



© 2003 Center for Reproductive Rights

www.reproductiverights.org

formerly the Center for Reproductive Law and Policy

9. Regional Trends in Reproductive Rights

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

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

I. Setting the Stage: The Legal and Political Framework

The seven French-speaking countries selected for this report share a common history in that they were all French colonies for more than a century and a half (Cameroon was initially a German protectorate before it was partitioned into two entities, administered by the British and the French). Up until the 19th century, these countries were part of empires or kingdoms that annexed all or part of their present-day territory; based on territorial wars, the boundaries of these empires shifted at different stages to include parts of Mali and Senegal; Burkina Faso, Côte d'Ivoire and Mali; Benin and Burkina Faso; and Cameroon and Chad. This explains the many similarities in their social, cultural and religious practices, as well as their laws.

Although all obtained their independence in 1960, their political development took different directions. In fact, three of the countries (Cameroon, Côte d'Ivoire and Senegal) have always been politically stable, while the other four (Benin, Burkina Faso, Chad and Mali) have undergone coups d'état and military regimes. Benin, Burkina Faso and Mali have

experimented with socialism, while Cameroon, Chad, Côte d'Ivoire and Senegal have always maintained a liberal system. Until the 1970s, all of these countries had a single-party system. It was not until 1974 that the first multiparty democracy was established in Senegal.

In 1990, during the Conference of Francophone countries held in La Baule, France, French President Mitterrand linked aid from France to greater progress toward democracy in the former colonies. That policy shift coincided with the emergence of national civil societies that demanded greater democratization of politics, recognition of opposition parties, and more open elections. These demands, reinforced by the pressure from France, resulted in national reconciliation conferences (in Benin, Chad and Mali) and increased democratic participation.

However, due to the slow emergence of democratic processes, the politics in these countries are still characterized by problems of governance. For example, in all the countries except Benin and Mali, elections do not provide a means by which the population can truly elect the party of its choice. Corruption and anti-democratic behavior, inherited from the days of single-party politics, persist. In the majority of these countries, the state is weakened by civil conflict, and by political and social instability (e.g., disputes and strikes)—factors that also significantly hamper economic and social development.

The socio-economic environment in all these countries is marked by a deepening crisis, characterized both by the impoverishment of their citizens, particularly women, and by increased inequality, particularly between men and women. According to UNICEF's West and Central Africa Division, 40% of the region's population lives below the poverty line. The region is also characterized by ongoing military conflict, either within the countries (Chad, Mali and Senegal) or on their borders (Cameroon and Côte d'Ivoire).

A. THE STRUCTURE OF NATIONAL GOVERNMENTS

The region's colonial heritage is evident in the fact that French is still an official language in all seven of the countries; it can also be seen in the governments' structure and in the legal systems. In each of the countries, the constitution is the fundamental law, and establishes three branches: executive, legislative, and judicial.

1. Executive Branch

Executive power is vested in the President of the Republic, who is the head of state, guardian of the constitution, commander-in-chief of the armed forces, and who sets the policy agenda. In all the countries, the Executive Branch, whether it is occupied by the military or not, is extremely powerful.

2. Legislative Branch

In Benin, Côte d'Ivoire and Mali, the legislature is made up of a unicameral body called the National Assembly. Its members, who are called "députés" [members of parliament], are elected by universal suffrage and by popular vote. The National Assembly passes laws, which the President of the Republic must enact within eight to 15 days. In the other countries, the legislature is bicameral, with both a National Assembly (in Burkina Faso, the People's Assembly) and a Senate (in Burkina Faso, the Chamber of Representatives). The Senate, which represents regional or local governments, is elected indirectly by the people.

In Chad, Mali and Senegal, when the National Assembly disagrees with the cabinet's program or policy agenda, it may challenge the cabinet by passing a vote of censure that results in the cabinet's resignation. However, this chain of events seldom, if ever, occurs.

3. Judicial Branch

In each of the seven countries featured in this report, the judicial branch is independent of the other branches. Judicial power is vested in the Constitutional Council, the Supreme Court, the Courts of Appeals, the lower courts and their divisions. There are also other regulatory and watchdog agencies with an advisory role: the High Court of Justice; the Magistrature Council; the Economic and Social Council; and the High Communication Council.

B. THE ROLE OF WOMEN IN GOVERNMENT

Although in all seven countries women's participation in political parties predates independence, women's access to political power is a relatively recent phenomenon. Two of the most important catalysts to women's political access were the International Women's Year (1975) and the United Nations Decade for Women (1975-1985). These UN-sponsored international events led to the creation of national mechanisms

to promote the advancement of women, including ministries, secretariats, or departments, both within government and in the civil service. In most cases, these offices are run by women.

Although there is female representation in all of the governments, women are most often confined to areas of the family, social affairs, health, culture, tourism, and the like. Thus, women's representation in government most often takes the form of ministerial posts that are lacking in prestige and budgetary resources, and are therefore highly dependent on funding from international donors.

C. SOURCES OF LAW

1. International Sources of Law

All seven countries have signed the following international and regional instruments: the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Convention on the Rights of the Child; and the African Charter on Human and People's Rights. Although in theory in all seven countries international agreements are recognized as having precedence over domestic law, in practice this is rarely the case.

2. Domestic Sources of Law

In all seven countries, the constitution is the supreme law of the land, setting forth fundamental human rights and civil liberties. In Côte d'Ivoire, however, rights are less explicitly stated than in other nations as its constitution, in the preamble, makes a general reference to international human rights documents. In the other countries, specific rights such as those to life, physical integrity, and equality before the law without regard to gender, origin, race, or religion, are stated explicitly in the body of their constitutions. For example, Article 17 of the Chadian Constitution stipulates that: "The human person is sacred and inviolable. Every individual has a right to life, bodily integrity, security, liberty, and protection of his or her privacy and property."

The dichotomy between statutory law and custom in Francophone Africa is also worth noting. Each country's constitution establishes statutory law as the principle source of law. French law is the model for national statutory laws, except in Cameroon, which in addition draws upon the English legal tradition. Only the Constitution of Chad makes an explicit reference to custom in Articles 161 to 163, which provide that customary law is only applicable when the parties are willing to be bound by it. Moreover, in case of a conflict between statutory law and customary law, the former will supercede the latter. The other countries seem to deny the existence of custom and make no reference to it in their constitutions. Still, although

only residual in some places, such as in Senegal, custom sometimes assumes a central place. Thus, in Cameroon there are still customary tribunals that mediate disputes to which parties agree to submit. In Mali, although the customary courts were abolished at the time of independence, it should be noted that a dispute related to an inheritance has never been settled without the magistrate turning to the party's customary rules for assistance. In Benin, too, the *Coutumier du Dahomey* is still widely used. This absence of explicit statutory reference to custom is disturbing to the extent that custom often governs areas that are important for women's rights, such as marriage, divorce, child custody and inheritances.

With the exception of the Burkina Faso Constitution, which protects maternal and child welfare in Article 18, the constitutions do not appear to explicitly highlight reproductive rights. However, other rights that may directly or indirectly affect women's reproductive rights are guaranteed. For example, the right to bodily integrity, recognized by all the countries (e.g., in Article 15 of Benin's Constitution and Article 1 of Mali's), may make it possible to combat female genital mutilation. Some of the countries recognize the right to the welfare of the person; this implies freedom of choice that is fundamental for women as far as reproduction is concerned (e.g., Chad's Constitution, Article 19; Benin's Constitution, Article 18). The right to education is also recognized, as in the preamble to Cameroon's Constitution. Finally, it should be noted that Senegal cites marriage and the family in a paragraph specifically focused on these issues (Articles 14 and 15).

II. Examining Reproductive Health and Rights

The concept of reproductive health and rights was introduced in 1994 during the International Conference on Population and Development (ICPD). It is essentially a way of conceptualizing holistically the various issues related to human reproduction. The ICPD definition of reproductive health and rights incorporates gains from the other international conferences and human rights conventions, particularly in the area of women's rights. It emphasizes women's life cycle, health and sexuality, and the rights associated with these. Furthermore, it brings into focus a previously neglected group—men—who have a significant effect on the status of women's health. The majority of the countries participating in the ICPD adopted the concept of reproductive health and rights as a main strategy in conceptualizing their national population policies and programs.

As signatories to the ICPD Plan of Action, some of the countries featured in this report—Benin, Burkina Faso, and Senegal—have developed reproductive health policies or programs. However, while nations such as Burkina Faso, Côte d'Ivoire and Senegal have passed laws prohibiting female genital mutilation, for example, policy and program development is generally proving to be much more advanced than legislative action. Still, international donors that provide the technical and financial support for programs, in conjunction with the domestic NGOs that implement these programs, are exerting increasing pressure on the governments to adopt policies that further the goals of international agreements.

We should note also that each country, while in principle supporting the ICPD Plan of Action, has identified its own set of priorities with regard to reproductive health. In all seven countries, the main concern is to reduce maternal and child mortality, a policy that often leads to focusing on women of childbearing age (15 to 49) at the expense of adolescents, older women, and men. In general, adolescents still have insufficient access to reproductive health services. A consequence of this is a significant number of unwanted pregnancies and clandestine induced abortions. Early age of first marriage is the norm in all seven countries, and early pregnancies, which are an important risk factor in maternal mortality, are common. Reproductive health programs also continue to neglect sexual and mental health and gynecological cancers, as well as the reproductive health needs of men.

A. HEALTH LAWS AND POLICIES

In the featured countries, the public sector is the main provider of health care. Ministries of Health are generally responsible for formulating health policy, overseeing and evaluating the performance of health programs, and mobilizing the financial and technical resources necessary to implement these programs. The Ministries are divided into health and technical divisions. The divisions are responsible for:

- Operating and overseeing medical facilities (hospitals, health care centers and clinics);
- Managing public health;
- Controlling the major endemic diseases;
- Ensuring maternal and child welfare;
- Administrating school and university health programs;
- Regulating and overseeing pharmaceutical services;
- Organizing and overseeing private and occupational medicine.

With the support of the Ministry of National Education, the Ministries of Health contribute to the training of medical

and paramedical professionals. In addition, the United Nations and bilateral donor agencies, as well as national and international NGOs, help to develop, finance, and implement national health programs.

Since the mid-1980s, however, two phenomena have affected public access to health care, one negative and the other positive. On the one hand, structural adjustment policies (SAPs), in conjunction with the economic crisis faced by the countries of sub-Saharan Africa, have contributed to the reduction of government provision of social services, and health care services in particular. These two processes have led to a dramatic decline in allocations for social service budgets, including the budgets of the Ministries of Health. The result is cutbacks in both the recruitment of personnel and the purchase of drugs. In all seven countries, medical facilities and equipment are suffering from a lack of regular maintenance, and health care providers are under- or irregularly paid. The result is the deterioration of the quality of the entire health care system. SAPs have also contributed to the privatization of services, which, in turn, diminishes public access.

On the other hand, a second trend is having a more positive effect on public access to health care services. This is the plan to implement health care services for all by the year 2000, with a commitment from governments to provide accessible, low-cost health care to the entire population. This strategy aims to replace the hierarchical health care model inherited from the colonial period with a new system emphasizing decentralization of health care at the community level. The new policy also seeks to make the provision of a minimum health care package available at primary health care centers. It promotes the use of essential drugs, as well as increased access and greater participation of the population in managing the health system. Under the new plan, certain financial decisions are made at the local level and communities are more involved in operating health centers. For example, communities contribute to financing health care by collecting very modest user fees. Special provisions, however, are made for the most destitute who are unable to pay.

1. Objectives of the Health Policy

The overall objective of health policies in all seven countries is the promotion and protection of the population's health and welfare by providing access to quality primary health care. Increased access will result from improved health coverage and managed health services. In the specific area of reproductive health, the objectives are:

- Reducing maternal and child morbidity and mortality by providing prenatal care, assisted childbirth, and postpartum follow-up;

- Reducing clandestine induced abortions and increasing contraceptive prevalence;
- Controlling sexually transmissible infections and curbing the spread of HIV/AIDS;
- Reducing child malnutrition.

In four of the countries—Benin, Burkina Faso, Mali and Senegal—the governments are striving to bring their approach into line with the ICPD consensus definition of reproductive health. To do so, they have developed sub-programs dealing with: the psychosocial aspects of health (Senegal); preventing violence against women; promoting responsible sexual behavior in men; confronting the health problems of the elderly; offering gynecological cancer screening programs; and promoting post-abortion care, sexuality information and counseling. In general, however, the objectives do not incorporate sufficiently the needs of adolescents, men, or disabled persons, nor do they address the need for access to safe abortion. If these aspects of reproductive health are not included in reproductive health policy objectives, it is unlikely that governments will incorporate them into programs or allocate funding to implement them.

2. Infrastructure of Health Services

Health care infrastructures are organized hierarchically within the overall context of primary health care. Patients in need of care begin at the village or community level and, if their needs are not met, are referred to services offered at the next level up—regional or district level, and finally to urban centers. The underlying goal is to decentralize the provision of health care. At the base of the health pyramid are the community facilities (e.g., health huts, rural health and maternity clinics), which dispense primary health care. Community facilities offer a minimum package of services that include: prevention and control of priority diseases; prenatal and postnatal care; family planning; assisted childbirth; and pediatric care, including prevention of malnutrition. At the intermediate level are the regional or district hospitals. Specialized care and medical/surgical emergencies can be handled at this level. At the upper level are hospitals in the capital that offer more sophisticated care.

In general, health coverage is still poor in all seven countries. Of the countries featured in the report, Cameroon has the highest access to primary health care, with 70% of its population receiving health care coverage. Benin has the lowest rate, with only 18% of its population covered. Mali falls in between these two extremes, with access to primary health care for 30% of its population. In 1995, the public sector in Benin had just one national hospital, four departmental hospital centers, 84 subprefectural health centers, 339 community

centers, and 352 village units. In Cameroon, in 1995, hospital capacity was only 29,124 beds for a population of nearly 14 million. In Chad, there is one Central Referral Hospital located in the capital and 14 prefectural hospitals. However, only four of the prefectural hospitals meet the required standards. There are 51 health districts, but only 30 of them have functioning hospitals. Finally, there are 642 health zones, but only 407 of them have functioning health centers. Moreover, there is insufficient medical personnel in relation to the needs of the population. For example, in Côte d'Ivoire, in 1995, the doctor/patient ratio was one per 9,500. In Mali, there is one doctor for every 15,785 inhabitants, and in Chad, there is only one doctor for every 36,000 inhabitants.

In addition to insufficient medical infrastructures and personnel, other reasons for poor access to health care throughout the seven countries are: the concentration of health facilities and personnel in the capital, rendering them remote from rural populations; noncompliance with the health pyramid, wherein individuals go directly to facilities of last resort, resulting in congestion at the top; the high cost of transportation; unfriendliness on the part of health personnel; relatively long waits; inadequate information/reception facilities; and the high cost of services.

3. Private Sector

Private sector health facilities may include for-profit, not-for-profit, religious, traditional and unregistered, sometimes illegal, types of organizations. Together they provide a range of health services in urban and rural areas.

The for-profit private sector comprises hospitals, medical and dental offices, clinics, pharmacies and infirmaries. The non-profit private sector includes: hospitals and health clinics, often run by Catholic missions; dispensaries; infirmaries; workplace health services; and social services.

In 1996, the private sector in Benin had 417 doctors, eight pharmacists, 223 midwives, 73 laboratory technicians, 1,268 auxiliary health care providers, 83 social workers, and 462 others (including traditional health care providers). In 1993, the private sector in Côte d'Ivoire had 219 doctors, 364 pharmacists and 69 dentists. In 1994, the private sector in Senegal had 353 doctors, including 270 general practitioners. There were also 13 pediatricians, 126 specialists, and 98 primary health care providers.

4. Cost of Health Services

Although the public sector is the main health care provider in all seven countries, government allocations to health ministries are relatively small. In light of structural adjustment policies, however, modest health budgets should not be seen as an indicator of governments' commitment to providing ade-

quate health coverage for the population. Rather, it should be viewed as a sign of government compliance with austerity guidelines and conditions imposed by international lending agencies.

In general, all seven countries have recorded shrinking health budgets, and none of them conform to the World Health Organization's (WHO) standards. These standards were set at the 1995 Social Development Conference in Copenhagen and call upon governments to allocate 10% of their budgets to the social sector. For example, in Benin, in 1996, the health budget constituted 5.9% of the national budget. In Burkina Faso, the government devotes approximately 7% of its budget to the health sector. In Côte d'Ivoire, the health sector budget represented 8% of the national budget. In Mali, the proportion of the national budget devoted to the health sector was 6.2%, and in Chad, it was 5.8%.

Public funding generally pays for personnel and the maintenance of infrastructure. Community financing through cost recovery at public health facilities is used to supply essential drugs and to contribute to the operation of community health centers. Community financing represents an important portion of public resources for health care, totaling 7% in Benin and between 8 and 9% in Senegal. In Chad, it is estimated that community financing represents 20% of the national health budget.

Until the 1980s, before the adoption of structural adjustment policies, health care was provided to the public free of charge. This benefit, along with health insurance policy for workers, was part of the French colonial heritage. Today, government subsidies are inadequate to provide free services, and public facilities must charge service fees. Employers pay for health care for civil servants and private sector workers. Civil servants and their families (wives and children) contribute to their own health care costs by paying into a national health insurance fund. The proportion they pay is specified by the provisions of the government workers' statutes. The fund covers approximately 75% of civil servants' medical costs, while the servants pay the additional 25% out-of-pocket. For workers in the private sector, health care is paid for by the employers and the employees themselves. The proportion is specified in the work contracts that both parties sign.

Health care costs vary depending on the category of patient. For example, persons who can prove they are indigent may be treated free of charge. However, other than these three categories—civil servants, private sector workers and the indigent—the rest of the population has no social security. African women, who generally are less likely to work in the formal sector, have even less of a chance than others of having health insurance of any sort. The average cost of a medical vis-

it is approximately U.S.\$1 and the cost of assisted childbirth is U.S.\$10. In Côte d'Ivoire, childbirth in a public hospital costs approximately U.S.\$7 and a prenatal visit is U.S.\$19. However, in rural areas, costs are much more affordable. Childbirth in a maternity clinic costs U.S.\$4 and a prenatal visit U.S.\$1.

In order to limit costs and comply with WHO recommendations, public health facilities generally prescribe generic drugs. However, one consequence of the devaluation of the CFA franc has been an increase in the price of pharmaceutical products, most of which are imported. This has led a large portion of the population to turn away from modern health services and toward traditional medicine.

5. Regulation of Health Care Providers

In all seven countries, there are strict regulations governing the medical profession in order to ensure that ethical standards are met. In some countries, such as Burkina Faso, Cameroon and Mali, the practice of traditional medicine is also subject to regulation. In each country, physicians, dentists, pharmacists, midwives and nurses must possess a state diploma or its officially recognized equivalent in order to practice. It is also necessary to be affiliated with the appropriate professional association and to be of good character. Service providers in the same profession are grouped together in a professional association with a specific status. Thus, physicians, dentists and pharmacists each have their own professional orders. Similarly, midwives, nurses and laboratory technicians also have professional associations.

In some countries, it is necessary for health care providers to be citizens of the country in order to practice. Thus, in Benin, it is necessary for doctors, pharmacists, midwives and dentists to be citizens. In Cameroon, it is necessary for doctors, pharmacists and dentists to be citizens of the country. In Mali, all health care providers must be citizens; on the other hand, in Côte d'Ivoire, only pharmacists and nurses must be citizens. Doctors and dentists can practice their profession if they are citizens of the country, if they hold a degree recognized by Côte d'Ivoire, or if they hold a degree from a country that has entered into a reciprocity agreement with Côte d'Ivoire.

In all cases, affiliation with a professional order is required in order to practice these professions. These orders uphold professional standards of morality, integrity and dedication considered essential to the practice of medicine, dentistry and pharmacy. All members of professional orders must comply with a Code of Ethics that specifies appropriate moral and professional behavior and ensures the integrity and autonomy of the profession. In some countries, such as Côte d'Ivoire, the professional orders are decentralized at the departmental level. The private practice of medical professions is authorized;

nonetheless, private practitioners are still required to register with the professional orders and to comply with their rules.

In each country, the Penal Code prohibits the practice of medicine, pharmacy, midwifery, or nursing without the proper diplomas and professional affiliation. Violators are subject to a fine or to one to three months in prison, which may be increased in the event of a repeat offense. In any event, a judge also may decide to confiscate the equipment used in any illegal practice and temporarily or permanently close the establishment. Misrepresentation to any of the professional orders is considered forgery and punishable by a fine and/or imprisonment. In the event of a violation of the Code of Ethics, the accused practitioners are brought before the disciplinary chamber of the appropriate order.

Some countries regulate the practice of traditional medicine. For example, in Cameroon, regulations exist with regard to the facilities in which traditional practitioners work, the remedies they administer, and their liability. In Mali, the conditions for opening a private practice for traditional care, an herbalist shop, or an improved traditional drug production unit, are set by decree. In Burkina Faso, traditional medicine has been officially defined and its practice is recognized. According to the official definition, traditional medicine is the body of accumulated knowledge and practices, whether logical or not, used to diagnose, prevent or eradicate a physical, mental, emotional or social imbalance. This knowledge is based solely on personal experience handed down from generation to generation, either orally or in writing. Someone who practices traditional medicine is called a traditional healer; healers must be recognized by the community in which they live as competent to dispense health care.

Chad does not regulate the practice of traditional medicine. Nevertheless, a research facility for traditional health care practices was created within the Health Department of the University of N'Djamena called "The Pharmacopoeia and Traditional Medicine Research and Study Unit." This research facility is affiliated with the Central African traditional medicine and pharmacopoeia network.

6. Patients' Rights

Patients' rights include: to be greeted in a friendly manner; to have access to appropriate services; to quality care; to receive accurate information; to freedom of choice; to privacy; to confidentiality; and to dignity. In all seven countries, legislation regarding patient's rights is relatively weak; indeed, no country has specific legislation in this regard. Even in the absence of specific laws, however, different legal instruments exist that can protect patients. For example, in some cases, their rights may be protected under constitutional law. Thus, Article 8 of Benin's

Constitution proclaims the individual to be “inviolable and sacred” and requires the government to respect and protect the individual and to ensure that all citizens have equal access to health care. In Burkina Faso, Article 2 of the Constitution guarantees life, security and bodily integrity. In addition, Article 26 stipulates that “the right to health care is recognized, [and] the government works to promote it.”

Different ethical codes can also be the source of patients’ rights. Thus, for example, in Côte d’Ivoire, Chapter II of the Codes of Ethics for Doctors and Dental Surgeons describes their obligations to patients. In Mali, Article 2 of the Medical Code of Ethics stipulates that respect for human life in all circumstances is the medical practitioner’s first obligation. Pursuant to Article 3 of the same code, he or she must provide care to all his or her patients with the same conscientiousness without discrimination. According to Article 4, he or she is prohibited from exercising professional responsibilities under conditions that might compromise the quality of medical care and treatment. Finally, Article 7 requires professional confidentiality of all medical practitioners unless the law provides for a dispensation.

The medical order may also sanction a physician found guilty of committing any wrongdoing recognized as sufficiently serious to cause loss of affiliation and suspension of his or her medical license. For example, in Cameroon, the association boards designate a disciplinary committee that acts as a first jurisdiction in cases of professional misconduct. The disciplinary committee may invoke one of the following sanctions: a warning, a reprimand, suspension of activities for three months to one year depending on the seriousness of the misconduct, or expulsion from the association.

In addition, patients’ rights may also be protected under provisions of the Penal Code. For example, in Côte d’Ivoire, the Penal Code states that a patient who is injured as a result of a medical procedure may lodge a complaint and recover judgment if “the care that was provided was not in conformity with scientific data, medical ethics and accepted practice.” When the Penal Code does not provide specific measures for holding a health care provider liable, the more general provisions regarding criminal liability—including accidental homicide and injury—may be used to bring suit against a doctor, a dentist, a pharmacist, or a nurse. In Mali, the Penal Code stipulates that “someone who, through clumsiness, carelessness, neglect, negligence, or failure to comply with regulations, involuntarily strikes, injures or causes the illness of another, is subject to...” imprisonment and/or a fine. The code also stipulates that, “whoever intentionally treats a person without intent to kill, or engages in practices or procedures, even with the patient’s consent, that cause or might have caused an illness

or inability to work, shall be punished by...” a prison term and may be subject to a fine. If an illness, permanent disability or death result, the sentence shall be increased and local banishment may be ordered.

Civil liability is difficult to pursue, and there are severe limitations in the texts guaranteeing patients’ rights. For example, there is a provision stipulating that a medical professional is subject to civil liability only when there is proof of wrongdoing. This presupposes not only that a patient has indeed been injured, but also that he or she will be able to establish to the satisfaction of the civil court the causal relationship between the medical care and the injury. For the average African patient, especially if he or she is poor, illiterate and without the means to hire an attorney, providing sufficient proof of medical wrongdoing and standing up to the litany of expert opinions and counter-opinions during a legal procedure can be an undertaking of insurmountable odds. Consequently, those who commit injurious medical wrongdoing often go unpunished; the victims are either so mistrustful of the system, or pessimistic about the prospects for a successful outcome, that they refuse to lodge a complaint with the courts. This reluctance explains the fact that there are virtually no malpractice litigation disputes in any of the countries featured in the report.

In short, both the weakness of sanctions and the unlikelihood of victims collecting damages in civil suits serve as strong deterrents to initiating legal action. Thus, we find in Burkina Faso a case of a laboratory technician’s blatant negligence when he refused to administer blood necessary for a transfusion with the excuse that he did not have a “voucher” signed by the doctor to do so. The patient died as a result. The technician incurred a sentence of only two months of imprisonment and 4,000,000 CFA francs (US.\$6,367.50) in damages to the victim’s family. Although he was initially charged with involuntary manslaughter, the Ouagadougou Court of Appeal reduced the charge to merely “lack of assistance to a person in danger.”

B. POPULATION AND FAMILY PLANNING

1. Population and Family Planning Policy

Economic, health and demographic trends, as well as pressures from international donor agencies, led all seven countries to adopt a Population Policy: Senegal in 1988, Mali and Burkina Faso in 1991, Cameroon in 1992, Chad in 1994, Benin in 1996, and Côte d’Ivoire in 1997. The policy’s general objective is to improve the standard of living and quality of life for everyone. The emphasis of the policies, however, varies depending on the country. They promote either responsible fertility (Benin, Burkina Faso, Cameroon and Côte d’Ivoire), to provide a better balance between human resources and development efforts (Chad), or the reduction of both fertility

and population growth rates (Mali and Senegal).

More specifically, the countries featured in this report have included the following objectives in their population policy: providing for the basic needs of the population with regard to health, education, food, nutrition and housing (Burkina Faso, Côte d'Ivoire); reducing mortality, particularly maternal and child mortality (Burkina Faso, Chad); increasing the contraceptive prevalence rate (Benin, Burkina Faso); preserving the environment and improving living conditions (Cameroon, Côte d'Ivoire); controlling internal and cross-border migration (Benin, Côte d'Ivoire); and implementing a territorial development policy that enables a better geographical distribution of the population (Benin, Chad). Generally, all of the policies include programs to promote the advancement of women that aim at improving their social status, but also—in the case of Burkina Faso—at reinforcing their rights within the family and society.

With regard specifically to reproductive health, the Population Policies are still relatively traditional in both focus and scope. In fact, for decades, all population programs have focused on mothers and children. Objectives have included reducing maternal and child mortality, increasing access to education, and even promoting the advancement of women, through access to income-generating activities and reduction of household tasks.

In Burkina Faso, Côte d'Ivoire and Senegal, the main strategies for achieving population objectives are: promoting maternal and child health; reviewing and developing regulatory provisions; geographically redistributing the population; regulating fertility by increasing access to family planning information and services; and improving the role and status of women. Mali also has included strategies targeting traditional practices that have harmful effects on the health of girls, such as female genital mutilation. The strategies also focus on developing and supporting traditional medicine, as well as conducting a census of the entire population, ideally every ten years. Senegal has been developing strategies aimed at promoting the welfare of young people and of the elderly, as well as conducting research on population issues. Côte d'Ivoire advocates cutting off all benefits after a maximum of four children and restoring “family values.” Burkina Faso and Senegal have introduced education on demographic issues into schools. All of the countries encourage sensitizing the population through information, education and communication (IEC) activities.

In all seven countries, population and family planning programs are administered through a decentralized bureaucracy at the level of the prefectures or regions. This bureaucracy is in charge of coordinating and monitoring population activities,

under the authority of the Ministry of Planning. This ministry, in turn, is responsible for overseeing the integration of national population policy elements within the broader development policy. The population bureaucracy includes all of the Ministries involved in implementing the population policy (i.e., Economy, Finance, Health, Women, National Education, Interior, Youth and Sports, and Agriculture). In Burkina Faso and Côte d'Ivoire this bureaucracy has only an advisory capacity.

It should be noted that two of the countries, Burkina Faso and Senegal, have adopted a Family Planning Policy. In 1986, Burkina Faso adopted a Family Planning Policy that identified family planning as one of the components of primary health care, as well as a factor in the promotion of family welfare. The Family Planning Policy adopted by Senegal in 1996 pledges to provide contraceptive services, HIV/AIDS/STI services, and IEC services. In addition, the government has designed and published a national reference guide entitled “Norms and Standards for the Provision of Family Planning Services in Senegal.”

2. Government Delivery of Family Planning Services

In their Population Policies, the governments have affirmed their desire to promote family planning by incorporating it into existing public health services. Governments have been developing national family planning programs that are coordinated, implemented and monitored by specific bureaucracies reporting to the Ministry of Public Health (Benin, Burkina Faso, Chad, Mali and Senegal) or the Ministry of the Family (Côte d'Ivoire).

In order not to offend the sensibilities of their deeply pro-natalist populations, the governments distanced themselves from the concept of fertility regulation by emphasizing birth spacing, a practice that is well known and observed throughout sub-Saharan Africa. The official purpose of family planning programs is therefore family welfare, not birth control. Although the goal is certainly to offer means of birth control, governments also seek to make a range of services available to individuals and couples in the areas of obstetrics and gynecology, maternal and child health, prevention and treatment of sexually transmissible infections, and prevention and treatment of infertility and sterility.

Burkina Faso adopted a National Plan of Action in the area of Family Planning in May 1986. In Cameroon, Family Planning Centers have opened in some urban areas, particularly in Maternal and Child Welfare Centers in the major cities. In Côte d'Ivoire, the Ministry of Public Health has incorporated a family planning component into services offered in 35 public health facilities. It is also developing a National Family Plan-

ning Program. Senegal adopted its Family Planning Policy in 1996. This policy is implemented through a National Family Planning Program, which contains three components: a Child Survival and Family Planning Project, a project that supports the National Family Planning Program, and a project that supports the Maternal and Child Health Program. Mali also has a National Family Planning Program. Its National Public Health Directorate is responsible for developing, implementing and coordinating it.

The integration of family planning into all public health or maternal and child health programs demonstrates a political will on the part of governments to promote family planning. The services offered include gynecological examinations, distribution of contraceptives and IEC programs. Burkina Faso, Mali and Senegal were the first to incorporate family planning into existing public health facilities. It is also in these countries that services are best integrated and contraceptives are most regularly available and accessible. For example, in Senegal, 92% of family planning points of service are located in public sector facilities.

In Mali, family planning has been integrated into maternal and child health services since 1978, when the government adopted its primary health care strategy. The same applies in Côte d'Ivoire and in Cameroon, where family planning services are available, especially in the cities of Yaoundé and Douala. In Chad, the integration of family planning into basic health facilities and hospitals is one of the objectives of the "Safe Motherhood" project. In Benin, where family planning only recently has been introduced officially, there are family planning services at the Maternal and Child Welfare Center in Cotonou, in public health centers, and in state medical and nursing schools.

All seven countries have made special efforts to meet the needs of rural populations. For example, since 1991, in an effort to extend family planning coverage, Mali developed a community-based contraceptive distribution program using village-level welfare workers to supply contraceptives. In Cameroon, a Social Marketing Program promotes and supplies condoms. In addition, some of the countries have recently shown a concern for providing quality services and respecting clients' rights. Senegal, for example, has developed family planning service standards and protocols.

3. Services Provided by NGOs and the Private Sector

In the 1970s and 1980s, when family planning services were rarely offered at public health facilities, they were offered at private NGO clinics, most often under the auspices of the International Planned Parenthood Federation (IPPF). In order not to offend the sensibilities of the populations and the govern-

ments, both of which had strong reservations about family planning at that time, NGOs opted for the concept of family welfare, which they incorporated into their names. Thus, in Burkina Faso, the association took the name of Burkinabe Association for Family Welfare (ABBWF); in Benin, the Beninese Association for Family Welfare (ABPF); in Côte d'Ivoire, Ivorian Association for Family Welfare (AIBF); in Senegal, Senegalese Association for Family Welfare (ASBEF); and in Chad, Chadian Association for Family Welfare (ASTBEF).

In some of the featured countries (Benin, Chad and Côte d'Ivoire), family welfare NGOs still play a pioneering role in the delivery of family planning services. They now enjoy official recognition and a privileged relationship with government and international donors, providing services in their own clinics, which are often decentralized at the regional, prefectural or provincial levels. In all seven countries, these NGOs are often the main channels for distributing and popularizing contraceptive methods. They have made a significant contribution both to the removal of legal barriers, such as the French Law of July 1920, which prohibits incitement to abortion and to contraceptive propaganda, and to the development of national population policies. To achieve their objective of contributing to the improvement of maternal and child health, they promote not only birth spacing and contraceptives, but also offer gynecological examinations. They provide IEC activities, including Family Life Education. Although they serve the general population, many of these NGOs also make special efforts to serve women and adolescents. They seek both to raise awareness about preventing unwanted pregnancies through the use of contraception, and to educate the public about sexually transmissible infections, including HIV/AIDS and the causes and treatment of infertility and sterility.

Recently, NGOs essentially operating in major public and private national companies have begun to emerge that offer services to a previously neglected group: men. Senegal, for example, has seen an increase in these types of organizations. Other non-profit NGOs also offer contraceptive services, such as private Catholic health facilities and organizations that emphasize natural family planning methods. Finally, the for-profit private sector also offers family planning services. Their services, however, are generally expensive.

C. CONTRACEPTION

1. Types of Contraceptives Available and Rates of Prevalence

In all seven countries, modern contraception, consisting of hormonal contraceptives and barrier methods, are available. Traditional methods (e.g., periodic abstinence, withdrawal), as

well as “folk” methods (e.g., talismans, herbs, and roots) are also prevalent. As far as hormonal methods are concerned, the birth control pill, injectables and implants (Norplant®) are available. The most common barrier methods are spermicides, foams and gels, condoms and intrauterine devices (IUDs). Sterilization, through tubal ligation for women and vasectomy for men, is also available. Significantly, however, all of the countries are experiencing severe shortages, and even a total lack of certain methods—a situation that considerably limits the choices available to users.

Although knowledge about modern contraceptives is relatively high throughout the region, their use is still limited. Despite a slightly increasing trend toward greater use, the contraceptive prevalence rate continues to be very low, especially when compared to Northern and Asian countries. For example, in Burkina Faso, only 7.7% of women practice family planning and, of those, 4% use modern contraception. In Chad, 3.9% of women use contraception and, of those, 1.2% use modern methods. In Mali, 8% of women use family planning and, of those, 5% use modern methods.

2. Cost of Family Planning Methods and Services

In most of the featured countries, contraceptives are not considered to be essential drugs. However, since international donors, especially USAID, supply contraceptives to the countries free of charge, their cost is modest. The cost of examinations prior to selecting a contraceptive method is also generally low. Furthermore, the cost of family planning services in both public facilities and the private not-for-profit sector are becoming standardized in each country. In Mali, for example, the cost of an examination is set at 100 CFA francs (U.S.\$0.16). In Senegal, it is 150 CFA francs (U.S.\$0.50).

The cost of contraceptives varies significantly. In Senegal, a packet of pills costs 135 CFA francs (U.S.\$0.22), an IUD 485 CFA francs (U.S.\$0.77), the injectable contraceptive 330 CFA francs (U.S.\$0.53), a condom 60 CFA francs (U.S.\$0.10) and a spermicide tablet 30 CFA francs (U.S.\$0.05). In Benin, the Norplant® costs 600 CFA francs (U.S.\$0.96), the injectable contraceptive 500 CFA francs (U.S.\$ 0.80), and an IUD 400 CFA francs (U.S.\$0.64).

The local affiliates of international organizations contribute to supplying the domestic market with contraceptive products. The main partners of the Ministries of Health and the Family Welfare Associations are the United Nations Population Fund (UNFPA), the International Planned Parenthood Federation (IPPF) and the United States Agency for International Development (USAID). The World Bank also contributes to financing the supply of contraceptive products.

However, despite the efforts of public authorities and the

support of international donors, both of whom are deeply committed to the development of family planning programs, there are still significant obstacles. Local populations are generally not well informed about family planning and about where to obtain services. Access to family planning is also limited by a lack of sufficiently trained service providers, limited availability and range of methods, and lack of interventions aimed specifically at men and adolescents. In addition, there is still a strong desire for large families in African societies, as well as continued resistance to modern family planning methods from the Catholic and Muslim religions.

In contrast to condoms and spermicides, governments consider hormonal contraceptives to be drugs and they are available only by prescription. Moreover, women's and adolescents' access to hormonal contraception is restricted by the fact that service providers often require the consent of the husband, parents, or guardians (for minors). This requirement is in flagrant violation of both national regulations governing access to family planning, and government-endorsed international commitments that recognize access to contraception as an individual right.

3. Legal Status of Contraceptives

Governments' desire to liberalize their policies on contraception is evidenced in existing laws, as well as in their endorsement of the ICPD Plan of Action and the Population Policies. With the exception of Benin, all the countries have abolished the part of the 1920 French Law restricting the sale and advertising of contraceptives. Burkina Faso and Senegal have adopted a family planning policy (see Section on Population and Family Planning Policies). Burkina Faso's Public Health Code also authorizes all family planning techniques and methods, with the exception of induced abortion, at public and private health facilities that meet the requisite conditions.

In Benin, following the Symposium on Eliminating Legal Barriers to Sexual and Reproductive Health in French-speaking Africa, held in March 1997, the Ministry of Health, Social Welfare and the Status of Women proposed legislation to repeal the 1920 Law. The National Assembly must now review this draft bill.

Although in theory no contraceptive methods are prohibited, some countries impose certain purchase requirements that serve to dissuade potential buyers. For example, Chad heavily regulates the sale and distribution of contraceptives through Ordinance No. 008/PR/93, which stipulates that married women seek the advice of their spouse before they are allowed access to contraceptives; minors must have parental consent. Further, only authorized pharmaceutical companies

are permitted to import reversible contraceptives, and their sale is allowed only in public and private establishments specifically authorized to do so. Offenders are subject to imprisonment and fines. Côte d'Ivoire also heavily regulates all technologies and equipment used for contraception and abortion.

4. Regulation of Information on Contraception

Some of the countries featured in this report have penal provisions, which can contribute to restricting the flow of information on contraception. For example, in Cameroon, Law No. 90/035 relative to the profession of pharmacist prohibits contraceptive propaganda. In Burkina Faso, the Penal Code contains clauses about indecency that define it as "any act or intention contrary to good moral standards, carried out publicly or in a private place accessible to public scrutiny, likely to offend the sense of propriety of persons who are the involuntary witness thereto." Similarly, the Information Code prohibits any publication or dissemination of obscene material via notices, audiovisual media, or film. In Benin, in theory, the 1920 Law proscribes contraceptive advertising. Persons who breach the law are subject to criminal punishment. In practice, however, the law is not enforced and the government permits advertising about contraceptive methods. Although this type of law does not exist in Senegal, the chapter on Public Health and Hygiene in the Code of Minor Offenses contains an article that punishes those who display or cause the display of indecent notices or images on public highways or in public places.

In the other countries, information about contraception through advertising is unrestricted. Governments and family planning advocates use the media to disseminate information about family planning and various contraceptive methods. In efforts to curb the spread of HIV/AIDS, certain countries (Côte d'Ivoire) have approved television advertising of condoms. In Mali, a 1972 ordinance authorized contraceptive advertising, and the government actively encourages certain types of information about contraception. In Chad, Article 17 of Order No. 008/PR/93 states that "birth control methods may be advertised through all information resources: awareness-raising meetings in cities, neighborhoods, and villages; radio and television broadcasts, and films."

D. ABORTION

Some of the featured countries have a legal definition of both induced and spontaneous abortion. For example, Cameroon defines abortion as expulsion of the product of conception before it is viable. In Mali, abortion is defined as an act using specific means or substances in order to induce premature expulsion of the fetus, regardless of when during the pregnancy the expulsion occurs.

All seven countries have retained the section of the 1920 French Law that considers induced abortion a criminal act and authorizes it only under very limited conditions. In Mali, the fetus' right to life is recognized in the Constitution and the Penal Code. The Penal Code, in particular, is very restrictive in this area, and explicitly states that there can be no grounds for abortion: whatever the circumstances and conditions under which the pregnancy occurred, and whatever consequences the pregnancy poses to the woman's health, there is no exception to this prohibition. However, various Codes of Ethics of the health professions, as well as certain sections of the Population Policy that have drawn upon specific stipulations in the Penal Code, provide a basis for liberalizing the law on abortion. Specifically, the Penal Code deems that there is no crime or offense in cases of homicide, violence, assault and battery when if it can be shown that these acts were committed in either self-defense or defense of another. In Burkina Faso, according to the provisions of the Code of Persons and the Family, personhood begins at the live birth of the baby and ends at death. Thus, life begins at birth, and a conceived child only has rights if she is born alive. However, abortion is still not legal, except in certain cases determined by law.

1. Legal Status of Abortion

In all seven countries, the 1920 French Law serves as a basis for prohibiting abortion. Reiterated in the Penal Code, it stipulates, "Whosoever by food, drink, medicine, violence or by any other means, procures or attempts to obtain an abortion for a pregnant woman, whether or not with her consent, will be punished by one to five years in prison, as well as a fine, which varies depending on the country." The punishment is more severe if the procedure results in the woman's death. Members of the medical profession or a related public health profession who either facilitate or provide the means to obtain an abortion are also subject to very severe penalties (imprisonment and fine) and may be prohibited from practicing their profession. When a woman obtains an abortion or attempts to do so, she is subject to imprisonment. The length of the sentence varies depending on the country.

However, some of the countries, such as Benin, Chad and Côte d'Ivoire, authorize therapeutic abortions to save the life of the woman. Burkina Faso, Cameroon and Senegal authorize an abortion to protect a woman whose health (not only her life) is endangered by the pregnancy. Other countries authorize an abortion when the pregnancy is the result of rape (Cameroon) or if it is the result of rape or incest (Burkina Faso). Finally, in certain cases, abortion is permitted if there is a great likelihood of fetal abnormality (Burkina Faso, Senegal).

2. Requirements for Obtaining a Legal Abortion

In circumstances where abortion is permitted, most countries require that certain conditions be met for it to be legally practiced. In Mali, when a pregnant woman's life is endangered, rendering abortion a possibility, the medical practitioner must notify the woman's family, or, when that is not possible, her next of kin. If the woman is a minor or a disabled person, the medical practitioner must obtain the consent of her legal representative. If it is impossible to notify the family in due time, the medical practitioner may perform the required procedure. In Benin, Chad and Côte d'Ivoire, the attending medical practitioner must obtain the opinion of two other doctors certifying that the requisite conditions have been met. In Côte d'Ivoire, if the attending physician is the only one present, he can certify on his honor that the requisite conditions for abortion have been met. In Burkina Faso, while the Penal Code requires the judgment of two doctors, the Medical Ethics Code requires the judgment of three doctors. In Cameroon, the patient's consent alone is required, but the procedure must be performed by a licensed physician in a specially designated facility. In Senegal, only the physician makes the decision about whether or not to perform an abortion.

3. Policies Related to Abortion

In general, reproductive health programs in some countries, such as Senegal, offer post-abortion care following a clandestine abortion. One of the main goals of Mali's Population Policy is to reduce the number of clandestine abortions by introducing family planning programs aimed at managing fertility. These programs consist of promoting the protection of adolescents against early and unwanted pregnancies and developing IEC campaigns. Still, in all seven countries, although abortion may be authorized in exceptional cases, such as preserving the health of woman or in cases of fetal abnormality, it generally remains illegal.

4. Regulation of Information on Abortion

There are strict regulations on information about abortion, in conformity with the 1920 Law. Since all the countries featured in this report consider abortion a crime, advertising it in any form is punishable by law—even if it is ineffective. Incitement to abortion, or encouraging an abortion, is also illegal. In Burkina Faso, Côte d'Ivoire and Senegal, for example, the Penal Code punishes “anyone who promotes abortion by any means” with imprisonment and/or a fine. Furthermore, in Burkina Faso, the Public Health Code prohibits all of the following: displaying in any way or making available abortion remedies, substances, and instruments; or the utterance of speech inciting abortion.

In Chad, the Penal Code sanctions all of the following for promoting or practicing abortion: “doctors, midwives, dental surgeons, and pharmacists, as well as medical students, pharmaceutical students or employees, herbalists, truss manufacturers, surgical instruments merchants, nurses or masseurs.” In addition, the Code calls for suspending for a minimum of five years those found guilty of such crimes, along with a ban on practicing their professions.

In Cameroon, Chapter 4 of Act 80/10 of July 14, 1980 upholds the 1920 Law's prohibition on promotion of abortion, either through the sale or distribution of abortifacient materials or through dissemination of information on abortion. In Côte d'Ivoire, the Public Health Code authorizes pharmacists to display or sell remedies and substances, intrauterine probes, or other similar objects capable of inducing an abortion, upon delivery of a medical prescription that is recorded in a register filed with and initialed by the mayor or police commissioner.

E. STERILIZATION

In Benin, Burkina Faso and Senegal, there are no specific laws concerning sterilization. Nevertheless, the procedure can be legally performed with the explicit consent of the patient. In addition, the patient must be fully informed about the methods and consequences of the operation.

In Côte d'Ivoire, the Penal Code defines sterilization “as the act of depriving a person of the ability to procreate, by means other than the amputation of an organ required for reproduction.” Article 343 imposes the death penalty on anyone found guilty of performing a sterilization procedure. Other than cases of ectopic pregnancy or abortion that may require tubal ligation and sectioning of one or both tubes, Côte d'Ivoire prohibits sterilization as a contraceptive method under criminal law.

In Cameroon, a physician may perform this procedure only under certain conditions. If he violates these conditions, he is subject to 10 to 20 years of imprisonment. This is because, according to Cameroonian law, “anyone who deprives another of the permanent use of all or part of a limb, organ or sense” is subject to such a penalty. On the other hand, there is no penalty if the procedure is performed by a qualified practitioner, with the consent of the patient or of his or her guardian, or in the case of a patient who is not in a position to consent, with the consent of his or her legal representative.

In Chad, consent must be in writing, except in cases when the woman's life may be jeopardized by a future pregnancy. If she is married, the husband's written consent is required. Chad's law allows three types of persons to be sterilized: women whose lives may be endangered by another pregnan-

cy; women over age 35 who have at least five living children; and men with at least five living children. Sterilization may be performed only in public or private hospitals, or in maternal health clinics with operating rooms.

Since this method is usually irreversible, it is rare for service providers to perform or advise it. In Benin, according to the 1996 DHS, 3.4% of the population uses modern contraceptive methods. Of these modern contraceptive users, 0.3% were sterilized. In Mali, according to the 1995–96 DHS, 5% of the population uses modern contraceptive methods. Of these modern contraceptive users, 0.2% were sterilized. In Senegal, according to the 1997 DHS III, 7% of the population uses modern contraceptive methods. Of these modern contraceptive users, 0.4% were sterilized.

F. FEMALE CIRCUMCISION/FEMALE GENITAL MUTILATION

Female circumcision/female genital mutilation (FC/FGM) is widespread in all seven countries, although it seems to be only a residual practice in certain regions of Cameroon. There are relatively high estimated prevalence rates in most of the countries featured in this report: 94% in Mali; 66.35% in Burkina Faso; 60% in Chad; 43% in Côte d'Ivoire; between 30 and 50% in Benin; and 20% in Senegal.

For decades, FC/FGM has been considered a taboo subject, which explains the reluctance of governments either to define it, to undertake actions to end it, or to legislate in this area. However, governments have begun to respond to pressure from NGOs, women's organizations, and the international community, all of which have called for its eradication at recent international conferences. Some of the countries, such as Burkina Faso, Côte d'Ivoire and Senegal, have adopted legislation criminalizing the practice; other countries, such as Chad, Cameroon and Mali consider the practice harmful to the health of women and children and have included activities in their reproductive health programs aimed at eradicating it.

1. Definition of FC/FGM

The definition adopted in Burkina Faso is relatively similar to the ones in Côte d'Ivoire and Senegal. It defines female genital mutilation as "harming the integrity of the female genital organ by total ablation, excision, infibulation, desensitization, or any other means." In addition, in some of the countries, such as Senegal, FC/FGM is defined as an act of violence against women and girls.

2. Laws to Prevent FC/FGM

There is disagreement over what the most effective strategy would be for promoting change in communities still strongly attached to FC/FGM. Should the practice be crimi-

nalized, or should education and sensitization campaigns be launched to change behavior? Public officials have been confronting this thorny question ever since the debate on the criminalization of FC/FGM began. Although in all seven countries, the constitution guarantees the right to bodily integrity, FC/FGM, which directly violates this right, is often punished only under the heading of "assault and battery or criminal assault." Furthermore, there has always been a lack of political will to punish it under that heading. Only very recently have governments passed laws punishing FC/FGM, first in Burkina Faso, then in Côte d'Ivoire, and finally in Senegal.

In Burkina Faso, FC/FGM is treated as a specific infraction, punishable by six months to three years of imprisonment and/or a fine of 150,000 (U.S.\$238.78) to 900,000 CFA francs (U.S.\$1,432.69). In the event of the victim's death, the penalty is increased to five to 10 years of imprisonment. If the person who performed the mutilation is a member of the medical or paramedical profession, the maximum penalty is given. Furthermore, the authority ruling in the case may suspend the health care provider's license to practice for up to five years. In addition, the Penal Code also punishes persons who know the law, witness the offense, and do not inform the proper authorities, with a fine of 50,000 (U.S.\$79.59) to 100,000 CFA francs (U.S.\$159.19).

In May 1998, Côte d'Ivoire's National Assembly adopted a draft law prohibiting FC/FGM, early marriage, and sexual harassment. The punishment for those who practice excision is one to five years in prison and a fine of 360,000 (U.S.\$573.08) to 2,000,000 CFA francs (U.S.\$3,183.75). The law also punishes those who attempt to perform the procedure. If death results, the punishment is 20 years in prison; if the girl survives, the penalty is one to five years in prison. If the guilty party is a member of the medical profession, he may have his license to practice medicine suspended for up to five years. The Ivorian government has also introduced a draft law targeting the "excisionists" who perform FC/FGM. It has developed a program falling under the Committee to Prevent Practices Harmful to the Health of Women to retrain them for small- and medium-enterprise jobs.

Senegal passed a law on January 13, 1999 regarding intentional assault and battery, other intentional assaults on bodily integrity, and sex crimes. It invokes a penalty of six months to five years of imprisonment and is given to anyone who harms the female genital organ by total or partial ablation, desensitization or infibulation. The maximum penalty applies when a member of the medical or paramedical profession performs or promotes the sexual mutilation. If the procedure has resulted in death, it is punishable by a life sentence of hard labor.

Benin, Cameroon, Chad, and Mali have no specific laws against FC/FGM. However, the constitutional right to bodily integrity, in conjunction with the provisions of the Penal Code regarding assault and battery and criminal assault, provide a basis for combating FC/FGM, depending on the particular case. In Benin, the Ministry of Health has presented a draft law regarding FC/FGM to the National Assembly for review.

Today, addressing the issue of FC/FGM constitutes an important challenge, not only for governments, but also for women's rights advocates. In fact, despite reform efforts, there has been no decrease in the prevalence rate in any of the countries. An additional danger is that even if governments promote policies to eliminate FC/FGM, they may be difficult to enforce and parents may still practice the custom clandestinely.

3. Policies to Prevent FC/FGM

In all seven countries, there are national mechanisms responsible for preventing harmful customs, including FC/FGM. It should be noted, however, that the governments of Benin, Chad, and Cameroon have not developed any applicable policy.

In Burkina Faso, the objective of the Committee to Prevent the Practice of Excision (CNLPE) is to eliminate FC/FGM throughout the country. The CNLPE is under the supervision of the Ministry of Social Action and the Family, but has functional autonomy. Its efforts to prevent FC/FGM include coordinating preventive measures throughout the country, conducting research, gathering and publishing data, and monitoring and evaluating all policies. It also conducts IEC campaigns and is coordinating cooperative efforts among institutions likely to work together for prevention. The CNLPE has a decentralized structure that is made up of provincial committees.

Mali developed a strategy to eliminate FC/FGM in 1997. The strategy consists of a five-year plan of action (1998–2002) that government agencies, NGOs and private sector organizations will implement throughout the country. The objectives are to establish an FC/FGM database, to support the development and implementation of preventive action programs, to establish working relationships with national and international agencies involved in the fight against the practice, and to evaluate the implementation of the plan of action.

In Senegal, the National Reproductive Health Program seeks to reduce the incidence of female genital mutilation by 50% and to reduce various forms of violence against women, adolescents and girls by 50%. The National Action Plan for Women, which is part of Senegal's follow-up to the 1995 Bei-

jing Conference, contains many provisions related to the prevention of FC/FGM and all types of violence against women.

G. HIV/AIDS AND OTHER STIS

1. Prevalence

Sexually transmissible infections are widespread in the region. The most common is gonorrhea. In Burkina Faso, for example, in 1994, the syphilis rate was 4 out of 10,000 for the entire country. In 1995, a study done by the Research and Planning Department showed 4,201 cases of syphilis and 8,535 cases of gonorrhea. In Senegal, in 1996, 7 out of 1,000 women and 10 out of 1,000 men stated they had an outbreak of a sexually transmissible infection during the last 12 months.

With regard to HIV/AIDS, the trend in all seven countries, as on the rest of the continent, is ominous. Making matters worse is that the number of healthy HIV carriers is still unknown. Regarding the seven countries featured in this report, it is in Côte d'Ivoire and Burkina Faso that the pandemic is most alarming. In other countries, the trends are less pessimistic. The disease seems most under control in Mali and in Senegal, however, where the prevalence rate is relatively low.

The first declared AIDS cases appeared in the West African sub-region between 1984 and 1987. Their increase was exponential, as evidenced by the recorded prevalence rates. With 10.06% of the adult population affected, Côte d'Ivoire is in first place among the countries in the sub-region affected by the epidemic, with 41% of the AIDS cases reported in all of West Africa. In Burkina Faso, the prevalence rate is 7.17%, followed by Benin at 2.06%, Senegal at 1.77% and Mali at 1.67%.

The mode of transmission of the disease is relatively well known (sexual transmission is the main route in Africa), as are the means of prevention. Nonetheless, there has been little behavioral change, and condom use is still very limited, especially in rural areas. The segment of the population that is most sexually active, adults and youths, is the most affected.

2. Laws Related to HIV/AIDS and other STIs

The AIDS pandemic raises a number of legal dilemmas, including how to protect both virus carriers and third parties from infection. At present, none of the countries featured in this report have passed specific laws on HIV/AIDS. It may be possible, however, to combine certain provisions of both the Penal and Civil Codes in order to prosecute tortious actions, such as the willful transmission of HIV.

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

Some of the countries have been slow to implement

HIV/AIDS prevention and treatment programs due to a delayed awareness of the seriousness of the epidemiological situation. It was not until 1986 that any of the governments instituted a national AIDS control committee or nationwide prevention programs.

In general, the programs that have been put in place focus on reducing the spread of HIV through prevention, patient management and follow-up, laboratory work, epidemiological monitoring, and operational research. The programs seek to involve communities in controlling the spread of the virus. In addition, they try to mobilize human and financial resources in order to carry out prevention activities.

AIDS prevention programs receive substantial support from international donors. Many NGOs and private associations play an active role in AIDS prevention, with strategies that focus especially on information, education and communication (IEC), as well as visitation and psychological support for patients. Generally, AIDS prevention activities are reinforced by programs that target other sexually transmissible infections, as well as tuberculosis, both of which create conditions that can foster or aggravate the disease.

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

By examining the contrasts between the featured countries' legal status of women and women's actual experiences, we can clearly see the subordinate role to which Francophone African societies relegate women. Since their independence—and even more so since the United Nations Decade for Women (1975–1985)—these governments have indicated through official speeches and policy positions their desire to improve the status of women by integrating them more extensively into the economic and social development process. In addition, all the countries have signed and ratified most of the international legal instruments promoting theoretical equality of all citizens, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child. They have also signed and ratified other legal instruments, such as the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and the African Charter on Human and People's Rights. Some of the countries are in the process of developing initiatives to bring national legislation in line with the international instruments. Furthermore, pressure from both women's associations and the

international community has prompted governments to take other measures, including the creation of ministries to advance women's rights and the implementation of economic and social programs intended to generate revenue for women and lighten their domestic tasks.

Still, by examining the status of women in the seven countries, we can see that these policies have not brought about significant changes in women's social status or economic condition; an imbalance of power continues to characterize women's relationships with men. Certainly in all of the countries, the fundamental law as stated in the constitution proclaims the equality of all citizens, regardless of origin, race, gender or religion. That law, however, like other domestic and international instruments, exists within a societal context where sex discrimination is the norm. Moreover, governments rarely reform existing laws, especially those relating to customs regarding the family. In addition, in countries with significant Muslim populations, such as Chad, Mali and Senegal, Islamic cultural norms are often incorporated into laws governing the family. All of these elements explain women's marginalization in society in terms of having access to knowledge, capital goods, and financial resources.

A. RIGHTS WITHIN MARRIAGE

Marriage is regulated by several types of codes: the Civil Code in Benin, Cameroon and Chad, the Family Code in Senegal, and the Code of Persons and Property in Burkina Faso, Côte d'Ivoire and Mali.

1. Legal Age of First Marriage

Early marriage profoundly affects a woman's life in that it has a direct effect on her reproductive behavior, as well as on her reproductive health and her social status. Generally, early marriage leads to early childbearing. Early pregnancy, in turn constitutes a significant risk factor in both maternal mortality and the school dropout rate. It also represents a major risk factor for the children born to these young mothers.

For women in all seven countries, the legal age at marriage is still very young. The legal age of marriage for women is 15 in Benin, Cameroon and Mali, 16 in Chad and Senegal, 17 in Burkina Faso, and 18 in Côte d'Ivoire. In Benin, there seems to be a contradiction between the Civil Code, which stipulates that a marriage cannot be contracted by a girl younger than 15, and the *Coutumier du Dahomey*, which reduces this age to 14. Similarly, in Chad, there seems to be a contradiction between the Civil Code, which fixes the legal age of first marriage at 16, and the Penal Code, which authorizes customary marriages of much younger girls, as long as the marriage is not consummated before the girls reach 13 years of age. For men, the legal age at marriage is higher: it is 18 years in Benin, Cameroon and

Mali, 19 in Chad, and 20 in Burkina Faso, Côte d'Ivoire, and Senegal.

This minimum age, however, is often disregarded. Thus, in Benin, in rural areas there are reports of arranged marriages imposed on girls of 12 to 15 years and even on newborns, though these marriages are not recognized by law. In Senegal, marriage is proscribed for girls under the age of 16; it often happens, however, that girls younger than 15 are given in marriage to much older men, frequently without their consent. Similarly, in Chad, in practice, the age at the time of customary marriage for girls varies between 10 and 12 years old.

2. Consent to Marriage

In all seven countries, the law requires the consent of both spouses. Forced marriage is prohibited, as is the custom of levirate whereby a man must marry the widow of his brother. There are, however, a number of contradictions between the law and the practice. Thus, in Burkina Faso, even though forced marriages are not legally recognized, they are still being practiced, especially in rural areas. The practice of forced marriages can also be found in Senegal. In Benin, forced marriages are common in certain regions, and among certain ethnic groups, as soon as a little girl reaches the age of seven years, she must leave her family to join her in-laws. In Cameroon, according to certain customs, once a girl reaches puberty, she must leave her father's home to join her husband.

3. Types of Marriages

All of the countries featured in this report, with the exception of Côte d'Ivoire, recognize polygamous marriages. In Côte d'Ivoire, polygamy is criminally punishable by six months to three years of imprisonment and a fine of 50,000 (U.S.\$79.59) to 500,000 CFA francs (U.S.\$795.94). Attempted polygamy is also punishable and a registrar or clergyman who abets such marriage is subject to the same penalties. However, the law does recognize polygamous marriages performed prior to 1964. In the other countries, polygamy is either the norm, and is automatically applicable unless the spouses specify otherwise (e.g., Benin, Cameroon, Chad, Mali and Senegal), or it results from the explicit choice of the spouses, as in Burkina Faso. Benin also recognizes polyandry. It is important to note the negative consequences that can result from these types of marriages, in view of the AIDS pandemic. The practice of polygamy, and indeed of polyandry, can facilitate transmission of the virus to all of the spouses.

In Burkina Faso, Cameroon, Côte d'Ivoire and Mali, the only marriage that is legally recognized is the union of a man and woman performed by a registrar. In Côte d'Ivoire, the law recognizes customary marriages that took place before the Law of 1983 took effect, as long as they are reported to the authorities. Otherwise, customary marriages are considered "com-

mon law" marriages.

Customary marriages are recognized in a number of countries. In Benin, customary marriages are governed by the *Coutumier du Dahomey*. In Senegal, although general and local customs were repealed by Article 830 of the Family Code, exceptions are made for traditional marriage customs. The state officially recognizes traditional marriages that follow animistic and fetishistic customs. Senegal recognizes two types of marriage: those performed by a registrar and "reported" marriages, which occur when the prospective spouses choose to marry in accordance with their custom. Spouses are required to inform the registrar of their plans one month in advance. An unreported marriage is valid, but the spouses may not use it to receive family benefits from the state, local government, or public and private institutions. The spouses have six months in which to appear before the registrar with two witnesses who can certify their exchange of vows. Even a late declaration of marriage will enable the couple to make claims based on the marital relationship. In Chad, there is still no Family Code and a variety of customs are applicable alongside the French Civil Code of 1958.

Religious marriages are also recognized. In Côte d'Ivoire, a civil marriage must take place before a religious ceremony is performed, and no clergyman may perform a religious marriage ceremony if the couple does not present a civil marriage certificate. The same rule applies in Mali; nevertheless, many families disregard the law, and perform exclusively the religious marriage ceremony. This practice leaves the spouses in a vulnerable situation, because the law does not recognize such marriages.

4. Bride-price

The payment of a bride-price, which according to some customs validates marriage, is authorized in some of the countries. This practice is objectionable because it reduces the status of the wife to that of an object that was bought by the husband, who can then dispose of her as he wishes. This is why married women are sometimes considered as part of their husband's property (for example, in Benin).

In Mali and Senegal, the payment of a bride-price is legal and regulated by law. The amount varies depending on whether the bride is a young girl, or a woman who has already been married one or more times. In addition, the husband has the right to claim that amount when there is a subsequent divorce judgment that finds the wife entirely at fault, or even when it finds both spouses at fault. In Chad, where the legislature is partial to custom, bride-price payment is obligatory.

By contrast, the payment of a bride-price has been abolished in Burkina Faso, Cameroon and Côte d'Ivoire. In the lat-

ter, both active and passive forms of bride-price are punishable by six months to two years imprisonment and a fine equal to twice the value of the promised bride-price or the goods received or requested. In Burkina Faso, its payment is punishable under the Penal Code by sentences of three to six months' imprisonment and/or a fine.

5. *Pecuniary Effects of Marriage*

In the countries featured in this report, there are various types of marital property systems. In Chad, even before the marriage is performed, the prospective spouses may choose among three forms of division of property: community property, separate estates, and reduced community property. They must make the choice in a prenuptial agreement drawn up by a notary in the presence of the future spouses. If there is no contract, community property is the default system. However, Order 03/INT/61 of June 21, 1961 stipulates that, if no choice is made, the default system is separate estates, even though the Civil Code specifies the opposite. Consequently, there is a contradiction in Chad's legal system with regard to the pecuniary effects of marriage.

In Senegal, the default system is separate estates, but the couple may choose either community property or a settlement in trust. Property acquired by the wife through practice of a profession separate from that of her husband constitutes reserved property, which, according to the rules of separate estates, she administers and may dispose of under all systems.

In Mali, the spouses choose between community property or separate estates. Spouses who choose community property must write a marriage contract. In polygamous marriages, each wife is considered a household and the husband cannot use one wife's income to the profit of another. However, in practice, this principle is not respected: it is common to find husbands who force their wives to live together under one roof.

6. *Personal Effects of Marriage*

Marriage entails a set of obligations for both spouses. In Benin, for example, spouses mutually pledge fidelity, assistance, and support. Cohabitation is also obligatory. In Côte d'Ivoire, marriage law stipulates that spouses who pledge mutual fidelity, assistance, and support each contribute to household expenses in proportion to his or her abilities.

In all seven countries, the husband is recognized as the head of the family, over which he exercises moral and financial control. In that capacity, he determines where the family will live and has paternal rights over the children. He is principally responsible for the material support of the family. The wife must also participate in maintaining the family. If the husband is not in a position to exercise control due to disability, absence, separation, or any other reason, his wife replaces him as head

of the family. In Cameroon, the husband is also in charge of the couple's community property. He alone administers this property, as well as his wife's personal property.

B. DIVORCE AND CUSTODY LAW

1. *Types of Divorce*

All seven countries prohibit the repudiation of a wife, and any divorce must be granted by the court. Some countries allow no-fault divorce, which takes place when the spouses submit a joint petition to a judge. This is the case in Burkina Faso, Côte d'Ivoire and Senegal. In Burkina Faso and Côte d'Ivoire, spouses may not petition for a no-fault divorce in the first two years of marriage.

In all seven countries, fault-based divorce is recognized. The grounds for divorce vary from one country to the other. In Côte d'Ivoire, the law recognizes the following grounds for divorce: adultery, excessive behavior, physical abuse or insults, conviction for serious wrongdoing bringing loss of honor and pride to the family, and abandonment of the family or household. To be admissible as grounds for divorce, these actions must make it intolerable to maintain the marital bond or life together. Adultery is grounds for divorce, and is punishable by two months to one year of imprisonment. However, while a wife found guilty of committing adultery is punished along with her partner in adultery, a husband is punished for the same crime only if the act is committed in the marriage bed or he has ongoing sexual relations with a woman other than his wife outside of the marriage bed. Moreover, the man's partner in adultery is not punished.

Cameroon only recognizes fault-based divorces. The spouse who submits the petition for divorce must prove that the other committed wrongdoing—either in the form of adultery, a criminal conviction, excessive behavior, physical abuse or insults. This wrongdoing must constitute a serious or repeated violation of marital duties or obligations, and render the continued marital relationship intolerable. There are also customary grounds for divorce that may be invoked before traditional jurisdictions. Such cases are left to the discretion of the judge. In the court proceedings, the rules of the Civil Code are applicable to all of the parties; however, the rules of custom apply only when all parties to the suit give their consent. They do not apply if one of the parties refuses to be judged according to traditional rules.

In Senegal, the Family Code recognizes the same grounds for divorce as Cameroon, but adds sterility, serious and incurable illness diagnosed during the marriage, and incompatibility. In Burkina Faso, medically proven impotence or sterility constitute additional grounds for divorce. In Mali, in addition to the grounds cited above, wives have the right to ask for a

divorce when their husbands refuse to pay the bride-price by the deadline agreed upon at the time of the marriage.

In Benin, the grounds for divorce differ for men and women. Men may ask for divorce on the basis of adultery or sterility, while women may ask for it on the basis of mistreatment (on the condition this exceeds mistreatment normally allowed by custom), impotence, failure to support the household, or sexual relations with the sister-in-law. Both may ask for divorce based on incurable illness (e.g., leprosy), attempted murder, abandonment, or insanity.

2. Effects of Divorce

i. Effects on Spouses

Divorce terminates the obligation of mutual support among spouses. Concerning alimony, in Senegal, the obligation to provide support exists only if the person who is claiming the support can prove vital need based on income or if the sued person has sufficient resources to provide the support. In Burkina Faso, a spouse in need can obtain a food allowance not exceeding one quarter of his or her former spouse's income. The spouse exclusively at fault, however, is not entitled to these provisions, except when refusing it to him or her would be manifestly inequitable. In Côte d'Ivoire, if a divorce is granted on the basis of the exclusive fault of one spouse, that spouse is not entitled to a family allowance. However, damages may be paid to the spouse granted the divorce.

Regarding the division of property upon divorce, in Chad, if a woman was married under the community property system, she is entitled to half the home's property. The property shall be divided after an inventory is presented to the court. In Côte d'Ivoire, in the case of polygamy, when only one of the partners breaks the marital bond, the share awarded that person is equal to a fraction of one half the community property. This fraction is derived by using the number one as numerator, and the number of wives (including the wife who is divorcing) as the denominator. In Cameroon, to guarantee her rights either to the community property or her own property, both of which the husband manages during the marriage, a woman can obtain protective measures, such as having seals affixed on the property. In addition, she can request that the judge who is deciding the divorce nullify all the deeds executed by the husband to alienate the joint assets. All these temporary measures can be amended during the hearing.

ii. Effects on Children

In all seven countries, the divorce or separation agreement stipulates child custody. Although usually awarded to the spouse who files for divorce, the judge may award children to the other spouse or a third party if it is deemed to be in the

children's best interest. Under these conditions, the judge sets child support for each child and the child's guardian exerts paternal rights over him or her and his or her property. The court also sets the conditions for visitation by the non-custodial parent. Both parents, even the non-custodial parent, retain the right to provide for the rearing and education of the children. In practice, custody of the children is awarded to the mother when they are young, unless she prefers that the custody be awarded to the father. When the father obtains custody of a child, the mother is rarely required to pay child support.

C. ECONOMIC AND SOCIAL RIGHTS

1. Property Rights

In all the countries featured in the report, the right to own property is generally recognized in the constitution. Thus, for example, Article 22 of the Benin Constitution stipulates that "everyone has a right to property." Article 13 of Mali's Constitution states that "the right to property is guaranteed." In all instances, property rights can be infringed upon only for the public good and the property owner must be subject to just and prior compensation. Under modern law, women have the same right as men to own property. Even with regard to land ownership, the law does not discriminate against women. Legally, anyone has the right, either individually or collectively, to acquire land and conduct any transactions associated with it. In practice, however, since it is usually the men who possess financial wealth, it is difficult for women to acquire property.

With regard to inheritance, laws vary from country to country. For example, in Cameroon, when the deceased person is not survived by close relatives who are eligible to inherit, or by illegitimate children, the estate belongs completely to the surviving spouse, except in cases of divorce or legal separation. A woman may also inherit from her husband when he is survived by relatives who are eligible to inherit on only one side of his family, either the paternal or maternal side; in this case, the share that the other side of the family would have inherited is allocated to the surviving spouse, except in cases of divorce or legal separation. In Côte d'Ivoire, in the case of a spouse's death, the share of property reserved for the surviving spouse is distributed according to the inheritance law, which bars discrimination. The surviving spouse ranks fifth among heirs; he or she is excluded from inheritance if there are children. Children and their descendants inherit from their father and mother, grandfathers, grandmothers, or other relatives regardless of gender or primogeniture, even if these children were born to different marriages or out of wedlock.

While the laws do not discriminate against women, practice and customs constitute an impediment to the right of

women to own or inherit property. In fact, under most customs, women are not permitted to own or exercise rights over property. This is because under most customs women are considered stateless, and therefore, unfit to own land, which by its very nature is fixed. A woman does not reside permanently in one place, either in her family of origin, which she is supposed to leave to get married, or in her family by marriage, to which she remains an outsider. The inheritance system favors men, and girls cannot even inherit from their own father or husband, especially not land. In fact, in certain cases, they may themselves be part of the deceased's estate, as his other personal property. Moreover, in countries such as Chad, Mali and Senegal, where the deceased's belongings are distributed according to *Shari'a* or Islamic Law, girls continue to receive half the boy's share.

2. Labor Rights

All seven countries recognize that all citizens have the right to work. In Benin, Burkina Faso, Cameroon, Chad, Mali and Senegal, this right is grounded in the constitution. In Côte d'Ivoire, it is cited in the Labor Code. Whether it is the constitution or the Labor Code, the state guarantees the principle of equal access and equal treatment for working men and women. In the area of employment, labor legislation does not discriminate with regard to women; they are guaranteed the same opportunities for employment, free choice of profession and job, and the right to equal pay and equal treatment for equal work.

Labor legislation also guarantees the right to healthy and safe working conditions and, except in Benin, prohibits night work in industries. Burkina Faso has additional provisions protecting women who, while pregnant, may not be assigned tasks that may affect their reproductive ability, their health, or the health of their child. In Chad, it is forbidden to employ women for work that exceeds their strength or is hazardous or of a nature harmful to their character. They may not be employed at a job that exceeds 10 hours per day or in underground jobs or quarries. Nor may they be required to carry or push loads whose weight exceeds the allowable limit.

In all the countries featured in this report, women receive special protection when they are pregnant. Labor law, in all seven countries, prohibits the dismissal of a woman based on her pregnancy or matrimonial status, and institutes paid maternity leave. The length of this leave varies from 14 to 15 weeks, six weeks before delivery and eight weeks after delivery. The maternity leave may be extended by no more than three to six weeks in the event of a medically proven inability to return to work. Since maternity leave is not equivalent to a suspended work contract, employers are required to take women back

when the leave is over. During the leave, she has the right to the entire salary that she was earning when she stopped working. Labor law also grants women the right to take nursing breaks for a period of approximately 15 months after the birth of their child. The total length of this break may not exceed one hour per workday. Furthermore, the law allows a pregnant woman to break the work contract unilaterally without notice or without having to pay her employer any compensation if her health no longer allows her to perform her job. However, dismissal of a woman in an obvious or medically diagnosed state of pregnancy is considered wrongful termination.

In Burkina Faso, married female civil servants may have the benefit of a family allowance if their husbands are not gainfully employed; the same applies to single women who have legal custody of their children. By contrast, Senegalese law prohibits working women from supporting their spouses and children in the event of illness. In that country, family allowances are paid in principle to the father and only in exceptional cases to the mother. In Cameroon, husbands have the right to prevent their wives from practicing their own profession or conducting business by citing the interests of the household and the children. This opposition to women's work may only be overturned by a court decision.

It should be noted that the above legislation is applicable only to employees in the formal sector. These benefits do not apply to home-based workers, domestic employees, independent contractors and women employed in small businesses (i.e., those with only a small number of workers or those employing only family members). Since the vast majority of women in Francophone Africa work in the informal sector, they are not entitled to the benefits provided by the law. For example, although 89% of Beninese women work, 78% are employed in the informal sector. Only 22% are employed in the formal sector.

3. Access to Credit

No provision governing financial institutions and credit in any of the seven countries officially discriminates against women. In Côte d'Ivoire, however, banks require the husband's consent for any transaction involving women married under the community property system. Those married under the separate estates system are not bound by this requirement.

In reality, very few women have access to bank credit because of the amount of collateral required by the bank (e.g., real property, land, or other property with a monetary value). Women are rarely able to provide such collateral because, in their societies, they are prevented from owning valuable property. In all seven countries, women have a substantial need for credit to conduct their economic activities in both urban and

rural areas. Since they are unable to meet those needs with official loans from banks, they often form their own credit unions, or *tontines*—a system of credit distribution found throughout Francophone Africa.

4. Access to Education

Each country's constitution guarantees citizens the fundamental right to an education. Thus, for example, Article 35 of the Chadian Constitution provides that "[e]very citizen is entitled to an education. Public education is free and secular. Private schooling is recognized and practiced under conditions defined by the law. Basic education is mandatory." The Preamble to the Cameroonian Constitution states the following principle: "The State ensures a child the right to education. Primary education is mandatory. Organization and control of education at all levels are essential duties of the State." Public education is generally free and secular, and private education is permitted.

Statistical data on education in these countries reveal low school enrollment rates, particularly for girls. In all of the countries, families do not yet consider the schooling of girls a priority. Consequently, there is unequal access to education for girls and boys. In Burkina Faso, girls represent only 38% of students in the entire country. In Côte d'Ivoire, in the 15 to 19 year old age group, 38% of men have had education beyond primary school, versus 18% of women. In Chad, only 28.3% of primary school students are girls; in secondary school, there is only one girl to every four boys. Gender inequality is also prevalent in Senegal, where only 41% of girls attend primary school, as compared to 68% of boys.

Literacy rates are also generally low: in Burkina Faso, in 1995, the literacy rate for the adult population was 22.2%, with disparities between women and men, and between rural and urban areas. In Benin, 74% of women are illiterate, compared to 51% of men. In Côte d'Ivoire, the illiteracy rate for women is 70%, compared to 50% for men.

In some countries, governments have adopted policies that seek to increase the level of education and literacy of their population. Thus, in Burkina Faso, one of the objectives of the Population Policy is to "hasten the formulation of a Plan of Action to eliminate illiteracy, particularly among the active population, while endeavoring to promote equal access to education for women and men." Another objective of the policy is to "promote equal access to education for girls by means of an awareness-raising campaign." One of the objectives of Cameroon's Population Policy is to promote basic education for all, particularly for girls. This general objective is further developed in a specific goal that proposes to promote and reinforce education for girls, thereby discouraging school dropouts,

and increasing the age of girls at first marriage. The Chadian government, through its Population Policy, expresses its will to "combat the taboos, which prevent girls' education, and to take appropriate measures to increase the school enrollment rate for girls."

Governments are also making efforts to reduce the discrepancy between men and women by implementing schooling and literacy programs. In Chad and Mali, these programs are incorporated into their population policies. In other countries, such as Senegal, such programs are supported by the World Bank.

D. RIGHT TO PHYSICAL INTEGRITY

1. Rape

The constitutions of all seven countries recognize the right to life and to bodily and mental integrity. In all of the countries, rape is a crime prohibited by the Penal Code, and in some of the countries, this crime is defined. Thus, in Benin, rape is defined in the Penal Code as "the act whereby a man has sexual relations with a woman against her will, whether the lack of consent results from physical or mental violence or from any other means of duress or surprise." By contrast, the definition in force in other countries is neutral with regard to the gender of the perpetrator or the victim. For example, in Burkina Faso, rape is defined as "an act of sexual penetration of any sort, committed upon another person by violence, duress or surprise." In Mali, rape is defined as "having sexual relations with a person without that person's consent, with or without violence." In Senegal, the recently amended Penal Code defines rape as "any act of sexual penetration, of any nature whatsoever, which has been perpetrated against another person by means of violence, force, threat or surprise."

Whether or not it is defined, rape is punishable in all seven countries by imprisonment of five years minimum, and up to 10 or 20 years of hard labor. The penalty is increased, potentially to life in prison, if the crime is committed by several persons, if it is committed by an older relative or person with authority over the victim, and if it is attempted or committed on persons who are particularly vulnerable, such as pregnant women, persons with a physical or mental disability, or minors under age 13 (15 in Côte d'Ivoire). Marital rape, by contrast, is neither condemned nor punished in any of the featured countries. For women, any type of conjugal sexual relations, whether forced or not, are considered normal, in light of their obligation to submit to and obey their husbands.

2. Domestic Violence

In Francophone Africa, domestic violence is common and accepted by society. With the exception of Senegal, none of the countries featured in this report have specific laws to protect

women against these acts. At best, they can invoke general articles of the Penal Code that prohibit intentional assault and battery and, depending on the severity of the crime, set sentences of one to five years or five to 10 years and a fine varying from 20,000 (U.S.\$31.84) to 500,000 CFA francs (U.S.\$795.94). It is in Chad that the sentences for domestic violence are the lightest, ranging from six days to one year in prison, along with a fine of 500 (U.S.\$0.80) to 50,000 CFA francs (U.S.\$79.59). However, if there is premeditation or ambush, or if the violence results in illness, inability to work, mutilation, amputation or loss of use of a limb, or death, the sentence may be more severe, ranging anywhere from six months to 10 years in prison and the fine from 5,000 (U.S.\$7.97) to 500,000 CFA francs (U.S.\$795.94). These articles, however, do not take into account the location where the assault and battery was committed, or the relationship between the abuser and the abused.

By contrast, in Senegal, the Law of January 13, 1999, modifies the articles of the Penal Code relating to assault and battery by punishing a spouse who intentionally commits battery or any other violence if the result of the violence is illness or total inability to work for more than 20 days. The sentence is one to five years in prison and a fine of 50,000 (U.S.\$79.59) to 500,000 CFA francs (U.S.\$795.94). Among the seven countries featured in this report, Senegal is the only country that has specifically legislated against domestic violence. It is hoped that the other countries will follow suit.

3. Sexual Harassment

This offense, although common in professional settings, is rarely reported, since the victims often remain silent and do not accuse the perpetrators in order to avoid reprisals or loss of their job. Sexual harassment is not mentioned in any laws except in Côte d'Ivoire and Senegal. In Senegal, it is punishable by a sentence of six months to 13 years in prison without parole. In Côte d'Ivoire, it is punishable by three years in prison and a fine of 360,000 (U.S.\$573.08) to 1,000,000 CFA francs (U.S.\$1,591.88). The attempt is also punishable. It is noteworthy, however, that a paragraph in the same article of the Penal Code specifies that "whoever accuses someone of sexual harassment, when the intent of the false accusation was solely to defame the character and discredit the accused or cause him injury, shall be punished by the same penalties as those who commit sexual harassment." It is obvious that such a restriction may limit the number of cases victims bring before the courts.

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

and Adolescents

In general, Francophone Africa is characterized by the unusually large proportion of young people in its population. Demographic statistics reveal the preponderance of those under age 20, who constitute more than two-thirds of the population. Africa is still a region of the world where men and "elders" tend to dominate. Thus, adolescent girls, because of their gender and youth, are a segment of society with little social and economic power.

Adolescent girls have an overwhelming need for information and services in the area of reproductive health, not only because of physical and emotional changes that occur during these years, but also because of the continued promotion in all the countries featured in this report of customs such as early marriage and childbearing, and harmful traditional practices such as female genital mutilation or force-feeding.

A. REPRODUCTIVE HEALTH OF FEMALE MINORS AND ADOLESCENTS

For a host of reasons, adolescent girls have a special need for access to services, information and counseling in all areas of reproductive health. These include the early onset of their sexual lives, the fact that they are the principle victims of clandestine abortion and, as new evidence culled from the most recent UNAIDS statistics shows, that they now constitute a particularly vulnerable group for HIV/AIDS. Their access to family planning information and services, however, is still extremely limited for at least two reasons: lack of basic information regarding their reproductive health, and cultural norms that do not acknowledge their right to sexuality outside of marriage. Thus, it is important to have health facilities specifically focused on the needs of adolescents.

In all seven countries, by the age of 17, the majority of adolescents have begun their fertile lives. For example, in Burkina Faso, of young women 18 years of age, one out of every two has already had at least one child. In Cameroon, among the women aged between 15 and 19 years, 297% have already had a child and 5.3% are pregnant for the first time. In Mali, by age 17, 46% of women have already had a child or are pregnant and, at 19, more than two-thirds of the women (69%) have begun their fertile life. In Chad, by age 17, 40% of women have already had one child or are pregnant; 62% of women aged 19 have already had at least one child. Yet, according to health care professionals, one of the main factors in high rates of maternal and child morbidity and mortality is early pregnancy and childbirth. These factors also constitute a major obstacle to educating young girls.

It is encouraging to note, therefore, that governments' com-

mitment to the ICPD has led to the creation of programs or activities specifically aimed at young people. In Burkina Faso, for example, the Strategic Health Plan includes a program in adolescent sexual and reproductive health. The general objectives of this program are to provide sexuality education to promote responsible behavior and to offer services in order to reduce the number of unwanted pregnancies. Cameroon's National Population Policy recommends facilitating access to voluntary family planning services, especially for young women, and increasing the level of education of girls in order to delay the age of first marriage. Mali's National Population Policy incorporates strategies to facilitate girls' access to family planning, to raise the population's consciousness about the harmful effects of early marriage and the benefits of responsible parenting, and to make men aware of the benefits of contraception. In that country, adolescent girls are entitled to the same maternal and child welfare services and family planning services as other women. In Senegal, the Ministry of Youth and Sports has initiated a vast Project for the Advancement of Young People operating out of Adolescent Counseling Centers. The project's emphasis is on offering reproductive health services and family education.

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

There is no available data on FC/FGM prevalence among adolescent girls. Studies on FC/FGM among the general female population, however, show that it is being practiced at an increasingly early age—before age seven in most cases. Adolescents are particularly affected by the repercussions of the operation, in terms of its physical, psychological and sexual dimensions. During childbirth, which occurs relatively early in all of the featured countries, adolescents face particular risks due to long labor caused by the narrowness of their pelvis. Those who have undergone FC/FGM face increased risks due to the small vaginal opening left after the procedure. Although the conditions under which FC/FGM is practiced are well known, in most of the countries there are no provisions specifically prohibiting it.

Of the seven countries, only Burkina Faso, Côte d'Ivoire and Senegal have passed laws criminalizing FC/FGM, but there is no specific provision relating to adolescents. In Burkina Faso, FC/FGM is a specific offense punishable by the Penal Code with six months to three years in prison and/or a fine of 150,000 (U.S.\$238.78) to 900,000 CFA francs (U.S.\$1,432.69). In Côte d'Ivoire, FC/FGM is punishable with one to five years in prison and a fine of 360,000 (U.S.\$573.08) to 2,000,000 CFA francs (U.S.\$3,183.75). In Senegal, any person who interferes

with the integrity of the female genital organ by total or partial ablation or by infibulation receives a sentence of six months to five years in prison.

In Chad and Mali, the Penal Code punishes amputation, mutilation, loss of the use of a limb and other impairments resulting from either assault and battery, or other types of violence. Sentences vary according to the severity of the consequences of the assault. In Benin and Cameroon, action by public authorities is limited to organizing awareness campaigns in areas where the practice is prevalent. It is noteworthy, however, that Benin is currently considering the adoption of a bill criminalizing the FC/FGM.

C. MARRIAGE OF FEMALE MINORS AND ADOLESCENTS

In all seven countries, the legal age of first marriage continues to be very young. It is 17 in Burkina Faso, 18 in Côte d'Ivoire, and 15 in Benin. The President of the Republic may even grant an age dispensation if the fiancée has not yet reached even that very young age. Furthermore, girls who marry under customary or Muslim laws, tend to do so at an even younger age. For example, in Benin, the *Coutumier du Dahomey* allows girls to marry at 14 years.

In practice, the majority of girls, especially those who live in rural areas, are actually married at puberty (about age 13). These marriages often take place without the girls' consent, even though consent is legally required in all of the countries. For example, in Burkina Faso, the Penal Code stipulates that whoever forces a person of minor age to marry, will be punished with one to three years of imprisonment. The maximum sentence is given if the girl is a minor under the age of 13. In Mali, an individual who performs or attempts to perform a sex act allowed by custom on a girl under the age of 15 is subject to one to five years of imprisonment, in addition to any punishment he may receive for crimes or misdemeanors committed in performing the act. Furthermore, any persons, including the girl's parents, are punished as accomplices if they knowingly caused or consciously aided or abetted the perpetrator of the acts, or planned or facilitated them.

It should be noted that in all seven countries there is a trend indicating an increase in the median age at first marriage. In Mali, between 1995 and 1996, 23% of women aged 45 to 49 had married by age 15, compared to 19% of women aged 20 to 24, and 16% of women aged 15 to 19. In Benin, in 1996, the median age at first marriage for women aged 45 to 49 was 17.9 years, compared to 18.8 years for women aged 20 to 24. In Côte d'Ivoire, in 1994, the median age at first marriage was 17.9 years for women aged 45 to 49, compared to 18.2 years for women

aged 25 to 29, and 18.8 years for women aged 20 to 24 years. In all of the featured countries, the marriage age tends to be older in urban areas, and increases with the level of education. As noted above, the main outcome of delayed marriage is a later first pregnancy.

D. SEXUALITY EDUCATION FOR FEMALE MINORS AND ADOLESCENTS

A great number of taboos govern the sex life of adolescent girls, including the insistence on virginity at marriage. Even those who are supposed to provide adolescents with information about reproductive health (e.g., parents, teachers and service providers) are still strongly reluctant to do so. Recently, in light of the frequency of sex outside of marriage and the spread of sexually transmissible infections, especially among girls, governments are starting to promote sexuality education, which they call “family life education.” However, information continues to be disseminated through courses in civics, morals and biology, or through talks given by local family planning associations. The content of this information includes sexuality and reproduction, family planning, home economics, and environmental, health and population issues. Unfortunately, information provided through schools ignores the needs of the great mass of adolescents who do not attend school.

Of the seven countries featured in this report, only Burkina Faso has adopted a National Family Life Education Policy. One of its main objectives is “to contribute to encouraging young people to adopt responsible behaviors in managing their sexuality and respecting social codes.” The government incorporated a program into secondary education to introduce population-related education for the purpose of better informing adolescents about sexuality and family life. It will soon extend this program to other levels of the formal education system and to youth training centers.

E. SEXUAL OFFENSES AGAINST FEMALE MINORS AND ADOLESCENTS

All seven countries have signed and ratified the Convention on the Rights of the Child and have national legislation providing legal protection to minors (regardless of gender). Sexual offenses against minors include rape, indecent assault, indecency, incest, kidnapping and abduction of a minor, incitement to debauchery and corruption of a minor, and homosexuality. When parents, guardians or teachers are involved in these acts, they may be deprived of their paternal rights or other rights relative to their status. Furthermore, crimes against minors are more severely punished than those against adults.

1. Rape

In all seven countries, a rape committed against a minor carries a stiffer penalty than one committed against an adult. In Benin, for example, rape is punishable by 10 to 20 years in prison. If the rape victim is a child under the age of 13, the rapist will be given the maximum sentence with hard labor. In Burkina Faso, sentences for rape are doubled when the victim is under the age of 15. If it is committed by a parent or a person with authority over the victim, or if the victim is particularly vulnerable due to pregnancy, illness or a physical or mental handicap, or if the victim is under the age of 15, and the crime is committed with a weapon, the prison sentence is 10 to 20 years. In Mali, rape carries the penalty of five to 20 years of forced labor and an optional one- to five-year residence ban. If it was committed with the help of several persons or on a child younger than 15 years of age, the perpetrator shall be sentenced to 20 years of forced labor and a five- to 20-year residence ban. In Chad, the rape of a child under the age of 13, rape that has been committed with the assistance of others, or rape that has been committed by an older relative of the victim, carries the penalty of a life sentence of forced labor.

2. Indecent Assault

Benin, Chad, Côte d'Ivoire and Senegal punish indecent assault, committed or attempted against a minor. In Senegal, any act of indecent assault, attempted or committed without violence on a child of either sex under the age of 13 years will carry a prison sentence of two to five years. Similarly, in Chad, indecent assault, committed or attempted without violence against a child of either sex younger than 13 years of age is punishable by imprisonment of two to 10 years.

In Côte d'Ivoire, indecent assault committed or attempted with violence against a person of either sex is punishable by imprisonment of five to 10 years and a fine of 200,000 (U.S.\$318.38) to 2,000,000 CFA francs (U.S.\$3,183.75) if the perpetrator is the father or mother, an older relative, or a person with authority over the victim; if the perpetrator is responsible for the victim's education, intellectual or professional training; or if the victim is younger than 15. Indecent assault committed or attempted without violence against a minor 15 years old or younger of either sex is punishable by imprisonment of three years and a fine of 360,000 (U.S.\$573.08) to 1,000,000 CFA francs (U.S.\$1,592.88). The penalties are increased if the perpetrator who commits or attempts the indecent act without violence against a minor of either sex under the age of 15 is the father or the mother, an older relative, or a person with authority over the victim, or if the perpetrator is responsible for the victim's education, intellectual or professional training.

3. Indecency

Burkina Faso and Cameroon punish indecency or “an act contrary to good moral standards” committed in the presence of a minor. In Burkina Faso, if the indecent act is committed in private in the presence of a minor, it is considered an offense of inciting a minor to debauchery. The sentences are increased if, in addition, 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. In Cameroon, any person who commits an indecent act in the presence of a person younger than 16 years of age shall be punished by two to five years in prison and a fine of 20,000 (U.S.\$31.84) to 200,000 CFA francs (U.S.\$318.38). The penalties are doubled if the indecent act is committed with violence, or if the perpetrator is a person who has authority over the victim, or legal or customary custody; a civil servant or a religious minister; or a person assisted by one or several other persons.

4. Incest

In Cameroon, incest is defined as the act of having sexual relations with close relatives (e.g., legitimate or illegitimate parents, legitimate or illegitimate brothers and sisters, or half brothers and sisters). Incest is punished by imprisonment of one to three years and a fine of 20,000 (U.S.\$31.84) to 500,000 CFA francs (U.S.\$795.94). Significantly, a perpetrator of incest can be prosecuted, and therefore punished, only if a blood relative, regardless of how distant, brings a tortious action.

In Côte d’Ivoire, incest is not defined, but rape carries the penalty of life in prison if the perpetrator is the father, an older relative or a person with authority over the victim, or if that person is responsible for the victim’s education, intellectual or professional training. The penalty is the same if the victim is younger than 15 years of age. Likewise, in Burkina Faso, rape committed or attempted by an older relative is punishable by stiffer penalties (10 to 20 years in prison). Similarly, in Chad, rape committed by an older relative carries the penalty of a life sentence of forced labor.

In Mali and Senegal, the Penal Code does not define the crime of incest. However, indecent assault committed by an older relative against a child under the age of 15, or against a minor between 15 and 21 years is punished by the law. Likewise, in Senegal, indecent assault committed by a child’s older relatives or by any person who exercises authority over the victim, even if the child is over the age of 13, will carry the maximum penalty (five years).

5. Kidnapping and Abduction of Minors

Abduction of a minor is prohibited in Burkina Faso, Cameroon, Chad and Senegal. Thus, in Cameroon, the Penal code punishes anyone who, without deception or violence,

abducts a person younger than 18 against the wishes of those who have legal or customary custody of him or her, with imprisonment from one to five years and a fine of 20,000 (U.S.\$31.84) to 200,000 CFA francs (U.S.\$318.38); these penalties do not apply, however, if the minor subsequently marries the perpetrator. Moreover, the same Code punishes with imprisonment of five to 10 years anyone who, by deception or violence, abducts or kidnaps a person younger than 21 years of age against the wishes of those who have custody of that person. If a physical assault against an abducted minor results in death, the penalty is increased and the perpetrator may be sentenced to death.

Similarly, in Burkina Faso, kidnapping of minors is an offense punishable by the Penal Code, which provides that anyone who uses violence, threats, or fraud to kidnap a minor or have him or her kidnapped shall be punished by imprisonment of five to 10 years. This sentence is increased to 10 to 20 years in prison if the minor who is kidnapped or abducted is younger than 13. However, if the 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.

Likewise, in Senegal, the Penal Code provides that whoever, without fraud or violence, kidnaps or abducts, or attempts to kidnap or abduct a minor under the age of 18 years, will be liable to two to five years imprisonment and a fine of 20,000 (U.S.\$31.84) to 200,000 CFA francs (U.S.\$318.38). If a perpetrator subsequently marries a minor after kidnapping or abducting her, he can be brought to court only by persons who would be authorized to request the annulment of the marriage. The perpetrator can only be found guilty after the marriage has been annulled.

6. Incitement to Debauchery and Corruption of Minors

Incitement to debauchery and corruption of minors are prohibited in Cameroon, Chad, Côte d’Ivoire, Mali and Senegal. In Mali, the Penal Code stipulates that “Whoever habitually incites, promotes, or facilitates debauchery or the corruption of young people of either sex to satisfy the passions of others, causes or leads a girl or woman astray for purposes of debauchery, even with her consent; detains a person against her will in a house of ill-repute, or forces her to become a prostitute, will be liable to six months to three years imprisonment and to a fine of 20,000 (U.S.\$31.84) to 1,000,000 CFA francs (U.S.\$1,591.88), and an optional one- to 10-year residence ban.” In Côte d’Ivoire, the Penal code imposes a sentence of two to five years imprisonment and a fine of 500,000 (U.S.\$795.94) to

5 million CFA francs (U.S.\$7,959.38) for any offense against public decency that involves inciting, promoting or facilitating debauchery or corruption of a young person of either sex under the age of 18. In Senegal, the habitual corruption of a minor of either sex under the age of 21 years is prohibited. If this corruption occurs only occasionally, it will be punished only if the corrupted minor is under the age of 16 years. In addition, Law No. 06-99 of January 16, 1999 punishes pedophilia, and the holding of meetings with a sexual connotation involving a minor.

7. Homosexuality

Cameroon, Chad and Senegal prohibit "acts against nature" committed with a minor of the same sex. Thus, in Chad, the Penal Code imposes a sentence of three months to two years, and a fine of 5,000 (U.S.\$797) to 100,000 CFA francs (U.S.\$159.19) on whoever commits an obscene and unnatural act with another person of the same sex, under the age of 21. Cameroon's Penal Code punishes any person who has sexual relations with a person of the same sex by imprisonment of six months to five years and a fine of 20,000 (U.S.\$31.84) to 200,000 CFA francs (U.S.\$318.38). The same article further punishes, with more severe penalties, if necessary, indecent acts committed between persons of the same sex when the perpetrator is older than 21 and the victim younger than 18 years of age. In Senegal, the Penal Code punishes whoever commits an act against nature with an individual of the same sex with one to five years imprisonment and a fine of 100,000 (U.S.\$159.19) to 1,500,000 (U.S.\$2,387.81). If this act was committed with a minor under the age of 21 years, the maximum sentence applies.

V. Conclusion

An examination of regional trends in laws, policies and programs affecting reproductive health reveals many similarities among the seven countries featured in this report. These similarities are explained by a common colonial and legal heritage. The report also reveals that the governments, although willing to adopt at least some types of reproductive health policies and programs, lack the political will to promote related rights. Those rights that have been granted to women, by both domestic legislation and international legal instruments ratified by many governments, are still mere formalities. In all the countries, the family is the basic unit of society and primary means for socialization of individuals. At the same time, it is a source of discrimination that blocks women's access to knowledge and, in turn, to economic and social power. In many of

the countries, custom and religion, which treat women as a social minority, are a source of law. This reliance on traditional law and norms blatantly contradicts the public commitments governments have made to promoting women's rights.

In addition, laws regarding women are often poorly applied or not applied at all. In Mali, for example, laws regarding marriage are rarely enforced, and forced marriages are still common. Religious marriage ceremonies are often publicly performed prior to civil marriages, and in some families, only religious marriages are performed. With respect to bride-price and gifts, the legal limits are never obeyed. In addition, the principle by which each wife in a polygamous marriage must have her own household is routinely violated and husbands frequently force all of their wives to live together. In Cameroon, the Constitution and the Labor Code guarantee equality among men and women; however, in practice there is much discrimination against women in the workplace. Moreover, the law gives the husband the right to prevent his wife from working outside the home by invoking the interest of the household or children. A husband's prerogative in this regard may be overridden only by court intervention. Also, in Cameroon, laws regarding incest are only rarely enforced; victims refrain from bringing legal action in order to protect the family's privacy and to prevent its ostracism.

A third area of contradiction that was highlighted by the report is the one between laws and policies. In Mali, for example, the law prohibits abortion, but the 1991 National Population Policy advocates the legalization of therapeutic abortions. In Burkina Faso, although providing information on contraception is no longer considered illegal since the adoption of the Family Planning Policy in 1986, the Penal Code still prohibits it.

Finally, there are tensions and disparities between modern and customary law. Customary law, which tends to be unfavorable to women, is often in contradiction with modern law in the area of women's rights. Benin's *Coutumier du Dahomey*, for example, sets a lower age at first marriage than civil law. Similarly, in Chad, there seems to be a contradiction between the Civil Code, which fixes the legal age at first marriage at 16, and the Penal Code, which authorizes customary marriages of much younger girls, as long as the marriage is not consummated before the girl reaches the age of 13. In Burkina Faso, although the constitution guarantees individuals the right to property, customary law prohibits women from exercising these rights, especially with regard to real estate. Furthermore, not only does customary law not recognize inheritance rights, but, under the levirate system, regards women themselves as property to be inherited upon the death of their husbands.

All of these contradictions create confusion over what laws

are applicable. In order to set clear and workable guidelines for governance, it seems necessary to reconcile the different sources of law within each country. Unfortunately, with the exception of Chad, national constitutions do not address the appropriate relationship between modern law and custom. Chad's Constitution is exemplary in this regard. In general, judicial systems in the seven countries should be strengthened so that they have the means to apply existing laws. Beyond any institutional problem, however, it seems that attitudes must change. Patriarchal norms and habits persist in all of the countries, creating strong barriers to adopting legal reforms aimed at advancing women's rights and raising their status.