

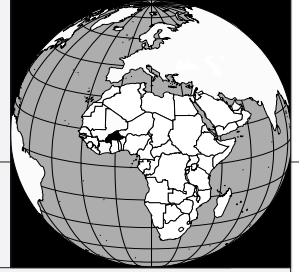


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# 3. Burkina Faso



## Statistics

### GENERAL

#### Population

- The total population of Burkina Faso is approximately 11.4 million.<sup>1</sup>
- The average annual population growth rate between 1995 and 2000 was estimated to be 2.8%.<sup>2</sup>
- Women comprise 51.7% of the total population.<sup>3</sup>
- In 1995, 27% of the population resided in urban areas.<sup>4</sup>

#### Territory

- Burkina Faso covers an area of 274,200 square kilometers.<sup>5</sup>

#### Economy

- In 1997, the estimated per capita gross national product (GNP) was U.S.\$240.<sup>6</sup>
- Between 1990 and 1997, the average annual growth rate of the gross domestic product (GDP) was 3.3%.<sup>7</sup>
- Approximately 44.5% of the population have access to primary health care.<sup>8</sup>
- The government allocates 7% of the national budget to the health sector.<sup>9</sup>

#### Employment

- In 1995, women comprised 47% of the workforce, compared to 48% in 1980.<sup>10</sup>
- The distribution of women in the different sectors of the economy was as follows: 85% in agriculture, 11% in services, and 4% in industry.<sup>11</sup>
- In Ouagadougou, the unemployment rate increased from 13% in 1991 to 25% in 1993.<sup>12</sup>

### WOMEN'S STATUS

- In 1995, the average life expectancy for women was 47 years, compared to 45.1 for men.<sup>13</sup>
- The adult illiteracy rate was 91% for women, compared to 71% for men.<sup>14</sup>
- Fifty-one percent of married women live in polygamous unions.<sup>15</sup>
- In 1993, the average age at first marriage was approximately 17.5 years.<sup>16</sup>

### FEMALE MINORS AND ADOLESCENTS

- Approximately 48.3% of the population is under 15 years of age.<sup>17</sup>
- In 1995, primary school enrollment for school-aged girls was 30%, compared to 47% for boys. In secondary school, it was 6% for girls and 11% for boys.<sup>18</sup>
- In 1995, the fertility rate of adolescents aged 15 to 19 was estimated at 157 per 1,000.<sup>19</sup>
- The prevalence of female circumcision/female genital mutilation is estimated at 66.35%.<sup>20</sup>

### MATERNAL HEALTH

- Between 1995 and 2000, the average total fertility rate (TFR) was estimated at 6.57 children per woman.<sup>21</sup>
- Maternal mortality is estimated at about 567 per 100,000 live births.<sup>22</sup>
- Infant mortality is estimated at 93.7 per 1,000 live births.<sup>23</sup>
- Approximately 43% of births are assisted by trained birth attendants.<sup>24</sup>
- In 1993, the average age at first birth was estimated at 19 years.<sup>25</sup>

## CONTRACEPTION AND ABORTION

- In 1993, contraceptive prevalence was estimated at 21.7% for all methods combined (traditional and modern) and at 99% for modern methods.<sup>26</sup>
- Of those using modern methods in 1993, 5.2% used the birth control pill, 1.5% used intrauterine devices, 0.7% used injectables, 1.3% used the diaphragm, 5.2% used the condom, and 0.4% of women were sterilized.<sup>27</sup>
- In 1994, according to the Department of Research and Planning's health statistic reports, health units recorded 7,123 abortions, including 234 clandestine abortions.<sup>28</sup>

## HIV/AIDS AND OTHER STIS

- In 1997, the number of HIV-positive adults was estimated at 350,000, or 7.17% of the adult population.<sup>29</sup>
- Among HIV-positive adults, the number of HIV-positive women was estimated at 170,000.<sup>30</sup>
- Since the beginning of the epidemic, 270,000 confirmed cases of AIDS have been recorded.<sup>31</sup>
- In 1997, there were an estimated 22,000 HIV-positive children and 200,000 orphans due to AIDS.<sup>32</sup>
- The Department of Research and Planning's health statistics reports showed 4,201 cases of syphilis and 8,535 cases of gonorrhoea in 1995.<sup>33</sup>

## ENDNOTES

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4. THE STATE OF WORLD POPULATION, *supra* note 1, at 70.
5. INSTITUT NATIONAL DE LA STATISTIQUE ET DE LA DÉMOGRAPHIE, ENQUÊTE DÉMOGRAPHIQUE ET DE SANTÉ—1993, at 1 (1993) [hereinafter, 1993 DHS.]
6. THE WORLD BANK, WORLD DEVELOPMENT REPORT, at 190 (1998/99).
7. *Id.*, at 210.
8. MINISTÈRE DE L'ÉCONOMIE ET DES FINANCES, TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX (April 1999).
9. MINISTÈRE DU PLAN ET DE LA COOPÉRATION, POLITIQUE DE LA POPULATION AU BURKINA FASO, at 22 (June 1991).
10. WORLD DEVELOPMENT REPORT, *supra* note 6, at 194.
11. UNITED NATIONS, THE WORLD'S WOMEN 1995, *supra* note 3, at 147.
12. MINISTÈRE DE L'ÉCONOMIE ET DES FINANCES, TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX – RAPPORT DE SYNTHÈSE, at 37 (September 1998).
13. THE STATE OF WORLD POPULATION, *supra* note 1, at 67.
14. WORLD DEVELOPMENT REPORT, *supra* note 6, at 192.
15. 1993 DHS, *supra* note 5, at 65.
16. *Id.*, at 67.
17. POLITIQUE DE LA POPULATION AU BURKINA FASO, *supra* note 10, at 13.
18. THE STATE OF WORLD POPULATION, *supra* note 1, at 67.
19. *Id.*
20. MARIAM LAMIZANA, COMITÉ NATIONAL DE LUTTE CONTRE LA PRATIQUE DE L'EXCISION, LUTTE CONTRE LA PRATIQUE DE L'EXCISION: L'EXPÉRIENCE DU BURKINA FASO, at 3 (December 1998).
21. THE STATE OF WORLD POPULATION, *supra* note 1, at 70.
22. MINISTÈRE DE LA SANTÉ, DIRECTION DE LA SANTÉ DE LA FAMILLE, PLAN STRATÉGIQUE DE DE LA SANTÉ DE LA REPRODUCTION DU BURKINA FASO, 1998 – 2008, at 11 (September 1998).
23. *Id.*, at 12.
24. THE STATE OF WORLD POPULATION, *supra* note 1, at 70.

25. 1993 DHS, *supra* note 5, at 37.

26. *Id.*, at 47.

27. *Id.*

28. MINISTÈRE DE L'ÉCONOMIE, DES FINANCES ET DU PLAN, FONDS DES NATIONS UNIES POUR LA POPULATION, BURKINA FASO: EXAMEN DE PROGRAMME ET DÉVELOPPEMENT DE STRATÉGIES EN MATIÈRE DE POPULATION, at 71 (November 6, 1996).

29. UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC, at 64 (June 1998).

30. *Id.*

31. *Id.*, at 67.

32. *Id.*, at 64.

33. COMITÉ NATIONAL DE LUTTE CONTRE LE SIDA, GROUPE THÉMATIQUE ONUSIDA DOCUMENT PROVISOIRE, DEUXIÈME VERSION, LA LUTTE CONTRE LE VIH/SIDA ET LES MST AU BURKINA FASO, at 8 (November 1997).

## I. Introduction

A former French colony, Burkina Faso achieved independence in 1960 under the name of Upper Volta. In 1984, it took the name Burkina Faso or “Land of Honest People.”<sup>1</sup> Its first president, Mr. Maurice Yaméogo, was democratically elected in 1960 and overthrown by a military coup on January 3, 1966.<sup>2</sup> As a result of this putsch, Colonel Sangoulé Lamizana became President of the Republic.

In 1970, political and social pressure led to the drafting of a new constitution that ended a ban against political parties<sup>3</sup> yet left General Lamizana in power. This constitution also created a government that was one-third military personnel and two-thirds civilian<sup>4</sup>—a mixed system that General Lamizana overthrew in 1974.<sup>5</sup> Three years later a third constitution was drafted, restoring democracy, and in 1978, Lamizana was again elected president.<sup>6</sup>

Nineteen eighty marked the beginning of an era of political instability characterized by a succession of coups. That year, Colonel Saye Zerbo overthrew General Lamizana and took over the government.<sup>7</sup> Zerbo was displaced in 1982 by the Major and Doctor Jean-Baptiste Ouédraogo. In 1983, Captain Thomas Sankara took control and instituted a people’s democracy.<sup>8</sup> Finally, in 1987, Captain Blaise Compaoré seized power after a bloody military coup in which Sankara himself and several of his colleagues lost their lives.<sup>9</sup>

By 1990 internal and external events had pressured Compaoré’s regime into opening its political system, and the government instituted a more democratic process. Burkina Faso’s current constitution was drafted that year, and adopted by referendum on January 2, 1991;<sup>10</sup> it established a multiparty system and direct elections.<sup>11</sup>

Culturally, Burkina Faso is quite diverse. Its total population is estimated at 11.4 million,<sup>12</sup> 51.7% of which are women.<sup>13</sup> The main religions are Islam (50%), indigenous religions (40%), and Christianity (10%).<sup>14</sup> The country has nearly 60 ethnic groups, the most important of which is the Mossi, which represents almost 48% of the population.<sup>15</sup> While French is the official language,<sup>16</sup> there are almost 60 national languages, the most frequently spoken of which are Mooré, Dioula, and Fulfuldé.<sup>17</sup>

Administratively, Burkina Faso is divided into: 8,205 villages, 103 communes, 315 departments, and 45 provinces.<sup>18</sup> In addition, as a result of ongoing efforts to decentralize the economy, the Orientation Text on Decentralization (OTD) provides for the creation of 10 economic regions, each under the jurisdiction of local government.

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

To understand the various laws and policies affecting women’s reproductive rights in Burkina Faso, it is necessary to examine the country’s legal and political systems. Without this background, it is difficult to determine the manner in which laws and policies are enacted, interpreted, modified, and challenged. The passage and enforcement of laws often involve specific formal procedures. Policy enactments, however, are not subject to such processes.

### A. THE STRUCTURE OF GOVERNMENT

According to the 1991 Constitution (the Constitution), Burkina Faso is a “democratic, united, and secular state” with a republican form of government.<sup>19</sup> The Constitution establishes three branches of government: executive, legislative, and judicial.

#### 1. Executive Branch

The President of Burkina Faso (the President of Faso) is the Head of State. He ensures respect for the Constitution, and sets the major priorities of national policy. In addition, he is responsible for preserving national unity and sovereignty.<sup>20</sup> The President of Faso is elected by majority vote to a seven-year term. Pursuant to the revised Article 37 of the Constitution, the President of Faso can be reelected indefinitely.<sup>21</sup>

The President of Faso appoints the Prime Minister, and can also put an end to his tenure.<sup>22</sup> The President of Faso also appoints the other members of the cabinet on the advice of the Prime Minister,<sup>23</sup> and presides over the Council of Ministers. The Prime Minister may stand in for the President of Faso when necessary.<sup>24</sup> The President of Faso has both shared and autonomous powers. He appoints civil and military officials, ambassadors, and special envoys, as well as the Grand Chancellor of the Bar.<sup>25</sup> He is the commander-in-chief of the armed forces and has the power to grant pardons.<sup>26</sup> Despite this presidential role in assembling the cabinet, it is actually the Prime Minister who is its head, directing and supervising all executive action. He is also responsible for implementing the national defense policy that the President of Faso establishes. Moreover, the Prime Minister has broad regulatory powers and is responsible for enforcing laws.<sup>27</sup> In consultation with the Prime Minister and the Chairman of the Chamber of Representatives, the President of Faso can dissolve the Assembly of People’s Deputies. When he does so, national elections must take place between 21 and 40 days after the dissolution.<sup>28</sup>

The somewhat overlapping responsibilities of Prime Minister and President of Faso are particularly evident in the area of lawmaking. Upon consultation with the Prime Minister and the Chairman of the Chamber of Representatives, the President of Faso may submit to referendum any bill relevant to any issue of national interest.<sup>29</sup> Upon consultation with the Council of Ministers, the President of Faso and the Prime Minister can enact regulations in any area that comes under the legislature's jurisdiction.<sup>30</sup> To implement its programs, the cabinet can request authorization from the Assembly to issue executive orders for a limited period of time, or to undertake any action that falls within the jurisdiction of the legislature.<sup>31</sup>

## **2. Legislative Branch**

Legislative power rests with a bicameral parliament composed of the Assembly of the People's Deputies (the Assembly), and the Chamber of Representatives (the Chamber).<sup>32</sup> The members of the Assembly, known as deputies, are democratically elected by popular vote<sup>33</sup> and exercise legislative authority; members of the Chamber, known as representatives, are elected indirectly<sup>34</sup> and play an advisory role.

The Assembly and the Executive Branch initiate legislative actions concurrently. The draft texts proposed by both the deputies and the government are called "bills."<sup>35</sup> The Council of Ministers deliberates over the proposed bills before they are introduced in the Office of the Assembly of the People's Deputies.<sup>36</sup> (The Office of the Assembly also records petitions for legislative action initiated by the general public: citizens can introduce proposal drafts signed by at least 15,000 individuals who have the right to vote.)<sup>37</sup>

The Assembly has the power to legislate in most fields, including criminal, educational, and civil rights law.<sup>38</sup> It also presents the annual national budget.<sup>39</sup> Organic laws are approved by an absolute majority and enacted after the Supreme Court confirms that they comply with the Constitution.<sup>40</sup>

The President of Faso must promulgate a draft law that has been approved by the National Assembly within 21 days of receiving the final text.<sup>41</sup> During that grace period, the President can order the review of the entire bill or some of its articles.<sup>42</sup> If the bill is not executed within the mandatory time limit, it automatically becomes law after the Supreme Court has determined its constitutionality.<sup>43</sup>

## **3. Judicial Branch**

The Constitution establishes an independent judiciary,<sup>44</sup> which includes the Supreme Court, the courts, and the tribunals.<sup>45</sup> The Supreme Court is the highest authority and comprises four chambers: the Constitutional Chamber, the Judicial Chamber, the Administrative Chamber, and the Accounting Chamber.<sup>46</sup>

The Constitutional Chamber, as its name implies, determines the constitutionality of laws.<sup>47</sup> In addition to the Chairman of the Supreme Court, its members include three magistrates and three persons appointed by the President of Faso, as well as three persons appointed by the Chairman of the Assembly of the People's Deputies.<sup>48</sup> All of these, with the exception of the Chairman of the Supreme Court, are appointed for a single nine-year, non-renewable term, with a third of the membership reappointed every three years.<sup>49</sup> In addition to approving the enactment of organic laws, the Constitutional Chamber monitors the legality of elections and referenda<sup>50</sup> as well as general compliance with the Constitution.<sup>51</sup>

Each of the myriad courts that make up the judicial system has its own clearly delineated duties. For example, the Court of Appeals has jurisdiction to hear appeals in civil, criminal, and social matters, as well as to arbitrate appeals in group conflicts.<sup>52</sup> The Assize Court, in contrast, hears only the first trial and highest appeal of criminal cases.<sup>53</sup> The lower courts have general jurisdiction, as well as jurisdiction in civil, business, and criminal matters.<sup>54</sup> Finally, the Labor Court, which presides over conflicts between employers and employees, has the same level of jurisdiction as the lower courts.<sup>55</sup>

While the Constitution guarantees the autonomy of the judiciary,<sup>56</sup> it is well integrated with the other branches of government. The President of Faso serves as Chairman of the Council of Magistrates, which means that he presides over any issue that involves the autonomy of magistrates or the granting of pardons.<sup>57</sup> There is also a High Court of Justice composed of magistrates and deputies—the former appointed by the Chairman of the Supreme Court, and the latter elected by the Assembly of the People's Deputies following each general election.<sup>58</sup> The High Court of Justice has jurisdiction to review presidential actions that may constitute high treason, violations of the Constitution, or misappropriation of public funds;<sup>59</sup> it also has jurisdiction to try members of the Executive Branch for any offense committed in the exercise of their duties.<sup>60</sup> The Constitution also provides for the creation of supplemental judicial bodies that play an advisory role to the Executive and the Legislative branches. Their field of jurisdiction includes economic, social, and cultural issues of a national interest.<sup>61</sup> They provide technical expertise and make recommendations, as well as conduct inquiries and issue reports.<sup>62</sup>

## **B. SOURCES OF LAW**

Laws that affect women's legal status in Burkina Faso—including their reproductive rights—derive from a variety of sources, both international and domestic.

### 1. *International Sources of Law*

Several international human rights treaties recognize and promote specific reproductive rights. Because they are legally binding on governments, these international instruments impose specific obligations to protect and advance these rights: all international treaties or agreements lawfully ratified by Burkina Faso override domestic laws,<sup>63</sup> and can be cited before national courts.<sup>64</sup>

Burkina Faso is a party to, *inter alia*: the African Charter on Human and People's Rights; the International Covenant on Civil and Political Rights;<sup>65</sup> the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination against Women; the International Convention on the Elimination of all Forms of Racial Discrimination; and the Convention on the Rights of the Child.<sup>66</sup> In addition, treaties relating to human rights such as the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights have been integrated into the Constitution.<sup>67</sup>

### 2. *Domestic Sources of Law*

Since the legal system of Burkina Faso is based upon civil law, legislation is the highest source of law. Individual rights and duties are guaranteed in articles one to 30 of the Constitution. The most fundamental of these rights is the prohibition against all forms of discrimination, "especially those based on race, ethnicity, region, color, gender, language, religion, caste, political opinions, wealth, and birth."<sup>68</sup> The Constitution further guarantees "the protection of life, security, and bodily integrity,"<sup>69</sup> and the right to an education, the right to work, and the right to a healthy environment.<sup>70</sup>

For the most part, French colonial law was revised and adapted in Burkina Faso to fit local realities. Such revisions occurred with the Penal Code, the Business Code, the Labor Code, and with agrarian and land reform. The 1989 Persons and Family Code (the 1989 Code) was enacted in the mid-1990s and replaced the existing Civil Code.<sup>71</sup> The 1989 Code resulted from efforts to integrate the Civil Code and customary law into a single source of law.<sup>72</sup> Today only general civil law—such as contracts, obligations, and property—is still regulated by the French Civil Code.

## III. Examining Reproductive Health and Rights

In Burkina Faso, issues of reproductive health and rights are addressed in the context of the country's health and population policies. Thus, an understanding of reproductive rights in

Burkina Faso must be based on an examination of the documents that set forth these policies.

### A. HEALTH LAWS AND POLICIES

#### 1. *Objectives of the Health Policy*

In general, health conditions in Burkina Faso are characterized by high levels of morbidity and mortality.<sup>73</sup> There are several contributing factors to this unfortunate situation. First, health coverage is inadequate, both from a quantitative and qualitative perspective. Second, coordination between public health services and traditional pharmacopoeia is weak—a fundamental disconnect that is significant because most of the population still relies on traditional methods. Third, basic sanitation and fresh drinking water are lacking (a mere 12 to 17% of the population have adequate access to the latter). Finally, malnutrition and related illnesses persist.<sup>74</sup>

Burkina Faso adopted a primary health care strategy after the Alma-Ata Conference in 1978, and has had a national health program since March 1979. In May 1994, it adopted a Public Health Code delineating the government's obligations regarding the protection and promotion of public health.<sup>75</sup> This Code sets forth the goal of enabling all people to achieve socially and economically productive lives.<sup>76</sup> Specifically, it calls for the defense of the individual, the family, and society against disease,<sup>77</sup> as well as the overall betterment of health by improving living and working conditions.<sup>78</sup>

The Ministry of Health is responsible for implementing and monitoring a national health policy whose priorities are based on a plan for sustainable development adopted by Burkina Faso in 1995.<sup>79</sup> These strategies project beyond the year 2000, and are aimed at the 2005–2010 period. The government's main strategy calls for provision of primary health care, as set forth in the Bamako Initiative.<sup>80</sup>

One of the government's priorities is to provide the public with health security that would give all citizens access to medical care at the lowest cost. To reach this goal by 2000, the government must:<sup>81</sup>

- Reduce the general, infant and maternal mortality rates by one half;
- Significantly reduce malnutrition for children under five;
- Increase contraceptive prevalence from 1.5% to 9% in rural areas, and from 17% to 32% in urban areas between 1995 and 1999;
- Reduce the spread of sexually transmissible infections including HIV/AIDS;
- Improve life expectancy from 48 in 1993 to 54 by the year 2000 and to 57 by the year 2005.

Today, 50% of the rural population lives at least 30 kilometers from health care centers. Thus, achieving health security should also include gradually reducing the distance to health centers to no more than five kilometers. Finally, health security should include the provision of essential drugs and medicines to primary health care centers.<sup>82</sup>

Progress is also necessary in the field of information, education, and communication (IEC) for rural populations, particularly with regard to improved hygiene and more efficient use of water resources. IEC activities must also include campaigns against STIs/HIV/AIDS, tobacco and drugs, as well as the eradication of the Guinea worm and behavior harmful to health.<sup>83</sup>

Burkina Faso's concept of reproductive health derives from the 1994 International Conference on Population and Development. This concept provides the basis for the government's reproductive health strategy, the main goal of which is the significant reduction of morbidity and mortality rates in specific beneficiary groups. To achieve this goal, the strategy identifies four key components: safe motherhood; the elimination of obstacles to improving reproductive health; the prevention and treatment of infectious and non-infectious conditions of the reproductive tract; and adolescent sexual and reproductive health.<sup>84</sup>

Several institutions work together to administer the country's reproductive health policies and programs: decision-making bodies (e.g., the Health Sector's Board of Directors and the Conference of Regional Health Directors); advisory bodies (e.g., the Higher Health Council and the National Advisory Commission); and implementing bodies (e.g., the Coordinating Committee).<sup>85</sup>

The strategy for safe motherhood, adopted in September 1998, is aimed at a significant drop in the morbidity and mortality rates of women and infants.<sup>86</sup> Its objectives are:<sup>87</sup>

- Improving the quality and accessibility of maternal and child health services (MCH) available to beneficiary groups such as pregnant women, women in labor, new mothers, and newborns;
- Reducing socio-cultural barriers that obstruct access to safe motherhood services;
- Promoting community involvement in the management of safe motherhood services.

## **2. Infrastructure of Health Services**

In 1995, Burkina Faso had 921 public health facilities organized in a hierarchical manner consisting of, from top to bottom: two national hospital centers (NHC); nine (out of a projected 10) regional hospital centers (RHC); 16 medical centers with surgical branches (MCB); 59 medical centers (MC);

686 health and social welfare centers (HSWC); 134 village dispensaries; and 14 district maternity hospitals.<sup>88</sup>

Unfortunately, these resources are inadequately supplemented at the local level. In 1985, the government created primary health stations (PHS) with the idea of eventually establishing one station in each village. In practice, though, their functions vary, and they generally offer poor-quality services. In addition, the volunteer community health officials that run them are not well motivated because they are not paid. These same community officials, however, are counted on to play a vital role by helping implement government community programs.<sup>89</sup>

In the private sector, surveys conducted in 1995 counted 199 health facilities, including 13 birthing clinics, 12 medical offices, and 15 pharmacies. The majority of these facilities are in the country's two largest cities, Ouagadougou and Bobo-Dioulasso. In addition, some villages still maintain maternity wards and health centers that provide minimal maternal and child health care. Their exact number, however, is unknown.<sup>90</sup>

Despite recent efforts, health coverage remains inadequate. Only 51% of the urban population and 48% of the rural population have access to health services. All health facilities, except village health centers, offer maternal and child health services—however, the vast majority of existing services are not used, especially in rural areas. Studies conducted in some rural areas indicate that only 10% to 14% of the population consult health services for either minor or serious illnesses. This percentage is even lower for preventive care, particularly reproductive health services.<sup>91</sup>

The number of health workers remains substantially below the standards put forth by the World Health Organization (WHO). In 1995, Burkina Faso had one doctor for every 28,673 inhabitants, as opposed to the WHO recommendation of one for 10,000; one nurse for 13,214 inhabitants, instead of the WHO-recommended ratio of one for 5,000; and, most glaringly, one midwife for every 29,316 inhabitants as opposed to the WHO-recommended standard of one per 5,000. The same surveys show a ratio of health aides (midwife, midwife's assistant, or traveling health official) of 1: 6,549.<sup>92</sup>

The 1993 Demographic and Health Survey (1993 DHS) identifies two main factors responsible for the meager use of health services. First, 40% of the population lack easy access to health services. Second, for 37% of the population, it is difficult to obtain medicines because of scarcity and high cost.<sup>93</sup> Health services are also less accessible to women in rural areas than women in cities. Furthermore, the financial cost of access to health services for women, the poor quality of the equipment and of the care itself—these, too, are factors in the low rate of usage.<sup>94</sup>

### 3. Cost of Health Services

The health care system is financed by the government, international donor agencies, non-governmental agencies, territorial communities, and consumers. On average, Burkina Faso allocates 7% of its national budget to the health sector. WHO recommends that 10% of a country's national budget be allocated to health.<sup>95</sup>

The Public Health Code stipulates that the government is responsible for protecting and promoting public health, as well as providing health care services.<sup>96</sup> The law specifies, however, that the provision of health care services is subject to payment, whether provided by government agencies, the private sector, or nonprofit organizations to which individuals are asked to make contributions.<sup>97</sup>

Health care, therefore, is not free, even in the public sector. Formerly, health care fees were paid to the Department of Finance, but since 1991 Ministry of Health reforms have converted hospitals into public institutions that are financially and administratively autonomous. In 1992, the Ministry extended this autonomy to the country's other health facilities.<sup>98</sup>

### 4. Regulation of Health Care Providers

To practice medicine, oral surgery, midwifery or nursing in Burkina Faso, a person must:<sup>99</sup> hold a state degree or a government-certified equivalent; be of Burkinabe nationality; and be registered in one of the four professional associations (the Medical Association, the Oral Surgeons Association, the Midwives Association, or the Nurses Association). Similarly, to qualify as a pharmacist, a person must: hold a state pharmacist's degree or a certified equivalent; be of Burkinabe nationality; and be registered in the Pharmacists Association. The medical and paramedical professions are regulated by a Code of Ethics that the professional associations establish and the regulatory boards approve.<sup>100</sup>

Illegal practice of medical professions is punishable by law.<sup>101</sup> Specifically, the Penal Code stipulates that "any person who illegally practices medicine or falsely claims to hold a professional degree is subject to three months to two years in prison and/or a fine of 75,000 (U.S.\$119.39) to 600,000 CFA francs (U.S.\$955.13)."<sup>102</sup> In addition, the Public Health Code bans the illegal practice of medical professions: Article 132 stipulates that any person who practices medicine without a degree, or who is not registered with a medical association, is subject to punishment. Similarly, Article 133 bans the illegal practice of dentistry; Article 134 prohibits the illegal practice of obstetrics and gynecology; Article 135 prohibits the illegal practice of nursing; and Article 151 prohibits the illegal practice of pharmacology.

Burkina Faso recognizes the practice of traditional medicine.<sup>103</sup> It defines such medicine as "all knowledge and

practices that are used to diagnose, prevent, or treat a physical, mental, or psychosocial illness and that rely exclusively on experience and knowledge passed down, either orally or in writing, from generation to generation."<sup>104</sup> A person who practices traditional medicine is called a "traditional health practitioner." He or she must be recognized as competent by the community in which he or she lives to provide health care by means of metals and/or vegetable, animal or mineral substances, as well as other traditional methods.<sup>105</sup> The practice of traditional medicine, like the practice of other types of health care, is also government-regulated.<sup>106</sup>

### 5. Patients' Rights

Patients' rights are protected under the Constitution, which guarantees the right to life, security, and bodily integrity.<sup>107</sup> According to Article 26, "The government recognizes the right to health and aims to promote this right." Moreover, patients' rights are also protected by the prohibition against the illegal practice of medical professions. And although the Penal Code does not specify the responsibility of medical practitioners, general clauses pertaining to homicide and involuntary injury can be applied to the criminal conduct of doctors, oral surgeons, pharmacists, and nurses.<sup>108</sup>

By law, health care professionals are not obligated to provide cures—though they must provide treatment. This obligation releases them from any civil or criminal liability in case of accidents, except when professional negligence or medical malpractice is suspected. Thus, Article 1382 of the Civil Code stipulates that "any human action that causes harm to others obligates the perpetrator to make amends."<sup>109</sup> It equally condemns negligence and poor judgment that result in harm to others.<sup>110</sup> In addition, the various professional associations require their members to adhere to a Code of Professional Ethics.

Despite legislative safeguards, few victims of medical malpractice press criminal charges. In one of the rare cases that was litigated, the sentence was so mild that it is unlikely to encourage other potential victims to press charges. In this case, a woman with complications in childbirth was transferred from the Kongoussi hospital to Kaya, which was viewed as better equipped to serve her needs. The patient, Mrs. Z.J., arrived at the Kaya Hospital at about 7:30 AM. She gave birth without surgical intervention, but a hemorrhage followed, which led the attending physician to prescribe an emergency blood transfusion. For this purpose, blood samples were taken from the patient's relatives to discern blood types because the hospital did not have any available blood. D.Y., the laboratory technician on duty, participated in taking these samples. The midwife then asked him to collect the blood for the transfusion. He



refused to do so, claiming he had not received authorization in the form of a sampling “voucher” from the doctor. He then went home. Mr. D.Y.’s behavior showed intentional misconduct and negligence that bordered on medical malpractice. The necessary transfusion did not occur until 4:00 PM, and Mrs. Z.J. died soon after.

When the case was submitted to the Kaya Court, it found D.Y. guilty of involuntary manslaughter and sentenced him to eight months in prison and 4,000,000 CFA francs (U.S.\$6,367.50) in damages and interest to Mrs. Z.J.’s beneficiaries. On appeal, the Ouagadougou Court of Appeals reclassified the crime as “non-assistance to a person in danger” and reduced D.Y.’s sentence to two months in prison, though it did uphold the amount of damages to be paid.<sup>111</sup>

## **B. POPULATION AND FAMILY PLANNING**

### **1. The Population Policy**

In June 1991, Burkina Faso adopted a population policy integrated with its overall development strategy, which addresses its demographic, economic, and socio-cultural needs.<sup>112</sup> The policy regards the population itself as the nation’s most important resource, but notes that “the effects of population growth on individual welfare are significant and concern developed as well as developing countries.”<sup>113</sup> The policy rests upon a number of principles and assumptions, among which are the following:<sup>114</sup>

- The significant impact of population growth on the development process;
- Respect for the basic right of couples and individuals to decide freely and responsibly the number and spacing of their children;
- The right to education and unbiased information about family planning and contraceptive methods;
- Recognition of the basic right of children to survival, care, education and training;
- Women’s need for equal access to education, public office, and all goods and services, and for equal treatment in all sectors of life.

The Population Policy’s objectives incorporate individual welfare, economic potential, natural resources, and environmental quality. The general objectives include:<sup>115</sup> providing for basic human needs with regard to food and nutrition, health, education and training, employment and housing, information and culture; reducing morbidity and mortality, particularly, maternal and child rates, especially in rural areas; providing for women’s advancement by increasing their productivity, easing their tasks in the home, and eliminating oppressive institutions and cultural practices; promoting responsible parenting;

providing a better geographical distribution of the population within the context of a national development policy; and introducing demographic variables into the analysis of different economic sectors and into the establishment of objectives in these sectors.

The policy’s specific objectives include the following:<sup>116</sup>

- Increasing contraceptive prevalence from 44% to 60% by 2005;
- Reducing the infant mortality rate from 134 per 1,000 to 70 per 1,000 and the overall mortality rate from 17.5 per 1,000 to 14 per 1,000 by 2005;
- Reducing the birth rate by 10% every five years beginning with 2005, and assessing it periodically to adapt it to the nation’s needs with respect for the basic rights of couples and individuals to decide freely and responsibly the number of their children;
- Making population information more widely available, especially to adolescents, by 2005, to enable individuals to become more responsible parents;
- Promoting equal access to education for girls through sensitization campaigns aimed at parents;
- Promoting women’s access to paid work; improving women’s productivity; and easing women’s tasks in the home;
- Undertaking actions to eliminate oppressive social institutions and cultural practices that discriminate against women.

The government organized a workshop in December 1996 to revise the Population Policy by taking into account recent political changes in the country.<sup>117</sup> It also adopted language and incorporated recommendations from international conferences held after the policy’s enactment. Ten-point strategies were developed to implement the following objectives:<sup>118</sup>

- Promoting maternal and infant health;
- Reducing adult morbidity and mortality;
- Disseminating information on activities related to fertility and family planning;
- Fostering education and communication regarding population issues;
- Improving women’s role and status;
- Strengthening education and training;
- Developing measures regarding employment, migration, urbanization, and territorial development;
- Supporting rural development;
- Funding population and development studies and research.

Since February 1983, a national advisory body, the National Population Council (NAPOCO),<sup>119</sup> has been in charge of developing a population policy to meet the realities of Burkina Faso, and setting the terms for the policy's implementation. The NAPOCO is also responsible for coordinating all activities related to population.<sup>120</sup> The implementing organizations of the Population Policy are various ministries, public and private associations, and non-governmental organizations.<sup>121</sup>

## 2. *The Family Planning Policy*

The Public Health Code defines family planning as "all technical, psychosocial, and educational means available to couples and individuals to enable them to: plan their pregnancies; avoid unwanted pregnancies; and space the births of their children. It also addresses sterility problems and contributes to the prevention of sexually transmissible infections, including HIV/AIDS."<sup>122</sup>

In April 1985, the Burkinabe government adopted a national family planning action plan, with the following main objectives:<sup>123</sup>

- Revising the 1920 French law prohibiting incitement to abortion and contraceptive propaganda;
- Integrating family planning services into health care facilities;
- Introducing sexuality education in the schools;
- Helping Burkinabe men, women, and young people understand the connection between population growth and development, and the role that family planning plays in preventing maternal and infant mortality, malnutrition, and clandestine abortions;
- Demonstrating to the Burkinabe how the practice of family planning can help improve their living conditions.

In 1986, the government adopted a family planning policy that repealed the part of the 1920 law regarding contraceptive propaganda. The policy also identified family planning as one of the components of primary health care, as well as a factor in the promotion of family welfare.<sup>124</sup> In addition, in 1992, the Ministry of Health, Social Action and the Family developed a strategy for implementing a national family planning program for the 1993-1998 period.<sup>125</sup> This strategy incorporated three components: family planning services; information, education, and communication (IEC); and institution-building.<sup>126</sup>

With regard to the provision of family planning (FP) services, the main objective was to reduce significantly the number of unwanted or high-risk pregnancies and to meet the unmet need for FP. The government sought to increase contraceptive prevalence from 8% to 15% among women of reproductive age and to increase significantly the use of modern methods.<sup>127</sup> In terms of information, education, and communication (IEC), the key goal was to raise awareness among ben-

eficiaries of FP's role in spacing births.<sup>128</sup> With regard to institution-building, the primary objective was to strengthen the capacity of the national and local health facilities that administer and monitor MCH/FP activities. To do so, it was necessary to provide management tools as well as human, material, and organizational resources. These facilities would thus be equipped to resolve existing management problems and to handle the quantitative expansion of the program.<sup>129</sup>

The government is currently passing in final review a document entitled "Policies and Standards of Maternal and Child Health/Family Planning Services." Developed in 1991 by a national working group, this document will serve as an MCH/FP guide for managers and service providers in all health facilities, both public and private, in Burkina Faso.<sup>130</sup>

## 3. *Government Delivery of Family Planning Services*

The government initiated maternal and infant health and family planning activities (MIH/FP) in 1985.<sup>131</sup> The implementation of various programs made it possible to increase the number and range of services—services offered mainly to women of reproductive age and their children (they slightly affect other groups of potential users, such as adolescents, youth and men).<sup>132</sup> MCH/FP activities focus on IEC, vaccination, prenatal examination, childbirth assistance, child health care up to age five, premarital counseling, and family planning. MCH/FP services are offered primarily at the first level of health services, in the health and social welfare centers (HSWC). The referral agencies (medical centers, medical centers with surgical branches, and regional hospitals) accept cases that surpass the skills of health providers in the peripheral facilities. In practice, health facilities at the various levels offer all types of services. Currently, however, private-sector health care facilities are not closely linked to public facilities, with the exception of private birthing clinics.<sup>133</sup>

In theory, FP services are available in every province, but in reality only 250 of the country's 921 health facilities have actually integrated FP into their activities. Geographic accessibility to FP services is greater in urban than in rural areas.<sup>134</sup> According to the 1993 DHS, 54.5% of married women see the MCH centers as the most accessible facilities for obtaining family planning services. However, these centers are more accessible in Ouagadougou (where 88.9% of women have access), than in the country's other cities (where only 77.4% of women have access).<sup>135</sup> This problem is even more pronounced in rural areas (where only 49% of women have access). For 16.4% of the women in other cities, the nearest service facilities after the MCH centers are public hospitals.<sup>136</sup> For 18% of women in rural areas, public health centers are the most accessible.<sup>137</sup>

Two thirds of the women (64.7%) who use modern contraceptive methods obtain them from the public sector. Slightly more than one-quarter of these women (29.6%) obtain their contraceptives from the MCH; 16.9% from dispensaries or maternity hospitals; and 14.5% from hospitals and medical centers.<sup>138</sup>

#### 4. Services Provided by NGOs and the Private Sector

Because the government is aware that it cannot meet the population's health needs on its own, it has encouraged the growth of private-sector health services, both fee-based and free-of-charge. Current population policy authorizes private organizations to offer family planning services,<sup>139</sup> and the government has recognized several NGOs and private associations as legitimate providers. In particular, these are: the Burkinabe Association for Family Welfare (ABBEF), which supports government efforts and administers two FP clinics; the Association for Family Action (APAF), which offers natural family planning services; and the Burkinabe Association of Midwives (ABSF), which manages two clinics that focus on the promotion of family health (CPFH).

Figures show that 19.3% of women who use modern contraceptive methods obtain them from the private sector.<sup>140</sup> Of these, 9.5% obtain them from a pharmacy; 9.2%, in a family planning clinic; and 0.6% from a doctor or a nurse.<sup>141</sup> For women in rural areas, the remoteness of health services, the scarcity of public transportation, and weak communication resources are all factors that limit access to maternal and infant health and family planning services.<sup>142</sup>

### C. CONTRACEPTION

#### 1. Prevalence

Contraceptive methods in Burkina Faso fall into the two categories: modern (e.g., birth control pills, IUDs, injectables, vaginal methods, condoms, and female and male sterilization); and traditional (e.g., periodic abstinence, withdrawal). According to the 1993 DHS, 66.1% of women are aware of at least one contraceptive method.<sup>143</sup> Among these women, 62.4% are aware of modern methods, and 41.3% know of traditional methods.<sup>144</sup>

Although the total contraceptive prevalence rate in Burkina Faso is estimated at 7.7%, the use of modern methods is estimated at only 4%.<sup>145</sup> At the time of the 1993 DHS, about 2% of women used birth control pills, 9% used condoms, 0.7% used IUDs, 0.3% were sterilized, 0.1% used injectables, and 0.1% used diaphragms.<sup>146</sup> An estimated 3.7% of women used a traditional method.<sup>147</sup> Among these, 3.4% used periodic abstinence.<sup>148</sup> At the time of the survey, 92.3% of Burkinabe women did not have recourse to any method

of contraception.<sup>149</sup> Only 30.2% of women knew where they could obtain any contraceptive device whatsoever.<sup>150</sup> Significantly, these women were more aware of where modern methods were available (28.4%) than traditional methods (11.7%).<sup>151</sup>

#### 2. Legal Status of Contraceptives

Since October 24, 1986, Burkina Faso has had a law to promote family planning<sup>152</sup>—a law that abrogates the part of the 1920 French law prohibiting contraceptive propaganda.<sup>153</sup> In addition, the Public Health Code authorizes the provision of family planning in public and private health facilities that meet the required conditions.<sup>154</sup>

#### 3. Regulation of Medical Technology

The Public Health Code regulates the sale and distribution of pharmaceutical products and traditional pharmacopoeia.<sup>155</sup> The policy on medicines is defined as all the guidelines and provisions pertaining to the sale, distribution and manufacture of drugs.<sup>156</sup> The manufacture and importation of any drug is also subject to regulation.<sup>157</sup>

#### 4. Regulation of Information on Contraception

Since the adoption in 1986 of the Family Planning Policy, “contraceptive propaganda” is no longer illegal. Information about contraception may be censored only with regard to those portions that are deemed offensive to public morality, and in theory this proscription can be interpreted quite broadly. The Penal Code, for example, contains clauses about indecency<sup>158</sup> that define it as “any intentional act contrary to good moral standards, committed publicly, or in a private place accessible to the public view, that is capable of offending the sense of decency and morality of persons who are involuntary witnesses to it.”<sup>159</sup> Similarly, the Information Code prohibits “dissemination of any information, photograph or film that is offensive to decency and good moral standards, through posters, audio-visual means or any other form of mass communication.”<sup>160</sup>

In practice, however, birth control advertisements are quite common and appear on television, radio, billboards and in newspapers. Many are sponsored by the Ministry of Health, the Ministry of Social Welfare, and NGOs. Recently, some groups have objected to the content of some of these commercials, which they consider obscene or immoral (i.e., the demonstration of how to wear a condom). Moreover, while most women approve of family planning and are amenable to using contraceptive devices,<sup>161</sup> their spouses are more reluctant and even hostile to the idea, especially in rural areas.

### D. ABORTION

In accordance with the provisions of the Code of Persons and

the family, life begins at birth and ends with death.<sup>162</sup> Children, therefore, acquire rights at birth so long as they are born alive.<sup>163</sup> Obtaining an abortion, however, is not easy. In principle it is prohibited, with few exceptions.

### 1. Prevalence

Clandestine abortion is a growing public health problem in Burkina Faso, especially among adolescents. Early sexual activity and limited access to information and family planning services result in numerous cases of unwanted pregnancies among adolescent girls.<sup>164</sup> The number of clandestine abortions is difficult to estimate, as health care facilities treat only those cases that have developed complications. According to the 1994 Health Statistics Report, health facilities recorded 7,123 cases of abortion, including 234 clandestine ones.<sup>165</sup> Referral facilities such as medical centers with surgical branches, regional hospital centers, and national hospital centers, also receive cases of abortions with complications.<sup>166</sup>

### 2. Legal Status of Abortion

The Burkinabe Penal Code does not define abortion. It does, however, call for punishment of from one to five years of imprisonment and fines of 300,000 (U.S.\$477.56) to 1,500,000 CFA francs (U.S.\$2,387.81) when: “Whosoever, by food, drink, medicine, violence, or by any other means, procures an abortion of a pregnant woman, whether or not with her consent.”<sup>167</sup> The sentence increases to 10 to 20 years of imprisonment if the abortion results in a woman’s death.<sup>168</sup>

Abortion is prohibited in all cases, irrespective of whether a woman performs the abortion herself or another party assists her. The sentence, however, is more severe for the person who helps a woman to abort than for the woman who resorts to a “voluntary interruption of pregnancy” (VIP). The Penal Code stipulates that: “the voluntary interruption of pregnancy or its attempt is punishable by imprisonment of six months to two years and a fine of 150,000 (U.S.\$238.78) to 600,000 CFA francs (U.S.\$955.13), with the exception of the cases stipulated in the following articles.”<sup>169</sup> One of these articles cites instances when VIP is acceptable: “A pregnancy can be voluntarily interrupted at any time if two doctors, one of whom practices in a public health facility, certify after examinations that continuation of the pregnancy puts the woman’s health in danger or that there is a strong probability that the fetus has a particularly serious affliction that is recognized as incurable at the time of diagnosis.”<sup>170</sup> The same article allows a VIP in case of rape or incest.<sup>171</sup>

Although the Public Health Code bans induced abortion, or VIP, in Article 88, it does allow “therapeutic abortions to be performed in Burkina Faso.”<sup>172</sup> This article, however, is more restrictive than it appears, since it considers therapeutic abortions only those that are “induced to save a [woman’s] life.”<sup>173</sup>

### 3. Requirements for Obtaining a Legal Abortion

As noted above, the Penal Code stipulates that a VIP may be performed at any time “if two doctors, one of whom practices in a public health organization, certify after examinations that continuation of the pregnancy puts the woman’s health in danger, or that there is a strong probability that the fetus has a particularly serious affliction that is recognized as incurable at the time of diagnosis.”<sup>174</sup> In addition, “in cases of rape or incest, which must be recognized as such by a public ministry, a woman may ask a doctor in the first 10 weeks to interrupt her pregnancy.”<sup>175</sup>

As for the Health Code, it requires three doctors’ opinions before a therapeutic abortion is authorized: “The need for a therapeutic abortion must be recorded by the attending physician and confirmed by two other doctors.”<sup>176</sup>

There is no particular center that performs VIP and the law does not require that the procedure be performed in a specific facility. Furthermore, spousal consent is not required for a VIP.

### 4. Policies Related to Abortion

One of the objectives of the national Family Planning Policy is to prevent clandestine abortions. Similarly, the Population Policy, with regard to family planning strategies, cites “numerous cases of clandestine abortions with serious consequences for women’s lives.” It therefore recommends “the implementation of laws regulating the practice of abortion.”<sup>177</sup>

### 5. Penalties for Abortion

Although Burkina Faso’s abortion laws are not liberal, a positive development has occurred through the reclassification of the procedure under the new Penal Code. While the old Penal Code designated abortion a crime, the new code makes it a misdemeanor—that is, an infraction that falls somewhere between a minor offense punishable only by a fine,<sup>178</sup> and a crime that is punishable by a five-year minimum term of imprisonment.<sup>179</sup>

In addition to being subject to prison sentences and fines, health providers who perform illegal abortions risk losing their licenses, and the closing of the facility where the abortion took place.<sup>180</sup> Article 386 of the Penal Code provides that women who obtain abortions are subject to less severe penalties than the practitioners or other third parties involved.

### 6. Regulation of Information on Abortion

“Incitement to abortion” is punishable by law. The Penal Code stipulates a penalty of two months to two years and/or a fine of 50,000 (U.S.\$79.59) to 600,000 CFA francs (U.S.\$955.13) for anyone responsible for publishing any advertisement relating to abortion.<sup>181</sup> Similarly, the Public Health Code prohibits both advertising and provision of all abortifacients,<sup>182</sup> as well as public speaking that in any way promotes

abortion.<sup>183</sup>

## **E. STERILIZATION**

The Public Health Code does not explicitly address sterilization. However, Article 86 of the Code may be interpreted to authorize the practice. It stipulates that “all family planning methods, except for induced abortion or voluntary interruption of pregnancy, that meet the required conditions, are authorized in public or private health facilities.” The use of sterilization as a method of family planning, nevertheless, is uncommon.<sup>184</sup>

## **F. FEMALE CIRCUMCISION/FEMALE GENITAL MUTILATION**

### **1. Prevalence**

Excision is the most common form of female genital mutilation in Burkina Faso. Despite sensitization campaigns, female circumcision continues to be common practice, particularly in rural areas among girls up to seven years of age.<sup>185</sup> Its prevalence varies across region, ethnicity and religious affiliation.<sup>186</sup> Significantly, female circumcision is increasingly practiced on very young babies.

In 1980, the Yalgado Ouédraogo Hospital of Ouagadougou reported that 70% of the women admitted to this hospital had been circumcised.<sup>187</sup> More recent data from the Paul VI Medical Center showed that 90% of the women who gave birth there had been circumcised.<sup>188</sup> The ethnic groups that practice female circumcision most frequently are the Mossi (37.12%), the Senoufo (8.1%), and the Gourmantche (7.88%). Other ethnic groups have a prevalence rate lower than 6%.<sup>189</sup>

### **2. Laws to Prevent FC/FGM**

Burkina Faso is one of the few countries that has adopted laws that explicitly prohibit female circumcision/female genital mutilation (FC/FGM). Before female circumcision was declared a criminal offense, it was prohibited under the category of “assault and battery.”

Under the Penal Code, FC/FGM now constitutes an offense punishable by six months to three years imprisonment and/or a fine of 150,000 (U.S.\$238.78) to 900,000 CFA francs (U.S.\$1,432.69).<sup>190</sup> FC/FGM is defined as “the violation of the physical integrity of the female genital organ, either by total ablation, or by excision, infibulation, desensitization, or any other means.”<sup>191</sup> When the victim dies, the sentences are increased to between five and 10 years imprisonment.<sup>192</sup> The law imposes the maximum sentence if the person who performs the procedure is a licensed health care professional. Depending on the jurisdiction in which the case is tried, perpetrators may be subject to losing their professional licenses for a period not exceeding five years.<sup>193</sup>

Efforts to end the practice of female circumcision have resulted not only in the punishment of perpetrators and accomplices, but also of those who, knowing the procedure is imminent, do not alert the appropriate authorities. The Penal Code stipulates that “any person who is aware of the acts specified in Article 377 and does not alert the appropriate authorities to said acts shall be punished by a fine of 50,000 (U.S.\$79.59) to 100,000 CFA francs (U.S.\$159.19).”<sup>194</sup>

### **3. Policies to Prevent FC/FGM**

Due to growing awareness of the devastating effects of FC/FGM on the health of young girls and women, in 1990 the Burkinabe government established a National Committee to Prevent the Practice of Female Circumcision (CNLPE). The CNLPE is an autonomous agency within the Ministry of Social Welfare and the Family, and comprises a General Assembly, a Permanent Secretariat, and provincial committees. Its main goal is to end the practice in Burkina Faso,<sup>195</sup> and its responsibilities include:<sup>196</sup>

- Coordinating all actions to combat the practice of FC/FGM throughout the country;
- Mobilizing the necessary resources to abolish gradually all types of practices harmful to women’s health;
- Conducting research on these practices;
- Collecting and publishing data related to these practices;
- Providing follow-up and evaluation of its various activities.

The CNLPE has developed a three-year action plan to carry out its objectives. The plan is to be implemented through the following five-point strategy:<sup>197</sup>

- Coordination of information, education, and communication activities at all levels of society;
- Initiation of dialogue between all institutions working to prevent the practice of female circumcision, as well as between the members of the Committee;
- Decentralization of the Committee into provincial committees and identification of resource persons able to support the campaign;
- Generation of research on the practice of FC/FGM;
- Supervision, follow-up, and assessment of the activities carried out.

Studies conducted two years after the implementation of the Action Plan indicate that the public does not yet perceive the seriousness of this practice’s health consequences; as a result, attitudes are slow to change.<sup>198</sup> There is a recurring debate about the most effective strategy against FC/FGM: is it necessary to criminalize the practice, or simply to raise awareness

about it? After years of sensitization, the government has chosen to criminalize it, while continuing awareness campaigns. The press occasionally reports the arrest of persons who perform FC/FGM, as well as victims' parents.<sup>199</sup>

## G. HIV/AIDS AND OTHER STIS

### 1. Prevalence

Sexually transmissible infections (STIs) mainly consist of gonorrhea, syphilis, and chlamydia infections.<sup>200</sup> Left unchecked, their consequences are disastrous. They can cause reproductive tract infections and sterility.<sup>201</sup> In 1994, the national incidence rate for syphilis was 4 out of 10,000.<sup>202</sup> In 1995, the Department of Research and Planning reported 4,201 cases of syphilis and 8,535 cases of gonorrhea.<sup>203</sup>

HIV/AIDS is the emerging epidemic of the last decade.<sup>204</sup> The most frequent method of transmission is heterosexual contact (85% of the cases), followed by blood transfusion and perinatal transmission.<sup>205</sup> The first cases of AIDS in Burkina Faso were recorded in 1986,<sup>206</sup> and by 1997 a UNAIDS report estimated the number of HIV-positive adults at 350,000, or 7.17% of the adult population.<sup>207</sup> Among these, an estimated 170,000 were women.<sup>208</sup> In addition, an estimated 22,000 children were HIV-positive, and the number of orphans due to AIDS was estimated at 49,000.<sup>209</sup> Since the beginning of the 1990s, 270,000 cases of AIDS have been confirmed among adults and children.<sup>210</sup> The HIV prevalence rate in the adult population could reach 10% by this year.<sup>211</sup>

AIDS awareness has increased significantly throughout the country. Overall, more men than women have heard of the disease (94% compared to 84%, respectively).<sup>212</sup> Nevertheless, despite the disease's increasing prevalence, it is very difficult to change sexual behaviors. For example, the rate of condom use still remains low: 43.46% in urban areas and 13.7% in rural areas.<sup>213</sup>

### 2. Laws Related to HIV/AIDS

Burkinabe law does not explicitly address HIV/AIDS. Nevertheless, the Public Health Code makes medical monitoring of prostitutes mandatory. In addition, the Ministry of Health is responsible for both supervising and consciousness-raising among patients infected by acquired immune deficiency virus(es).<sup>214</sup> Finally, the Public Health Code stipulates that family planning programs must include STI/HIV/AIDS prevention.<sup>215</sup>

### 3. Laws Related to other STIs

As with AIDS, Burkinabe law does not explicitly address other sexually transmissible infections. However, the Public Health Code does stipulate that any person afflicted with an STI must be treated until he or she is no longer contagious.<sup>216</sup>

### 4. Programs Related to Prevention and Treatment

### of HIV/AIDS and other STIs

As soon as the government recognized the existence of AIDS in 1986, it established a technical committee at the Ministry of Health to prevent its spread.<sup>217</sup> With the support of the WHO, the committee developed a short-term plan, and thus launched the national AIDS prevention program.

In 1990, the government created a National Committee for AIDS Prevention (CNLS).<sup>218</sup> The CNLS set guidelines for the development of a Medium-Term Plan I and a Medium-Term Plan II. The CNLS was reorganized and revitalized in 1994 and 1995, and is now the national coordinating body for all AIDS prevention activities. The CNLS's functions include:<sup>219</sup> evaluating national STI/AIDS prevention program strategies and defining such strategies; involving all communities in the struggle against the spread of STIs/HIV/AIDS; mobilizing human and financial resources to implement programs; and garnering international support.

The Population and AIDS Prevention Project (PPLS), an STI/HIV/AIDS prevention program, provides an example of an integrated approach in the context of reproductive health. The PPLS's activities include the following: promoting better practices and changing behavior; conducting qualitative and quantitative research; encouraging interpersonal and mass communication; producing IEC and media materials; and providing miscellaneous support.<sup>220</sup>

Because public-sector social services are weak, several communities have undertaken initiatives to slow the impact of HIV/AIDS—particularly Ouagadougou and Bobo Dioulasso.<sup>221</sup> Community-based associations lend psychological support and material assistance to persons living with HIV/AIDS as well as their families.<sup>222</sup> Some NGOs have projects that set up home visits and offer psychological support for patients with HIV/AIDS,<sup>223</sup> and social workers trained in HIV/AIDS treatment participate in counseling and support programs.<sup>224</sup> The Social Marketing of Condoms Project (PROMACO) is also active in the HIV/AIDS field.

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that affect reproductive rights, but such laws often have a direct impact on women's ability to exercise those rights.

The legal context of family life, women's access to education, and the laws and policies affecting their economic status can contribute to the promotion or the restriction of women's access to reproductive health care and their ability to make voluntary, informed decisions about such care. Laws regarding the age of first marriage can have a significant impact on young women's reproductive health. Furthermore, rape laws and others related to sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health.

### **A. LEGAL GUARANTEES OF GENDER EQUALITY/ NON-DISCRIMINATION**

The Burkina Faso Constitution states that "all Burkinabe are born free and with equal rights. All have an equal right to exercise all their constitutional rights and liberties. Discrimination of any type, in particular that based on race, ethnicity, region, color, gender, language, religion, caste, political opinions, wealth, and birth, is prohibited."<sup>225</sup> In principle, neither men nor women can be deprived of a right (e.g., to work, to own private property) or a freedom (e.g., to travel, of association) based on his/her gender. Moreover, the Penal Code prohibits "any discriminatory behavior...capable of causing divisiveness between people."<sup>226</sup>

### **B. RIGHTS WITHIN MARRIAGE**

#### **1. Marriage Law**

The Constitution stipulates that the family is the basic unit of society and that marriage is based on the free consent of both parties. With regard to marriage, any discrimination based on race, color, religion, ethnicity, caste, social origin, or wealth is prohibited.<sup>227</sup> Marriage is defined as the celebration of a union between a man and a woman, and is regulated by provisions of the Code of Persons and the Family, in force since 1990.<sup>228</sup> The only marriage ceremonies Burkina Faso recognizes are those that take place before a registry official. The Code of Persons and the Family does not recognize "forms of union other than those specified under this Code, especially customary marriages and religious marriages"<sup>229</sup>—prior to its adoption, both civil and customary marriages were recognized.

However, by far the most significant change that the Code of Persons and the Family has instituted is the requirement of consent. The Code stipulates that "without the consent of each prospective spouse at the time of the marriage ceremony, there is no marriage."<sup>230</sup> The legal emphasis on consensual marriage can also be seen in the fact that marriage can be contracted only between men over 20 and women over 17 (unless a civil court grants an age exemption).<sup>231</sup> Thus, forced marriages are prohibited by law.<sup>232</sup> In prohibiting forced and levirate marriages, the law intended to grant women the freedom to mar-

ry, to remarry, or to remain single. It specifically prohibits "forced marriages, particularly customary marriages and those imposed by families, which compel the surviving spouse to marry one of the deceased spouse's relatives."<sup>233</sup> In practice, however, girls and widows are often subject to these customary rules. The Penal Code thus provides that anyone who forces a person into marriage shall be "punished by imprisonment of six months to two years."<sup>234</sup>

The Code of Persons and the Family designates monogamy as the legal form of marriage, even though prospective spouses can choose polygamy. Before the adoption of the Code of Persons and the Family, the nature of any specific marriage, whether monogamous or polygamous, was determined by whether it was recognized under customary or written law. Today, prospective spouses must choose explicitly between monogamy and polygamy, and mutually consent to it. Those who choose polygamy must sign a polygamy declaration before a registry official<sup>235</sup> who must ensure "the free consent of those appearing before him."<sup>236</sup> If the registry official detects dissension between the prospective spouses, or if he believes the consent is coerced, he can refuse to conduct the marriage ceremony. In polygamous unions, the woman maintains the power to oppose her husband's other marriages if she provides evidence that he has abandoned her and her children.<sup>237</sup>

To ensure freedom of choice and the consent of the prospective spouses, bride-price is now prohibited in Burkina Faso.<sup>238</sup> Articles 378 and 379 of the Penal Code subsequently reinforced this prohibition by stipulating sentences of three to six months in prison and/or a 150,000 (U.S.\$238.78) to 900,000 CFA francs (U.S.\$1,432.69) fine for offenders.<sup>239</sup>

#### **2. Divorce and Custody Law**

The two types of divorce in Burkina Faso are no-fault divorce and fault-based divorce. No-fault divorce takes place when spouses jointly petition the court. It can also occur when the spouses only reached an agreement after beginning divorce proceedings. Such an agreement must be recorded before the judge.<sup>240</sup> When the spouses petition for divorce together, they do not have to disclose the grounds for it.<sup>241</sup> However, spouses may not petition for no-fault divorce during the first two years of marriage.<sup>242</sup>

The grounds for fault-based divorces are numerous. They include: adultery; physical and psychological abuse rendering the marriage intolerable; jeopardizing family life or children's safety through egregious misconduct or physical or material neglect of the home; desertion in accordance with Article 14 of the Code of Persons and the Family; *de facto* separation for a period of at least three months; and cases of medically diag-

nosed impotence or infertility.<sup>243</sup>

Divorce terminates financial responsibility between the spouses.<sup>244</sup> A spouse in need, however, can obtain a food allowance not exceeding one quarter of his or her ex-spouse's income.<sup>245</sup> The spouse exclusively at fault, however, is not entitled to these provisions<sup>246</sup> except when refusing it to him/her would be manifestly inequitable.<sup>247</sup> Upon divorce, the court grants custody of children to either of the parents on the basis of the children's best interests.<sup>248</sup> Nevertheless, custody of children younger than seven years of age must be given to the mother, unless specific circumstances make such custody prejudicial to the child.<sup>249</sup> The spouse to whom custody of the children has not been granted must contribute to their support and education in proportion to his or her capacity.<sup>250</sup> The parent who assumes primary responsibility for children over 18 who are unable to provide for their own needs can ask the other parent to contribute to their support and education.<sup>251</sup>

## C. ECONOMIC AND SOCIAL RIGHTS

### 1. Property Rights

The Constitution guarantees the right to own property,<sup>252</sup> and Burkina Faso's law does not make a gender distinction with regard to property ownership. In fact, in 1984 the government adopted an agrarian land reform that granted women equal status to men as property managers and owners.<sup>253</sup> Because of this, women enjoy equal rights with men with regard to property, especially in the urban or semi-urban areas where land titles designate property ownership.

In practice, however, since it is men who generally have financial resources, it is rare for women to own real estate. Moreover, Burkinabe women have only a small possibility of gaining access to the best lands. Instead, they often have a tentative right to use small patches of land that their husbands have granted to them. Furthermore, women's access to agricultural stock and equipment is almost nonexistent due to prohibitive costs.<sup>254</sup>

Customary law unequivocally prohibits women from the right to own property, particularly real estate. In rural areas, land belongs to the family of the man whom the woman marries. This practice virtually eliminates any potential claim to own property. Furthermore, in regard to inheritance, not only does customary law not recognize this right for women, but it regards the woman herself as property that, under the levirate system, can be inherited upon her husband's death. Since the Code of Persons and the Family became law, however, the surviving spouse does enjoy the following inheritance rights:

- One quarter of the estate when the deceased is sur-

vived by children or their descendants;<sup>255</sup>

- One quarter of the estate when, in the absence of descendants, the deceased is survived by one or more relatives specified in Article 734 (father, mother, brothers, or sisters);<sup>256</sup>

- Half the estate when the deceased is not survived by any of the relatives mentioned in the preceding paragraph;<sup>257</sup>

- The full estate, when the deceased is not survived by any relatives who are eligible to inherit.<sup>258</sup>

### 2. Labor Rights

In general, labor law in Burkina Faso is favorable to women. To start with, the Constitution guarantees all Burkinabe workers the right to work.<sup>259</sup> It states: "All workers have an equal right to work. Employment and pay discrimination based on gender, color, social origin, ethnicity, or political opinion is prohibited."<sup>260</sup> Moreover, the government promotes the ongoing improvement of working conditions, and ensures workers' safety.<sup>261</sup> Also, various texts have specific clauses for the protection of women. Article 82 of the Labor Code, for example, stipulates that "a worker cannot be assigned to work that may endanger his/her reproductive capacity or, in the case of a pregnant woman, her health or that of her child."

Employment laws are also fairly progressive in the areas of maternity, child rearing and child labor. All salaried pregnant women are entitled to 14 weeks maternity leave, including six weeks before the presumed delivery date and eight weeks after the birth.<sup>262</sup> In addition, a mother has the right to take a break to nurse her child for a period of up to 15 months after she resumes work.<sup>263</sup> The law also contains a special clause to protect children and adolescents in the workforce by setting the minimum age for any type of employment at 14.<sup>264</sup> In addition, "the labor inspector can call for a medical examination of women and adolescents to ensure that the work to which they are assigned does not exceed their strength."<sup>265</sup> Also significant is the March 19, 1986 *kitti* that regulates family allowances. This text states that a female civil servant whose spouse does not perform any salaried activity is entitled to a family allowance. The same entitlement holds for an unmarried female civil servant who is raising children.

### 3. Access to Credit

Although there are no specific laws governing credit for women, there are numerous initiatives, both public and private, that aim to promote and facilitate their access to credit. One government initiative, co-sponsored by the United Nations Development Fund (UNDP), is the Support Fund for Women's Remunerating Activities (FAARF). In 1994, the FAARF granted loans totaling 130 million CFA francs



(U.S.\$206,943.76) to more than 2,000 individual women and 49 women's groups.

In addition to the FAARE, various people's funds and some NGOs make loans to women, and strive to reduce their economic dependence. Nevertheless, these loans have not yet had a visible effect on reducing women's poverty. In addition, the complexity of the loan applications tends to act as a deterrent, especially for the large majority of women who are illiterate and impoverished. In general, most loans are inaccessible to women. The banks and credit organizations consider them high-risk customers, since they do not have the collateral guarantees that are usually required.<sup>266</sup>

#### 4. Access to Education

In theory, Burkina Faso public policy places a premium on education: the Constitution not only grants every citizen the right to education and training,<sup>267</sup> but also guarantees a fundamental right to learn.<sup>268</sup> It further stipulates that public education must be secular and that private education is allowed.<sup>269</sup> Further documentation of the government's intentions in this area can be found in the Population Policy, which includes as objectives to "develop as soon as possible an integrated plan to eradicate illiteracy, especially among the working population, and to provide equal educational access to women and men;" another of its goals is "to promote girls' equal access to education through an awareness-raising campaign among girls."<sup>270</sup>

Although the government devotes almost 25% of the national budget to the educational sector, improving access to education remains an elusive goal.<sup>271</sup> For example, the school enrollment rate is still quite low—37.7% in 1995–1996<sup>272</sup>—and significant disparities exist between rural and urban areas, as well as between boys and girls. In addition, high school dropout rates are high and relatively few students make the transition from primary to secondary school.<sup>273</sup>

With regard to gender disparities, while female school enrollment is clearly on the rise (a 10.02% increase for girls compared to 8.8% for boys), it represents only 38% of school enrollment for the nation as a whole.<sup>274</sup> Girls are better represented in private schools than in public schools and in urban than rural areas. Further, the educational success rate for girls is low, because they do not benefit from the same learning conditions as boys.<sup>275</sup>

The adult literacy rate remains very low, with progress as slow in this regard as with raising the school enrollment rate. In 1995, the literacy rate overall was about 22.2%, with disparities between men and women, between urban areas and rural areas, and between regions.<sup>276</sup>

The government has taken several steps to address both the low school enrollment rate of girls and the high rate of female

illiteracy. First, it developed a 1994–2000 national action plan for girls' education. The plan aims at a one-third reduction in the discrepancy between the school enrollment rates of boys and girls. Second, the government opened a number of satellite schools, and launched the Basic Education Center Project in December 1995, which is still in its experimental stages. It has also taken the following action: transforming the Girls' Education Service into the Department for the Promotion of Education for Girls; revising school curricula, taking into consideration the special concerns of girls and women; identifying and eliminating sexist stereotypes in school textbooks; and promoting gender awareness among teachers and other education staff.<sup>277</sup>

#### D. RIGHT TO PHYSICAL INTEGRITY

As with the protection of life and security, the Constitution guarantees physical integrity. It stipulates that: "Slavery, enslaving practices, inhuman, cruel, degrading and humiliating treatments, physical or psychological torture, physical abuse, child abuse, and all other forms of human degradation are prohibited and punishable by law."<sup>278</sup>

##### 1. Rape

Rape in Burkinabe law is defined as "any type of sexual penetration that one person commits against another with the use of violence, force, or surprise,"<sup>279</sup> and is punishable by five to 10 years of imprisonment.<sup>280</sup> The sentence is increased to 20 years if: the perpetrator is an older relative of the victim of the rape or attempted rape; the perpetrator is in a position of authority vis-à-vis the victim; the perpetrator has acted with others; the rape or attempted rape victim is especially vulnerable due to pregnancy, disease, disability, or physical or mental deficiency; the rape or attempted rape victim is a minor 15 years old or younger; or the rape is committed using the threat of a weapon.<sup>281</sup>

##### 2. Domestic Violence

No specific legislation relating to violence against women currently exists in Burkina Faso. However, clauses in the Penal Code prohibiting assault and battery are applicable to domestic violence cases.<sup>282</sup>

##### 3. Sexual Harassment

No specific legislation relating to sexual harassment currently exists in Burkina Faso.

## v. Focusing on the Rights of a Special Group: Female Minors and Adolescents

The reproductive health needs of adolescents are often unrecognized or neglected. Because early pregnancy has disastrous consequences for the health of mothers and children, it is important to study the reproductive lives of adolescents between 15 and 19 years old.

The Burkinabe population is very young; 48% of the population is below the age of 15.<sup>283</sup> Moreover, adolescents comprise 16% of all the childbearing Burkinabe women.<sup>284</sup> The 1993 DHS documented this pattern of early childbearing among Burkinabe women: among the 20 to 34 year olds surveyed, one third had their first child before age 18, and 64% had their first child before age 20.<sup>285</sup> Early childbearing is even more prevalent in rural areas where 35% of adolescents bear children at ages 15 to 19, compared to 25% in other cities and 15% in Ouagadougou.<sup>286</sup>

Unwanted pregnancies pose an additional serious problem for young women. A recent study shows that 31.8% of patients hospitalized for complications from an abortion were between 16 and 19 years old, and 28.2% of them were students<sup>287</sup>—further proof that it is crucial to meet this group's reproductive health needs.

#### **A. REPRODUCTIVE HEALTH OF FEMALE MINORS AND ADOLESCENTS**

Because sexual activity begins at a relatively early age in Burkina Faso, the reproductive health of adolescents is an important aspect of the nation's overall health profile.<sup>288</sup> One out of every two 18 year-old women already has one child or is pregnant for the first time, and more than three out of five are already in a sexual relationship.<sup>289</sup> According to the 1993 DHS, by the age of 15, 11% of 20 to 49 year-old women had already had a sexual relationship; 69% of them had done so by the time they reached 18, and almost all the women surveyed (88%) had already had their first sexual relationship by age 20.<sup>290</sup>

Lack of awareness of the risks associated with early sexual activity, and limited access to family planning services result in an increase in the number of adolescent pregnancies. Early pregnancies, in turn, often lead young girls to abandon their studies or to resort to clandestine abortions.<sup>291</sup>

School health services do not cover all adolescent health needs, particularly with regard to reproductive health. Moreover, these services benefit only educated youth—a small fraction of the population. Aside from school health services, there are no national health facilities that specifically target the needs of adolescents. Consequently, they use health facilities designed for the general population. However, NGOs such as the Burkinabe Association for Family Welfare (ABBEF) have initiated projects to educate young people and promote their access to existing services.

A key component of Burkina Faso's reproductive health strategic plan is aimed at adolescent sexual and reproductive health. The broadly stated goals of this component of the plan are: helping young people to better understand their sexuality in order to promote responsible behavior; providing them with needed services; and reducing the number of unwanted pregnancies. To these ends, specific objectives include making appropriate counseling services available to young people, as well as achieving a 25% reduction in early and unwanted adolescent pregnancies.<sup>292</sup>

#### **B. FEMALE CIRCUMCISION/FEMALE GENITAL MUTILATION OF FEMALE MINORS AND ADOLESCENTS**

As described above, the Penal Code designates female circumcision/female genital mutilation (FC/FGM) an offense punishable by imprisonment of six months to three years and/or a fine of 150,000 (U.S.\$238.78) to 900,000 CFA francs (U.S.\$1,432.69).<sup>293</sup> Even though they are the principal victims of these practices, no specific clause in the FC/FGM law addresses adolescents or minors. Female circumcision is usually performed on girls up to seven years old. The most common form of FC/FGM in Burkina Faso is excision of the clitoris, often performed with excision of the *labia minora*: prevalence is estimated at 66.35%, and is more common in rural than urban areas.<sup>294</sup> In 1990, the Burkinabe government established a national committee to combat the practice of female circumcision, with the main objective of eliminating its practice (see the section on FC/FGM).

#### **C. MARRIAGE OF FEMALE MINORS AND ADOLESCENTS**

The age at first marriage or first sexual relationship has a significant effect on a woman's reproductive behavior as well as on her reproductive health and her social status. Generally, marriage of a minor results in early pregnancy. Early pregnancy, in turn, constitutes a significant risk factor in both maternal mortality and school drop-out rate—not to mention a major risk factor for children born to these young mothers. In light of these risks, the Burkinabe legislature has expressly determined a minimum age at first marriage: by law, Burkinabe men must be older than 20 and women older than 17.<sup>295</sup> An exemption may be provided "for a serious reason," but in no case can it be granted to a girl younger than 15 or a boy younger than 18.<sup>296</sup> The law does not recognize marriage between persons who do not meet the age requirements, nor does it recognize other forms of marriage such as customary or religious marriages.<sup>297</sup>

Although forced, customary, or religious marriages have no legal standing, they are still performed, especially in rural areas.

In some regions, girls between the ages of 12 and 13 or even younger are thus subjected to sexual relationships and early pregnancies. The Penal Code stipulates that anyone who forces a minor into marriage shall be punished by imprisonment of one to three years.<sup>298</sup> The maximum sentence is incurred if the victim is a girl younger than 13 years old.<sup>299</sup>

According to the 1993 DHS, the average age at first marriage was 17.5.<sup>300</sup> This age has essentially held steady across all age groups in society: it varies only slightly, between 17.7 for the older generations (45–49 years old) and 17.3 years for younger generations (20–24 years old).<sup>301</sup> The level of education appears to be strongly correlated with age of first sexual relationship: for women without education, the average age is 17.4 years; for women with a secondary education or above, it is 19.3 years.<sup>302</sup>

#### **D. EDUCATION FOR FEMALE MINORS AND ADOLESCENTS**

In Burkina Faso it is common for parents to provide education for their male children while keeping their female children at home. Despite laws prohibiting gender discrimination, parents prefer to send their boys to school, particularly when a household is experiencing financial difficulties.

Consequently, the school enrollment for girls is lower than for boys.<sup>303</sup> In 1995, the enrollment rate of school-aged girls in primary school was 30.4%, compared to 44.7% for boys. The enrollment rate of girls and boys in secondary schools was 14%.<sup>304</sup> Significantly, there are almost no girls in school in certain provinces.<sup>305</sup> For example, in Gnagna, Seno, and Namentenga, the provinces with the lowest level of education, girls represent 5% of the students.<sup>306</sup>

It should be noted, though, that the government has taken several steps to remedy the problem of under-educating girls. It developed a national action plan for the education of girls (1994–2000) to reduce by one-third the discrepancy between the overall education rates of boys and girls (see the section on Access to Education).<sup>307</sup>

#### **E. SEXUALITY EDUCATION FOR FEMALE MINORS AND ADOLESCENTS**

In 1997, the Burkinabe government adopted a National Family-Life Education Policy. One of its general objectives is “to encourage young people to adopt informed behavior through responsible exercise of their sexuality and respect for social codes.”<sup>308</sup> The major objectives of the policy include the following:

- Introducing adults, and especially adolescents, to the concept of responsible childbearing, and helping them better manage their sexuality;
- Creating spaces for dialogue and exchanges of experi-

ence and information among adolescents, and between adolescents and adults;

- Raising adolescent awareness about the physical, physiological, and emotional changes they are experiencing, and adopting positive attitudes about their sexuality;
- Raising adolescent awareness about their rights and responsibilities, and about prevailing social norms;
- Encouraging young people to acquire useful knowledge and skills so that they can share this information with, and raise awareness among, other young people.

To attain these objectives, the government plans to initiate an information, education, and communication campaign, as well as a training program in collaboration with partners and through social mobilization.<sup>309</sup>

The Ministry of Social Welfare and the Family, in collaboration with an advisory body, is responsible for implementing and coordinating the Family-Life Education Policy.<sup>310</sup> Within this context, it has established, at the secondary school level, an introductory program to population education (PE), aimed at giving adolescents better information about sexuality and family life. Since the trial stage has been successfully completed, the Ministry of Social Welfare and the Family is in the process of extending the program to primary and preschool education. The PE program also contains a component that addresses the needs of young people who do not attend school.<sup>311</sup>

#### **F. SEXUAL OFFENSES AGAINST FEMALE MINORS AND ADOLESCENTS**

##### **1. Rape**

Sexual offenses committed against minors are punished more seriously than those committed against adults. Thus, the sentences for rape are doubled when committed against minors who are 15 years or younger. The Penal Code states that: “A sentence of imprisonment of 10 to 20 years shall be imposed if: the perpetrator is an older relative of the rape or attempted rape victim; he or she is a person who has a position of authority vis-à-vis the victim; he or she has acted in concert with others; the rape or attempted rape victim is especially vulnerable due to pregnancy, disease, disability, or physical or mental deficiency, or is a minor 15 years or younger; or the crime is committed under the threat of using a weapon.”<sup>312</sup>

##### **2. Indecency**

The Penal Code defines indecency as “any intentional act contrary to good moral standards, committed publicly, or in a private place accessible to the public view, that is capable of offending the sense of decency and morality of persons who are involuntary witnesses to it.” If the indecent act is commit-

ted in private in the presence of a minor, it is considered an offense of inciting a minor to debauchery.<sup>313</sup> The sentences are increased if the perpetrator is an older relative of the minor, if he or she is a person with authority over him or her, or if he or she has abused the authority of his or her position.<sup>314</sup>

### 3. Kidnapping of Minors

Kidnapping of minors is an offense punishable by law. The Penal Code states that: “Anyone who uses violence, threats or fraud to kidnap a minor or have him/her kidnapped shall be punished by imprisonment of five to 10 years. . . .”<sup>315</sup> This sentence is increased to 10 to 20 years in prison if the minor who is kidnapped or abducted is younger than 13.<sup>316</sup> It is noteworthy, however, that when a female minor who has been kidnapped or abducted marries her kidnapper, the kidnapper can be prosecuted only if the persons authorized to petition for annulment of the marriage do so. In that case, the kidnapper can be sentenced only after the court has granted an annulment.<sup>317</sup>

#### ENDNOTES

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109. 1804 FRENCH CIVIL CODE, still applicable in Burkina Faso, Art. 1382.
110. CIVIL CODE, Art. 1383.
111. Ouagadougou Court of Appeals, 25 March 1994. See comments on this decision in the *Revue burkinabé de droit*, no. 29, 1st. Semester 1996, at 140.
112. POPULATION POLICY, *supra* note 73, at 26.
113. *Id.*, at 25.
114. *Id.*, at 27.
115. *Id.*, at 27-28.
116. *Id.*, at 28-30.
117. MINISTÈRE DE L'ÉCONOMIE ET DES FINANCES, DIRECTION GÉNÉRALE DE L'ÉCONOMIE ET DE LA PLANIFICATION, RAPPORT DE L'ATELIER D'ACTUALISATION DE LA POLITIQUE DE POPULATION AU BURKINA FASO (Ouagadougou, December 1996).
118. POPULATION POLICY, *supra* note 73, at 31-42.
119. Decree no. 83-0104/CSP/PRES/PL creating a National Population Council, modified by Decree no. 85/277/CNR/PRES/PLAN. The NAPOCO was reorganized by Decree no. 93-413/PRES/MFP of 28 December 1993.
120. POPULATION POLICY, *supra* note 73, at 43.
121. *Id.*
122. PUBLIC HEALTH CODE, *supra* note 75, Art. 85.
123. Annual Review of Population Law, Vol. 12, 3, p. 23, (1985), last visit, 18 November 1998, PRIVATE HREF=<http://cyber.law.harvard.edu/population/cgi-bin/dbtcegi.ege> MACROBOTTON HtmlResAnchor <http://cyber.law.harvard.edu/population/cgi-bin/dbtcegi.ege>.
124. Zatu No. AN IV-008/CNR/EF-SN of October 24, 1986, adopting a family planning policy in Burkina Faso [hereinafter, FAMILY PLANNING POLICY].
125. MINISTÈRE DE LA SANTÉ, DE L'ACTION SOCIALE ET DE LA FAMILLE, DIRECTION DE LA SANTÉ DE LA FAMILLE, STRATÉGIE POUR LE DÉVELOPPEMENT DU PROGRAMME DE PLANIFICATION AU BURKINA FASO DURANT LA PÉRIODE 1993 – 1998 (November 1992).
126. *Id.*, at 15.
127. *Id.*, at 16.
128. *Id.*
129. *Id.*
130. *Id.*, at 3.
131. PROGRAMME DE DÉVELOPPEMENT DE L'ENSEIGNEMENT DE LA SANTÉ DE LA REPRODUCTION AU BURKINA FASO (December 1997).
132. MINISTÈRE DE L'ÉCONOMIE, DES FINANCES ET DU PLAN, FONDS DES NATIONS UNIES POUR LA POPULATION, BURKINA FASO: EXAMEN DE PROGRAMME ET DÉVELOPPEMENT DE STRATÉGIES EN MATIÈRE DE POPULATION, at 68 (6 November 1996).
133. *Id.*, at 68.
134. MINISTÈRE DE L'ÉCONOMIE, DES FINANCES ET DU PLAN, BURKINA FASO – EXAMEN DE PROGRAMME DE DÉVELOPPEMENT DE STRATÉGIES EN MATIÈRE DE POPULATION, at 69 (6 November, 1996).
135. 1993 DHS, *supra* note 93, at 191.
136. *Id.*
137. *Id.*
138. *Id.*, at 53.
139. POPULATION POLICY, *supra* note 73, at 43.
140. 1993 DHS, *supra* note 93, at 53.
141. *Id.*, at 53.
142. *Id.*, at 188.
143. *Id.*, at 44.
144. *Id.*
145. *Id.*, at 48.
146. *Id.*
147. *Id.*
148. *Id.*
149. *Id.*
150. *Id.*, at 44.
151. *Id.*
152. FAMILY PLANNING POLICY, *supra* note 124.
153. July 31, 1920 French law prohibiting publicity about contraceptives.
154. PUBLIC HEALTH CODE, Art. 86.
155. *Id.*, Book IV.
156. *Id.*, Art. 207.
157. *Id.*, Art. 208 and the following.
158. PENAL CODE, Art. 410.
159. *Id.*
160. Act No. 56/93/ADP of December 30, 1993 concerning the Burkina Faso Information Code, Art. 89.
161. 1993 DHS, *supra* note 93, at 60.
162. ZATU AN/VII/0013/FR/PRES of November 16, 1989, instituting the Burkina Faso Code of Persons and the Family, Art. 2 [hereinafter, Code of Persons and the Family].
163. *Id.*
164. EXAMEN DE PROGRAMME ET DÉVELOPPEMENT DE STRATÉGIES EN MATIÈRE DE POPULATION, *supra* note 134, at 71.
165. *Id.*
166. *Id.*
167. PENAL CODE, Art. 383, ¶1.
168. *Id.*, Art. 383, ¶2.
169. *Id.*, Art. 386.
170. *Id.*, Art. 387, ¶1.
171. *Id.*, Art. 387, ¶2.
172. PUBLIC HEALTH CODE, *supra* note 75, Art. 93.
173. *Id.* The Public Health Code precedes the Penal Code. Thus, it can be deduced that the Penal Code is applicable when there is a conflict between the two.
174. PENAL CODE, Art. 387.
175. *Id.*, Art. 387. Article 421 of the Penal Code defines incest as “the act of having sexual relations with a person's ancestors or descendants without limitation on the degree or with a full or half brother or sister on either the father's or the mother's side.”
176. PUBLIC HEALTH CODE, *supra* note 75, Art. 93.
177. POPULATION POLICY, *supra* note 73, at 34.
178. PENAL CODE, Art. 12.
179. *Id.*, Art. 22.
180. *Id.*, Arts. 383 and 389.
181. *Id.*, Art. 388.
182. PUBLIC HEALTH CODE, *supra* note 75, Art. 89.
183. *Id.*
184. 0.3% according to 1993 DHS, *supra* note 93, at 48.
185. MARIAM LAMIZANA, COMITÉ NATIONAL DE LUTTE CONTRE LA PRATIQUE DE L'EXCISION, LUTTE CONTRE LA PRATIQUE DE L'EXCISION: L'EXPÉRIENCE DU BURKINA FASO, at 3 (December 1998).
186. *Id.*
187. CELLULE DE LA RECHERCHE EN SANTÉ DE LA REPRODUCTION (CRESAR) ET POPULATION COUNCIL, REVUE DOCUMENTAIRE ANALYTIQUE SUR LA SANTÉ DE LA REPRODUCTION AU BURKINA FASO, a study conducted by A. Nougara and Y. Yaro (June 1996).
188. *Id.*
189. LUTTE CONTRE LA PRATIQUE DE L'EXCISION: L'EXPÉRIENCE DU BURKINA FASO, *supra* note 185, at 3.
190. PENAL CODE, Art. 380.

191. *Id.*
192. *Id.*
193. *Id.*, Art. 381.
194. *Id.*, Art. 382.
195. LUTTE CONTRE LA PRATIQUE DE L'EXCISION: L'EXPÉRIENCE DU BURKINA FASO, *supra* note 185, at 4.
196. *Id.*
197. *Id.*, at 5.
198. EXAMEN DE PROGRAMME ET DÉVELOPPEMENT DE STRATÉGIES EN MATIÈRE DE POPULATION, *supra* note 134, at 71.
199. See especially the national daily 'l'Observateur paalga' no. 4731 of September 4 and 6, 1998, at 4.
200. EXAMEN DE PROGRAMME ET DÉVELOPPEMENT DE STRATÉGIES EN MATIÈRE DE POPULATION, *supra* note 134, at 70.
201. *Id.*
202. PROGRAMME DE DÉVELOPPEMENT DE L'ENSEIGNEMENT DE LA SANTÉ REPRODUCTIVE AU BURKINA FASO (December 1997).
203. COMITÉ NATIONAL DE LUTTE CONTRE LE SIDA, ONUSIDA, LA LUTTE CONTRE LE VIH/SIDA ET LES MST AU BURKINA FASO, at 8 (November 1997).
204. TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX: SANTÉ, EAU, ET ASSAINISSEMENT, *supra* note 88, at 9.
205. LA LUTTE CONTRE LE VIH/SIDA ET LES MST AU BURKINA FASO, *supra* note 203, at 5.
206. 1993 DHS, *supra* note 93, at 169.
207. UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC, at 64 (June 1998).
208. *Id.*
209. *Id.*
210. *Id.*, at 67.
211. LA LUTTE CONTRE LE VIH/SIDA ET LES MST AU BURKINA FASO, *supra* note 203, at 5.
212. 1993 DHS, *supra* note 93, at 169.
213. LA LUTTE CONTRE LE VIH/SIDA ET LES MST AU BURKINA FASO, *supra* note 203, at 41.
214. PUBLIC HEALTH CODE, *supra* note 75, Arts. 73 and 74.
215. *Id.*, Art. 85.
216. *Id.*, Art. 72.
217. LA LUTTE CONTRE LE VIH/SIDA ET LES MST AU BURKINA FASO, *supra* note 203, at 12.
218. *Id.*
219. *Id.*
220. *Id.*, at 32.
221. *Id.*, at 53.
222. *Id.*
223. *Id.*
224. *Id.*
225. BURKINA FASO CONST., TITLE I, Chapter I, Art. 1.
226. PENAL CODE, Art. 132.
227. BURKINA FASO CONST., TITLE I, Chapter IV, Art. 23.
228. CODE OF PERSONS AND THE FAMILY, TITLE II, Art. 237.
229. *Id.*, TITLE I, Art. 233.
230. *Id.*, TITLE II, Chapter I, Art. 240.
231. *Id.*, TITLE II, Chapter I, Art. 238.
232. *Id.*, TITLE I, Art. 234.
233. *Id.*
234. PENAL CODE, Art. 376.
235. CODE OF PERSONS AND THE FAMILY, TITLE II, Chapter I, Art. 258.
236. *Id.*, TITLE II, Chapter I, Art. 259.
237. *Id.*, TITLE II, Chapter I, Art. 272.
238. *Id.*, TITLE II, Chapter I, Art. 244.
239. PENAL CODE, Arts. 378 and 379.
240. *Id.*, TITLE IV, Chapter I, Art. 355.
241. *Id.*
242. *Id.*, TITLE IV, Chapter I, Art. 358.
243. *Id.*, TITLE IV, Chapter I, Art. 367.
244. *Id.*, TITLE IV, Chapter I, Art. 399.
245. *Id.*
246. *Id.*, TITLE IV, Chapter II, Art. 400.
247. *Id.*
248. *Id.*, TITLE IV, Chapter II, Art. 402.
249. *Id.*
250. *Id.*, TITLE IV, Chapter II, Art. 406.
251. *Id.*, TITLE IV, Chapter II, Art. 407.
252. BURKINA FASO CONST., TITLE I, Chapter III, Art. 15.
253. Act no. 014/96/ADP concerning agrarian and land reform in Burkina Faso (ALR). The ALR was adopted in 1984, revisited in 1991, and updated in 1996.
254. MINISTÈRE DE LA PROMOTION DE LA FEMME, PLAN D'ACTION 1998 – 2000, at 8 (April 1998).
255. CODE OF PERSONS AND THE FAMILY, TITLE IX, Chapter III, Section V, Art. 742.
256. *Id.*, TITLE IX, Chapter III, Section V, Art. 743, ¶1.
257. *Id.*, TITLE IX, Chapter III, Section V, Art. 743, ¶2.
258. *Id.*, TITLE IX, Chapter III, Section V, Art. 744.
259. BURKINA FASO CONST., TITLE I, Chapter IV, Art. 18.
260. *Id.*, TITLE I, Chapter IV, Art. 19.
261. *Id.*, TITLE I, Chapter IV, Art. 20.
262. Act No. 11-92/ADPV of December 22, 1992 concerning the Labor Code, Art. 84; Zatu No. AN VI-008/FP/TRAV of October 26, 1988 concerning the General Civil Service Statute, Art. 112.
263. LABOR CODE, Art. 85, General Civil Service Statute, Art. 117.
264. *Id.*, Art. 87.
265. *Id.*, Art. 88.
266. PLAN D'ACTION 1998 – 2000, *supra* note 254, at 9.
267. BURKINA FASO CONST., TITLE I, Chapter IV, Art. 18.
268. *Id.*, TITLE I, Chapter IV, Art. 27.
269. *Id.*
270. POPULATION POLICY, *supra* note 73, at 30.
271. UNICEF, ANALYSE DE LA SITUATION DES FEMMES AND ENFANTS AU BURKINA FASO, at 69 (November 1994).
272. MINISTÈRE DE L'ÉCONOMIE ET DES FINANCES, TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX – ÉDUCATION, at 7 (April 1999).
273. *Id.*
274. *Id.*, at 69.
275. *Id.*
276. TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX – POPULATION ET DÉVELOPPEMENT DURABLE, *supra* note 13, at 8.
277. PLAN D'ACTION, 1998 – 2000, *supra* note 254, at 11.
278. BURKINA FASO CONST., TITLE I, Chapter I, Art. 2.
279. PENAL CODE, Art. 417, ¶ 1.
280. *Id.*, Art. 417, ¶ 2.
281. *Id.*, Art. 417, ¶ 3.
282. *Id.*, Art. 327 to 332.
283. POPULATION REFERENCE BUREAU, 1997 WORLD POPULATION DATA SHEET (1997).
284. 1993 DHS, *supra* note 93, at 38.
285. *Id.*, at 37.
286. *Id.*, at 39.
287. Study conducted by F. Ramdè, Yalgado Ouédraogo National Hospital Center, Maternity Section, in Ouagadougou.
288. TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX – POPULATION ET DÉVELOPPEMENT DURABLE, *supra* note 13, at 7.
289. *Id.*, at 5.
290. 1993 DHS, *supra* note 93, at 68.
291. TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX – POPULATION ET DÉVELOPPEMENT DURABLE, *supra* note 13, at 8.
292. PLAN STRATÉGIQUE DE LA SANTÉ DE LA REPRODUCTION DU BURKINA FASO, *supra* note 18, at 37.
293. PENAL CODE, Art. 380.
294. LUTTE CONTRE LA PRATIQUE DE L'EXCISION: L'EXPÉRIENCE DU BURKINA FASO, *supra* note 185, at 3.
295. CODE OF PERSONS AND THE FAMILY, TITLE II, Chapter I, Art. 238, ¶1.
296. *Id.*, ¶2.
297. *Id.*, TITLE I, Art. 233.
298. PENAL CODE, Art. 376.
299. *Id.*
300. 1993 DHS, *supra* note 93, at 67.
301. *Id.*

302. *Id.*, at 68.

303. ANALYSE DE LA SITUATION DES FEMMES ET DES ENFANTS AU BURKINA FASO, *supra* note 271, at 69.

304. THE STATE OF WORLD POPULATION, *supra* note 12, at 67.

305. ANALYSE DE LA SITUATION DES FEMMES ET DES ENFANTS AU BURKINA FASO, *supra* note 271, at 69.

306. *Id.*

307. PLAN D'ACTION, 1998 – 2000, *supra* note 254, at 11.

308. MINISTÈRE DE L'ACTION SOCIALE ET DE LA FAMILLE, POLITIQUE NATIONALE D'ÉDUCATION À LA VIE FAMILIALE DU BURKINA FASO, at 31 (February 1997).

309. *Id.*, at 33 to 35.

310. *Id.*, at 37.

311. TABLE RONDE DES BAILLEURS DE FONDS POUR LE DÉVELOPPEMENT DES SECTEURS SOCIAUX – SANTÉ, EAU ET ASSAINISSEMENT, *supra* note 88, at 10.

312. PENAL CODE, Art. 417, ¶3.

313. *Id.*, Art. 410.

314. *Id.*, Art. 410 *et seq.*

315. *Id.*, Art. 398.

316. *Id.*, Art. 399.

317. *Id.*, Art. 402.