Juris Civilis*. In the nineteenth century, principal Western European states adopted civil codes based on Roman civil law, of which the French *Code Napoléon* of 1804 is the archetype.⁷⁹ These codes were later introduced to the region during the colonial rule of France and Belgium.

The most obvious feature of this French civil law system is that it is codified by the state and that these laws are the principle source of the rule of law.⁸⁰ Under this system, the legislative and executive branches regulate the judiciary to ensure that it restricts itself to objectively applying the laws, rather than interpreting them. Unlike in the common law tradition, there is little judicial lawmaking.

In addition to statutes and administrative regulations, the civil law tradition recognizes custom as a third source of law. If a person acts in accordance with custom, and there is no contrary applicable statutory law, her action will be accepted as legal.⁸¹ In the context of Francophone Africa, this was particularly relevant, because the pre-colonial African legal system was based on customary law.⁸² As a result, the colonizers established a dual judicial system, in which written civil law co-existed with the customary law.⁸³ This system remains today. Customary law is commonly given the force of law under the constitution or statutes, even though it is often limited to particular areas of law, such as marriage and succession. In Burki-

na Faso, for example, the recently adopted civil code represents an integration of the former French civil code and customary law. However, the legal system in Cameroon is unique because it represents the integration of customary law with the French and British legal traditions. Moreover, a Cameroonian may choose to bring her claim in either a civil law court or a traditional court, if there are laws in both systems governing the same issue. By contrast, customary law plays a relatively minor role in countries such as Côte d'Ivoire and Senegal.

B. COMMON REPRODUCTIVE HEALTH PROBLEMS

High levels of maternal and infant mortality characterize each of the seven nations featured in this report. In addition, most women in these countries tend to bear many children. Among these countries, the range of these rates varies. Chad's maternal mortality rate of 800 deaths per 100,000 live births,⁸⁴ is estimated to be among the highest in the world. Its infant mortality rate is 180 deaths per 1,000 births.⁸⁵ The average number of children borne by a Chadian woman is 6.6.⁸⁶ In Mali, all these three indicators are also viewed as being high. Mali's maternal mortality is estimated to be 577 deaths per 100,000 live births;⁸⁷ its infant mortality rate is 149 deaths per 1,000 births;⁸⁸ and the average number of children borne by a Malian woman is 6.7.⁸⁹ On the other hand, the statistics for Cameroon, while still high, are lower than those of the two countries previously cited. Its average maternal mortality rate is 550 per 100,000 live births;⁹⁰ its infant mortality rate is estimated at 58 deaths per 1000 births;⁹¹ and the average number of children borne by a Cameroonian woman is 5.3.⁹²

Key factors contributing to the alarming rate of maternal mortality include: poverty, lack of prenatal care services, unattended births, malnutrition and anemia, and delays in treating obstetric emergencies due to the lack of funds, transportation, and spousal consent.⁹³ The high rates of infant mortality can be partly explained by women's lack of access to postnatal care and information. The large number of children borne by women, however, is a reflection of cultural attitudes in predominantly rural societies where each child is viewed as an asset.

While the prevalence rates for the incidence of HIV/AIDS are widely regarded to be under-estimated, the official number of HIV-infected people remains very high in many of the seven Francophone African nations discussed in this report. Among these seven nations, Côte d'Ivoire has the highest rate of HIV infection. It is estimated that, in 1997, there were 670,000 HIV-infected adults in Côte d'Ivoire, representing a prevalence rate of 10.06%.⁹⁴ In addition, there were 32,000 HIV-infected children, in 1997, in Côte d'Ivoire.⁹⁵ Since the beginning of the epidemic, 450,000 AIDS cases have been

reported in Côte d'Ivoire.⁹⁶ The statistics for Burkina Faso are also very high. It is estimated that, in 1997, there were 350,000 HIV-infected adults in Burkina Faso, representing a prevalence rate of 7.17%.⁹⁷ In 1997, there were 22,000 HIV-infected children in Burkina Faso.⁹⁸ Since the beginning of the epidemic, 270,000 AIDS cases have been reported in Burkina Faso.⁹⁹ On the other hand, Senegal does not appear to have been as affected by the epidemic as some of the other African nations. It is estimated that, in 1997, there were 72,000 HIV-infected adults in Senegal, representing a prevalence rate of 1.77%.¹⁰⁰ In addition, in 1997, there were 3,800 HIV-infected children in Senegal.¹⁰¹ Since the beginning of the epidemic, 60,000 AIDS cases have been reported in Senegal.¹⁰²

Finally, in all seven nations, adolescents suffer from many unique reproductive health problems. In many nations, traditional practices harmful to women, particularly teenage women, continue to exist. For example, in many Francophone African nations, female circumcision/female genital mutilation (FC/FGM) is still widely practiced. The prevalence rate of the practice in the countries featured in the report varies from an extremely high prevalence rate in Mali (94%),¹⁰³ to a fairly high rate in Burkina Faso (66.35%),¹⁰⁴ to a rather low rate in Cameroon (20%).¹⁰⁵ Early marriage and early pregnancy are also common in Francophone Africa, often compounding the health problems caused by other traditional practices. Early sexual intercourse can cause tearing in the genital region, while childbearing at a young age is correlated with a higher incidence of obstructed labor, anemia, and obstetric fistulae. In all of the seven profiled nations, women marry very young. In Chad, the median age of first marriage for women aged between 20 and 49 years is 15.9 years, while in Cameroon and Mali the median age of first marriage for women aged between 25 and 49 years is 16 years. In Benin, Burkina Faso, Côte d'Ivoire and Senegal, the median age of first marriage for women aged between 25 and 49 years is approximately 17 years.

C. WOMEN'S SOCIO-ECONOMIC STATUS

In all of the seven nations featured in this report, women generally fare far worse than men. Gender inequalities in access to education are prevalent in each country. For example, in Benin, 44% of girls are enrolled in primary schools, compared with 88% of boys; the enrollment percentage for girls in secondary schools is 7%, compared with 17% for boys.¹⁰⁶ Similarly, in Mali, 19% of girls are enrolled in primary schools, compared with 32% of boys; the enrollment percentage for girls in secondary schools is 5%, compared with 10% for boys.¹⁰⁷ The image of women in society constitutes a major obstacle to girl's access to education, because women are per-

ceived principally in their roles as wives and mothers. Socio-economic factors compound these socio-cultural biases. Girls represent a significant source of help for their mother in domestic tasks and in her business or agricultural activities. The low percentages of school enrollment for girls are reflected in the high illiteracy rates for women. The illiteracy rate for women in Benin is 77% compared with 57% for men.¹⁰⁸ In Mali, the illiteracy rate for women is 77% compared with 61% for men.¹⁰⁹ In Cameroon, the illiteracy rate for women is lower than in the other nations studied, nevertheless, it is still high — 48% for women compared with 25% for men.¹¹⁰

In addition, legal discrimination against women persists in all the countries, particularly in terms of rights under family law. Generally, women do not have the same rights to marry and divorce as men; their rights to inheritance, particularly if they are widows, are also often curtailed. Finally, in many countries, women's ability to own property is limited in practice by customary laws.

III. Format for Country Reports

This report presents an overview of the content of the laws and policies that relate to specific reproductive health issues as well as to women's rights more generally. It discusses each country separately, but organizes the information provided uniformly in four main sections to enable regional comparisons.

The first section of each chapter briefly describes the basic legal and political structure of the country, providing a critical framework within which to examine the laws and policies affecting women's reproductive rights. This background information seeks to explain how laws are enacted, by whom, and the manner in which they can be challenged, modified, or repealed. It also lays the foundation for understanding the process by which a country adopts certain policies.

In the second section, we detail the laws and policies affecting specific reproductive health and rights issues. Reproductive laws and policies that are of concern to the international and regional community are described. The report thus reviews governmental health and population policies, with an emphasis on general issues relating to women's status. It also examines laws and policies regarding contraception, abortion, sterilization, FC/FGM, and HIV/AIDS and other STIs.

The next section of each chapter provides general insights into women's legal status in each country. To evaluate women's reproductive health and rights in these seven Francophone African countries, it is essential to explore their status within the society in which they live. Laws relating to women's legal

status are important because they reflect societal attitudes that will affect reproductive rights. Moreover, such laws often have a direct impact on women's ability to exercise reproductive rights. Therefore, this report describes laws and policies regarding marriage, divorce, custody of children, property rights, labor rights, access and rules regarding credit, access to education, and the right to physical integrity, including laws on rape, domestic violence, sexual harassment, and female circumcision/female genital mutilation (FC/FGM).

The final section of each chapter focuses on the reproductive health and rights of adolescents, recognizing that discrimination against women often begins at a very early age and leaves women less empowered than men to control their sexual and reproductive lives. Women's unequal status in society may limit their ability to protect themselves against unwanted or coercive sexual relations and thus from unwanted pregnancies, HIV/AIDS, and STIs. Furthermore, young women are often subjected to harmful traditional practices such as FC/FGM. The segment on adolescents focuses on laws and policies relating to reproductive health, FC/FGM, marriage, sexuality education, and sexual offenses against minors.

This report is the product of a collaborative process involving the Center for Reproductive Law and Policy, based in New York, and seven NGOs from Francophone Africa committed to women's empowerment issues. The regional coordinator for the project was the Groupe de Recherche Femmes et Lois au Sénégal (GREFELS), based in Dakar, Senegal. The other collaborative NGOs involved in the process were: Association camerounaise des femmes juristes, Association des femmes juristes du Bénin, Association des juristes maliennes, Association internationale pour la démocratie en Afrique, Groupe de recherche sur les initiatives locales, Réseau femmes et développement.

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