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9. Regional Trends in Reproductive Rights

This chapter identifies trends in reproductive rights and women's empowerment that emerge from a review of seven Anglophone African nations. These regional characteristics provide an invaluable guide for assessing the effort required to promote reproductive rights and to focus attention on the laws and policies that could be utilized to achieve such rights. Highlighting certain issues featured in this report, our discussion of regional trends identifies where appropriate the relevant national-level laws that can serve as a basis for regional reform efforts. Recent legal and policy proposals already implemented or now under consideration are also mentioned. We note the rare instances in which information was unavailable.

This regional assessment is based only upon an analysis of the factual content of relevant laws and policies. We do not examine the manner in which laws and policies are enforced and implemented. While we regard such information as critical to the realization of reproductive rights, we believe that it is first important to determine the general legal and policy framework. It is our hope that the regional trends identified in this chapter can serve not as a conclusion but as the initiation of a dialogue regarding the manner in which reproductive rights and women's empowerment should be promoted.

I. Setting the Stage: The Legal and Political Framework

Although the current legal and political framework in each of the seven Anglophone African nations discussed in this report varies considerably, the nations demonstrate two primary similarities. With the exception of Ethiopia, all nations emerged as independent states in the post-World War II era. For the purpose of this report's analysis, a key legacy of colonial domination was the creation of new nation-states that inherited a legal system — primarily the English common law system — modeled upon that of the colonizing nation. In each country, this European legal structure was coexistent with indigenous legal regimes that reflected local customs and religious practices. This legal backdrop must be combined with the differing political structures in order to understand the overall legal and political framework of each nation. Political stability in the region varies. The political structures of the seven nations vary from military rule in Nigeria to a socialist multiparty

democratic state in Tanzania to a newly elected multiracial democratic government in South Africa.

A. THE STRUCTURE OF THE GOVERNMENT

The governments of all seven Anglophone African nations have three branches — executive, judicial, and legislative. The relative importance of each of these varies by nation, but it appears that the executive branch is generally strong, especially in nations currently or formerly ruled by the military, while the judicial system remains weak. Often, failure to enforce laws or their selective enforcement further undermines the rule of law. In Nigeria, for example, the military government has restricted the power of the courts in a number of arenas, including the protection of individual rights, by ensuring that none of its actions, such as the promulgation of decrees, are subject to judicial review. Although the distribution of power in South Africa's reformed political system still must be determined, the executive branch has already proven to play an extremely important role. In almost all of the seven nations, the strength of the executive branch is enhanced by the fact that some political power also rests with traditional chieftains, who enforce laws and informally adjudicate disputes.

The role of women is limited at every level of government in each of the Anglophone countries. The number of women in all branches of government remains disproportionately low, although some nations require that a number of seats in the legislature be reserved for women. Most traditional chiefs are also men.

B. SOURCES OF LAW

Each of the seven Anglophone African countries is characterized by a mosaic of laws. As with most countries of the world, the constitution is the highest domestic source of law. Not only

does a constitution validate the structure of government, but for these nations it may also generally set forth rights that are critical to any discussion of reproductive rights and women's empowerment. At the same time, laws are also derived from European models, African customs, and specific religions.

With the exception of Ethiopia, the nations inherited legal systems based on English common law. Ethiopia's legal system combines elements of the common law tradition with those of the civil law system. In addition to being influenced by English common law, the laws of South Africa and Zimbabwe have also been affected by Roman-Dutch law. However, in all seven nations, the common law tradition generally governs in almost all realms of law except family law, where African customary law and religious laws based on Islamic and Hindu principles usually apply. The application of African customary legal principles is often complicated by the existence of numerous customary law regimes of different groups. Most customary law remains uncodified.

In most countries, guidelines regarding the application of customary law remain unclear, particularly when the general and customary laws pertaining to a particular situation conflict. With the exception of Kenya and South Africa, Anglophone nations have not explicitly addressed how to reconcile competing laws. The 1987 landmark Kenyan case of *Otieno v. Ougo* held that customary law complements relevant written laws. The court further held that if a clear customary law exists, it would apply to a matter of personal law not governed by written law. As a result of the *Otieno* decision, a Kenyan woman was denied the right to determine the location of her husband's burial ground. In South Africa, a court may rely on customary law if it can be "ascertained readily and with sufficient certainty" and is not "opposed to the principles of public policy or natural justice."

Domestic Sources of Law

The constitutions of five out of the seven Anglophone African countries — Ethiopia, Ghana, Nigeria, South Africa, and Zimbabwe — contain provisions explicitly prohibiting discrimination on the basis of gender. The Kenyan constitution, which does not bar gender discrimination, protects against discrimination based on "race, tribe, and political opinion," among other factors; however, this non-discrimination language does not apply to numerous personal law matters. In contrast, while the Tanzanian constitution's antidiscrimination provision fails to list gender in its definition of discrimination, it does state that "[a]ll people are equal before the law, and have the right, without discrimination of any kind, to be protected and to be accorded equal justice before the law" and decrees that "the Government and all its instruments of the

people offer equal opportunities for all citizens, men and women, regardless of color, tribe, religion, or creed."

Among the five nations that forbid gender discrimination, their constitutions vary greatly in the scope of protection guaranteed to women. Ethiopia's 1994 Constitution contains additional provisions declaring that women have equal rights with respect to property ownership, employment, and marriage. Similarly, Ghana's 1992 Constitution is progressive in its prohibition of gender discrimination, its protection of spousal property rights, and the right to maternity leave; Article 26(2) protects cultural practices but bars "practices which dehumanize or are injurious to the physical and mental well-being of a person." The Nigerian Constitution lists gender as an impermissible ground for discrimination and includes a provision mandating equal pay for equal work. The Bill of Rights enshrined in the South African Constitution of 1996 contains express prohibitions against unfair discrimination on the basis of gender, sex, pregnancy, marital status, or sexual orientation. A 1996 amendment to the Zimbabwe Constitution extends the constitutional prohibition against discrimination to cover gender; but Section 23 explicitly exempts laws that give effect to constitutional provisions, take "due account of physiological differences," or are "in the interests of defense, public safety or public morality." Moreover, the non-discrimination provisions do not limit the application of customary laws in Zimbabwe.

Of all seven countries, only the constitutions of Ethiopia and South Africa explicitly refer to rights associated with reproduction. Ethiopia's 1994 Constitution focuses on women's right to plan their families; Article 35 states that "[t]o prevent harm arising from bearing or giving birth to a child and in order to safeguard their health, women have the right to information and to means that would enable them to plan their families." The new South African Bill of Rights grants everyone the right to bodily and physical integrity, which expressly includes the right "to make decisions regarding reproduction" and the right of access to health care services, including reproductive health care.

International Sources of Law

Most of the seven Anglophone African countries have ratified numerous major international human rights treaties. All of these nations have ratified the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW") and the Convention on the Rights of the Child. Only Ghana has yet to ratify the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. With the exception of Ethiopia and South Africa, these countries are also parties to the African Charter on Human and Peoples'

Rights. While most nations require the implementation of legislation to incorporate international legal standards into domestic law, there appears to be considerable uncertainty concerning the domestic legal effect of a government's assumption of international legal obligations. Hence, for example, in all countries, domestic legal principles regarding the extent to which courts and other branches of government are required to adhere to international law, especially when such international obligations conflict with national law, remain unclear.

Regional Legal Models

Regional legal models to advance reproductive rights and women's empowerment should focus on two primary areas: enhancing constitutional protection of these rights and ensuring that customary law principles are not applied in a manner that subverts protection of women's reproductive rights.

Given that a nation's constitution is the highest source of domestic law, it is first critical to ensure that prohibitions on discrimination extend to gender. Regional references for such constitutional protection can be obtained from several nations, including Ethiopia, Ghana, South Africa, and Zimbabwe. Additional safeguards for reproductive rights, including the right to reproductive health care, could be based upon provisions in South Africa's Bill of Rights, which grants everyone the right to bodily and physical integrity, and includes the right "to make decisions regarding reproduction" and the right of access to health care services, including reproductive health care.

A regional legal model can also be utilized to restrict the application of customary law, which has the potential to discriminate against women. Article 26(2) of the Ghanaian Constitution protects cultural practices subject to a specific prohibition on "practices which dehumanize or are injurious to the physical and mental well-being of a person." Such a constitutional principle could be used to protect women from customary practices such as female genital mutilation ("FGM") — also referred to as female circumcision — and female religious bondage.

II. Examining Reproductive Health and Rights

Although the Anglophone African region experiences common reproductive health problems, the responses of governments to these realities have varied. Some governments, such as those of Ghana, Kenya, and Zimbabwe, have sought to enact laws and policies that attempt to address a number of concerns. Others have issued policies without seeking to enact laws that effectuate such policies. Still others, such as

Ethiopia and South Africa, are in the process of establishing and assessing new national priorities.

Despite this range of responses to reproductive health and rights, it appears that governments deal with laws differently than they do with policies. In general, other than the recent changes in South Africa, legal reform tends to occur infrequently. Rather, governments seem to opt for policies as vehicles by which to establish a given framework; such policies are almost always issued by the executive branch. Although it is difficult to determine reasons for this preference for policy over legal reform, it can be partially attributed to the relative ease with which the executive branch can act alone. Promulgating statutes, on the other hand, requires considerable coordination with the legislature and may necessitate public education campaigns. By the same token, these measures may be more difficult to revoke. Regardless, reflecting some national priorities in law provides a nation's citizens with greater certainty regarding their rights and increased ability to exercise and enforce such rights.

A second pattern that emerges is that laws and policies are often in contradiction. Numerous instances of this can be cited. For example, all of the nations' governments utilize policies to reflect their commitment to the provision of family planning services to assist women in planning family size. Yet laws in every Anglophone African nation profiled, except South Africa, sharply restrict the availability of abortions. Moreover, while the policies of many nations discuss the need to deal with customary practices that are harmful to women, such as FGM, only Ghana has enacted a specific law that seeks to address this matter.

A. HEALTH LAWS AND POLICIES

In Anglophone Africa health policies are formulated and generally administered by a national ministry of health. Most governments are also very involved in the provision of health care and indicate a desire to increase access to health services, particularly primary health care. The region has shown trends to both centralize and decentralize implementation of the health system; Kenya and Ghana, for example, have recently attempted to nationalize the health care system by increasing central coordination, while both Ethiopia and South Africa have taken steps to decentralize the health care structure. Whatever the approach, in most countries the infrastructure of the health care system remains riddled with problems. At the same time, government health expenditures vary greatly. Some nations provide free services to all of the population, while others subsidize health care.

Objectives of the Health Policy

The major objective of national health policy in all seven

countries is to increase access to public health services, a goal that has met with mixed results. In Nigeria, the government estimates that only 40% of the population has access to health facilities. Sixty percent of the population has access to some form of modern medical facilities in Ghana, but this figure drops to 45% in rural areas. In contrast, in Zimbabwe, where the government has identified health as a human right, the government claims that 80% of the rural population and 90% of the urban population had access to health care between 1985 and 1991. In every nation, governments have focused on the provision of primary health care services, which seek to deal with a range of basic health care problems, including maternal and child care and family planning. Only two nations, Ghana and South Africa, expressly deal with HIV/AIDS as part of primary health care services. No nation fully incorporates a broad range of reproductive health services into primary care.

Infrastructure of Health Services

In all seven Anglophone African countries, health care services are provided through a multitiered system in which the degree of sophistication and specialization of health services increases with each level. Governments are key actors in the provision of health care services, a fact best illustrated by Zimbabwe and Tanzania. The Ministry of Health and Child Welfare in Zimbabwe is that nation's largest provider of all health care services. Despite the decentralized nature of the health care delivery system in Tanzania, a nation of 29 million people, the Ministry of Health provides most health services through 152 hospitals, 250 health centers, and over 2,600 dispensaries. Private medical practice was banned in 1980 to ensure that everyone received free health care; in recent years, however, the Tanzanian government has attempted to increase the involvement of the private sector in the provision of health care services. Due to the government's efforts to establish a comprehensive health infrastructure system, in 1987 approximately 70% of the Tanzanian population lived within five kilometers of a health facility.

Despite the high degree of government involvement, all seven countries suffer from an inadequate health service infrastructure. This is particularly true in Ethiopia and Nigeria. In Ethiopia, there are only 72 hospitals (with approximately 9,500 beds), 153 health centers, and 2,094 health stations to serve a population of approximately 55 million people. Nigeria, a nation of about 112 million people, has only approximately 1,071 health facilities, 119 district hospitals, and 780 general hospitals. In addition, in recent years the Nigerian health system has deteriorated as a result of rising costs and the continuing shortages of drugs, personnel, and equipment and has not been able to eliminate sharp disparities in the avail-

ability of medical services. Not only are health care systems in most countries biased toward the provision of services in urban areas, but their ability to provide a consistent level of services throughout a particular country is limited. For example, the government of Ghana acknowledges that health care delivery in rural areas remains woefully inadequate.

Cost of Health Services

The commitment of Anglophone African nations to promoting access to health care translates into differing degrees of government spending in the area. Kenya provides an example of a government that has spent a high proportion of its budget on health: about 2.7% of its gross domestic product in 1990. Nigeria, on the other hand, represents a nation that has allotted a lower than average amount; in 1987, the last year for which full figures are available, health expenditures comprised 0.8% of the national budget.

Just as government expenditures on health care vary, so does the extent to which a government pays for or subsidizes health services. Two nations — Ethiopia and Tanzania — provide free public health services. Ethiopia's 1994 Constitution states that it is the duty of the state to finance health services and that the government is committed to providing free medical care in public facilities. Because of consistent underfunding, the likelihood of comprehensive implementation of Ethiopia's current health policy will depend on the degree of financing available. In Tanzania, the government is considering charging patients for health services on an income-progressive scale while providing compulsory health insurance for workers. A third country, South Africa, provides free primary health care and health services to pregnant women and children under the age of six.

Four countries — Ghana, Kenya, Nigeria, and Zimbabwe — provide subsidized health services as well as free services to specific groups. In Ghana, the government subsidizes health care services obtained in public facilities and exempts certain classes of citizens, including students, maternity patients, and seniors from payment for most hospital services. In addition, prenatal and postnatal services, standard immunizations, and treatment for certain communicable diseases, including venereal diseases, are free. Health care is also free to those deemed indigent by social welfare officials. In Kenya, fee exemptions and waivers are available to some people and for certain services and illnesses. Family planning counseling, antenatal and postnatal care, child welfare, and STD clinic services are all exempted from outpatient charges, as is the treatment of illnesses such as AIDS and antenatal complications of pregnancy. Nigeria's national health policy commits state and local governments to the provision of health subsidies for preventive care, with additional public assistance for low-income

individuals. Finally, Zimbabwe's Ministry of Health and Child Welfare, which administers the national health policy, provides fee exemptions for families earning less than a threshold monthly income. All immunization services for children and pregnant women are provided free of charge.

For some nations, financial commitments to health have been influenced by structural adjustment programs. Ghana's ongoing structural adjustment programs have resulted in the withdrawal of subsidies for some health services. Tanzania's system has recently come under great pressure for the same reasons, resulting in the introduction of user charges. While this change has the potential to improve quality of care by devoting greater resources to health services, care must be taken to ensure that it does not diminish the ability of the poorest segments of the population to obtain basic health care services, including reproductive health care.

Regulation of Health Care Providers

All countries regulate modern health care providers, such as doctors, dentists, and nurses, and attempt to ensure that only licensed professionals practice modern medicine. A few nations also impose ethical guidelines within which such professionals are to operate. The effectiveness of these regulations depends upon the political will of professional associations to rigorously enforce standards of conduct. Although most Anglophone African governments do not regulate traditional medical practitioners, they permit such persons to practice their trade.

Modern Medical Providers

In at least six of the Anglophone African nations, there are separate laws that govern three categories of health providers — doctors, nurses, and pharmacists. In general, there is one statute that governs medical and dental practitioners, another regarding nurses, and a third that is concerned with pharmacists. Each of these laws establishes a statutory body, such as the Medical Council, the Nurses Council, and the Pharmacy Council, that is composed primarily of members of that profession. The central objectives of these councils are to set forth educational criteria for training professionals, establish standards of professional conduct, maintain a registry of all practitioners, and exercise disciplinary actions. All bodies are thus empowered to undertake disciplinary measures that include the removal of a practitioner from the relevant registry. In Ethiopia, although regulations promulgated by the Council of Ministers regarding the licensing of health institutions refer to laws regulating medical practitioners, and the penal code refers to the “unlawful exercise” of the medical profession, we were unable to locate the relevant laws regulating the registration of medical practitioners. However, even in that country, laws and policies are explicit in stating that only registered medical practitioners can practice their profession.

At least five Anglophone African nations generally make it a criminal offense for a person to practice modern medicine without being registered, licensed, or otherwise legally recognized to do so. Ethiopia's Penal Code calls for simple imprisonment and a fine for the “unlawful” exercise of the “medical or public-health professions,” but provides an exception for traditional health practitioners whose methods are neither dangerous nor injurious to a person's health or life. In Ghana, anyone who willfully and falsely practices, or receives payment for practicing medicine or dentistry or practicing as a nurse without having registered, is guilty of an offense and subject to imprisonment not exceeding 12 months and/or a fine. Similarly, in Kenya the unlawful practice of a medical profession is a criminal offense. In Tanzania, if an unregistered person provides medical treatment, he or she will be liable upon conviction for a fine or to imprisonment for a term not exceeding five years, or both. A health practitioner not registered with the relevant council in Zimbabwe is subject to prosecution. In South Africa and Nigeria, it is difficult to determine if criminal penalties are imposed for such actions. This is especially true in the case of South Africa, which is attempting to reform all the statutory councils governing medical professionals.

In at least three Anglophone African countries, the medical community has issued ethical guidelines, almost all of which address informed consent and confidentiality. Ghana's Medical Council has ethical guidelines stating that, in their own interests, practitioners should obtain informed consent from either the patient or a relative prior to undertaking medical or surgical procedures. In Nigeria, violation of the Medical and Dental Council's ethical guidelines may result in disciplinary action by the council or suspension from practice. Medical practitioners must always obtain the consent of the patient or competent relatives before embarking on any special treatment procedures with determinable risks. Public disclosure of patient information relating to matters such as “criminal abortion” and venereal disease is prohibited unless required by law. Zimbabwe's Health Professions Council has promulgated a code of ethics setting forth “the fundamental duties and requirements to be fulfilled by all registered health personnel,” including a duty to protect patient confidentiality, to stay abreast of developments in medical technology and any legal developments, and to maintain medical facilities and equipment.

In Ethiopia and Zimbabwe, the government has established ethical standards governing the conduct of modern medical practitioners. In Ethiopia, the Minister of Health recently published the only such guidelines in the country in a book entitled “Medical Ethics for Physicians Practicing in Ethiopia.” The guidelines include a general code of ethics,

which addresses issues such as “the physician as a professional,” “advertisement and publicity,” “certificate, prescription and signature,” the “supervisory role of the physician,” and “patients’ informed consent.” Finally, the guidelines state that it is the physician’s duty to inform the patient about treatments, including surgical procedures, and that physicians are always obliged to obtain a patient’s written consent before carrying out procedures. Guidelines for medical conduct in Zimbabwe are set out in statutory regulations issued pursuant to the Medical, Dental and Allied Professions Act. The guidelines provide, for example, that medical practitioners in non-emergency situations may not perform any procedure for which they have not received adequate training or in which they are insufficiently experienced; nor may they use any apparatus or pursue a course of treatment that is inadequate for the procedure required.

Traditional Medical Practitioners

Of the seven nations, only Zimbabwe explicitly regulates the provision of health care by traditional providers. Regulated pursuant to the Traditional Medical Practitioners Act and the Natural Therapists Act, all traditional medical practitioners and natural therapists must also be registered with the appropriate supervisory body. The Natural Therapists Council and the Traditional Medical Practitioners Council have the power to regulate the practice of registered practitioners, to define and investigate improper conduct and incompetence, and to suspend registration. However, there are no formal training or examination requirements for traditional medical practitioners.

At least three other nations permit traditional medical practice despite the lack of regulation. In Ghana, the practice of “an indigenous system of therapeutics” is permitted by indigenous inhabitants who do not perform acts dangerous to life or supply, administer, or prescribe any restricted drug. The government of Ghana recently introduced a bill, entitled the “Ghana Traditional Medicine Act,” to regulate and control the practice of traditional medicine. The statutory scheme governing modern medical providers in Nigeria does not affect the nonsurgical practices of traditional medical practitioners who have received community recognition for being trained in “the system of therapeutic medicine traditionally in use.” However, any unregistered person who performs an “activity involving an incision in human tissue” in return for a fee or reward is subject to a fine. In Tanzania, the Medical Practitioners Ordinance states that nothing in it should be construed as prohibiting or preventing the “bona fide practice of a system of therapeutics” according to “native methods” by persons recognized by the community to which they belong, as long as such practice is not or is not likely to be dangerous to life.

Regional Legal and Policy Models

Given the importance of modern medical practitioners to health care, it is critical to ensure that a government effectively regulates such professionals. All seven Anglophone African governments have issued such regulations. Of the seven countries described, it appears that Zimbabwe has issued numerous laws and policies relating to modern medical providers. Not only does Zimbabwe’s Medical, Dental and Allied Professions Act provide guidelines for medical conduct, but its Health Professions Council has also promulgated a code of ethics for health personnel. In terms of regulating traditional medical practitioners, Zimbabwe can again be regarded as a regional model because it is the only nation that has enacted specific laws addressing such health providers, although we note that Ghana is currently considering the passage of a law that seeks to regulate traditional providers.

Patients’ Rights

None of the seven Anglophone African countries provides a sufficiently developed legal framework for the protection of patients’ rights. While a few nations have particular criminal provisions that recognize some rights of patients, this set of rights remains insufficient. There is even less protection for patients in those countries in which such criminal provisions do not exist. In addition, in almost all the nations, tort law relating to the rights of patients remains to be developed.

Rights Based on Criminal Law

The criminal laws of four nations recognize specified rights for patients. Ghana’s Criminal Code provides that anyone engaged in medical or surgical treatment of any person who negligently endangers that person’s life is guilty of a misdemeanor punishable by imprisonment of up to three years and/or a monetary fine at the court’s discretion. Kenyan law requires medical practitioners to render treatment with “reasonable care,” skill, and the informed consent of the person undergoing the procedure. Section 240 of the Kenyan Penal Code provides that a person is not criminally responsible for performing, in good faith and with reasonable care and skill, a surgical operation upon any person for his or her benefit, if the performance of the operation is reasonable. In addition, Section 243(e) of the Penal Code provides that any person rendering medical or surgical treatment that negligently endangers human life is guilty of an offense. Tanzanian law also requires medical practitioners to render treatment with “reasonable care,” skill, and the informed consent of the person undergoing the procedure. Tanzania’s Penal Code contains provisions identical to Section 243(e) of the Kenyan Penal Code and to the Kenyan penal provisions that exempt a person from criminal liability if an operation is performed for a patient’s benefit. In Zimbabwe, the failure to meet the

requirements of informed consent may result in a criminal prosecution for assault or medical negligence.

There are two nations, Ethiopia and Nigeria, whose criminal laws do not specifically address patients' rights. In Ethiopia, criminal laws mandate that a medical practitioner provide the government with information regarding his or her patient. A modern medical provider or other person who fails to fulfill the legal obligation to notify the competent authorities of information relating to a patient, particularly as it relates to the spread of "contagious diseases" and drug addiction, is subject to criminal penalties. Nigeria's criminal laws protect individuals against general "grievous harm." While this provision could be enforced in non-medical contexts, it could also provide the basis for providing patients with particular rights.

Rights Based on Tort Law

At least five Anglophone African countries have basic tort principles that promote the rights of patients. The Ethiopian Civil Code establishes tort principles, such as negligence and "imprudence," that could be applied in the context of patients' rights. Ghanaian law also permits an aggrieved patient to bring a tort action against a health care provider for any alleged medical malpractice. In Kenya, the requirement of informed consent is an established principle of applicable English common law, and medical procedures that are performed without consent may constitute an actionable tort — "trespass" to the patient's person. In addition, patients who suffer injury due to a medical practitioner's negligence may be able to assert a legal claim under tort principles of common law. Similarly, in South Africa, common law imposes a legal duty on medical practitioners to respect the confidentiality of their patients and to obtain consent from their patients in almost all situations. In Zimbabwe, medical treatment cannot be performed legally without the informed consent of the patient and disclosure of all major risks of a medical procedure. An individual does not need spousal approval in consenting to medical treatment. However, pursuant to customary law, a woman is required to obtain her husband's consent for all medical treatment, including the use of contraceptives.

B. POPULATION AND FAMILY PLANNING

A review of population and family planning policy reveals that almost all Anglophone African nations seek to reduce the rate of population growth. The region also reflects very little movement towards the broader reproductive health perspective endorsed at recent international conferences. Ghana has recently promulgated a reproductive health services policy, while South Africa and Kenya are in the process of reformu-

lating their policies. Yet family planning services continue to be the primary, often the exclusive, public reproductive health services made accessible to citizens in the region.

Population and Family Planning Policy

The hallmark of the population policies issued by all seven governments is their focus on the need to reduce population growth rates. In attempting to establish concrete objectives, some governments have established quantifiable targets, such as specified rates of population growth, maternal mortality, and fertility. Numerical goals with respect to women's age at first marriage and access to secondary levels of education have also been set.

In all of the nations, the objective of policies relating to population has been to reduce the rate of population growth so as to enhance the country's development capacity. Zimbabwe, the only nation that did not issue a self-described population policy, has associated population issues with development concerns and prioritized family planning activities by establishing a program nationalizing these efforts.

Each country has placed a differing emphasis on population, with three countries apparently paying particular attention to such issues. Ghana's recent Constitution specifically refers to the state's obligation to "maintain a population policy consistent with the aspirations and development needs and objectives of Ghana." The new South African Constitution also expressly addresses population as a legislative and executive responsibility of provincial governments. The South African national government, however, has concurrent jurisdiction to enact laws on population development when national interests are at stake. In Ethiopia, the Population Policy acknowledges that existing delivery systems are limited in scope and that the choice of family planning methods is limited. To correct these problems, the government calls for an expansion of reproductive health service delivery — currently available only through the limited formal health structure — to clinical and community-based outreach services; implementation of these measures is constrained by financial resources.

Four Anglophone African nations include improvements in women's empowerment as an additional goal of their population policy. The general objectives of Ethiopia's Population Policy include raising the economic and social status of women by freeing them from the restrictions of traditional life and making it possible for them to participate productively in the larger community. Similarly, in Ghana, the aims of the population policy include enhancing the status of women in society through the elimination of discriminatory laws and cultural practices, promoting wider productive and gainful

employment opportunities for women, and increasing the proportion of women entering and completing at least secondary school. Tanzania's population policies make specific reference to the role of women in the implementation of population and development programs. The government seeks to increase employment opportunities for women at all levels, review and amend laws that inherently discriminate on the basis of gender, raise the minimum age of marriage for girls to 18 years, and increase the number of women in decision-making positions.

The population policies of four Anglophone African countries contain quantified goals. Ethiopia and Zimbabwe have established a few numerical objectives. In Ethiopia, the primary numerical goals are a reduction of the current fertility rate of 7.7 children per woman to 4.0 by the year 2015 and an increase in the contraceptive prevalence rate from 4.0% to 44.0% by the year 2015. Zimbabwe's Second National Development Plan seeks both to reduce the total fertility rate from an average of 5.5 children per woman to 4.5 children per woman and to increase contraceptive prevalence rates for modern contraceptives to 50% of women of reproductive age. Both Ghana and Kenya have set many more numerical goals. Common target rates for both of these countries include reductions in population growth rates, infant mortality, and the number of women who marry before the age of 18. Even within these common targets, the actual numerical goal to be achieved is different. For example, Kenya's policy seeks to reduce the rate of population growth to 2.0% by the year 2000; Ghana's policy aims to achieve a population growth rate of 1.5% by the year 2020.

Implementing Strategies

To implement their population policies, countries have established several different strategies. In Ethiopia, implementation includes expanding contraceptive distribution, promoting breast-feeding as a means of birth-spacing, and integrating women into the "modern" sector of the economy. In addition, Ethiopia's strategy involves amending all laws "impeding, in any way, the access of women to all social, economic and cultural resources" and amending relevant laws to remove unnecessary restrictions on the "advertisement, propagation and popularization of diverse contraception control methods." Ghana's implementation strategies appear to be broader. In 1996, the Ministry of Health issued the Reproductive Health Service Policy, which sets out rules and regulations for the provision of reproductive health care. As a result, implementation strategies for the nation's population policies focus not only on the provision of affordable family planning services, but they also include a host of other measures, such as: developing programs aimed at the empow-

erment of women; educating the general public about HIV/AIDS and other sexually transmitted diseases; and ensuring that law-making bodies are well sensitized to population issues. Nigeria's population policy also identifies several means for meeting its objectives. One strategy is to embark on an aggressive information and communication campaign to educate individuals about the importance of maintaining a reasonable family size. The policy also proposes to encourage the use of family planning methods by raising the status of women, to promulgate legislation to eliminate discrimination against women in education and employment, and to increase the age of first marriage to 18 years.

Executing Agency

In most nations, a specific "population" agency is charged with implementing the population policy. In Ethiopia, the National Population Council and the Office of Population, within the Office of the Prime Minister, were created to carry out the Population Policy. In Ghana, the National Population Council, under the office of the president, oversees population policy implementation at both the national and regional levels. Similarly, in Kenya, the National Council for Population and Development, which coordinates and supports the activities of all agencies involved in population, falls within the jurisdiction of the office of the vice president and the Minister for Economic Planning and National Development. In South Africa, the numerous agencies responsible for implementing the Population and Development Programme include an Interdepartmental Committee and a Chief Directorate of Population Development, which is currently located within the Department of Welfare. Finally, in Zimbabwe, the National Family Planning Council is responsible for the provision of child spacing and fertility services, as well as treatment and research in infertility, reproductive health, and related family health areas. The Zimbabwe National Board of Family Planning oversees general policy and ensures the integration of family planning activity into the national development program.

The relationship and coordination between population agencies and the national ministry of health vary within the region. In most countries, these population-related bodies are not usually located within the ministry of health, making it difficult to determine the level of coordination between reproductive health services, on the one hand, and overall health services, on the other. However, in three nations, the ministry of health has an important role to play in population policies. In Ghana, the Ministry of Health is involved in formulating population policy, while in Nigeria and Tanzania, the federal Ministry of Health is the primary administrator and implementor of the national population policy. In both of

the latter two nations, the government must coordinate population policy with numerous other bodies. In Nigeria, the Ministry of Health coordinates population policy with the Department of Population Activities, the National Consultative Group on Population for Development and the Population Working Group, and the National Population Commission. The population policy of Tanzania states that the implementation of maternal and child health and family planning programs will be carried out by the Ministry of Health, the Tanzania Food and Nutrition Center, and the Attorney General's office.

Recent Changes in Population Policy

Of the seven Anglophone African countries, only Ghana has attempted to move toward a broader reproductive health model. In 1996, the Ministry of Health issued the Reproductive Health Service Policy, which seeks to directly address issues affecting the provision of reproductive health care. Recognizing that the previous concentration on family planning failed to address other components of reproductive health care, the policy sets out general rules and regulations for health care providers to provide uniform policy guidance and standards concerning a wide array of reproductive health issues. Thus, the government has included the following components: safe motherhood (including antenatal care, labor and delivery care, and postnatal care); adolescent reproductive health; the prevention and management of unsafe abortion; reproductive tract infections including STDs and HIV/AIDS; infertility; and the discouragement of harmful traditional reproductive health practices.

Two Anglophone African countries, Kenya and South Africa, are in the process of reformulating their population policies. In 1995, Kenya prepared a draft National Population Policy for Sustainable Development that was to replace its current Population Policy Guidelines. The document addresses a wide variety of issues, such as the environment, gender, poverty, disability, youth, and HIV/AIDS. It also outlines demographic, health services, and social services goals, which are to guide the implementation of population programs until the year 2015. A notable inclusion in this draft is its emphasis on the empowerment of women, as well as the improvement of women's social status and role in development, and the elimination of all forms of discrimination against women and girls. But the draft has yet to be adopted by the Kenyan government. In South Africa, the Ministry for Welfare and Population Development also recently released a discussion document inviting public comment on the possible content of a population policy for the nation. This "Green Paper on Population Policy" was intended to stimulate debate on the relationship between population issues and development. It

acknowledges that a policy concerning development and population should deal not only with population trends, but also with the environment, resources, production, and patterns of consumption. The Green Paper raises a variety of issues, including, for example, whether or not South Africa should set specific goals in relation to the average number of children a woman or man should have, and what mechanisms, if any, should be available for coordinating activities aimed at women's empowerment.

Government Delivery of Family Planning Services

A central theme for the seven Anglophone African nations is the focus of governments upon the provision of family planning services, which appears to have been translated into a focus on the provision of modern contraceptive methods, including sterilizations. While these services are provided within the overall health care system, there is little to indicate that the majority of governments are moving toward a broader approach to reproductive health. Moreover, existing services seem to be inadequate and inequitable. For example, in South Africa, family planning services in predominantly white areas are better than services in predominantly black areas. A general urban bias in the delivery of services has also been evident in many of the countries.

In each nation, the government provides family planning services within the context of the general health care system. Since 1987, family planning services in Ethiopia have been rendered through health institutions run by the Ministry of Health. The government of Ghana provides reproductive health services at every level of its health system. In Nigeria, family planning services may be obtained through the primary health care system and are available at approximately 20% to 25% of maternal and child health facilities. Family planning services in South Africa are provided in community hospitals, clinics, and community health centers. In Kenya, Tanzania, and Zimbabwe, public hospitals and clinics are the main source of family planning services for most modern contraceptive users. In three countries — Tanzania, South Africa, and Zimbabwe — the government also provides additional family planning services in stand-alone clinics.

While most governments appear to focus on the provision of numerous contraceptives, including sterilizations, some also provide essential counseling services within their family planning programs. Although the Nigerian National Health Policy defines family planning to include education, counseling, and information on child-spacing and fertility treatment, most government facilities only distribute contraceptives (condoms, spermicides, intrauterine devices ["IUDs"], injectables, the pill, and sterilizations). In Ghana, a broader range of contraceptive methods and information is

available through the Reproductive Health Service Policy, which also contains an information, education, and communications (“IEC”) component whose principal purpose is to foster awareness, educate, and enable people to make informed choices and take action with respect to their reproductive health. The Kenyan government provides both contraceptive services and an abundance of IEC information, but it has no comprehensive IEC policy, strategy, or program framework. Zimbabwe is similar in that it supplements the provision of a broad range of contraceptives within public health facilities with IEC campaigns. South Africa is the only government that has recently introduced the female condom.

Cost of Family Planning Services

A number of governments in the Anglophone African region provide some or all family planning services free of charge. In Kenya, sterilizations and contraceptives are provided without a fee. Government hospitals and clinics in Ghana do not charge for antenatal and postnatal services (except for hospital accommodation and catering), while Child Welfare Clinics provide general treatment for free; treatment and services for persons with HIV/AIDS are also free. Since 1974, South Africa has provided family planning services in all government facilities at no cost.

In at least three countries, patients pay for contraceptive services provided by the government. The fees charged in Ghana for all reproductive health services, including male and female sterilizations, are mandated by the Hospital Fees Regulations; clients in public facilities are required to pay for contraceptive devices. In both Kenya and Nigeria, government facilities have begun to charge fees for the provision of most types of contraceptives. In addition, in Kenya, legal abortions in government clinics are subject to the usual fees for surgical procedures.

C. CONTRACEPTION

Most Anglophone African countries have not adopted comprehensive laws or policies dealing with contraceptives. Rather, nations provide a patchwork of laws and policies, which are at times inconsistent.

Legal Status of Contraceptives

Although none of the seven countries have laws that restrict the use of contraceptives, each of the nations regulates contraceptives to some degree. Generally, contraceptives are regulated much like other drugs. The rules regarding labeling, adulteration of drugs, and regulations that apply to the approval of new drugs are thus also applicable to contraceptives. Ghana, South Africa, Tanzania, and Zimbabwe, for example, have regulations that specify that new drugs must be approved before entering the market. Some of the countries,

such as Kenya, Nigeria, and South Africa, regulate the importation of drugs.

Three countries have detailed regulations regarding the sale of contraceptives. In Ghana, certain contraceptives, classified as “restricted drugs,” have limitations on the manner in which they may be distributed and sold. The Ghanaian Pharmacy Council is empowered to issue general or limited certificates regarding premises where drugs are to be sold and to revoke such certificates if the premise ceases to be suitable. No person may carry on a business of supplying “restricted drugs,” which would include birth control pills and injections, unless that person has a valid general or limited license issued under the Pharmacy Act. Pursuant to that statute, a prescription is required for oral contraceptives and injections. In Kenya, hormonal contraceptives delivered as oral pills, implants (including NORPLANT®), or injectables (including Depo-Provera®) may only be sold by a pharmacist or other authorized dealer and can be purchased only by prescription. Spermicidal foams, jellies, and non-hormonal creams, on the other hand, may be sold over the counter. In South Africa, oral contraceptives containing only progestogen must be sold by a pharmacist who is required to record the particulars of every sale; a person under the age of 16 years may buy birth control pills only if a medical practitioner issues a prescription or a person older than 16 signs a written order disclosing the purpose for which the substance will be used. All other oral contraceptives and IUDs must be authorized by a medical practitioner’s written prescription or oral instructions, regardless of the purchaser’s age.

Each nation has implemented some policy dealing with access to and/or distribution of contraceptives. For example, the Kenyan government has created tax exemptions on imported contraceptives to promote the supply of contraceptives for family planning activities.

Regulation of Information on Contraception

All seven countries have laws that could be used to ban information on contraception. In only two, Ethiopia and Ghana, do statutes expressly restrict the dissemination of contraceptive information. The penal code in Ethiopia penalizes the advertisement or display in public, or the unsolicited sending, of contraceptive publications, or contraceptive samples; current policy, however, permits the advertisement of information regarding contraceptives. The Ethiopian government has recognized the need to revise its penal code. According to the population policy, existing laws should be amended to remove unnecessary restrictions pertaining to the advertisement of contraceptive methods; in the meantime, these penal laws remain in effect. In 1986, Ghana banned the advertisement of contraceptives in the mass media. However, the gov-

ernment encourages the dissemination of certain types of information through the Reproductive Health Service Policy, which requires service providers to give clients an array of information and counseling, including that regarding family planning and contraception.

Regional Legal Models

Regulatory schemes for contraceptives that include provisions regarding manufacturing, importation, new drugs, and sale to the public help provide women with safe and effective methods of contraception. Comprehensive regulatory schemes are not currently in place in any of the countries profiled in this report. Finally, governments should not penalize the advertisement of contraceptives.

D. ABORTION

With the notable exception of South Africa, the countries in Anglophone Africa place severe limitations on a woman's ability to obtain an abortion. Even in the limited circumstances in which abortions are available, legal requirements make it difficult and cumbersome to obtain this procedure. The penalties for performing an illegal abortion are also extremely severe.

Legal Status of Abortion

Three countries — Kenya, Nigeria, and Tanzania — permit abortion only to save the life of the pregnant woman. In Ethiopia, Ghana, and Zimbabwe, abortions are legally allowed in a few additional circumstances. Ethiopia's Penal Code also does not punish termination of pregnancies that arise from "imprudence or negligence," although these terms are not defined. A 1985 amendment to Ghana's Criminal Code legalizes abortions in cases of rape or incest, fetal abnormality or disease, and when there is a risk to the life or health of the pregnant woman, including her mental health. In Zimbabwe, abortions are permitted when the pregnancy represents a serious threat of permanent impairment to a woman's physical health, when there is a severe risk that the child born would suffer from a permanent physical or mental handicap, or if the pregnancy was the probable result of rape, incest, or intercourse with a mentally handicapped woman or girl.

In contrast, South Africa's 1996 Choice on Termination of Pregnancy Act makes abortions legal "upon request of a woman" during the first 12 weeks of gestation. Under the statute, abortions are available from the 13th to the 20th week of pregnancy for any one of four reasons: the continued pregnancy would pose a risk of injury to the woman's physical or mental health; there is a substantial risk of fetal abnormality; the pregnancy resulted from rape or incest; or the continued pregnancy would significantly affect the social or economic circumstances of the woman. After the 20th week, abortions are legal if the continued pregnancy would endanger the

woman's life, result in severe malformation of the fetus, or pose a risk of injury to the fetus.

Requirements for Obtaining Legal Abortion

Five of the seven countries — Ethiopia, Ghana, Kenya, South Africa, and Zimbabwe — have established specific requirements that must be met before a legal abortion may be performed. The laws in Ethiopia, Ghana, Kenya, and South Africa state that the procedure may only be performed by a properly registered medical practitioner. In Ghana and South Africa, a woman must also give her consent. South African law further describes which facilities may perform abortions. Ethiopia and Zimbabwe have fairly detailed requirements regarding the procedures to be followed by medical practitioners before a legal abortion may be performed. In Ethiopia, to obtain a legal abortion on medical grounds, the woman must obtain a written, certified diagnosis submitted by a registered medical practitioner after a medical examination. A second doctor (who is to be a specialist in the diagnosed condition) must then approve the diagnosis and send it to the appropriate government officials. Finally, the woman must consent to the procedure; if she cannot, her next of kin or legal representative must consent for her. In Zimbabwe, similar requirements must be met, although some of them depend upon the legal basis for the abortion. For example, if the abortion is being sought out of concern for the woman's life or physical health, two independent doctors must make a medical diagnosis. If the reason for the abortion is risk to the fetus, two doctors must also issue a diagnosis and certify that the risk to the fetus was properly investigated. Abortion in cases in which the pregnancy resulted from rape or incest requires a precertification by a local magistrate, who may only issue the certification after a criminal complaint has been filed and an investigation has established that the crime most likely occurred and could have resulted in the pregnancy.

Penalties

All seven countries prescribe penalties for violating the laws regarding abortion with differing degrees of severity. Kenya, Nigeria, and Tanzania impose the harshest penalties: a third party procuring an illegal abortion faces 14 years of imprisonment, while a woman convicted of procuring her own miscarriage is liable for imprisonment for seven years. In addition, in Kenya and Tanzania, any person who is convicted of unlawfully supplying "anything whatsoever" knowing that it is intended to be used to procure an illegal abortion may be sentenced to three years imprisonment. In Ethiopia and Ghana, the maximum penalty for a third party procuring an illegal abortion is imprisonment of five years. In Zimbabwe, contravening any of the abortion laws carries the penalty of a fine and/or incarceration for up to five years.

The South African Choice on Termination of Pregnancy Act sets penalties for persons who contravene its requirements by not meeting the professional qualifications required or failing to adequately maintain and furnish records. Most notably, the act makes it an offense for any person to prevent the lawful termination of pregnancy or to obstruct access to a facility for the termination of pregnancy. Anyone found guilty of this latter crime faces a fine or imprisonment for a maximum of 10 years.

Regulation on Abortion Information

Three countries — Ethiopia, Kenya, and Tanzania — have explicit laws restricting abortion information. Ethiopia's Penal Code prohibits the advertising or offer of sale of products designed to induce an abortion or to offer to perform an abortion. In Kenya and Tanzania, the Pharmacy Act states that it is an offense for any person to take part in the publication of any advertisement — except for those occurring in medical journals or other educational publications — that refers to “any item” to be used to obtain an abortion.

Both Ghana and South Africa seek to distribute some information regarding abortion. In Ghana, the Reproductive Health Service Policy explicitly seeks to create public awareness of the dangers of unsafe abortion and to educate clients on the complications of abortion. The South African abortion law contains a provision that states that when a woman requests a pregnancy termination, the medical practitioner is required to inform her of her rights under the act; the statute further obligates the state to promote the provision of non-mandatory and non-directive counseling before and after the abortion. We were unable to determine whether laws regarding abortion information exist in Nigeria or Zimbabwe.

Regional Legal Models

South Africa's Choice on Termination of Pregnancy Act, one of the most liberal abortion laws in the world, provides an outstanding model for other countries who wish to liberalize their abortion statutes. The South African law provides that abortions are to be made available upon the demand of the woman in the first trimester; abortions in later stages of pregnancy are also available with some limitations. Furthermore, the law requires medical practitioners to inform women of their rights and penalizes anyone who attempts to prevent a woman from obtaining an abortion or who obstructs access to facilities where abortions are performed.

E. STERILIZATION

Sterilizations are available in all seven Anglophone African countries. As is the case with contraceptives, these nations

generally lack comprehensive laws and/or policies regarding this method of family planning. With the exception of South Africa, none of the countries have statutes that address sterilization specifically. Most other nations have some laws that could potentially apply to sterilization procedures, such as the statutes regulating surgical procedures generally in Kenya and South Africa. Criminal code provisions in Ethiopia, Ghana, and Nigeria regarding “maiming and disabling of essential organs” and “grievous” bodily harm also potentially prohibit sterilization. However, as evidenced by policies and practices, these measures have not been interpreted to cover sterilizations. South Africa's Abortion and Sterilization Act, which governs the sterilization of any person who is incapable of or is legally incompetent to consent to the procedure, provides important protections for those who are not in a position to consent to being sterilized.

Sterilization is currently offered in public health institutions several countries. In Ethiopia, the procedure is performed in public hospitals as well as by a national non-governmental organization involved in population and family planning. Ghana's Reproductive Health Service Policy states that tubal ligation and vasectomy are to be available as family planning methods. In Kenya, male and female sterilization is provided free of charge in government health facilities. Sterilization is also available in Nigeria in government health institutions and teaching hospitals. Government facilities in South Africa provide the procedure at no cost. Sterilizations are to be made available at health centers and hospitals in Tanzania. In Zimbabwe, sterilizations are available at institutions of the Ministry of Health and Child Welfare and at private clinics.

No country mandates by law that a spouse consent to the performance of a sterilization. However, in Ghana and Zimbabwe, spousal consent is encouraged, while in Nigeria it is common for a medical practitioner to require spousal consent. It is not clear whether spousal consent is required for the procedure in South Africa. Additional requirements for obtaining a sterilization also vary by country. For example, in Ethiopia and Tanzania, a patient is eligible for sterilization as long as he or she expresses a desire to limit family size. In Ghana, a client must be fully informed and consent in writing to the procedure. Similarly, in Kenya, informed consent is required.

Regional Legal Models

To prevent abuse, laws and policies regarding sterilization must be carefully crafted to ensure a patient gives his or her informed consent to the procedure. The law in South Africa stands out because it establishes guidelines for sterilization procedures and clarifies requirements for consent in certain cases, thereby protecting the rights of individuals not capable of consenting to a medical procedure.

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

The practice of FGM is prevalent in five countries profiled in this report: Ethiopia (estimated at 90%); Ghana (estimated at 30%); Kenya (estimated at 50%); Nigeria (estimated at 60%); and Tanzania (estimated at 10%). FGM does not occur to a significant degree in either South Africa or Zimbabwe.

Of these five countries, only Ghana has specifically criminalized the practice as a second-degree felony. The Criminal Code provides that “[w]hoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person... shall be guilty of a second degree felony and liable on conviction to imprisonment of not less than three years.” In the other countries, criminal laws regarding assault may provide theoretical protection from FGM.

Two countries have constitutional provisions that could be used to address the issue of FGM. The Ethiopian Constitution states that “[w]omen have the right to protection by the state from harmful customs.” Laws, customs, and practices that oppress women or cause bodily or mental harm are also prohibited by the constitution. In Ghana, in addition to the criminal penalties described above, the constitution prohibits customary practices that harm one’s physical and mental well-being.

In four of the five nations where FGM is prevalent, governments have attempted to address FGM through means other than criminal statutes. The strategies listed in Ethiopia’s national health policy include identification and discouragement of FGM. In Ghana, the discouragement of FGM is one of the eight core components of the Ministry of Health’s Reproductive Health Service Policy. The Assistant Minister for Culture and Social Services in Kenya announced that the government had officially banned FGM. In Tanzania, a National Committee on Traditional Practices was created to raise awareness regarding FGM.

Regional Legal Models

Two models can be utilized to address FGM. The first, exemplified by Ghana, is a law that expressly criminalizes the practice. However, it should be noted that criminalizing FGM involves the risk of driving the practice underground and ignoring the vital need to educate communities regarding its health impact on women and the need to provide medical services to women who have undergone the practice. Constitutional provisions that prohibit traditional practices harmful to women, such as those present in Ethiopia and Ghana, can also provide the basis for barring the practice of FGM.

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

Few Anglophone African countries have laws and policies addressing HIV/AIDS and STD issues in a comprehensive manner. Those statutes now in existence give government officials potential power to discriminate against individuals with HIV/AIDS or STDs. None of the nations have adopted laws to protect individuals from discrimination by either the state or private persons. Policies and government initiatives addressing issues of HIV/AIDS and STDs are more prevalent than laws, but they, too, tend not to address HIV/AIDS and STD issues in a comprehensive manner.

Laws Affecting HIV/AIDS and STDs

Three nations — Ethiopia, Nigeria, and Tanzania — have no laws that deal expressly with either HIV/AIDS or STDs. To differing degrees, relevant laws are present in the remaining four countries. The Criminal Code in Ghana prohibits the publication of any advertisement arising from or relating to a “venereal disease” or other “infirmity” arising from or relating to sexual intercourse. In Zimbabwe, the Public Health Act criminalizes the transmission of certain STDs and empowers health authorities to investigate and detain infected persons.

In Kenya, AIDS is a “notifiable infectious disease,” a designation that requires certain activities to be reported to authorities. Furthermore, both AIDS and HIV have been deemed “infectious diseases” pursuant to the Public Health Act, thereby empowering medical officers to undertake actions such as entering and inspecting a premises in which the inhabitants may have been exposed to an “infectious disease” and examining anyone at that site. A medical officer may also remove a person to a hospital or to another place of isolation and detain the person there until he or she is determined to no longer constitute a danger to the public.

South Africa has several legal provisions that address issues of HIV/AIDS and STDs. For example, AIDS is listed as a “communicable disease” for the purpose of the Communicable Disease Regulations, which allow for the quarantine of persons carrying “communicable disease” and the compulsory medical examination of persons suspected of being carriers of “communicable disease” and who pose a danger to the public health. Other provisions relating to HIV include that found in the South African Medical and Dental Council Guidelines, which state that no health worker may ethically refuse to treat a patient solely on the grounds that the patient is, or may be, HIV positive. Despite these and other regulations, there is no comprehensive statute dealing with issues relating to HIV/AIDS and STDs in South Africa. The South

African Constitution does, however, have a provision that guarantees that everyone has the right to equal protection and benefit of the law and prohibits discrimination on enumerated grounds, including disability.

Policies Affecting HIV/AIDS and STDs

Three Anglophone African countries — Ghana, South Africa, and Tanzania — have issued policies addressing issues of HIV/AIDS and/or STDs. The Ghanaian government has demonstrated its commitment to containing the spread of AIDS through several policy measures. The Guidelines for AIDS Prevention and Control generally seek to integrate HIV/AIDS services into existing primary health care activities, while the Reproductive Health Service Policy targets the prevention and management of HIV/AIDS with respect to all sexually active individuals, including adolescents, pregnant women, and commercial sex workers. South Africa has issued a general health policy to combat HIV/AIDS. Perhaps the most comprehensive HIV/AIDS policy has been set forth by the Tanzanian government. The Ministry of Health has published a comprehensive and progressive national policy on HIV/AIDS and STDs. In addition to including strategies for the prevention and treatment of HIV/AIDS and other STDs, the policy sets forth the rights of individuals with HIV and AIDS, including the right to privacy, as well as to non-discrimination in a number of key areas such as employment, education, public transportation, and housing. A separate section of the policy addressing issues of AIDS and gender calls for women to be provided with basic education about their bodies, human sexuality, and HIV/AIDS and other STDs. The policy also encourages the criminalization of the willful spread of HIV/AIDS and other STDs.

Four nations — Ethiopia, Kenya, Nigeria, and Zimbabwe — have established either programs or government units to address HIV/AIDS. For example, Ethiopia has added to its administrative structure a Department of AIDS Prevention and Control which has undertaken a visible public education campaign regarding AIDS. The Kenyan government created a National AIDS Committee to advise it regarding control and prevention of the disease. Later, the Kenyan National AIDS Control Programme, replaced by the National AIDS and Sexually Transmitted Disease Control Programme, was launched. Nigeria established a National AIDS and STD Control Program with strategies to prevent and combat the spread of HIV/AIDS and STDs. In Zimbabwe, the Minister of Health and Child Welfare set up a National AIDS Coordination Unit and a National AIDS Advisory Committee to establish programming to provide care to AIDS patients, and to prevent and control HIV transmission.

Regional Legal Models

Comprehensive laws dealing with the issues of HIV/AIDS and STDs do not exist in any of the seven countries. However, broad policies, such as the one set forth in Tanzania, represent an important step toward addressing critical issues such as protection from discrimination, disease prevention, and the treatment and care for those individuals affected by HIV/AIDS or other STDs. This policy also focuses on the need to educate women regarding these issues.

H. REPRODUCTIVE TECHNOLOGIES

The only Anglophone African nation to promulgate a law relating to artificial insemination is South Africa, whose Human Tissue Act of 1983 regulates such procedures by restricting artificial insemination to married women and requiring spousal consent. This law will have to be reviewed in the light of the new Constitution's prohibitions against unfair discrimination on the basis of sex, gender, marital status, and sexual orientation. Laws regulating surrogacy have been proposed.

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

One of the most fundamental and serious problems confronting the majority of women in Anglophone African countries is the lack of legal reform in areas traditionally governed by customary and religious laws. Women suffer serious discrimination due to non-uniform marriage and divorce laws, the application of customary property laws that still favor men's ownership of land, societal norms that condone violence against women, and lack of equal access to education. Some governments have attempted to redress certain of these issues. For example, a few countries have sought to create uniform marriage and divorce laws, although in doing so they have codified certain discriminatory practices based on customary law. Other countries have failed to adequately reform marriage, divorce, and property laws that continue to discriminate against women. The issue of violence against women is inadequately addressed in all of the nations, although some governments have begun to initiate legal reform and institute policies to address this problem. The reform of laws relating to women's legal status is fundamental to improving women's lives and health in this region.

A. RIGHTS WITHIN MARRIAGE

With the exception of Tanzania and Ethiopia, marriage and divorce in most Anglophone African nations are governed by

parallel legal regimes of civil, customary, and some types of religious laws. Often, the customary and religious laws are unwritten, resulting in considerable uncertainty regarding their application.

Marriage Laws

In all seven countries, customary law continues to dominate the practice of traditional marriages and permits several practices within the institution that discriminate against women. These practices include: polygamy; families contracting unions between their sons and daughters and making arrangements to pay marriage consideration or bridewealth, which the woman's family may have to refund should the marriage be dissolved; "marital power," which disables the wife from contractually binding the joint household without her husband's consent; pledging of young girls in marriage; presentation of a young girl as compensation in a dispute; forced marriage of widows into their late husbands' families (widow inheritance); prohibitions on widows remarrying; harsh rites at widowhood and the periodic seclusion of women; and exclusion of widows from rights of inheritance related to their husbands' estate. In some customary unions, a woman's consent may not be necessary. In northern Nigeria, forced marriage is not prohibited, even though it is formally prohibited in the south. Although Ethiopia's 1994 Constitution provides that marriage may be entered into only with the consent of both spouses, the Civil Code specifies that if consent is prompted by "reverential fear" toward any person, it is not considered to have been obtained by violence in contravention of the Civil Code.

Uniform marriage laws applicable to every citizen do not exist in three nations: Ghana, Kenya, and Nigeria. Rather, each distinct ethnic or religious community is governed by its own set of customary laws. In both Ghana and Kenya, legal commissions concluded over 30 years ago that the parallel systems of statutory, customary, and religious marriage should be unified in a single statutory scheme. These initiatives were prompted, at least in part, by concerns regarding certain customary practices that discriminate against women, such as those that relate to inheritance. However, reform never occurred in either country. Ghana enacted a law in 1985 providing for the registration of all customary law marriages and divorces; six years later, however, the law was amended to make marriage registration optional. In Nigeria, both customary and civil marriages are legally valid throughout the country. In the northern states, marriages under Islamic law, in which a man may have up to four wives, are also legally recognized. In all three countries, even piecemeal legal reforms and efforts to enforce existing laws to end discriminatory practices in customary marriage

law, such as forced marriage in southern Nigeria, have been very limited.

In Mainland Tanzania and Ethiopia, civil, religious, and customary marriages are governed by a uniform statutory system. However, these uniform laws codify discriminatory practices. For example, the minimum age of first marriage is 18 for men and 15 for women in both countries. Moreover, in Tanzania, the Law of Marriage Act permits men, but not women, to enter into polygamous unions. In addition, statutory provisions that benefit women are not always followed. In Tanzania, despite the provision of the Law of Marriage Act that states that parties must freely consent to enter into marriage, the families often do not consider the consent of the bride-to-be for marriages celebrated under customary norms.

Despite ongoing shortcomings, significant reforms to marriage laws have been undertaken in several countries. In South Africa, "marital power," which restricted a wife's capacity to enter into a contract and to litigate, was abolished for all civil marriages in 1993. Tanzania's Law of Marriage Act reinforces the capacity of married women to enter into contracts and enables women to own their own property absent any agreement to the contrary. In Zimbabwe, a customary marriage is legally valid only if it is registered under the Customary Marriages Act. Unregistered customary marriages are, however, legally recognizable with respect to spousal claims of maintenance and the custody and rights of succession of children from the union. In response to the continued prevalence of customary marriage practices, the Zimbabwean government has prosecuted certain practices, introduced legislation to clarify existing laws aimed at combating these practices, and initiated training for magistrates and chiefs (who deal with the majority of customary law cases) on civil law developments that affect customary practices. For example, in 1993, Zimbabwe's Parliament prohibited the customary practice of refusing to bury women until payment of the bridewealth was complete.

Divorce and Custody Law

As is the case with marriage, customary legal regimes, rather than a uniform statutory scheme, are often applied to dissolve a customary marriage in four countries: Ghana, Kenya, Nigeria, and South Africa. In such cases, traditional authorities, families of the couple, or courts determine whether valid grounds for the divorce under customary law have been stated. They also decide issues of property division and child custody. But many traditional norms applied in this arena overtly discriminate against women. For example, among certain ethnic groups in Kenya, a single act of adultery by the wife is grounds for divorce, although the husband's adultery is never a cause for dissolving the marriage.

Similarly, the wife's barrenness is grounds for divorce whereas the husband's infertility is not. In Nigeria, women married under Islamic law may be unilaterally divorced by their husbands and those married under non-Islamic customary law are subject to undefined grounds for divorce applied by customary law courts. In contrast, women married under statutory law may have their marriages dissolved pursuant to the 1970 Matrimonial Causes Act, which specifies the situations under which the marriage may be deemed "irretrievably" broken; these include unreasonable marital behavior such as failure to pay maintenance for at least two years. Unfortunately, the fact that such statutes are not necessarily applied to marriages entered into under customary or religious law perpetuates the application of discriminatory norms detrimental to women.

In the three remaining nations, uniform laws do govern divorce and custody. Ethiopia's Civil Code provides for dissolution of marriage regardless of whether it was contracted under civil, customary, or religious law. "Family arbitrators" determine whether "serious cause" or "other causes" justify granting the divorce. Unfortunately, the system gives arbitrators substantial discretion in determining whether to penalize the spouse seeking divorce with respect to property distribution where no "serious cause" is demonstrated or if "serious cause" is attributable to one of the spouses. Tanzania's Law of Marriage Act also governs divorce, including division of property, payment of maintenance, and child custody. The law is generally progressive in its intent to ensure that women who did not contribute directly to the purchase of matrimonial property are not denied a share of that property. In Zimbabwe, a single statute, the Matrimonial Causes Act, applies to dissolution of civil and registered customary marriages. However, there is no legal action available for divorce from an unregistered customary marriage — the country's most common form of marriage. This statutory scheme prevents Zimbabwean women in customary marriages from obtaining a legal divorce.

Most customary practices related to child custody favoring the father's custody in patrilineal groups and the mother's custody in matrilineal groups have given way to statutes mandating that custody decisions be made on the basis of the child's best interests. However, some statutes and customary practices continue to favor granting custody to the husband or wife. For example, under South Africa's Guardianship Act of 1993, mothers retain guardianship of their children after divorce, thus reversing customary laws favoring the father's custody of children if bridewealth was paid. Ethiopia and Tanzania also have statutory presumptions favoring the mother's custody of young children.

Regional Legal Models

An optimal model law relating to marriage would establish a uniform statutory system applicable to all marriages. Tanzania's Law of Marriage Act, applicable in Mainland Tanzania, provides a useful example, although no model law should contain the overtly discriminatory provisions it contains concerning age at marriage and polygamy. The Ethiopian Civil Code, which recognizes marriages contracted under civil, religious, and customary laws, seeks to protect women by regulating the legal effects of marriage with respect to personal relations and property. A uniform marriage law that regulates all marriages and specifically prohibits all discriminatory customary marriage practices does not yet exist in any country — such reform would benefit women by fundamentally improving their legal status under the law.

As in the case with respect to marriage laws, none of the divorce laws in these seven countries can be used as a model. A uniform statutory regime should govern all divorces, mandating that all divorces be registered and that a civil court approve all property settlements and child custody arrangements. Where a uniform statutory scheme is already in place, all discriminatory provisions that adversely affect women with regard to grounds for divorce and property settlement must be repealed.

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

In all of the seven Anglophone African countries, constitutional and statutory recognition of women's right to acquire, control, transfer, and inherit property is often undermined by the continued application of customary laws that overtly discriminate against women. For example, although the Constitution of Ethiopia provides for women's equal right to "acquire, administer, control, transfer and benefit from property," as well as to equal treatment in the inheritance of property, under customary laws still applied in the north of Ethiopia a woman is not allowed to inherit land unless her father dies before giving her hand in marriage; in that case, she is entitled to a dowry. In the south of Ethiopia, customary law still bars women from inheriting land, despite the fact that this practice contravenes the Civil Code. Similarly, in Ghana, the Constitution guarantees the right of every person to own property and the right of spouses to equal access to property jointly acquired. Customary legal practices that have traditionally disfavored women's acquisition of desirable plots of land generally, upon dissolution of a marriage, and through inheritance and intestate succession, continue to be applied. A promising reform was enacted in 1985, the Intestate Succession Law, to provide a uniform law irrespective of the type

of marriage — customary, religious, or statutory — contracted by the couple and to reverse discriminatory provisions in earlier laws. The law is applied to customary marriages so long as the court concludes that the marriage was validly contracted under customary law.

Regional Legal Models

None of the seven countries have completed essential legal reforms with respect to property rights of women. While the Ghanaian and Ethiopian constitutions offer models of important constitutional guarantees in this area, integration of these guarantees into the legal fabric of everyday life has yet to be achieved. Statutory reform efforts such as the Intestate Succession Law in Ghana and the Succession Act in Kenya are promising initiatives that must be rigorously applied to eliminate discriminatory customary law.

Labor Rights

The Anglophone African region continues to fall short in legally protecting women's rights in employment. Several countries have constitutional provisions granting all citizens the right to work and to equal pay for equal work. Women, however, continue to be disadvantaged by paternalistic laws prohibiting them from working certain jobs and certain hours. For example, the Ethiopian Constitution provides that women have the right to equality in employment, promotion, pay, and the entitlement to bequeath pensions. It also entitles women to remedial and affirmative action measures to redress past inequality and discrimination. However, a 1993 labor proclamation prohibits women from doing certain types of work that are considered "arduous or harmful to their health." Similarly, the Ghanaian, Nigerian, and Tanzanian constitutions prohibit discrimination and guarantee equal pay for equal work, yet labor laws bar women from working at night or underground, such as in mines. All of these constitutions entitle women to certain maternity benefits.

Regional Legal Models

While the progressive constitutional provisions of various countries provide some hope that the shortcomings in labor laws will eventually be eradicated, none of these countries can be seen as a model because they have not yet repealed numerous discriminatory laws. The two countries with more comprehensive statutes protecting women in employment — South Africa and Zimbabwe — provide useful models. South Africa's 1995 Labour Relations Act prohibits unfair dismissal on the basis of pregnancy and direct or indirect discrimination on the basis of gender, marital status, and "family responsibility." In addition, the new South African government has published proposals for a new employment standards law which seek to provide uniform protections to all workers. The country's Employment and Occupational Equity Statute proposes

measures to eradicate discrimination in the workplace. Zimbabwean law prohibits gender discrimination in employment and provides for fines for violation of the specific provisions in this regard. Moreover, the government has an affirmative action policy in place for hiring in all civil posts.

Rules Governing Credit/ Access to Credit

While formal laws in the Anglophone African countries analyzed do not directly limit women's access to credit, many other customary laws disable women from acquiring land or other assets to serve as the collateral required by most commercial lenders. In some cases, commercial lenders still apply policies that require a male guarantor or a husband's support of a credit application. The governments of Ghana, Kenya, South Africa, and Zimbabwe have recognized that due to customary practices, most women lack the means to acquire the collateral ordinarily required by commercial banks. These governments have instituted programs to provide access to loans and training for women entrepreneurs. However, more affirmative policies to improve women's access to credit, as well as to improve women's educational level and social status, must be implemented in all of the seven countries.

Access to Education

Lack of effective access to education continues to plague the vast majority of girls and women in all of the Anglophone African countries. Government policy statements in virtually every nation recognize the issue of significant disparities in enrollment and completion rates for girls and young women at all levels of their educational systems. For example, Ghana's Constitution grants an equal right to educational opportunities and facilities and provides for free, compulsory basic education and the gradual introduction of free secondary education. The Education Act in Zimbabwe contains similar provisions. Kenya's 1994–1996 National Development Plan recognized the disadvantage of girls with respect to education and outlined various remedial steps. In Nigeria, the federal government has allocated funds to establish women's education centers in each local governmental area to promote opportunities for women, while some Nigerian states have made school attendance mandatory, prohibiting withdrawal of female students for the purpose of marriage. The new South African government has enacted specific laws and policies to eradicate gender disparities in the educational system. In all of the countries, governments must do more to address the causes of low female enrollment and completion rates.

Women's Bureaus

In most Anglophone African nations — Ethiopia, Ghana, Kenya, South Africa, and Tanzania — women's bureaus form part of the government and are assigned to deal with policy issues of concern to women. While progressive in concept,

greater resources should be provided to these institutions to facilitate their involvement in numerous legal reform measures including reproductive rights, access to education, and economic development, among others.

C. RIGHT TO PHYSICAL INTEGRITY

Rape

All of the seven Anglophone African countries criminalize rape. There are no significant differences in the definition of the crime, which is defined as a male having sexual intercourse with a woman without her consent or, in some countries, with consent obtained by force, fraud, threats, or intimidation. Rape other than by the insertion of the penis in the vagina does not fit this definition and may only be prosecuted as another sexual crime such as “indecent assault” or an “unnatural” sexual offense. In the Nigerian Criminal Code applicable in the north, the definition of rape recognizes that women are unable to freely consent to sexual intercourse in the face of nonviolent social or economic threats. Punishment for conviction for rape varies. In Kenya and Nigeria, it is life imprisonment; in Ethiopia it is 10 years’ “rigorous imprisonment”; and in Ghana and Zimbabwe it may be punished by either a fine or imprisonment for a period determined by the court.

Marital rape is only recognized as a crime in South Africa, where the 1993 Prevention of Family Violence Act provides that a husband may be convicted of raping his wife. In contrast, the northern Nigerian Penal Code and laws in Ethiopia specifically exempt marital intercourse from the definition of rape. In other countries such as Ghana and Kenya, it is accepted that a husband cannot rape his wife because her consent is implied by marriage; only if the couple is judicially separated could a husband theoretically be convicted of rape.

Another serious problem with Anglophone African rape laws is the application of evidentiary rules that favor defendants and disadvantage rape victims. For example, Ghana and South Africa apply the “cautionary rule,” which requires the court to take additional care in accepting the uncorroborated testimony of rape victims. Thus, the prosecution faces an additional burden of proof beyond the reasonable doubt standard applied to other assault crimes. The effect of this additional burden could be to dissuade law enforcement officials from pursuing charges based primarily on the rape victim’s testimony. In Ghana, forceful resistance to rape must be shown by the prosecution to establish lack of consent. In South Africa and Zimbabwe, the victim’s prior sexual history may be admitted as relevant in certain circumstances.

Regional Legal Models

Two issues emerge as essential to advancing the protection of rape victims in Anglophone Africa. First, rape laws must be

amended to specifically criminalize marital rape. Second, existing rape laws must be better enforced and rape survivors should be treated by law enforcement authorities with the dignity and sympathy that victims of any violent crime deserve. With respect to rape between non-spouses, the criminal laws in the seven countries are adequate. This is an instance where the existence of laws is insufficient to curtail a major societal problem.

South Africa’s marital rape laws, part of the Prevention of Family Violence Act, should provide a useful regional model. Also in South Africa, the Wynberg Sexual Offenses Court was established in 1992 to address the problem of a criminal justice system hostile to rape victims. The court employs women assessors and specially trained prosecutors and provides separate waiting rooms for plaintiffs and defendants. Moreover, police officers in the area are trained as rape specialists. This effort is promising, though it needs to be implemented on a far larger scale. Other countries should undertake similar measures as a means to communicate the government’s serious attitude toward prosecuting rapes in a manner that does not further victimize the victim.

Domestic Violence

Domestic violence is a serious problem in all of the countries, exacerbated by customary norms that permit husbands to assault their wives, at least to a certain degree. Virtually every customary legal regime in Kenya grants husbands the right to “chastise” their wives for “misconduct,” although “unjustified or excessive beating” by the husband is ground for divorce. Indeed, many customary divorce laws implicitly sanction wife beating and other forms of domestic violence by including only extreme forms of violence, such as grievous bodily harm, as grounds for divorce. Similarly, in northern Nigeria, husbands may “correct” their wives with physical punishment under certain customary regimes if the punishment is not “unreasonable in kind or in degree” and does not cause “grievous harm.”

There are few laws in the seven nations that deal specifically with domestic violence. In most cases, women must rely on general criminal code provisions that deal with assault — the unlawful infliction of bodily harm on any person — when confronted with abusive behavior. However, several countries have civil remedies that may provide redress to victims of domestic violence.

South Africa’s 1993 Prevention of Family Violence Act includes a specific civil remedy for victims of domestic violence that is expeditious and relatively inexpensive. It provides that an interdict may be issued by a judicial authority to prohibit the alleged abuser from engaging in various acts, including assaulting or threatening the complainant or a child living

with her. The interdict subjects the alleged abuser to arrest if he fails to comply and carries a penalty for violation of a fine, imprisonment up to 12 months, or both. The South African Law Commission is currently reviewing the act, which has been criticized on a number of grounds, including its failure to protect partners in homosexual relationships and family members who are not parties to a marriage; its inadequate definition of what constitutes family violence; and its failure to address the issue of rehabilitation and counseling for perpetrators of violence.

In Zimbabwe, a victim of domestic violence may apply to a court for a “binding-over” order to protect herself from any person, including her spouse, who is acting violently or using threats to her person or property. If a husband violates a binding-over order, he is subject to arrest and forfeits the bond posted. In 1993, the Zimbabwean government assigned community relations liaison officers to police precincts to provide counseling for victims of sexual assault. In March 1996, the president stated that incidents of domestic violence and sexual abuse had reached disturbing levels and encouraged legal organizations and advocacy groups to submit proposals for the reform of criminal law. Women’s organizations have suggested legislation that criminalizes acts of domestic violence within both registered and unregistered marriages, including acts of harassment, stalking, verbal abuse, and marital rape; requires health workers, teachers, and other care-givers to report suspected incidents of domestic violence to the police or social workers; and empowers judges to grant an injunction preventing the perpetrator from assaulting or threatening the victim, entering the victim’s home, or committing any other act the judge may specify. Although no specific remedy is provided for, Tanzania’s Marriage Act states that “notwithstanding any custom to the contrary, no person has any right to inflict corporal punishment on his or her spouse.”

Regional Legal Models

The lack of enforcement of existing criminal assault laws against domestic abusers must be urgently addressed by all of the Anglophone African countries. South Africa and Zimbabwe have civil remedies available to women that provide hopeful models. Other nations should consider enacting similar laws to encourage and better equip women to combat domestic violence. In Zimbabwe, recent government initiatives and rhetoric offer the most hopeful example of government action to combat the problem of domestic violence.

Sexual Harassment

Most countries in Anglophone Africa have not adapted specific laws prohibiting sexual harassment. Only Kenya specifically criminalizes both physical and verbal sexual harassment. Pursuant to Section 144 of Kenya’s Penal Code,

an act of physical sexual harassment constitutes a felony, whereas verbal sexual harassment is punishable as a misdemeanor offense.

Ethiopia, Ghana, Nigeria, and Tanzania have yet to address the issue in a systematic manner. While no legislation in South Africa specifically addresses sexual harassment, the government has begun taking action to combat the practice. Under the South African Labour Relations Act of 1995, a commission is charged with providing employers and employees with advice and training concerning prevention of sexual harassment in the workplace. In 1989, a South African court found a senior executive guilty of touching a woman co-worker inappropriately and held that employers have a duty to ensure that employees are not subjected to sexual harassment. In this case, the common law has substituted for the lack of statutory law on the subject. The case’s precedential value may assist other South African women to press sexual harassment claims pending the passage of specific legislation. Despite evidence that sexual harassment is a common complaint, Zimbabwe has no laws governing sexual harassment in the private sector, although public service regulations prohibit sexual harassment in the workplace of government employees.

Regional Legal Models

While apparently not enacted to address the issue of sexual harassment in the workplace, the criminal provisions in Kenya provide a useful starting point for other countries to draft laws addressing the issue.

iv. Focusing on the Rights of a Special Group: Adolescents

Many issues affecting adolescents and their health are not sufficiently addressed by the governments of the countries profiled in Anglophone Africa. For example, young women are often not protected from harmful practices due to the general lack of laws regarding FGM and age of first marriage. Similarly, policies regarding adolescents’ reproductive health and sex education for adolescents fail to take a comprehensive approach, and thus do not provide effective information and services to this special group.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

While many countries may in practice place restrictions on access to contraceptives for adolescents, two countries partially restrict access outright. The Child Care Act in South Africa prohibits persons under the age of 15 access to contraceptives without the consent of their parent or guardian. In Zimbabwe, the National Family Council and government

clinics do not dispense contraceptives to anyone under the age of 16.

Although five of the seven countries — Ethiopia, Ghana, Kenya, Tanzania, and Zimbabwe — address the issue of reproductive health and adolescents, they do so to differing degrees. In Ethiopia, Ghana, Kenya, and Tanzania, existing national policies specifically address the reproductive health needs of adolescents. Ghana has set forth a comprehensive strategy to address adolescents' reproductive health needs. In addition to seeking to integrate adolescent reproductive health issues into its Population Policy and Reproductive Health Service Policy, the government issued a separate Adolescent Reproductive Health Policy in 1996 addressing a range of issues including gender equity, education, employment, unsafe abortion, FGM, and HIV/AIDS. Ethiopia's Population Policy sets forth a strategy for the establishment of reproductive health counseling for teenagers and youth, and the inclusion of family planning in public schools, without mentioning the provision of reproductive health services to this group. Kenya raises the need to address the issue of contraceptives for youth in its Health Policy Framework. In Tanzania, the Family Planning Guidelines place much emphasis on the issue of reproductive health and adolescents by stating that all males and females of reproductive age, including adolescents, are entitled to family planning information, education, and services. Furthermore, these guidelines provide that adolescents are entitled to counseling on family planning information and that sexually active adolescents are to be counseled on access to methods that are suitable to them. While not incorporated into its policy framework, Zimbabwe, through its National Family Council, has attempted to modify its facilities to serve the youth population and to work with community youth organizations; the government has also established a Youth Advisory.

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

In the five countries where FGM is prevalent, Ethiopia, Ghana, Kenya, Nigeria, and Tanzania, it is usually performed on young girls or teenagers. For example, in Ethiopia, girls undergo FGM at the age of seven days, seven years, or during their teenage years. The procedure is performed in Nigeria on children when they are one week old or a few years old. Yet only Ghana has a specific law addressing FGM. For further discussion regarding the trends in this area, see earlier section on FGM above.

C. MARRIAGE AND ADOLESCENTS

In most countries, the mosaic of laws governing family law matters results in numerous laws, some of which may conflict, regarding the age of first marriage. For example, in Nigeria

the laws governing age at first marriage are not uniform throughout the federation. Under most forms of customary law in Nigeria, the minimum age is puberty or age 12 for girls; Islamic law provides no minimum age. Except in the eastern states, where a statutory minimum has been set, these customs have not been superseded by any other uniform law. Similarly, in Tanzania, there are contradictory laws regarding age of first marriage. For example, the Penal Code states that any person of African or Asiatic descent may marry or permit the marriage of a girl under the age of 12 as long as it is not intended that the marriage be consummated before the girl reaches the age of 12. This provision directly conflicts with the Law of Marriage Act, which establishes 15 as the minimum age of first marriage for women. The Marriage Act itself provides for exemptions to this provision, allowing for marriage with judicial consent for women and men who are at least 14 years old. Many countries, if they provide a minimum age of first marriage, prescribe different ages for men and women. For example, in Ethiopia and Zimbabwe, the civil codes set the minimum age of first marriage at 18 years for men and 15 for women.

D. EDUCATION AND ADOLESCENTS

See section on Access to Education above.

E. SEX EDUCATION FOR ADOLESCENTS

Most governments in the region have not issued comprehensive sex education policies, although some form of sex education is part of a school curriculum in four of the countries — Ghana, Nigeria, South Africa, and Zimbabwe. In South Africa, a comprehensive package on health, including sexual health, is to be introduced into schools for the first time in 1997.

F. SEXUAL OFFENSES AGAINST MINORS

All of the countries have provisions in their criminal codes that deal specifically with sexual offenses against minors. Statutory rape is criminalized in every nation, with the protected age ranging from 13 years in Nigeria to 16 years in Zimbabwe. Despite the existence of this protection, most of the criminal statutes also allow reasonable mistake concerning the girl's age as a defense to a statutory rape charge.

v. Conclusion

The numerous trends that have emerged from our analysis of the formal laws and policies of seven Anglophone African nations make it difficult to focus on only a few key themes affecting women's reproductive health and rights. Nonetheless, this assessment of a broad array of laws and policies does lead to the emergence of overall patterns that provide a critical context for reform efforts in the region. Each of these macro-

level trends represents a major challenge to the ultimate realization of reproductive rights and women's empowerment.

The first crucial regional pattern is the gap that exists between formal policy statements and their execution. Most of the seven Anglophone African nations have numerous policies addressing a range of common reproductive health problems, including high rates of maternal and infant mortality, and transmission of HIV/AIDS. Yet these health problems continue to persist and, in some cases, worsen. This difference between stated policy and its effect is most likely attributable to severe shortcomings in government actions. The lack of effective execution of policies is particularly evident with regard to women's empowerment. Almost all Anglophone African policies repeatedly refer to the need to address women's low status. Yet, most governments have made few systematic efforts to improve women's legal rights or their economic condition. The reason for this lack of policy enforcement can range from resource limitations to a lack of political will to a general lack of government accountability. Irrespective of the rationale for the weak enforcement of policies, the result is to diminish the utility of government policy enunciation as a tool by which to improve reproductive health and rights. For these reasons, the systems by which policies are to be enforced are as important to analyze as the policies themselves.

Another trend that emerges from this review of seven Anglophone African countries is the weak enforcement of laws. Two major facts explain this problem. First, in all of the nations, the judicial branch of government tends to be weak in comparison with the executive and legislative arms. Hence, particularly in a common law system, the ability of courts to develop laws and to adjudicate disputes is limited. Second, in most nations, there appears to be limited access to the formal judicial system. Legal services for low-income individuals are limited, as is their knowledge of the law and the rights it may bestow. One of the important effects of a weak legal system is that women aggrieved by legal measures that run contrary to constitutional principles or to other laws are not able to access effective judicial remedies to redress violations of their rights.

A third regional characteristic is that laws and policies affecting women's reproductive lives often contradict one another. A striking instance of these conflicts lies in the policy of all seven governments to provide comprehensive contraceptive and family planning services. Despite these commitments, all of the countries except South Africa legally restrict abortion, making it available only on a limited basis. Even legal abortions are generally not provided within government health facilities.

Finally, it appears that in most nations there may also be a disparity between constitutional provisions and international

human rights, on the one hand, and certain customary laws. This conflict is particularly relevant with respect to customary law that discriminates against women. For example, Ghanaian legislation permits customary personal laws to be applied by the courts in cases where the parties intended for them to apply. This legal scheme tends to leave women vulnerable to local customs — such as those relating to marriage, divorce, and property rights — that may discriminate against them. Yet the Ghanaian Constitution states that it prohibits discrimination on the basis of gender and “all customary practices which dehumanise or are injurious to the physical and mental well-being of a person.” In addition, Ghana, like the other Anglophone African nations, is a signatory to CEDAW. Hence, pursuant to both domestic and international laws, Ghana is obligated to take appropriate measures to ensure application of its constitutional precepts and those required under its international obligations to the lives of all Ghanaian women.

Despite the challenges associated with the enforcement and consistency of laws and policies, such regulations are critical tools by which to advance social changes that promote reproductive rights and women's empowerment. Formal laws and policies remain the primary means utilized by governments to express their objectives and to regulate the actions of their citizens. Such enunciations set the stage for the rights that are to be enjoyed by all people within that nation. Given the realities, a primary obstacle to the promotion of reproductive rights is the lack of governments' commitment to social justice, particularly those rights associated with women. While developing such commitment is a long-term endeavor, governments can undertake certain short-term measures to lay the groundwork for women's reproductive rights. Relevant legal and policy reform that advances women's rights and enhances their access to reproductive health care would constitute such a first step.