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Women of the World:

Laws and Policies Affecting Their Reproductive Lives

The Center for Reproductive Law and Policy
International Federation of Women Lawyers (Kenya Chapter) F.I.D.A.-K

Ethiopia Ghana Kenya Nigeria South Africa Tanzania Zimbabwe

WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES. ANGLOPHONE AFRICA

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Glossary

Frequently used abbreviations

AIDS
Acquired immunodeficiency syndrome

FGM
Female genital mutilation

HIV
Human immunodeficiency virus

MCH
Maternal and child health

MOH
Ministry of health

NGO
Non-governmental organization

PHC
Primary health care

STDs
Sexually transmitted diseases

Frequently used terms

Common law:
Common law is a body of law that develops and derives from judicial decisions, as distinguished from laws brought forth through legislative enactments.

Civil law:
Civil law, which derives from Roman law, is a legal system in which statutes provide the principal source of rights and obligations.

Customary law:
Customary laws are the rules of law which by custom are applicable to particular communities.

Iddat:
Pursuant to Islamic law principles, *iddat* is the period a woman must wait before remarrying, following divorce or her husband's death.

Levirate union:
The term "levirate union" refers to the situation in which a husband dies and his widow may remain living at his home and have sexual relations with a male relative of the deceased — usually the younger brother of the deceased, who is next in order of seniority — to have children.

Talaq:
The principal form of Islamic divorce is *talaq*, the unilateral repudiation of the marriage by a husband.

Tort:
A tort is a private civil wrong or injury, other than one that occurs within a contractual agreement, for which the court will provide a remedy in the form of an action for damages.

Foreword

This report on Anglophone Africa is the first in a unique series of collaborative reports describing and analyzing the content of formal laws and policies affecting women's reproductive lives in approximately 50 nations around the world. Future reports, which will be produced jointly in collaboration with national-level non-governmental organizations in each country profiled, will focus on East and Southeast Asia, Eastern and Central Europe, Francophone Africa, Latin America and the Caribbean, the Middle East and North Africa, and South Asia. In addition to examining the content of such measures in specific nations, each report will identify trends that emerge in particular regions. An eighth and final report will build on the regional analyses to provide a global synthesis of the trends in laws and policies regarding reproductive health and rights.

This series of reports seeks to enhance knowledge regarding the vast range of formal laws and policies that affect women's reproductive lives and to identify regional and global trends. The real-life impact of such laws and policies, particularly for women, stands in sharp contrast to the dearth of information in many Southern and nonindustrialized nations regarding their scope and level of specificity. We are committed to making such information accessible to a wider audience, particularly at the regional and international levels. It is our hope that the provision of such information will promote legal and policy advocacy to advance reproductive health and the status of women around the world.

Anika Rahman
Director, International Program
The Center for Reproductive Law and Policy
May 1997

1. Introduction

Reproductive rights are internationally recognized as critical both to advancing women's human rights and to promoting development. Governments from all over the world have, in recent years, both acknowledged and pledged to advance reproductive rights to an unprecedented degree. Such governmental commitments — at major international conferences such as the Fourth World Conference on Women (Beijing, 1995), the International Conference on Population and Development (Cairo, 1994), and the World Conference on Human Rights (Vienna, 1993) — have set the stage for moving from rhetoric to reality in the arena of women's human rights. But for governments and non-governmental organizations ("NGOs") to work towards reforming laws and policies so as to implement the mandates of these international conferences, they must be informed about the current state of national level formal laws and policies affecting reproductive rights.

Laws and policies create the framework by which governments affect the behavior of billions of people. In terms of reproductive health care, laws and policies are essential tools used to deny, obstruct, condition availability, or promote access to services. Nonenforcement of existing laws and the absence of law are equally important. For example, laws can act as barriers to reproductive health services by criminalizing medical procedures, such as abortions, or by imposing restrictions, such as requiring the consent of a spouse for obtaining contraceptives or a sterilization. Selective prosecution, or even nonenforcement, of certain laws can lead to lowering the quality of care and providing a tool with which to discriminate against women and service providers. In terms of reproductive rights, laws not only provide the basis for the recognition or negation of such rights, but also reflect the conditions that determine whether women and men are able to exercise these rights. For example, in societies in which women are legally unable to acquire or hold property or are legally unequal to men within marriage, women's ability to control their reproductive lives is limited by the social norms reflected in the laws that subordinate women. The degree to which formal laws and policies influence people's lives depends on numerous factors relating to the actual enforcement of such norms. Yet there can be little doubt that formal laws and policies establish societal objectives and regulate the conditions of individual lives.

This report details the factual content of national laws and policies in key areas of reproductive health and women's empowerment in seven Anglophone African nations — Ethiopia, Ghana, Kenya, Nigeria, South Africa, Tanzania, and Zimbabwe. Expansive in its scope, this report discusses laws enacted by legislatures and legal principles developed by courts while also examining relevant policies issued by government entities such as ministries, administrative agencies, and official councils or commissions. These bodies articulate policies, adopt binding regulations, and/or develop government policies and programs that can have a significant impact on reproductive health and rights. The report concludes with an analysis of the status of the laws affecting reproductive health and rights as well as women's empowerment, a discussion of regional trends, and a description of regional models of laws and policies that promote reproductive rights.

I. Common Features of the Nations Selected

For the purposes of this report, the seven Anglophone African nations being discussed have three critical common features — a shared legal tradition, similar reproductive health problems, and the low status of women. These similarities exist despite geographic, economic, religious, and political diversity among the seven nations. Not only are these countries located in various parts of Africa, they also demonstrate the economic realities of the continent. Most of the nations are low income, yet the extent of poverty varies greatly. Two countries, Ethiopia and Tanzania, are among the poorest countries in the world with average per capita gross national product ("GNP") estimated at $100 and $90, respectively. In contrast, South Africa's average per capita GNP of approximately $2,980 makes it one of the richest nations in sub-

Saharan Africa. Both within and between each country, religious practices vary, with Christianity, Islam, and traditional beliefs prevalent among the seven nations. Finally, each country's current political condition differs. Nigeria is ruled by its military; Ethiopia and South Africa are democratic nations that have recently emerged from major internal changes; Ghana is a democracy that is now governed by its previous military ruler; Kenya and Zimbabwe are democracies; and Tanzania is a socialist state that has moved toward a multiparty democratic state.

A. SHARED LEGAL TRADITION

Despite many differences, the Anglophone African region shares a critical common legal and political history. All the nations — with the exception of Ethiopia — achieved independence from the British after World War II. Unlike many other countries in sub-Saharan Africa, Ethiopia was not colonized by foreign interests; it was, however, occupied by Italy between 1936 and 1941. Thus, due to their history of colonization, all of the countries but Ethiopia inherited a legal system based on English common law. Nonetheless, Ethiopia has a legal system that contains elements of the English common law tradition. The common law system comprises the body of principles and rules of action that derive their authority solely from usages and customs of immemorial antiquity, particularly the ancient unwritten law of England, or from court judgments and decrees. Although courts have a particularly important role to play in the development of legal principles within the common law system, most recent legal developments in the seven Anglophone African nations profiled have occurred in the form of statutory interventions.

Two countries, South Africa and Zimbabwe, have also been affected by another European legal tradition — Roman-Dutch law. Originally the law of the province of Holland, Roman-Dutch law was imposed on nations colonized by the Dutch. Once the former Dutch colonies passed to the British crown, these laws were modified and influenced by English common law. In South Africa, for example, constitutional law, administrative law, and the laws of procedure and evidence have developed along English lines; criminal law, however, is a combination of elements of Roman-Dutch law and English common law, while the law of property is almost exclusively derived from Roman-Dutch law.

All of the nations have combined the English common law system with other indigenous legal regimes. Each of the seven nations is characterized by a mosaic of laws in which common law traditions often govern in most realms of law except family law, which is typically governed by African customary law and certain specific religious laws. African customary law is a blend of African customs and imported colonial common and civil law principles. Such customary law often applies to such matters as: property ownership; marriage and divorce; matters affecting the status of women, including the status of widows and children, child custody, legitimacy, and adoption; and intestate succession and administration of intestate estates. Additional religious legal regimes are derived from two major religions — Islam and Hinduism. Islamic law, known also as Mohammedan law, is a body of rules that gives practical expression to the religious faith of the Muslim, and the content of this law is based on religious principles. When Muslims are exempt from the application of secular legal principles, they follow the principles of Islamic law. But in Ghana, Kenya, and Tanzania, Muslims are required to submit to general marriage laws. Hindu law applies to Hindus, who live primarily in Kenya and Tanzania, in most issues relating to family law.

B. COMMON REPRODUCTIVE HEALTH PROBLEMS

Each of the seven nations is characterized by high levels of maternal and infant mortality and the large number of children borne by each woman. Among these countries, the range of these rates varies. Nigeria's maternal mortality rate, ranging from 800 to 1,500 deaths per 100,000 live births, is estimated to be among the highest in the world. Its infant mortality rate of 83 deaths per 1,000 births is also regarded as high. The average number of children born by a Nigerian woman is six. In Ethiopia, all these three indicators are also regarded as being high. Ethiopia's maternal mortality rate is estimated to be 560 per 100,000 live births, its infant mortality rate is between 99 and 123 per 1,000 births, and the average number of children borne by an Ethiopian woman is 6.8. South Africa, on the other hand, boasts some of the best rates in sub-Saharan Africa in terms of maternal and infant mortality and fertility rates. The average maternal mortality rate is 32 per 100,000 live births; this average rate reflects a maternal mortality rate as low as 5 per 100,000 amongst Indians to as high as 58 per 100,000 amongst Africans. While racial breakdowns are not available for the most recent infant mortality rate in South Africa, the annual average infant mortality rate is estimated to be 46 per 1,000 births. The average number of children borne by a South African woman is estimated to be 4.1. High rates of maternal mortality are partially attributable to women's lack of access to emergency obstetric services and to the very limited circumstances in each country in which a legal abortion is available. The high rates of infant mortality can be partly explained by women's lack of access to postnatal care and information. The large number of children borne by women, however, is a reflection of cultural attitudes

in predominantly rural societies where each child is viewed as an asset.

Although the prevalence rates for the incidence of human immunodeficiency virus ("HIV") and acquired immunodeficiency syndrome ("AIDS") are widely regarded to be underreported, the official number of HIV-infected people remains extremely high in many of the seven Anglophone African nations discussed in this report. Zimbabwe has one of the fastest growing HIV/AIDS prevalence rates in the world. Since 1985, over 48,000 cases of AIDS have been reported in Zimbabwe. In 1993, it was estimated that 841,700 persons in Kenya were infected with HIV; in 1996, the World Health Organization reported 64,647 cases of AIDS in Kenya. In 1994, the estimated number of AIDS cases in Tanzania was 250,000; the estimated HIV infection rates based on blood donor prevalence indicates that, by 1995, 1 to 1.5 million Tanzanians were infected by HIV/AIDS. Even the richest country in sub-Saharan Africa, South Africa, is suffering from high rates of HIV/AIDS. In the beginning of 1995, it was estimated that between 1.8 and 2 million South Africans were infected with HIV and that between 12,000 and 15,000 people had AIDS.

Finally, in all the seven nations, adolescents suffer from many unique reproductive health problems. In many nations, traditional practices harmful to women, particularly teenage women, continue to exist. For example, in Ethiopia, Ghana, and Kenya, a significant number of women — 90%, 30%, and 50% respectively — undergo female genital mutilation ("FGM"), also referred to as female circumcision. Early marriage and early pregnancy are also prevalent in Anglophone Africa, often compounding the health problems caused by traditional practices. Early sexual intercourse can cause tearing in the genital region, while childbearing at a young age is correlated with higher incidence of obstructed labor, anemia, and obstetric fistulae. The youngest rates of marriage are to be found in Tanzania and Ethiopia. In Tanzania, the median age of first marriage is 17 years; by the age of 20, more than 95% of women have married at least once. In Nigeria, the mean age at first marriage is 16 years, and half of all women have children by the age of 20. The highest age of first marriage occurs in Zimbabwe and South Africa. In 1994, the average age of first marriage in Zimbabwe was 19 years and 62% of women were married by the age of 20.

C. LOW STATUS OF WOMEN

In all of the seven nations, women generally fare far worse than men. Gender inequalities in access to education are prevalent in each country. For example, in Tanzania, although girls make up 48% of children in primary school, they represented only 18% of students attending an undergraduate university in 1992-93. In Kenya, 27.1% of females aged six and above have not received any formal education compared to 16.5% of males. Disparities between the number of women and men in the paid labor force also exist. In South Africa, while women comprise 36% of the total workforce, African women constitute 18% of the workforce and 48% of the unemployed. In Nigeria, 34% of the labor force is comprised of women. In addition, legal discrimination against women persists in all the countries, particularly in terms of rights under family law. Generally, women do not have the same rights to marry and divorce as men; their rights to inheritance, particularly if they are widows, are also often curtailed. Finally, in many countries, women's ability to own property is also limited in practice by customary law.

II. National-Level Information Discussed

In light of the shared legal traditions, reproductive health problems, and low status of women in Anglophone African nations, this report presents an overview of the content of laws and policies that relate to specific reproductive health issues as well as women's rights more generally. Each country is presented separately, but the information provided is organized uniformly in four main sections to enable regional comparisons.

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

In the second part of each chapter, we detail the laws and policies affecting specific reproductive health and rights issues. While not addressing all reproductive health matters, this segment describes laws and policies for major reproductive health issues that have been the concern of the international community and of governments. The report thus reviews governmental health and population policies, with an emphasis on general issues relating to women's status. It also examines laws and policies regarding contraception, abortion, sterilization, FGM, and HIV/AIDS and other sexually transmitted diseases ("STDs").

The next portion of each chapter provides insights into women's legal status in each country more generally. To evaluate women's reproductive health and rights in these seven

Anglophone African countries, it is essential to explore their status within the society in which they live. Laws relating to women's legal status are important because they reflect societal attitudes that will affect reproductive rights. Moreover, such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health services and her ability to make voluntary, informed decisions about such care. The report describes laws and policies regarding: marriage, including divorce and custody; property rights; labor rights; access and rules regarding credit; access to education; and the right to physical integrity, including laws on rape, domestic violence, and sexual harassment.

The final section of each chapter focuses on the reproductive health and rights of adolescents, recognizing that discrimination against women often begins at a very early age and leaves women less empowered than men to control their sexual and reproductive lives. Women's unequal status in society may limit their ability to protect themselves against unwanted or coercive sexual relations and thus from unwanted pregnancies, HIV/AIDS, and STDs. Furthermore, young women are often subjected to harmful traditional practices such as FGM. The segment on adolescents focuses on laws and policies relating to five areas: reproductive health; FGM; marriage; sex education; and sexual offenses against minors. Each of these subjects presents significant rights issues and can have direct consequences for women's health.

This report is the product of a collaborative process involving The Center for Reproductive Law and Policy, based in New York, and eight NGOs from Anglophone Africa committed to women's empowerment issues. The regional coordinator for the project was the International Federation of Women Lawyers-Kenya ("FIDA-Kenya"), based in Nairobi. The other collaborative NGOs involved in the process were: the Inter Africa Group in Addis Ababa, Ethiopia; the International Federation of Women Lawyers-Ghana ("FIDA-Ghana") in Accra-North, Ghana; Women Legal Aid Center in Dar-es-Salaam, Tanzania; the Women's Health Project in Johannesburg, South Africa; Lawyers for Human Rights in Pietermaritz, South Africa; The Civil Liberties Organisation in Lagos, Nigeria; and Women in Law and Development in Africa in Harare, Zimbabwe. We all hope that this publication will be useful in efforts to promote reproductive health and rights, especially at the national and regional levels. The achievement of such rights is critical not only to the advancement of women, but also to the development of nations.

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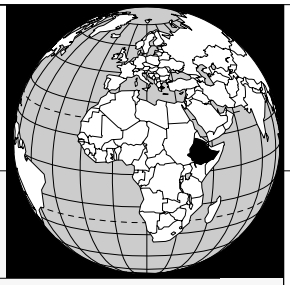
2. Ethiopia



Statistics

GENERAL

Population

■ The total population of Ethiopia is approximately 56 million.[1] The annual population growth rate is 2.9%;[2] the gender ratio is 98 males per 100 females;[3] the median age is 17.1 years.[4]

■ In 1996, the proportion of the population residing in urban areas was estimated to be 15%.[5] In 1993, 55.5% of Ethiopia's urban population was made up of women.[6]

Economy

■ In 1989, the estimated gross national product ("GNP") per capita was U.S.$120.[7]

■ In 1993, the average gross domestic product ("GDP") per capita was U.S.$400.[8]

■ The government spent approximately 4% of its GDP on health in 1990, compared to the U.S., which spent approximately 12.7% of its GDP on health in the same year.[9]

Employment

■ In 1993, 22 million persons were employed in Ethiopia, while an estimated 30% were unemployed.[10] Approximately 56% of women in Ethiopia are in the labor force, while the corresponding number for men is 79%. Women make up about 21% of professional and technical posts and 1% of administrative and managerial posts.[11]

WOMEN'S STATUS

■ The average life expectancy for women is 48.7 years, compared to 45.4 years for men. The average life expectancy for both sexes combined is 47 years.[12]

■ In 1990, over 1/3 of married women between the ages of 15 and 49 were married before the age of 15, while 41.1% married between the ages of 15 and 17.[13]

■ There is a strong gender differential in education. Women comprise 50% of the Ethiopian population, but only 23% of the student population.[14]

ADOLESCENTS

■ The prevalence of FGM in Ethiopia is estimated at 90%.[15]

■ Approximately 31% of the Ethiopian population is between the ages of 10 and 21.[16]

■ A study of fertility in rural areas estimated the mean age of marriage to be 15.2 years for girls and 21.5 for boys.[17] A study of fertility in the northwestern region of Ethiopia estimated that at least half of the women married at the age of 14 or younger.[18]

MATERNAL HEALTH

■ In 1990, the average total fertility rate was 6.8 children per woman. The rate was four children for women living in urban areas.[19]

■ In 1995, the maternal mortality rate was estimated to be 560 per 100,000 live births.[20]

■ The infant mortality rate is estimated to be between 99 and 123 out of 1,000 births.[21] The under-five mortality rate is estimated at 204 per 1,000 births.[22]

■ The number of births aided by midwives is approximately 5%.[23]

■ About 98% of mothers and potential mothers have no access to family planning.[24]

■ In 1993, 17% of births were to women under age 20 and 13% were to women over age 35.[25]

CONTRACEPTION AND ABORTION

■ The overall use of contraceptives in Ethiopia is low in comparison to other African countries.[26] In 1990, the use of

contraceptives among Ethiopian women between the ages of 15 and 49 was 3.9%.[27] Between 1988-93, 4% of married women of childbearing age used contraception (including women whose husbands use contraception).[28]

■ In 1994, birth control pills accounted for 57.9% of the total contraceptives used, condoms accounted for 15.5%, intrauterine devices (IUDs) accounted for 4.5%, NORPLANT® accounted for 1.4%, injectables accounted for 19.0%, and other methods accounted for 1.1%.[29]

■ Voluntary surgical contraception accounted for 0.6% of total contraception use.[30]

■ A 1988 survey in five hospitals showed that between 1985 and 1986, abortion cases accounted for 55.2% of the total number of cases in the gynecological departments. That figure rose to 58.6% in the following year.[31]

■ Unsafe abortion is the major cause of maternal death in Ethiopia, with the majority of cases occurring among young women.[32]

HIV/AIDS AND STDs

■ As of July 1994, an estimated 14,074 persons were suffering from AIDS.[33]

■ Of the reported AIDS cases between the years 1985 and 1995, 150 females suffering from AIDS were below the age of four; 900 were between the ages of 15 and 19; 3,750 were between the ages of 20 and 29; 1,750 were between the ages of 30 and 39; 500 were between the ages of 40 and 50; and 200 were between the ages of 50 and 59.[34]

■ A recent AIDS screening survey of 34,702 people (of whom 6,564 were commercial sex workers) showed that the overall rate of infection was 6.4%. The positivity rate for women was 16.8%.[35]

■ A study in the capital of Addis Ababa states that the rate of STD infection is higher among women than among men; it gives the figures of 45.3% and 32%, respectively.[36]

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In August 1995, the Federal Democratic Republic of Ethiopia ("Ethiopia") was established pursuant to a revised constitution ratified in December 1994.[1] National and regional elections were held in May and June 1995. These events occurred under the administration of the Transitional Government of Ethiopia, which was established in 1991 after the overthrow of Colonel Mengistu Haile Mariam's 17-year-long Marxist dictatorship. Mengistu's military government faced civil war in Eritrea and Tigray and conflict over the Ogaden region in the southeast. These conflicts exacerbated the region's cyclical drought and accompanying famine conditions, which brought millions to the brink of starvation in the 1970s and 1980s. In May of 1993, Eritrea established itself as an independent nation. Prior to the Mengistu government, Ethiopia was ruled by Emperor Haile Sellassie I, who took an active role in creating the country's legal system, much of which remains in force today.[2] Ethiopia differs from many other countries in sub-Saharan Africa in that it was not colonized by foreign interests, except for a five-year Italian occupation, from 1936 to 1941.[3]

The total population of Ethiopia is estimated to be 55,979,018.[4] Women make up 52% of the population.[5] Approximately 45% to 50% of the population is Muslim, 35% to 40% is Ethiopian Orthodox, and 12% of the population is animist.[6] Ethiopia has many ethnic groups.[7] The Oromo make up approximately 40% of the population, Amhara and Tigre about 32%, and Sidamo about 9%.[8] Other ethnic groups include the Afar, Somalia, Saho, and Agew peoples.[9] There are 286 languages spoken in Ethiopia;[10] the official language is Amharic.[11]

I. Setting the Stage: The Legal and Political Framework

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

A. THE STRUCTURE OF GOVERNMENT

Ethiopia has a parliamentary federal government administering nine states formed "on the basis of settlement patterns, identity, language and the consent of the people concerned."[12] The two primary federal bodies are the Council of Peoples' Representatives and the Federal Council; the membership of the former is elected by a majority vote in each electoral district,[13] whereas the latter consists of representatives of nations, nationalities, and peoples, elected either by state legislators or directly by the people of each state.[14] The Council of Peoples' Representatives has broad legislative powers,[15] while the Federal Council is responsible primarily for interpreting the Constitution and promoting unity among Ethiopia's various nationalities.[16]

The head of state is the president of the nation,[17] elected upon winning the support of two thirds of the members of both councils in a joint session.[18] The president signs into law the legislation approved by the Council of Peoples' Representatives.[19] The prime minister and the Council of Ministers have the highest executive powers in Ethiopia.[20] The prime minister is elected by the Council of Peoples' Representatives from among its members.[21] As chief executive, chairman of the Council of Ministers and commander-in-chief of the armed forces, the prime minister has broad powers to supervise and ensure the implementation of laws, policies, and directives adopted by the Council of People's Representatives.[22] The Council of Ministers, among other duties, determines the organizational structure of government administrative agencies, presents an annual budget to be approved by the Council of People's Representatives, and administers the National Bank.[23]

The Constitution establishes an independent judiciary branch at both the federal and state levels.[24] Federal judges are appointed by the Council of People's Representatives, and state judges are appointed by state legislatures.[25] Judges may not be removed before they reach a legally mandated retirement age, except for violation of disciplinary rules, gross incompetence, or illness.[26] All removal decisions by the Judicial Administration Commission require approval by a majority of the Council of Peoples' Representatives or State Council.[27] Ultimate power to review the constitutionality of laws lies with the Federal Council.[28]

Courts both create and interpret laws. The judicial system can have a significant impact on legislation, including that affecting reproductive rights, because it is able to both enforce law and deal with complaints from individuals challenging the constitutionality of specific laws.

The systematic modernization of Ethiopia's legal system began after the country's liberation from Italy's short occupation.[29] In 1954, Emperor Haile Sellassie I undertook to codify Ethiopian law.[30] While most similar to a civil law regime,[31] Ethiopian law has been characterized as "eclectic."[32] Free of colonial domination for most of its modern history,[33] Ethiopia has supplemented or replaced indigenous legal

principles[34] with laws from various foreign sources. The substantive law on civil matters is largely drawn from European civil law systems, while procedural codes are akin to those of Commonwealth countries.[35] Public law, including constitutional law, has historically reflected the Anglo-American system.[36] Under Colonel Mengistu's regime, influential socialist laws were reflected in the Constitution of the People's Democratic Republic, an instrument that is no longer in force.[37]

The judicial system of Ethiopia consists of regular courts, Mohammedan (Muslim) courts, special courts, and people's tribunals.[38] Regular courts consist of four levels: the Supreme Court, the High Court, the Awraja (province) Court, and the Woreda (district) Court. The Supreme Court, which sits in Addis Ababa and has a branch in Asmara, consists of three judges and has appellate jurisdiction. If the president of the court determines that the complexity of a case requires it, he or she may decide that a division may be constituted by more than three judges. Such a division is referred to as a panel. The High Court is a court of nationwide jurisdiction, and it sits in all provincial capitals. It has both original jurisdiction of some matters and appellate jurisdiction from cases coming from the Awraja court. The Awraja court sits in each Awraja and exercises jurisdiction within the local limits of the Awraja administration. The lowest court is the Woreda court, which sits in each Woreda and exercises jurisdiction within the local limits of the Woreda administration.[39]

Muslim courts were established in 1944 and consist of three levels: Naiba Councils, Kadia Councils, and the Court of Sharat — the court of last resort. These courts have jurisdiction over two types of cases: cases regarding marriage, divorce, maintenance, guardianship of minors, and family relationships, if the marriage to which the case relates was concluded in accordance with Mohammedan law, or if the parties are all Mohammedan; and cases regarding religious endowments, gifts, succession, or wills, if the endower or donor is a Mohammedan or the deceased was a Mohammedan at the time of his death. The Muslim courts apply the Mohammedan religious laws of the Koran.[40] Although the Civil Code of 1960 attempts to establish a uniform legal regime for all Ethiopians, without exception, Muslim courts continue to exist and function. In fact, the Court of Sharat sits as a division of the Supreme Court.[41]

Special courts, comprised of First Instance Special Court and an Appellate Special Court, serve the function of applying a special provision of the penal code dealing specifically with offenses against the Ethiopian government, the head of state, breach of trust, and offenses against the interest of the government or public, abuse of authority, and offenses against official duties.[42]

The People's Tribunals are the judicial tribunals that were developed after the eruption of the Ethiopian Revolution of 1974 by the Peasant Associations and the Urban Dwellers Associations at the same time that the Public Ownership of Rural Lands Proclamation and the Nationalization of Urban Lands and Extra Houses were passed. The jurisdiction of these tribunals is more or less limited to minor civil and criminal cases.[43]

B. SOURCES OF LAW

Domestic Sources of Law

As in other civil law regimes, legislation is the primary source of law, although in Ethiopia accepted statutory interpretation has progressed through case law.[44] The Constitution of the Federal Democratic Republic of Ethiopia (the "1994 Constitution") declares itself the supreme law of the land. Furthermore, Ethiopia has six major legal codes: the Penal Code of the Empire of Ethiopia,[45] the Civil Code of the Empire of Ethiopia,[46] the Maritime Code of the Empire of Ethiopia,[47] the Commercial Code of the Empire of Ethiopia,[48] the Criminal Procedure Code of the Empire of Ethiopia,[49] and the Civil Procedure Code of the Empire of Ethiopia.[50] The Civil Code explicitly repeals customary law,[51] and with over 3,000 provisions it is comprehensive in its coverage.[52] However, customary law is preserved in all matters not covered by the Civil Code.[53] The Civil Code generally incorporates customary law provisions when such custom is: sufficiently general; consistent with Ethiopian views of "natural justice"; conducive to economic and social development; and clearly articulable.[54] Other provisions explicitly refer to custom, particularly in matters of family law, property, contract, and torts.[55] For example, a Civil Code article on betrothal specifies that "[t]he form of betrothal shall be regulated by the usage of the place where it is celebrated."[56]

Any law, customary practice, or government order that contradicts the 1994 Constitution is invalid.[57] However, Article 34 of the 1994 Constitution proclaims that this Constitution shall not preclude the adjudication of personal or family disputes by "religious or cultural laws" if all parties agree.[58] Further, Article 78 specifies that the federal and state legislatures may establish or give official recognition to religious and cultural courts.[59]

International Sources of Law

Many international human rights treaties recognize and promote specific reproductive rights. Because they are legally binding on governments, these international instruments impose specific obligations to protect and advance these rights. All international agreements ratified by Ethiopia have the status of national law.[60] In addition, the Fundamental

Rights and Freedoms enumerated in the Constitution are to be interpreted "in conformity with the Universal Declaration of Human Rights, international human rights covenants, humanitarian conventions and with the principles of other relevant international instruments which Ethiopia has accepted or ratified."[61] Ethiopia has ratified, *inter alia*: 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 ("CEDAW"); the Convention on the Elimination of All Forms of Racial Discrimination; and the Convention on the Rights of the Child.[62]

II. Examining Reproductive Health and Rights

Issues of reproductive health and rights are dealt with in Ethiopia within the context of the country's health and population policies. Thus, an understanding of reproductive rights in Ethiopia must be based on an examination of those policies.

A. HEALTH LAWS AND POLICIES

Objectives of the Health Policy

Article 90 of the 1994 Constitution declares that "[t]o the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health...."[63] In 1993, the Transitional Government released a National Health Policy ("Health Policy"), which defines "health" as "constituting physical, mental and social well-being."[64] Criticizing the highly centralized health service infrastructure of the previous regime, which it calls "unresponsive, self-serving and impervious to change,"[65] the Health Policy declares a commitment to "democratization and decentralization of the health service system."[66] Strategies for promoting democratization of health services include the establishment of health councils with community representation and the formation of grassroots committees.[67] These bodies are intended "to participate in the identifying of major health problems, budgeting, planning, implementation, monitoring and evaluating health services."[68] Decentralization is to be achieved by transferring to the regional level significant responsibility for "decision-making, health care organization, capacity building, planning, implementation and monitoring."[69]

The Health Policy has as a priority, among other things, to control communicable diseases, epidemics, and diseases related to malnutrition and poor living conditions, and to give special attention to the health needs of the family, particularly women and children.[70] It is among the general strategies of the policy to ensure adequate maternal health care and referral facilities for high-risk pregnancies, to intensify family planning for the optimal health of the mother, child, and family, to encourage early utilization of available health care facilities for the management of common childhood diseases, and to address the special health problems and related needs of adolescents.[71]

In April 1995, the transitional government issued the Transitional Government's Health Sector Strategy ("Health Strategy"), which outlines the course of action to be taken by governmental public health officials.[72] Citing severe health service distribution problems — due in part to a very centralized system[73] — one of its key objectives is to implement the provision of basic health service at the community level.[74] The Health Strategy outlines a plan to establish equitably distributed "primary health care units with standard facilities and staffing" that will serve "a manageable population."[75] These units are to "provide a comprehensive and integrated health service encompassing health education, preventive activities and the treatment and control of common communicable and epidemic diseases."[76] Referral facilities are to be available at nearby hospitals.[77]

A commitment to family health — and thus, reproductive health — is reaffirmed in the Health Strategy.[78] The Health Strategy calls for special attention to be given to "maternal and child care with provision of antenatal, perinatal and postnatal care, family planning advice and service, growth monitoring, nutrition education and immunization."[79]

Infrastructure of Health Services

The Ministry of Health ("MOH") oversees the delivery of health care.[80] Its duties include the establishment and administration of hospitals, the determination of standards for health services, the licensing and supervising of health facilities established by foreign organizations and investors, and the licensing of health care professionals according to standards set by the MOH.[81] The ministry is also charged with devising strategies for the prevention and eradication of communicable diseases and initiating research on traditional medicines and nutrition.[82] Health care is intended to be delivered in a six-tier pyramid system, which, according to the Health Strategy, is in practice more of a reversed pyramid.[83] The pyramid is structured in the following descending order: hospitals, regional hospitals, zonal hospitals, health centers, health stations, and community health clinics.[84] As of 1994, the MOH operated 72 hospitals (with 9,538 beds), 153 health centers, and 2094 health stations,[85] serving a population of 55 million people. Roughly more than 50% of health facilities are in urban areas, most of them in Addis Ababa.[86] Geographic distribution of these health services also varies enormously from one state to another. For example, there are 21 hospitals and

801 health services in Oromia state, whereas there is only one hospital and 30 health stations in Gambela state.[87]

Cost of Health Services

The 1994 Constitution provides that it is the duty of the Ethiopian state to finance health care services.[88] The Transitional Government's Health Strategy explains that health services have always been underfunded; however, in the last decade or so, underfunding has been aggravated by a decline in the per capita share of public expenditure in health due to the utilization of resources for civil war efforts of "the previous regime."[89]

Thus, the likelihood of comprehensive implementation of Ethiopia's current health policy relies on the extent to which health care delivery can be financed. Article 41 of the 1994 Constitution obligates the State to allocate increasing resources to public health financing.[90] The Health Policy specifies that health services will be financed through public, private, and international sources.[91] While the government's recurrent health budget doubled from 1983 to 1993 (from 100 million Ethiopian Birr to 200 million Ethiopian Birr, which is approximately U.S.$16 million to U.S.$31 million),[92] it has been found inadequate to cover drugs, medical supplies, and general expenses.[93]

Regulation of Health Care Providers

The Council of Ministers provides regulation for the licensing and supervision of health service institutions.[94] Health institutions are defined as hospitals, health centers, clinics, or diagnostic centers run by any person who provides services either free of charge or by charging fees.[95] Any person who wishes to establish or operate a health service institution must obtain a license in accordance with these regulations.[96] A license may be suspended when the licensee: "1. fails to observe medical ethics; 2. engages in rendering services which are outside the competence of the health service institution for which the license is obtained; 3. allows a practitioner, who is not registered pursuant to the appropriate law or who has been suspended by a court from practicing his profession or who is addicted to alcohol or drugs, to work in the health service institution; 4. fails to observe laws, regulations and directives relating to health services; 5. fails to submit, accurately and on time, information required under these Regulations and directives issued for the implementation of these Regulations."[97] In addition, these regulations mandate that the licensing authority inspect health service institutions to ascertain that the licensee is working in conformity with these regulations and other laws, regulations, and directives relating to health services.[98]

A committee formed by the Minister of Health in Ethiopia has drafted and published a book entitled "Medical Ethics for Physicians Practicing in Ethiopia."[99] In addition to providing a code of ethics, this book compiles all provisions of laws relating to health care. Because the curricula of medical schools do not include medical ethics, and neither the Ministry of Health nor existing medical health associations have codes of ethics, these are the only guidelines concerning medical ethics in Ethiopia.[100] These guidelines include a general code of ethics, which addresses issues such as "the physician as a professional," "advertisement and publicity," "certificate, prescription and signature," the "supervisory role of the physician," and "patients' informed consent."[101] In regards to this last issue, the guidelines state that it is the duty of the physician to inform the patient about treatment, including surgical procedures. Furthermore, physicians are always obliged to obtain a written consent from the patient before carrying out procedures. The guidelines also allow physicians, on "legitimate grounds," to use their own discretion in withholding information about a serious diagnosis unless the patient demands it.[102]

The Penal Code also addresses issues of regulation of health providers. It calls for simple imprisonment[103] and a fine for the "[u]nlawful Exercise of the Medical or Public-Health Professions."[104] Article 518 states that "[w]hosoever, having neither the professional qualifications…nor the authorization to set up official practice required under the relevant regulations, makes a practice of treating sick persons in no matter what form…" shall be punished.[105] An exception is provided for the practice of "a system of therapeutics according to indigenous methods by persons recognized by the local community to which they belong," as long as such methods are not dangerous or injurious to the health or life of the person.[106]

The Penal Code also criminalizes those who "contravene[ ] the rules or regulations regarding: the permission to practise [sic], and the practice of, the medical, pharmaceutical and veterinary professions and auxiliary professions of any kind whatsoever, including physio-therapy, natural therapeutics and chiropractic"; or the sale or delivery of drugs and medicines; or the opening or management of establishments for cures of any nature.[107]

The Penal Code also provides for punishment for any physician, dentist, midwife, veterinary-surgeon, or person officially authorized to attend patients who fails to bring to the notice of the competent authority facts which, under the law, they are obliged to report in particular with a view to preventing the spread of contagious diseases, drug addiction, or epizootic.[108]

Patients' Rights

The Ethiopian Civil Code establishes tort principles[109] that could be applied in the context of patients' rights. For example, Article 2031, entitled "Profession fault," states that

"[a] person practising [sic] a profession or a specific activity shall, in the practice of such profession or activity, observe the rules governing that practice."[110] Such person shall be liable where he or she is guilty of "imprudence" or "negligence constituting definite ignorance" of his or her duties.[111]

B. POPULATION AND FAMILY PLANNING

The Population and Family Planning Policy

The broad goal of the Transitional Government's 1993 Population Policy is to promote social welfare by harmonizing the rate of population growth and the country's capacity for development and rational utilization of natural resources.[112] Citing political turmoil and adverse climatic conditions, the Population Policy notes that the Ethiopian population has been thrown into abject poverty during recent decades.[113] The Population Policy expresses particular concern over an age structure — Ethiopia's population is so dominated by young people that its mean age is 17 and the number of women of childbearing age is very high — that makes rapid population growth highly probable.[114] The 1994 Constitution focuses on women's right to plan their families. Article 35 of the Constitution states: "[t]o prevent harm arising from bearing or giving birth to a child and in order to safeguard their health, women have the right to information and to means that would enable them to plan their families."[115]

The Population Policy's general objectives include: closing the gap between high population growth and low economic productivity through planned reduction of population growth and increasing economic returns; expediting economic and social development processes through holistic, integrated development programs designed to expedite the structural differentiation of the economy and employment; reducing the rate of rural-to-urban migration; assuring environmental protections; raising the economic and social status of women by freeing them from the restrictions of traditional life and making it possible for them to participate productively in the larger community; and improving the social and economic status of vulnerable groups, such as adolescents, children, and the elderly.[116] Specific objectives of the Population Policy include: reducing the current total fertility rate of 7.7 children per woman to about 4.0 by the year 2015; increasing the prevalence of contraceptive use from 4.0% to 44.0% by the year 2015; reducing maternal, infant, and child morbidity and mortality, as well as promoting the level of general welfare of the population; significantly increasing female participation in the educational system at all levels; removing all legal and customary practices militating against the full enjoyment of economic and social rights by women including the full enjoyment of property rights and access to gainful employment; ensuring spatially balanced population distribution patterns with a view to maintaining environmental security and extending the scope of development activities; improving productivity in agricultural activities for the purpose of employment diversification; and mounting an effective countrywide population information and education program addressing issues pertaining to small family size and its relationship to human welfare and the environment.[117]

The strategies by which the goals of the Population Policy are to be attained are varied. The strategies include expanding contraceptive distribution, promoting breast-feeding as a means of birth-spacing, raising the minimum age of marriage for girls from 15 years to at least 18 years, implementing career counseling services in public schools, and integrating women into the "modern" sector of the economy.[118] In addition, one of the plan's strategies involves amending all laws "impeding, in any way, the access of women to all social, economic and cultural resources," and amending relevant articles and sections of the civil code to remove unnecessary restrictions to the "advertisement, propagation and popularization of diverse contraception control methods."[119] Other strategies listed include: establishing teenage and youth reproductive health counseling centers; increasing research in reproductive health; promoting male involvement in family planning; and diversifying available contraceptive methods.[120]

The Population Policy acknowledges that existing delivery systems are limited in scope and that choice of family planning methods is limited.[121] To correct these problems, it calls for an expansion of reproductive health service delivery — currently available only through the limited formal health structure — to clinical and community-based outreach services.[122] It also recommends the involvement of non-governmental organizations ("NGOs") in providing services, including the widest possible choice of contraceptives.[123] The Population Policy also acknowledges a need to expand capacity for performing population research and training family planning advisors. To implement the latter goal, the plan calls for family planning to be integrated into the curricula of medical schools, nursing and health assistants' schools, junior colleges, and technical vocational schools. Finally, the Population Policy calls for the expansion of Information, Education, and Communication ("IEC"), and community involvement in achieving the goals of the Population Policy.[124]

The Population Policy takes a multidisciplinary approach towards implementation.[125] The National Population Council and the Office of Population within the Office of the Prime Minister were created to implement the strategies of the Population Policy.[126] This national structure is to be replicated on the regional, zonal, and district levels.[127]

New duties for the MOH include the improvement of maternal/child health programs, the provision of family planning services at all levels of health service delivery, the strengthening of the content of reproductive health in education programs, the improvement and expansion of training for health personnel, and the setting of standards for the provision of family planning services.[128] Duties of the Ministry of Justice include the amendment of all "existing laws and ordinances that restrict the right of individuals and families to regulate their family size."[129] The Family Guidance Association of Ethiopia and other NGOs are called upon to, among other things, "expand networks of family planning service delivery by increasing the number of family planning clinics and reaching out heretofore unreached communities...."[130]

Government Delivery of Family Planning Services

Since 1987, family planning services have been rendered through health institutions run by the MOH.[131] The government health institutions that provide family planning services are hospitals, clinics, and health centers.[132] Government support for family planning is distributed in keeping with the Health Strategy's statement that health services should "emphasize the preventive and promotive aspect of health care" and not spend disproportionately on curative care.[133] According to the Health Policy, the promotion of "family health" is among the government's priorities.[134] It is in the context of family health that the Health Policy makes reference to reproductive health. Strategies for promoting family health include providing adequate maternal health care and medical facilities for women with high-risk pregnancies, implementing family planning services, educating pregnant women about maternal nutrition, and encouraging breastfeeding and the use of homemade baby foods.[135] Also listed as a strategy is the identification and discouragement of harmful traditional practices.[136]

C. CONTRACEPTION

Contraceptive prevalence in Ethiopia is approximately 4.0%.[137] In 1990, the most prevalent contraceptives were the pill (76%), condoms (7%), and intrauterine devices ("IUDs") (4.2%).[138]

Legal Status of Contraceptives

Since there is no official law authorizing the sale and use of contraceptives, they can be purchased in pharmacies without a prescription.[139] Present government policy on population planning aims at increasing access to reproductive health care and at repealing laws that inhibit the distribution of contraceptives.[140] The Population Policy lists as a strategy: "Amending relevant articles and sections of the civil code [sic] in order to remove unnecessary restrictions pertaining to the advertisement, propagation and popularization of diverse conception control methods...."[141] The current policy of the MOH's Family Health Department[142] is to provide complete access to contraceptives for every woman of reproductive age and at all socioeconomic levels.[143]

The Ethiopian supply of contraceptive products has been provided largely by international organizations and donor governments.[144] Because none of the widely used contraceptives is actually manufactured in Ethiopia,[145] the absence of domestic production of contraceptives makes the supply vulnerable to shortage.[146] The Family Health Department of the MOH is currently devising a plan for the widest possible distribution of contraceptives.[147]

The sale and distribution of contraceptives are governed by laws regulating pharmaceuticals in general. Articles 510(1) and 786(c) of the Penal Code and Article 23 of the Pharmacy Regulations[148] are concerned with the legal authority of those who produce and distribute poisons, drugs, and narcotics and with the manner in which they do so. Articles 52 and 54 of the Pharmacy Regulations give the MOH the power to set quality standards for all medicinal preparations.[149] Articles 510 and 786 of the Penal Code impose penalties for the adulteration or mislabeling of pharmaceutical products.[150]

Regulation of Information on Contraception

The Penal Code of Ethiopia penalizes the advertisement of contraceptive methods: "Whosoever, (a) advertises or displays in public, or sends to persons who did not solicit them or are not, by reason of their profession, interested therein, contraceptive publications, or contraceptive samples…is punishable with fine or arrest not exceeding one month."[151] However, because of the present government's policy on population, this provision of the Penal Code regarding advertisement of contraceptive methods is in effect void.[152] The Ethiopian Family Guidance Association, among others, including the Ministry of Health, are actively engaged in the promotion, sale, and distribution of various contraceptives.

D. ABORTION

Legal Status of Abortion

Ethiopian law restricts women's ability to obtain abortions. "The deliberate termination of a pregnancy, at whatever stage or however effected" is prohibited by the Penal Code[153] and, depending on the circumstances under which the abortion is performed, subject to varying levels of punishment. The Penal Code does not punish terminations of pregnancies that arise from "imprudence or negligence."[154] Moreover, an abortion obtained to save the pregnant woman from "grave and permanent danger to life or health" that "is impossible to avert in any other way" is not punishable when certain legal requirements

are observed.[155] (These requirements are discussed below.) Punishment for abortions may also be mitigated by a court when the pregnancy is terminated on account of "an exceptionally grave state of physical or mental distress, especially following rape or incest, or because of extreme poverty."[156]

Requirements for Obtaining Legal Abortion

A woman may obtain a legal abortion under defined circumstances only when several formalities have been completed. The requirements for terminating a pregnancy on "medical grounds" include the presentation of a written, certified diagnosis submitted by a registered medical practitioner after examination of the pregnant woman.[157] The diagnosis must be approved by a second doctor who is a specialist in the diagnosed condition and is empowered to make an authorization.[158] In addition, the pregnant woman must give her consent, or, if she is incapable of granting that consent, her next of kin or legal representative must consent for her.[159] The second doctor must keep a duplicate of the findings and the decision and transmit them to the appropriate government official.[160] If these formalities are not completed, the abortion shall be deemed illegal and the relevant penalties shall apply.[161]

While these requirements may be modified in the case of a pregnancy terminated upon the grounds of medical emergency, prior consent of the pregnant woman or that of her next of kin or legal representative and subsequent notice to the appropriate official are indispensable under the current law.[162]

Abortion is also addressed in the "Medical Ethics for Physicians Practicing in Ethiopia." These guidelines state that "[a]n abortion is justifiable only when it is performed for the purpsoe [sic] of saving the endangered life or health of a woman."[163] Furthermore, an abortion is "justifiable if performed by a physician in health institutions where appropriate facilities are available."[164] In addition, the guidelines state that it is mandatory to treat a patient who is suffering from the effect of a criminal abortion induced by another person and that the doctor must never disclose the cause of his or her patient's condition to anyone else without her consent, unless ordered to do so by a court of law.[165] A criminal abortion "leading to death should be reported to the concerned authorities by the treating physician."[166]

Penalties

The penalty for terminating a pregnancy upon grounds not permitted by the Penal Code varies. If an illegal abortion is procured by the pregnant woman herself, she is subject to three months to five years of "simple" imprisonment.[167] Anyone who procures an illegal abortion for her or assists her in the abortion shall be punished as an accomplice or co-offender and is subject to one to five years of simple imprisonment.[168] One who performs an illegal abortion, or one who assists in performing the abortion, is subject to a maximum of five years of "rigorous" imprisonment.[169] If the woman's consent is lacking, by virtue of her own incapacity to consent or understand the significance of her actions or because she was threatened, coerced, deceived, or physically forced, the abortion provider faces three to ten years of rigorous imprisonment.[170] When the performer of the abortion has acted for gain or has made a profession of performing abortions, the offense is deemed aggravated and the punishment is extended to three to ten years of rigorous imprisonment.[171] In addition, if the performer is a doctor, pharmacist, midwife, or nurse, he or she shall be barred from practice either temporarily or, if the offense is repeatedly committed, permanently.[172]

Regulation on Abortion Information

Article 802 of the Penal Code prohibits the advertising or offer for sale of products designed to cause abortion or the offer to perform an abortion; it states: "Whosoever…(b) advertises or offers for sale means or products designed to cause abortion, or publicly offers his services to perform abortion, is punishable with fine or arrest not exceeding one month."[173]

E. STERILIZATION

Although sterilization is not mentioned specifically in the Penal Code, Articles 537 and 538 of this law, which prohibit the "maiming and disabling of essential organs," have been interpreted to prohibit sterilization.[174] Nonetheless, in effect, the existence of Articles 537 and 538 of the Penal Code have not proven to be a significant legal barrier to sterilization.[175] Since 1987, sterilization has been utilized as a means of birth control in Ethiopia.[176] The procedure is performed in public hospitals, as well as by the Family Guidance Association of Ethiopia ("FGAE"),[177] a national NGO involved in population and family planning activities.[178] In practice, a person is not required to meet any stringent requirements before undergoing sterilization.[179] The patient is only required to express a desire to limit his or her family size.[180] Furthermore, health institutions do not require spousal consent.[181]

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

Muslims, Christians, and Ethiopian Jews (Falashas) practice female genital mutilation ("FGM") — also referred to as female circumcision — in Ethiopia, where its prevalence is estimated at 90%.[182] While there is no law that specifically refers to FGM, Article 35 of the 1994 Constitution provides that "[w]omen have the right to protection by the state from

harmful customs. Laws, customs and practices that oppress women or cause bodily or mental harm to them are prohibited."[183] The Health Policy also lists as a general strategy the identification and discouragement of harmful traditional practices.[184] For further discussion regarding FGM, see section on adolescents.

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

Examining HIV/AIDS issues within a reproductive health framework is essential insofar as the two areas are related from both a medical and public health standpoint. Hence, a full evaluation of laws and policies affecting reproductive health and rights in Ethiopia must examine HIV/AIDS and sexually transmitted diseases ("STDs"). The actual number of people in Ethiopia suffering from AIDS is estimated to be 350,000,[185] while approximately 1.7 million people are HIV-positive.[186] As of July 1995, 19,433 cases of AIDS had been reported to the MOH.[187] Forty-two percent of those who reportedly had the disease were women.[188] A study in Addis Ababa claims that the rate of STD infection in Addis Ababa is 32% for women and 45.3% for men.[189]

Laws Affecting HIV/AIDS

Presently, there is no explicit law that refers to HIV or AIDS.[190] The Penal Code does, however, criminalize the act of spreading or transmitting a "communicable human disease,"[191] and the degree of punishment depends on whether the act was done "intentionally," "maliciously," or through "negligence."[192] In addition, any offense of "sexual outrage"[193] is considered aggravated if the offender transmits a "venereal disease with which he knows himself to be infected."[194] These provisions of the code are arguably applicable to cases of STDs and HIV/AIDS.[195]

Policies Affecting Prevention and Treatment of HIV/AIDS

While the Health Policy cites as a priority "the control of communicable diseases" and "epidemics,"[196] the government has not yet issued a national policy on AIDS. However, the MOH has added to its administrative structure a Department of AIDS Prevention and Control, which has adopted the World Health Organization's ("WHO") AIDS Prevention and Control Strategy ("WHO AIDS Strategy").[197] The WHO AIDS Strategy outlines programs to prevent HIV infection and provide support to those living with AIDS.[198] It focuses on transmission of HIV through sexual contact, through blood, and through prenatal exposure.[199] The strategy calls for the prevention of HIV infection through sexual contact to be combated through improved health service delivery, condom distribution, and education via the media and schools with extra focus on target groups particularly at risk.[200]

The WHO AIDS Prevention and Control Department has already taken steps to implement the strategy through educational campaigns in schools and annual distribution of condoms.[201] A visible publicity campaign has been initiated, and signs reading "Let's stop AIDS together" are common sights in public health and school facilities, city buses, taxis, and busy public squares.[202]

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that will affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health care and her ability to make voluntary, informed decisions about such care. Laws regarding age of first marriage can have a significant impact on a young woman's reproductive health. Furthermore, rape and other laws prohibiting sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health.

A. RIGHTS WITHIN MARRIAGE

Marriage Law

The 1994 Constitution, pursuant to an article entitled "Marital, Personal and Family Rights," states that "[m]arriage shall be entered into only with the free and full consent of the intending spouses."[203] Article 34 provides that "[m]en and women, who have attained marriageable age as defined by law…are entitled to equal rights as to marriage, during marriage and at its dissolution."[204] The Civil Code bars marriage contracts between men under the age of 18 years and women under the age of 15 years.[205] It also prohibits marriage of any kind between persons related by consanguinity or affinity.[206] In addition, the Civil Code bars bigamy,[207] and the Penal Code provides criminal sanctions for it.[208] In accordance with Article 34 of the 1994 Constitution, consent for marriage obtained by violence is invalid under the Civil Code.[209] However, the Civil Code specifies that if consent is prompted by "reverential fear" towards an "ascendent" or another

person, such consent is not considered to have been obtained by violence.[210] This provision in the Civil Code is in potential contradiction with the provision of the 1994 Constitution that states that "[m]arriage shall be entered into only with the free and full consent of the intending spouses."[211]

The Civil Code recognizes three types of marriage: civil, religious, and customary.[212] Marriages contracted in accordance with the religious or local customs of the parties are recognized and regulated under the Code just as are marriages contracted before an officer of civil status.[213] A marriage may take place in any one of these forms, but the legal effects of the marriage, both in terms of the personal relationship between the spouses and in terms of their property, are regulated by the Code.[214] Therefore, even though a marriage may be consummated according to the custom of either of the spouses, the effects of the marriage are regulated by the Civil Code and not by the customary law. The Civil Code provides that spouses may determine by contract prior to marriage the "pecuniary effects" of their marriage as well as their reciprocal rights and obligations in their relationship.[215] These contracts cannot affect any mandatory provisions of the law,[216] and such contracts made between spouses have no effect under the law unless approved by family arbitrators[217] or the court.[218] Also, the provisions of a marriage contract may not refer simply to "local custom."[219] Regardless of the terms of the contract of marriage, spouses owe each other "respect, support and assistance."[220] In terms of "pecuniary effects," it is important to note that absent marriage contract provisions to the contrary, property belonging to either spouse on the day of marriage or acquired after marriage, either by succession or donation, remains that spouse's personal property.[221] Each spouse is entitled to administer, receive income from, and dispose of his or her personal property as he or she pleases.[222] Salaries and income of the spouses, property acquired by the spouses during marriage, and property bequeathed to both spouses jointly constitutes common property.[223] Also, under the Civil Code, common property is to be administered by the husband, although family arbitrators may entrust to the wife the administration of the common property.[224] The agreement of both spouses, however, is required for the alienation of common real estate and movables of high value, the contracting of a loan, or the making of a donation of high value.[225]

In the absence of a valid contract regulating the terms of the marriage, the "[p]ersonal effects of marriage" and the "[p]ecuniary effects of marriage" provisions of the Civil Code apply.[226] The personal effects of marriage concern the personal relationship between the spouses; the pecuniary effects concern the property that belongs to each spouse as well as the property the spouses have in common. These provisions dictate, for example: that the husband is the head of the family and, unless otherwise expressly provided in the Civil Code, the wife must obey him in all lawful things which he orders;[227] that the common residence is to be chosen by the husband;[228] and that the husband owes his wife protection and may "guide her in her conduct, provided this is in the interest of the household, without being arbitrary and without vexatious or other abuses."[229] For a discussion on marriage and adolescents, see section on adolescents below.

Divorce and Custody Law

The laws regarding the dissolution of marriage are the same regardless of whether the marriage was contracted under civil, customary, or religious law.[230] A marriage can be dissolved on the following grounds: death of spouse;[231] when a court orders its dissolution as a sanction of one of the "conditions" of marriage;[232] or by divorce.[233] A divorce may be sought for "serious causes" or for "other causes."[234] "Serious cause" for divorce is present when one of the spouses has committed adultery,[235] or when one of the spouses has deserted the couple's residence and the other spouse does not know his [or her] whereabouts for a period of two years.[236] "Serious causes" may also exist which are "not due to a spouse,"[237] when one spouse is "confined in a lunatic asylum" for a minimum of two years or when the "absence" of a spouse has been "judicially declared."[238]

Couples seeking divorce must first seek out "family arbitrators."[239] According to the Civil Code, the witnesses to the marriage should serve as arbitrators, but the couple may seek arbitration from other persons.[240] In cases where there is no "serious cause" for divorce, the arbitrators "shall attempt to reconcile the parties."[241] The Civil Code states that when reconciliation attempts fail, arbitrators shall grant a divorce, preferably upon terms agreed to by the parties.[242] If a spouse can establish "serious cause" for divorce "imputable to one of the spouses," the family arbitrator may distribute to the spouse responsible for the divorce a smaller share of the couple's common property.[243] When there is no serious cause, property is distributed unevenly to the disadvantage of the spouse who has petitioned for divorce.[244] The rules for distribution of property may not be altered contractually before or during marriage.[245] While arbitrators are bound to the apply the penalties enumerated in the Civil Code, they may use their discretion in deciding whether or not to penalize parties.[246] In particular, they may consider the "importance and the gravity of the faults by reason of which the divorce has been ordered and the more or less morally reprehensible nature of the petition for divorce."[247] The arbitrator's decision may be appealed to the courts. The court will only overturn

an arbitrator's decision upon a finding of arbitrator corruption, third-party fraud, or that the decisions were "illegal or manifestly unreasonable."[248]

Periodic support payments (or "alimony") to a former spouse after divorce are apparently not recognized in Ethiopian culture.[249] There is an article of the Penal Code, however, entitled "Failure to Maintain," which makes it an offense to refuse or omit "to provide the allowances, necessaries of life or maintenance which he owes, by virtue of family rights or of a judicial decision, to…his spouse, even where divorced.…"[250] Furthermore, support payments are often given (to the wife) pending the conclusion of the litigation related to a divorce.[251] That payment is then deducted from her share of property if divorce ultimately results.[252]

The Civil Code states that, following divorce, arrangements for the custody and maintenance of children born of the marriage shall be made solely with the interest of the children in mind.[253] This law specifies that unless there is a "serious reason" for deciding otherwise, the children shall be in the custody of their mother up to the age of five years.[254] All arrangements made for the custody and maintenance of the children may be revised at any time by the arbitrators upon the application of the father, mother, or other ascendent of the children.[255]

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

The 1994 Constitution provides for women's equal right to "acquire, administer, control, transfer and benefit from property."[256] In particular, women have "equal rights with men with respect to access, use, administration and transfer of land."[257] The 1994 Constitution also includes a provision guaranteeing equal treatment in the inheritance of property.[258] According to the Civil Code, spouses only inherit from each other pursuant to a will. Thus, if a person dies intestate, his or her spouse does not inherit the decedent's property.[259] Women's right to own property is also addressed in the Public Ownership of Rural Lands Proclamation of 1975,[260] which provides that "[w]ithout differentiation of the sexes, any person who is willing to personally cultivate land shall be allotted rural land sufficient for his maintenance and that of his family,"[261] and 10 hectares[262] per family was set as the maximum limit.[263]

Labor Rights

The 1994 Constitution assures women the right to "equality in employment, promotion, pay, and the entitlement to bequeath pensions."[264] There is also a measure declaring that "in recognition of the history of inequality and discrimination suffered by women in Ethiopia, women are entitled to remedial and affirmative measures" intended to "enable women to compete and participate on the basis of equality with men in political, economic and social life, and to gain access to opportunities and positions in public and private institutions."[265] The "Labour Proclamation" of 1993[266] also regulates the working conditions of women. It states: "Women shall not be discriminated against as regards employment and payment, on the basis of sex."[267] However, the proclamation then goes on to state that it is prohibited to employ women to do types of work that according to the Minister are particularly "arduous or harmful to their health."[268] Furthermore, pregnant women are not to be "assigned to night work between 10 p.m. and 6 a.m. or to be employed on overtime work,"[269] nor is a pregnant woman to be given an assignment outside her permanent place of work, unless it is determined by a medical doctor that her permanent work is dangerous to her health or pregnancy.[270]

The 1994 Constitution also guarantees women the right to maternity leave with full pay, leaving specific terms to be determined by law according to the "nature of the work, the health of the mother and the welfare of the child and the family."[271] It further states that maternity leave may include prenatal leave with full pay.[272] This constitutional provision has been at least partially implemented by the Labour Proclamation, which grants women, upon medical recommendation, the right to maternity leave with full pay, specifying that a woman worker shall be granted a period of 30 consecutive days of leave with pay preceding the presumed date of her confinement and a period of 60 consecutive days of leave, also with pay, after her confinement.[273]

Access to Credit

As stated above, the Constitution entitles women to remedial and affirmative measures to enable them to participate equally with men in economic life.[274] This principle is reiterated in the 1993 National Policy on Ethiopian Women (the "National Women's Policy").[275] While no specific reference is made in Ethiopian law to women's access to credit, a mandate to eliminate barriers to credit is most likely implicit in these broad policy statements. Moreover, the National Women's Policy states that it was based, in part, on the Convention on the Elimination of All Forms of Discrimination against Women, to which Ethiopia has been a party since 1981.[276] This international instrument specifically refers to "the right to bank loans, mortgages, and other forms of financial credit."[277]

Access to Education

Both the National Women's Policy and the 1993 National Population Policy of Ethiopia (the "Population Policy") call for improved access to education for women.[278] The Women's Policy asserts that, while the education policy of

Ethiopia makes no explicit distinction between the sexes, the curriculum is indirectly discriminatory against girls.[279] Traditionally, subjects are categorized as either appropriate for both girls and boys or as only appropriate for boys.[280] As the Population Policy points out, families with limited resources will often send only male children to school and keep girls at home.[281] The Population Policy calls upon the Ministry of Education to "[s]tudy the factors militating against female participation in the educational system and design appropriate corrective measurements [sic]."[282] For further discussion regarding education, see section on adolescents below.

Women's Bureaus

The Transitional Government's National Women's Policy implemented a Women's Affairs Sector, which has been placed in the Prime Minister's Office. The Women's Affairs Sector is "accountable to the Prime Minister and shall be responsible for the coordination, facilitation and monitoring of women's affairs activities at [a] national level."[283] The Women's Policy also provides for the establishment of women's affairs offices on the regional level and in governmental organizations on the department level.[284]

C. RIGHT TO PHYSICAL INTEGRITY

Rape

The Penal Code, pursuant to a section entitled "Injury to Sexual Liberty and Chastity," defines rape as compelling "a woman to submit to sexual intercourse outside wedlock, whether by the use of violence or grave intimidation, or after having rendered her unconscious or, incapable of resistance."[285] The punishment for such an offense is a maximum of 10 years of "rigorous imprisonment."[286] The punishment for rape can be extended to 15 years of rigorous imprisonment under the following circumstances: when the rape is committed against a child under the age of 15; against an institutionalized woman in the care of the offender; or by a number of persons acting in concert.[287] The Penal Code thus recognizes statutory rape, but since it defines rape as occurring "outside wedlock," it does not recognize marital rape as a crime.[288] For further discussion regarding sexual offenses against minors, see section on adolescents below.

Domestic Violence

While the Penal Code assigns criminal penalties for willful injury[289] and assault, [290] the laws do not specify the consequences of violence occurring between husband and wife. The Civil Code states, however, that "the spouses owe each other respect, support and assistance."[291] Moreover, as mentioned above, under the Civil Code, consent for marriage is invalid if obtained through violence.[292] Article 558 of the Penal Code on "abduction" assigns a maximum of three years of rigorous imprisonment for "[w]hosoever carries off a woman by violence, or after having obtained her consent to abduction by intimidation or violence, trickry [sic] or deceit."[293] There is no prosecution if the woman "freely contracts with her abductor a valid marriage" unless the marriage is later annulled by law.[294] One who "carries off an insane, idiot or feebleminded woman, one not fully conscious" or unable to defend herself, is punishable with a maximum of five years of rigorous imprisonment.[295]

Sexual Harassment

There is currently no law specifically addressing sexual harassment in Ethiopia. Because Article 2 of the Penal Code does not allow for the liberal interpretation of Penal Code provisions, it is difficult to consider using existing provisions in the Penal Code to address the issue of sexual harassment.

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

A minor is defined by the Civil Code as "a person of either sex who has not yet attained the full age of eighteen years."[296] The needs of adolescents are often unrecognized or neglected. Given that young people between the ages of 10 and 21 years represent about 31% of Ethiopia's population,[297] it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescents' rights, including those related to reproductive health, is important for women's right to self-determination as well as for their health.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

As of 1990, many family planning clinics did not offer services to women under the age of 18 .[298] However, no explicit laws or policies prevent adolescents from obtaining family planning or maternal/child health services.[299] While the Population Policy expressly sets forth a strategy for the establishment of reproductive health counseling for teenagers and youth,[300] and the inclusion of family life education in the public schools,[301] no mention is made of the provision of reproductive health services to this group.

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

Depending on the region, girls usually undergo FGM at the age of seven days, seven years, or during their teenage years.[302] Where FGM is practiced, girls who have not undergone it are ostracized and are considered unmarriageable in their communities.[303]

C. MARRIAGE AND ADOLESCENTS

As stated above, the Civil Code prohibits marriage of men under the age of 18 years and women under the age of 15 years.[304] Early marriage, however, is pervasive in Ethiopia, with girls often marrying at the age of 14 or younger.[305] These marriages, generally arranged by a couple's parents in conformity with tradition, are motivated in part by the need to ensure a girl's virginity at the time of marriage.[306]

D. SEX EDUCATION AND ADOLESCENTS

There is no comprehensive sex education policy in Ethiopia. However, various policies and programs run by the government agencies encompass sex education.[307]

E. SEXUAL OFFENSES AGAINST MINORS

As stated above, the punishment for rape can be extended to 15 years when the rape is committed against a child under the age of 15.[308] The Ethiopian Penal Code also criminalizes "sexual outrages" — defined as sexual intercourse, or performing an act corresponding to the sexual act — with infants or young persons under the age of 15,[309] as well as with minors between 15 and 18 years of age.[310] Furthermore, the Penal Code criminalizes the "seduction" of adolescent women. This law provides for "simple" imprisonment for "[w]hoever, by taking unfair advantage of the inexperience or trust of a female minor between 15 and 18 years of age, induces her to have sexual intercourse with him, whether by promise of marriage, trickery or otherwise."[311]

ENDNOTES

1. 1996 United States Department of State, DEPARTMENT OF STATE DISPATCH, ETHIOPIA HUMAN RIGHTS PRACTICES 1995 (Mar. 1996).
2. René David, *Sources of the Ethiopian Civil Code*, 4 J. ETH. L. 341 (1967) [hereinafter David].
3. John H. Beckstrom, *Transplantation of Legal Systems: An Early Report on the Reception of Western Laws in Ethiopia*, 21 AM. J. COMP. LAW 557, 557-58 (1973) [hereinafter Beckstrom].
4. THE WORLD ALMANAC AND BOOK OF FACTS 1997, 762 (1996) [hereinafter WORLD ALMANAC].
5. TRANSITIONAL GOVERNMENT OF ETHIOPIA, CENTRAL STATISTICAL AUTHORITY POPULATION ANALYSIS AND STUDIES CENTER, THE 1990 NATIONAL FAMILY AND FERTILITY SURVEY REPORT 45 (June 1993).
6. WORLD ALMANAC, *supra* note 4.
7. THE STATESMAN'S YEAR-BOOK 466 (1996-97). There are 8 major and 60 minor ethnic groups. *Id.*
8. WORLD ALMANAC, *supra* note 4.
9. 4 ENCYCLOPEDIA BRITANNICA, *Ethiopia* 579 (1992).
10. THE STATESMAN'S YEAR-BOOK 466 (1996-97).
11. 4 ENCYCLOPEDIA BRITANNICA, *supra* note 9.
12. CONSTITUTION OF THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA Art. 46 (Dec. 8, 1994)(unofficial Eng. trans.), *reprinted in* CONSTITUTIONS OF THE COUNTRIES OF THE WORLD (Gisbert H. Flanz ed., 1996) [hereinafter ETHIOPIA CONST.]. The nine States are: Tigrai; Afar; Amara; Oromia; Somali; Benshangul/Gumaz; Southern Nations; Nationalities and Peoples; Gambela Peoples; and Harari People. *Id.* at Art. 47. The Constitution grants each of these States the right to secede from the Federal Republic at any time. *Id.*
13. *Id.* at Art. 54.
14. *Id.* at Art. 61.
15. *Id.* at Art. 55.
16. *Id.* at Art. 62.
17. *Id.* at Art. 69.
18. *Id.* at Art. 70.
19. *Id.* at Art. 71.
20. *Id.* at Art. 72.
21. *Id.* at Art. 73.
22. *Id.* at Art. 74.
23. *Id.* at Art. 77.
24. *Id.* at Art. 78.
25. *Id.* at Art. 81.
26. *Id.* at Art. 79.
27. *Id.*
28. Courts and parties to disputes may submit claims to the Council of Constitutional Inquiry, which is supervised by the Federal Council. The chief justice and vice-chief justice of the Federal Supreme Court serve as the Council of Constitutional Inquiry's president and vice-president, respectively. The remainder of the body is comprised of six legal experts and three members of the Federal Council. While the Council of Constitutional Inquiry is deemed to have judicial powers, decisions are not final until they are confirmed by the Federal Council. *Id.* at Arts. 82-84.
29. Daniel Haile, *Legal Scholarship in Ethiopia, in* LEGAL SCHOLARSHIP IN AFRICA 29, (Marco Guadagni ed., 1989) [hereinafter Haile].
30. David, *supra* note 2.
31. Civil law (also called Roman law or Roman Civil law) is based upon statutes as opposed to court decisions. BARRON'S LAW DICTIONARY 78 (1996).
32. Haile, *supra* note 29, at 30.
33. The brief Italian occupation of Ethiopia from 1936 to 1941 had little impact on the development of public institutions. See Beckstrom, *supra* note 3.
34. Indigenous Ethiopian legal principles fall within two categories. The first category consists of principles derived from religious laws that govern both Ethiopian Christians and Muslims. The *Fetha Negast* (Justice of the Kings), drafted in the mid-thirteenth century by the Egyptian scholar Al-Asad Ibn-al-Assal, constitutes a codification of principles of divine law for Ethiopian Christians. Ethiopian Muslims consider Islamic Law sacred. Second, customary rules, though never unified nor systematized, have been important sources of community governance. David, supra note 2, at 342-43.
35. Haile, *supra* note 29, at 30.
36. *Id.*
37. *Id.*
38. Daniel Haile, *The Legal System of Ethiopia* § 1.3, *in* MODERN LEGAL SYSTEMS CYCLOPEDIA (Kenneth Robert Redden ed., 1990).

39. *Id.* § 1.3(A).
40. *Id.* § 1.3(B).
41. *Id.*
42. *Id.* § 1.3(C).
43. *Id.* § 1.3(D).
44. J.Vanderlinden, *An Introduction to the Sources of Ethiopian Law from the 13th to the 20th Century*, 3 J. ETH. L. 37, 55 (1966).
45. PENAL CODE OF THE EMPIRE OF ETHIOPIA 158/1957, 1 Negarit Gazeta, Gazette Extraordinary (July 23, 1957) [hereinafter PEN. CODE].
46. CIVIL CODE OF THE EMPIRE OF ETHIOPIA 165/1960, 2 Negarit Gazeta, Gazette Extraordinary (May 5, 1960) [hereinafter CIV. CODE].
47. MARITIME CODE OF THE EMPIRE OF ETHIOPIA 164/1960, 1 Negarit Gazeta, Gazette Extraordinary (May 5, 1960).
48. COMMERCIAL CODE OF THE EMPIRE OF ETHIOPIA 166/1960, 3 Negarit Gazeta, Gazette Extraordinary (May 5, 1960).
49. CRIMINAL PROCEDURE CODE OF THE EMPIRE OF ETHIOPIA 185/1961, 7 Negarit Gazeta, Gazette Extraordinary (Nov. 2, 1961).
50. CIVIL PROCEDURE CODE OF THE EMPIRE OF ETHIOPIA 52/1965, 3 Negarit Gazeta, Gazette Extraordinary (Oct. 8, 1965).
51. CIV. CODE Art. 3347.
52. George Krzeczunowicz, *Code and Custom in Ethiopia*, 2 J. ETH. L., 425, 433 (1965).
53. *Id.*
54. *Id.* at 429-30.
55. *Id.* at 430-33.
56. CIV. CODE Art. 567.
57. ETHIOPIA CONST. Art. 9
58. *Id.* at Art. 34.
59. *Id.* at Art. 78.
60. *Id.* at Art. 9.
61. *Id.* at Art. 13.
62. International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, 999 U.N.T.S. 171 (*entry into force* Jan. 3, 1976) (ratified by Ethiopia on June 11, 1993); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, 993 U.N.T.S. 3 (*entry into force* Jan. 3, 1976) (ratified by Ethiopia on June 11, 1993); Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 (*entry into force* Sept. 3, 1981) (signed by Ethiopia on July 8, 1980 and ratified Sept. 10, 1981); International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (*entry into force* Jan. 4, 1969) (ratified by Ethiopia on June 23, 1976); and Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, G.A. Res. 44/25, U.N.G.A.O.R., 44th Sess., Supp. No. 49, U.N. Doc. A/44/49, *reprinted in* 28 I.L.M. 1448 (*entry into force* Sept. 2, 1990) (ratified by Ethiopia on May 14, 1991).
63. ETHIOPIA CONST. Art. 90.
64. HEALTH POLICY OF THE TRANSITIONAL GOVERNMENT OF ETHIOPIA 23 (Sept. 1993) [hereinafter HEALTH POL.]. This definition is consistent with the Preamble of the Constitution of the World Health Organization, which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." 1 INT'L ENCYCLOPEDIA OF LAWS 55-59 (1993).
65. HEALTH POL., *supra* note 64, at 22.
66. *Id.* at 24. Other broad policies include the development of preventive and promotion health care services, the equitable distribution of services to all segments of the population, the promotion of intersectoral activities, the promotion of national self-reliance in health development, the assurance of health care service accessibility, increased cooperation with neighboring countries and international organizations, the development of capacity in meeting assessed needs, the scaling of health service fees according to patient ability to pay, and the encouragement of private sector and non-governmental organization participation in health care. *Id.* at 24-25.
67. *Id.* at 28.
68. *Id.*
69. *Id.*
70. *Id.* at 26-27.
71. *Id.* at 34.
72. THE HEALTH SECTOR STRATEGY OF THE TRANSITIONAL GOVERNMENT OF ETHIOPIA 14 (April 1995) [hereinafter HEALTH STRATEGY].
73. *Id.* at 11.
74. *Id.* at 13-14.
75. *Id.* at 13.
76. *Id.* at 14.
77. *Id.*
78. *Id.*
79. *Id.*
80. DEFINITION OF POWERS AND DUTIES OF THE EXECUTIVE ORGANS OF THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA 4/1995, 1 Federal Negarit Gazeta 1, 52-53 (1995) [hereinafter DEFINITION OF POWERS].
81. *Id.* at 53.
82. *Id.*
83. HEALTH STRATEGY, *supra* note 72, at 6.
84. *Id.* at 7.
85. *Id.* at 5. For a regional distribution of health facilities in Ethiopia, *see id.* at 5, tbl. 3.
86. *Id.* at 5.
87. *Id.*
88. ETHIOPIA CONST. Art. 41.
89. HEALTH STRATEGY, *supra* note 72, at 9.
90. ETHIOPIA CONST. Art. 41.
91. HEALTH POL., *supra* note 64, at 38.
92. HEALTH STRATEGY, *supra* note 72, at 10. One U.S. dollar is worth approximately 6.42 Ethiopian Birr. *See* U.N. Operational Rates of Exchange (visited Feb. 27, 1997) <gopher://gopher.undp.org./00/uncurr/exch_rates>.
93. HEALTH STRATEGY, *supra* note 72, at 11.
94. COUNCIL OF MINISTERS REGULATIONS TO PROVIDE FOR LICENSING AND SUPERVISION OF HEALTH SERVICE INSTITUTIONS 174/1994, 66 Negarit Gazeta of the Transitional Government of Ethiopia 331 (Feb. 16, 1994) [hereinafter HEALTH SERVICES].
95. *Id.* at Part I (2).
96. *Id.* at Part II (4).
97. *Id.* at Part II (11).
98. *Id.* at Part III (15).
99. MEDICAL ETHICS FOR PHYSICIANS PRACTICING IN ETHIOPIA (1992) [hereinafter MED. ETHICS].
100. *Id.* at 1-2.
101. *See id.* at 11-17.
102. *Id.* at 14.
103. "Simple" imprisonment is defined as a sentence applicable to offenses of a not very serious nature committed by persons who are not a serious danger to society. The Penal Code states that "[s]ubject to any special provisions of law and without prejudice to conditional release, simple imprisonment may extend for a period of ten days to three years; such period shall be fixed by the court." Furthermore, the sentence is to be served in "such a prison or in such section…as is appointed for the purpose." PEN. CODE Art. 105.
104. *Id.* at Art. 518.
105. *Id.* at Art. 518 (1).
106. *Id.* at Art. 518 (4).
107. *Id.* at Art. 789.
108. *Id.* at Art. 790.
109. *See* CIV. CODE Arts. 2028-65 (for "[l]iability arising from an offence"), 2066-89 (for "[l]iability in the absence of an offence.").
110. *Id.* at Art. 2031.
111. *Id.*
112. NATIONAL POPULATION POLICY OF ETHIOPIA, *Preface* (Apr. 1993) [hereinafter POP. POL.].
113. *Id.* at 1.
114. *Id.* at 4.
115. ETHIOPIA CONST. Art. 35.
116. POP. POL., *supra* note 112 at 27-28.
117. *Id.* at 28-29.
118. *Id.* at 30.
119. *Id.* at 31.
120. *Id.*
121. *Id.* at 32.
122. *Id.*
123. *Id.*
124. *Id.* at 34-36.
125. *Id.* at 37.
126. *Id.* at 38-43.
127. *Id.* at 44-52.
128. *Id.* at 55.

129. *Id*. at 57.
130. *Id*. at 59.
131. Report by Zewdu Alem, Inter Africa Group, Addis Ababa, Ethiopia (1996) (on file with The Center for Reproductive Law and Policy) [hereinafter Alem Report], *citing* FAMILY GUIDANCE ASSOCIATION OF ETHIOPIA, RESEARCH AND EVALUATION UNIT, STATISTICAL ABSTRACT, NO. 8, at 13 (1995)(available in the Wsrary) [hereinafter FGAE].
132. FGAE, *supra* note 131, at 13.
133. HEALTH STRATEGY, *supra* note 72, at 12.
134. HEALTH POL., *supra* note 64, at 27.
135. *Id*. at 34.
136. *Id*. at 35.
137. POP. POL., *supra* note 112, at 28.
138. UNITED NATIONS POPULATION FUND, PROGRAMME REVIEW AND STRATEGY DEVELOPMENT REPORT, *Ethiopia* 31 (1994) [hereinafter UNFPA Report].
139. KIRSTAN HAWKINS ET AL., REVIEW OF THE YOUTH PROGRAMME OF THE FAMILY GUIDANCE ASSOCIATION OF ETHIOPIA 1 (1993) [hereinafter HAWKINS ET AL.].
140. POP. POL., *supra* note 112, at 30-31.
141. *Id*. at 31.
142. The Department of Health initiates, proposes and executes national policies/programs designed to promote family health, with a special focus on children, adolescents, and women. Interview by Zewdu Alem with Woizero Hiwot Mengistu, Family Health Department, Ministry of Health, Addis Ababa, Ethiopia (July 25, 1996) [hereinafter Interview with Woizero Hiwot Mengistu].
143. *Id*.
144. *Id*.
145. Interview by Zewdu Alem with Ato Antenane Korra, Research Officer, Family Guidance Association of Ethiopia, Addis Ababa, Ethiopia (July 9, 1996).
146. Alem Report, *supra* note 131, at 8.
147. Interview with Woizero Hiwot Mengistu, *supra* note 142.
148. DANIEL HAILE AND ERKU YIMER, LAW AND POPULATION GROWTH IN ETHIOPIA 19 (1976) [hereinafter HAILE AND YIMER]. The government is currently conducting a study with a view to review and possibly amend the Pharmacy Regulations.
149. *Id*.
150. *Id*.
151. PEN. CODE Art. 802.
152. Alem Report, *supra* note 131, at 8.
153. PEN. CODE Arts. 528-35
154. *Id*. at Art. 528.
155. *Id*. at Art. 534.
156. *Id*. at Art. 533.
157. *Id*. at Art. 534.
158. *Id*.
159. *Id*.
160. *Id*. at Art. 535.
161. *Id*. at Art. 534.
162. *Id*. at Art. 536.
163. MED. ETHICS, *supra* note 99, at 19.
164. *Id*.
165. *Id*.
166. *Id*. at 20.
167. PEN. CODE Art. 529. For a definition of simple imprisonment see *supra* note 103.
168. PEN. CODE Art. 529.
169. *Id*. at Art. 530. "Rigorous" imprisonment is defined as a sentence applicable only to "offences of a very grave nature committed by offenders who are particularly dangerous to society." The Penal Code further states that "[b]esides providing for the punishment and for the rehabilitation of the offender, this sentence is intended also to provide for a strict cinfinement [sic] of the offender and for special protection of society." The Penal Code provides that "[w]ithout prejudice to conditional release, the sentence of rigorous imprisonment is normally for a period of one to twenty-five years," or when provided for by law, for life. The sentence is to be carried out in "such central prisons as are appointed for the purpose." PEN. CODE Art 107.
170. *Id*.
171. *Id*. at Art. 531.
172. *Id*.
173. *Id*. at Art. 802.
174. HAILE AND YIMER, *supra* note 148, at 22.
175. Alem Report, *supra* note 131, at 10.
176. FGAE, *supra* note 131, at 26.
177. *Id*.
178. UNFPA REPORT, *supra* note 138, at 49. The FGAE became a member of the International Planned Parenthood Federation in 1971. It advocates for family planning and provides family planning education, counseling, service delivery, and contraceptive technology. *Id*.
179. Interview with Woizero Hiwot Mengistu, *supra* note 142.
180. *Id*.
181. *Id*.
182. NAHID TOUBIA, FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION 25 (Rainbo 1995).
183. ETHIOPIA CONST. Art. 35.
184. HEALTH POL., *supra* note 64, at 30.
185. Interview by Zewdu Alem with Dr. Hailu Negassa, Acting Head, AIDS Prevention and Control Department, Ministry of Health (July 25, 1996) [hereinafter Interview with Hailu Negassa].
186. *Id*.
187. *Id*.
188. *Id*.
189. Alem Report, *supra* note 131, at 4, *citing* Adanech, K. and Azeb, T., "*Gender Influence on Women's Health; A Review of the Ethiopian Situation*," *in* PROCEEDINGS OF THE FIRST UNIVERSITY SEMINAR ON GENDER ISSUES IN ETHIOPIA 49 (Dec. 24-26, 1989).
190. Alem Report, *supra* note 131, at 10.
191. The term "communicable human disease" is not defined in the Penal Code.
192. PEN. CODE Art. 503.
193. For a discussion of the offenses defined as "sexual outrage" *see id*. at Art. 594.
194. *Id*. at Art. 598(b). "Venereal disease" is not defined in the Penal Code.
195. Alem Report, *supra* note 131, at 10-11.
196. HEALTH POL., *supra* note 64, at 26.
197. Interview with Hailu Negassa, *supra* note 185.
198. WORLD HEALTH ORGANIZATION, AIDS PREVENTION AND CONTROL STRATEGY (year not included in report).
199. *Id*.
200. *Id*.
201. Interview with Hailu Negassa, *supra* note 185.
202. Alem Report, *supra* note 131, at 11.
203. ETHIOPIA CONST. Art. 34.
204. *Id*.
205. CIV. CODE Art. 581.
206. *Id*. at Art. 582-83.
207. The Civil Code states: "A person may not contract marriage so long as he is bound by the bonds of a preceding marriage." *Id*. at Art. 585.
208. PEN. CODE Art. 616.
209. CIV. CODE Art. 589.
210. *Id*.
211. ETHIOPIA CONST. Art. 34.
212. *See* CIV. CODE Art. 577.
213. *Id*. at Art. 625.
214. *Id*.
215. *Id*. at Art. 627.
216. *Id*. at Art. 631.
217. Family arbitrators are, in theory, relatives, neighbors and friends who are selected by the couple to help resolve marital disputes. Courts have no jurisdiction to resolve these disputes prior to arbitration. John H. Beckstrom, *Divorce in Urban Ethiopia Ten Years after the Civil Code*, 6 J. ETH. L. 283, 290-91 (1969) [hereinafter Beckstrom, *Divorce in Ethiopia*].
218. CIV. CODE Art. 633.
219. *Id*. at Art. 631.
220. *Id*. at Art. 636.
221. *Id*. at Art. 647.
222. *Id*. at Art. 649.
223. *Id*. at Art. 652.
224. *Id*. at Art. 656.
225. *Id*. at Art. 658.
226. *Id*. at Art. 634. For the "Personal effects of marriage" provisions, *see id*. at Arts. 635-46; for the "Pecuniary effects of marriage" provisions *see id*. at Arts. 647-61.
227. CIV. CODE Art. 635.
228. *Id*. at Art. 641.

229. *Id.* at Art. 644.
230. *Id.* at Art. 662.
231. *Id.* at Art. 663.
232. *Id.* For a discussion of the "conditions" of marriage, *see infra* section on marriage.
233. CIV. CODE Art. 663.
234. *Id.* at Art. 667.
235. *Id.* at Art. 669.
236. *Id.*
237. *Id.* at Art. 670.
238. *Id.*
239. *Id.* at Art. 727.
240. *Id.* at Art. 725.
241. *Id.* at Art. 676.
242. *Id.* at Arts. 677-78.
243. *Id.* at Arts. 692-93.
244. *Id.* at Art. 694.
245. *Id.* at Art. 690.
246. *Id.* at Art. 695.
247. *Id.*
248. *Id.* at Art. 736.
249. Beckstrom, *Divorce in Ethiopia*, *supra* note 217, at 300, *citing* N. MAREIN, THE ETHIOPIAN EMPIRE, FEDERATION AND LAWS 163 (1954).
250. PEN. CODE Art. 625.
251. Beckstrom, *Divorce in Ethiopia*, *supra* note 217, at 300.
252. *Id.*
253. CIV. CODE Art. 681. The 1994 Constitution gives added force to this provision, stating that "[i]n all actions concerning children undertaken by…courts of law,…the primary consideration shall be the best interests of the child." ETHIOPIA CONST. Art. 36.
254. CIV. CODE Art. 681.
255. *Id.* at Art. 682.
256. ETHIOPIA CONST. Art. 35
257. *Id.*
258. *Id.*
259. *See id.* at Arts. 842-56 for the intestate succession laws. Under these intestate succession laws the decedent's descendants are the first to inherit (children first). If there are no descendants, the estate goes to the parents. If the parents do not survive the deceased, then to the grandparents, and so on. *Id.*
260. PUBLIC OWNERSHIP OF RURAL LANDS, 31/1971, 26 Negarit Gazeta 93 (April 29, 1975) [hereinafter PUB. LANDS].
261. *Id.* at Ch. 2, § 4.1.
262. One hectare is equivalent to 10,000 square meters (or 2.47 acres).
263. PUB. LANDS, *supra* note 260, at Ch. 2, § 4.3.
264. ETHIOPIA CONST. Art. 35.
265. *Id.*
266. LABOUR PROCLAMATION 42/1993, 27 Negarit Gazeta 268 (Jan. 20, 1993) [hereinafter LAB. PROC.].
267. *Id.* at Part Six, Ch. 1, § 87.1.
268. *Id.* at Part Six, Ch. 1, § 87.2.
269. *Id.* at Part Six, Ch. 1, § 87.3.
270. *Id.* at Part Six, Ch. 1, § 87.4.
271. ETHIOPIA CONST. Art. 35. Prior to the 1994 Constitution, the Civil Code provided that an employee "who expects a child shall be entitled to one month's leave during the period of her confinement." CIV. CODE Art. 2566. The employer under the Civil Code was only obligated to pay half the employee's salary during the leave. *Id.*
272. ETHIOPIA CONST. Art. 35.
273. LAB. PROC., *supra* note 266, at Part Six, Ch. 1, § 88.
274. ETHIOPIA CONST. Art. 35.
275. TRANSITIONAL GOVERNMENT OF ETHIOPIA, NATIONAL POLICY ON ETHIOPIAN WOMEN 25 (1993) [hereinafter WOMEN'S POL.].
276. Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 (*entry into force* Sept. 3, 1981) (signed by Ethiopia on July 8, 1980 and ratified Sept. 10, 1981).
277. *Id.* at Art. 13(b).
278. WOMEN'S POL., *supra* note 275, at 7; POP. POL., supra note 112, at 28.
279. WOMEN'S POL., *supra* note 275, at 18.
280. *Id.* at 18-19.
281. POP. POL., *supra* note 112, at 17-18.
282. *Id.* at 54.
283. WOMEN'S POL., *supra* note 275, at 34.
284. *Id.* at 36-41.
285. PEN. CODE Art. 589.
286. For a definition of "rigorous" imprisonment *see supra* note 169.
287. *Id.* at Art. 589.
288. *See id.*
289. *Id.* at Arts. 538-39.
290. *Id.* at Art. 544.
291. CIV. CODE Art. 536.
292. *Id.* at Art. 589.
293. PEN. CODE Art. 558.
294. *Id.*
295. *Id.* at Art. 559.
296. CIV. CODE. Art. 198.
297. HAWKINS ET AL., *supra* note 139.
298. *Id.*
299. *Id.*
300. POP. POL., *supra* note 112, at 31.
301. *Id.* at 54.
302. Tseganesh Gudeta, *The Silent Shame*, *in* PRIVATE DECISIONS, PUBLIC DEBATE: WOMEN, REPRODUCTION & POPULATION 95, 100-01 (Judith Mirsky et al. eds., 1994).
303. *Id.* at 101.
304. CIV. CODE Art. 581.
305. *See* HAWKINS ET AL., *supra* note 139.
306. Haile Gabriel Dagne, *Early Marriage in Northern Ethiopia*, 4 REPRODUCTIVE HEALTH MATTERS 35-36 (1994).
307. *See* HEALTH POL., *supra* note 64, at 29-30; POP. POL., *supra* note 112, at 35-36.
308. PEN. CODE Art. 589.
309. *Id.* at Art. 594.
310. *Id.* at Art. 595.
311. *Id.* at Art. 596.

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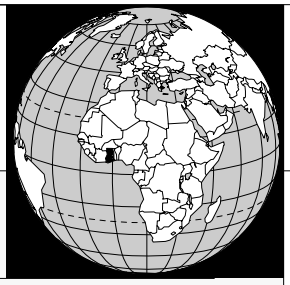
3. Ghana



Statistics

GENERAL

Population

■ Ghana's total population is 17.7 million, of which 50.4% are women.[1] The population growth rate is approximately 3.1% per annum;[2] the median age of the population is 17 years.[3]

■ In 1993, the proportion of the Ghanaian population residing in urban areas was estimated to be 35.4%.[4]

Economy

■ In 1993, the World Bank estimated Ghana's gross national product ("GNP") per capita to be U.S.$430.[5]

■ In 1995, the gross domestic product ("GDP") grew at an estimated rate of 4.5%, a significant increase since 1994, when the GDP growth rate was 3.8%.[6]

■ The government spent approximately 3.5% of its GDP on health in 1990,[7] compared to the U.S., which spent approximately 12.7% of its GDP on health in the same year.[8]

Employment

■ In 1993, approximately 6.2 million persons were employed in Ghana.[9] Women account for 39.5% of the total labor force.[10]

■ The gross national income per capita was U.S.$360 in 1993, down from U.S.$370 in 1992.[11]

WOMEN'S STATUS

■ The average life expectancy for women is 58 years, compared to 54 years for men. For both sexes combined, average life expectancy is 56.[12]

■ Approximately 28% of currently married women (including nearly 40% of married women in their forties) are in polygynous unions.[13]

■ Although there has been some improvement in overall literacy rates in Ghana, a strong gender differential in education remains. For example, between 1970 and 1995, the overall literacy rate more than doubled from 30% to 64%; however, the female adult literacy rate in 1995 was 53%, versus 76% for men.[14] Moreover, the literacy gap shrunk only marginally from 25 percentage points in 1970 to 23 percentage points in 1995.[15] In 1990, the primary school enrollment ratio for girls was 69%, whereas the overall primary school enrollment ratio was 77%.[16]

■ Violence against women, including rape and wife beating, remains a significant problem. Abuses generally go unreported and seldom come before the courts. Police tend not to intervene in domestic disputes.[17]

ADOLESCENTS

■ Approximately 48% of the Ghanaian population is less than 15 years old.[18]

■ An estimated 30% of Ghanaian women and girls (2.3 million) have undergone female genital mutilation ("FGM").[19]

■ The median age at first marriage for women is approximately 18.9 years.[20]

■ At least 4,500 girls and women are bound to various shrines in the *trokosi* system, a traditional practice that enslaves girls, often under the age of 10, to a fetish shrine for offenses allegedly committed by a member of the girl's family.[21]

MATERNAL HEALTH

■ Median age at first birth is 20 years.[22] The median birth interval is 36.4 months.[23]

■ The total fertility rate in 1996 was 4.6 children per woman, a decrease from the 1993 rate of 5.1 and the 1979 rate of 6.3 children per woman.[24]

■ The maternal mortality rate in Ghana is estimated to be 214 per 100,000 live births.[25]

■ The infant mortality rate for 1996 is estimated to be 80.3 per 1,000 live births. The under-five mortality rate is estimated to be 126 per 1,000 live births in 1996.[26]

■ Of pregnant women, 26.5% receive antenatal care from doctors, while 59.2% receive antenatal care from nurses or midwives. About 13% receive no antenatal care.[27]

■ Home deliveries account for 56.9% of births, while 42.2% of births are delivered in public health facilities or clinics.[28] Births are most commonly assisted by nurses or midwives (37.3%), followed by traditional birth attendants (15.3% trained, 15.2% untrained), friends or others (20.7%), and doctors (6.5%).[29]

CONTRACEPTION AND ABORTION

■ As of 1993, contraception was used by approximately 20.3% of all currently married Ghanaian women between the ages of 15 and 49 years,[30] but only about half of those women used modern contraceptive methods. Use among unmarried women is slightly lower.[31]

■ Approximately 0.9% of currently married women between the ages of 15 and 49 years have undergone a sterilization procedure.[32]

■ Little is known about the overall incidence of abortion in Ghana, but it is believed to be fairly common. According to a 1984 survey, 20% of obstetric patients had had at least one induced abortion.[33]

■ Between 9% and 13% of maternal deaths in 1990-1991 were due to abortion complications. Sixteen percent of total gynecological admissions were due to abortion-related complications.[34]

HIV/AIDS AND STDs

■ By 1994, approximately 16,000 cases of AIDS were reported to the World Health Organization ("WHO"), although the actual number of cases in Ghana is probably two to three times that number.[35] It is estimated that, as of 1994, approximately 172,000 adults in Ghana were infected with HIV, a prevalence rate of 2.3% among sexually active adults.[36]

■ Sentinel surveillance for HIV among pregnant women in 1992 showed prevalence rates of 3.2% and 4.2% in the urban centers of Koforidua and Kumasi, respectively.[37] Recent evidence shows an increasing level of HIV infection among commercial sex workers, from 25% in 1987 to 38% in 1991.[38]

ENDNOTES

1. Arjun Adlakha, U.S. Dep't of Commerce, Economics and Statistics Administration, Bureau of Census, Int'l Brief: Population Trends: Ghana 4 (July 1996) [hereinafter Population Trends: Ghana].
2. Government of Ghana/UNFPA, 3d Country Programme 1996-2000 2, U.N. Doc. DP/FPA/CP/151 (June 1995) [hereinafter Ghana/UNFPA].
3. *Id.* at 3.
4. World Bank, World Tables 1995, at 307 (1995) [hereinafter World Tables].
5. *Id.* at 305.
6. Hon. Kwame Peprah, The Budget Statement and Economic Policy of the Government of Ghana for the Financial Year 1996 1 (Feb. 2, 1996).
7. World Bank, World Development Report 1993: Investing in Health: World Development Indicators 210 (1993).
8. *Id.* at 211.
9. *Id.* at 307.
10. *Id.* at 307.
11. *Id* at 7.
12. Population Trends: Ghana, *supra* note 1, at 1.
13. Ghana Statistical Service, Demographic and Health Survey 1993 58-59 (1994) [hereinafter Demographic Survey].
14. Population Trends: Ghana, *supra* note 1, at 3.
15. *Id.*
16. World Tables, *supra* note 4, at 307.
17. U.S. Dep't of State, *Ghana Human Rights Practices, 1996*, 1996 Human Rights Report (1997), § V, *available in* LEXIS, World Library [hereinafter 1996 Human Rights Report].
18. Demographic Survey, *supra* note 13, at 2.
19. Nahib Toubia, Female Genital Mutilation, A Call for Global Action 25 (Rainb♀ 1995).
20. Demographic Survey, *supra* note 13, at 61-62.
21. 1996 Human Rights Report, *supra* note 17, at § V.
22. Demographic Survey, *supra* note 13, at 29-30.
23. *Id.* at 27-29.
24. Population Trends: Ghana, *supra* note 1, at 4.
25. Ghana/UNFPA, *supra* note 2, at 2.
26. Population Trends: Ghana, *supra* note 1, at 4.
27. Demographic Survey, *supra* note 13, at 93.
28. *Id.* at 96.
29. *Id.* at 97.
30. Population Trends: Ghana, *supra* note 1, at 4.
31. Demographic Survey, *supra* note 13, at 38-39.
32. Population Trends: Ghana, *supra* note 1, at 4.
33. United Nations Department for Economic and Social Information and Policy Analysis, Abortion Policies: A Global Review II 29 (1993).
34. International Planned Parenthood Federation, Africa Region, Unsafe Abortion and Post-Abortion Family Planning in Africa 28 (1994).
35. Population Trends: Ghana, *supra* note 1, at 2.
36. *Id.*
37. *Id.*
38. *Id.*

The Republic of Ghana was established in 1960, three years after Ghana gained political independence from British colonial rule.[1] A 1964 referendum conferred on Ghana's first president, Kwame Nkrumah, a wide range of powers that enabled him to establish a one-party socialist state.[2] In 1966, Ghana's "First Republic" was overthrown by a military coup.[3] A new constitution was promulgated and elections were held in 1969. From 1972 to 1993, with one exception of a brief constitutional period from 1979 to 1981, Ghana's Constitution was continually suspended and four different military governments ruled by decree.[4] The latter two military coups were led by Flight Lieutenant Jerry Rawlings, who was recently elected to a second four-year term as president.[5] The country's fourth republican Constitution, which permits multi-party politics, came into effect in January 1993.[6] December 7, 1996 marked the first time since independence that an elected government completed its first term and was democratically elected to a second term of office.[7]

Ghana's total population is approximately 17.7 million,[8] and approximately 50.4% of the population is women.[9] Ghana's principal ethnic groups are the Akans (44% of the population), Mole-Dagbani (16%), Ewes (13%), Ga-Adangbe (8%), Grussi (2%), and a number of smaller groups.[10] Approximately two thirds of Ghanaian heads of households are Christian, 14% are Muslim, 18% practice traditional religions, and 4% are adherents of smaller religious groups.[11]

I. Setting the Stage: The Legal and Political Framework

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

A. THE STRUCTURE OF GOVERNMENT

The Constitution of the Republic of Ghana, 1992 (the "Constitution"), was approved by national referendum on April 28, 1992, and it entered into force on January 7, 1993.[12] It establishes a constitutional democracy and declares itself to be the supreme law of the land[13] from which the power of the three independent branches of government — the executive, legislature, and judiciary — is derived.

The Executive Branch

The executive branch of government consists of a president, who is head of state, head of government, and commander-in-chief of the armed forces.[14] The president is not elected to more than two four-year terms.[15] The Constitution also provides for a vice-president,[16] as well as a cabinet appointed by the president and approved by Parliament to assist in determining the general policy of the government.[17] In addition, the president is advised, at his request, by a Council of State consisting of, *inter alia*, representatives from the various regions of Ghana, the president of the National House of Chiefs, and other members appointed by the president.[18] The Constitution guarantees the institution of chieftaincy[19] and establishes a National House of Chiefs, which is charged with certain functions relating to customary law and has certain appellate jurisdiction on matters affecting chieftaincy.[20]

Ghana is divided administratively into 10 regions that in turn are divided into 110 districts.[21] Ghana's Constitution prescribes a decentralized system of local government and administration.[22] The District Assembly is the highest political authority in each district, subject to the Constitution, and exercises deliberative, legislative, and executive powers[23] as prescribed by Parliament. Its powers include administering programs and plans for the district's development and the levying and collection of taxes.[24] Each District Assembly is composed of one person from each local government electoral area, elected by universal adult suffrage, the member(s) of Parliament pertaining to that district, up to 30% of other members appointed by the president in consultation with traditional and other interest groups,[25] and the district chief executive, who is appointed by the president and approved by two thirds of the District Assembly.

Each region has a House of Chiefs, composed of paramount chiefs who in turn head numerous traditional councils consisting of a paramount chief and his subordinate chiefs.[26] As prescribed in the Constitution and described above, regional and local traditional bodies deal exclusively with customary law.[27]

The Legislative Branch

Legislative power rests with a unicameral Parliament[28] which exercises its power through the passage of bills assented to by the president.[29] After considering the president's reasons for refusing to assent to a bill, Parliament may override him by a two-thirds vote of all members, and the president must then assent within 30 days.[30] Any order, rule, or regulation made by a person or authority under a power conferred by the Constitution or any other law is to be laid before Parliament prior to its entry into force, and Parliament is empowered to annul such order, rule, or regulation by a vote of two

thirds of all its members within 21 days of its being laid before Parliament.[31]

The Judicial Branch

Courts both create and interpret law. The judicial system can have significant impact on legislation, including that affecting reproductive rights, because it is able to enforce the law and deal with complaints from individuals challenging the constitutionality of specific laws. An independent judiciary, subject only to the Constitution, administers all judicial power.[32] The Constitution establishes an integrated hierarchical system of superior courts comprised of, in descending order, the Supreme Court, the Court of Appeal, the High Court, and Regional Tribunals, all of which constitute the Superior Courts of Judicature, and such lower courts or tribunals as Parliament shall establish.[33] The Supreme Court, headed by the chief justice and at least nine other justices,[34] is the highest court of appeal in all civil and criminal matters.[35] It has original jurisdiction to hear all matters relating to the enforcement or interpretation of the Constitution and all matters that arise when an enactment is allegedly made in excess of Parliament's or any other person's authority.[36] The chief justice and Supreme Court justices are appointed by the president in consultation with the Council of State and with Parliament's approval.[37] The chief justice is also a member of the Court of Appeal, the High Court, and each of the 10 Regional Tribunals.[38] The Court of Appeal hears appeals from the High Court and Regional Tribunals.[39] The justices of the Court of Appeal and of the High Court and the chairmen of Regional Tribunals are appointed by the president, acting on the advice of a judicial council established pursuant to the Constitution.[40]

The inferior courts,[41] which handle civil and criminal matters of a less serious nature, consist of circuit courts and tribunals,[42] community tribunals, and juvenile and family tribunals. In addition, the National House of Chiefs, the Regional House of Chiefs, and Traditional Councils that hear matters in their jurisdictions relating to chieftaincy are also considered to be part of the inferior courts.[43]

B. SOURCES OF LAW

Domestic Sources of Law

Laws that affect women's legal status — including their reproductive rights — derive from a variety of sources. Ghana's legal system encompasses concepts of English common law, indigenous customary law,[44] and Ghanaian statutory law.[45] The sources of law specified in Ghana's Constitution are: the Constitution itself; enactments made by Parliament; orders, rules, and regulations made pursuant to constitutional authority; existing law; and the common law.[46] Statutory law has played a central role in the Ghanaian legal system since colonial times, as "acts" passed by civilian governments subject to constitutionally mandated substantive and procedural requirements, and as "decrees" issued by military regimes when few limits on substantive lawmaking powers existed.[47] Subordinate forms of legislation, such as orders, rules, and regulations made by an authorized person under legislative or constitutional authority are also an important source of Ghanaian law often directly touching citizens' lives.[48]

Ghana's Constitution enumerates certain fundamental human rights and freedoms accorded constitutional protection, thus requiring all governmental organs and agents and, where applicable to them, all natural and legal persons in Ghana to respect and uphold such rights and freedoms.[49] Moreover, entitlement to those rights and freedoms occurs without regard to a number of factors including race, political opinion, religion, and gender. But such rights are made "subject to respect for the rights and freedoms of others and for the public interest."[50] There is also a specific non-discrimination provision that includes gender,[51] a provision granting spouses equal access to property and distribution thereof,[52] and a women's rights provision.[53] The Constitution also includes as a fundamental right the right of "every person to enjoy, practice, profess, maintain and promote any culture, language, tradition or religion subject to the provisions of this Constitution."[54] However, it prohibits "[a]ll customary practices which dehumanize or are injurious to the physical and mental well-being of a person."[55] Furthermore, the Constitution sets forth certain "Directive Principles of State Policy" that are intended to guide all citizens, all branches of government, and other bodies in "applying or interpreting this Constitution or any other law and in taking and implementing any policy decisions, for the establishment of a just and free society."[56] These policy objectives include a long list of objectives, such as the realization of basic human rights, the right to health care, and the right to education.[57]

The term "common law" in Ghana means "the rules of law generally known as the common law, the rules generally known as the doctrines of equity and the rules of customary law including those determined by the Superior Court of Judicature."[58] Ghanaian common law has been characterized as the most persuasive source of law in Ghana, an essential guide for judges where statutes are lacking or inadequate.[59]

The Constitution specifically incorporates customary law, the body of largely unwritten laws applicable to particular communities in Ghana. Such law, in effect, controls the day-to-day lives of a large segment of the population and is particularly relevant to all matters governing family law.[60] The Courts Act, 1993, guides a court's application of customary

law and its relationship to common law.[61] Ghanaian lower courts and tribunals are to ascertain whether, as a matter of law, the parties intended a system of customary law to apply to the transaction and, if so, the courts are to apply it.[62] Where the parties are not subject to a system of customary law, the court is directed to apply rules of the common law, or customary law, or both, as will do substantial justice, having regard to equity and good conscience.[63]

International Sources of Law

The Constitution authorizes the president to execute or cause to be executed treaties, agreements, or conventions on behalf of the government of Ghana.[64] Such agreements must be ratified by an Act of Parliament or a resolution of Parliament supported by the votes of not less than half of Parliament's members.[65] Moreover, international legal instruments become enforceable in Ghana after they are incorporated into domestic law by implementing legislation.[66] Ghana's Constitution has established as one of its "directive principles of state policy" the promotion of international law and treaty obligations and adherence to "the principles enshrined in or as the case may be, the aims and ideals of" the Charter of the United Nations, the Charter of the Organization of African Unity, and any other international organization of which Ghana is a member.[67] The Constitution also states that the government "shall be guided by international human rights instruments which recognize and apply particular categories of basic human rights to development processes."[68] Various international human rights treaties, particularly the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), recognize and promote specific reproductive rights. Such treaties are legally binding instruments and therefore create an obligation on the part of the government to take action at the national level. Ghana has ratified, *inter alia*, the following international legal instruments: the CEDAW;[69] the Convention on the Elimination of All Forms of Racial Discrimination;[70] the Convention on the Rights of the Child;[71] and the African Charter on Human and Peoples' Rights.[72]

II. Examining Reproductive Health and Rights

Issues of reproductive health and rights are dealt with primarily in Ghana within the context of the country's health and population policies. Thus, an understanding of reproductive rights in Ghana must be based on an examination of those policies.

A. HEALTH LAWS AND POLICIES

Objectives of the Health Policy

Ghana's national health policy is currently known as the Medium Term Health Strategy and its general objectives are to provide universal access to primary health care and to improve the quality of services.[73] Recent data indicate that only 60% of the population has access to some form of modern medical facilities and health services, a figure which drops to 45% in rural areas.[74] National health objectives were recently articulated in terms of both long-term and medium-term goals.[75] The objectives of Ghana's health policy in the medium-term are to: increase access to health services, especially in rural areas; reorient the health system toward delivery of public health services; reduce rates of infant, child, and maternal mortality; and control risk factors that expose individuals to major communicable diseases.[76] Other health objectives articulated by the Ministry of Health ("MOH") to be realized by the year 2000 include increasing the prevalence of family planning methods by 25%, improving coverage of antenatal care, intensifying the government's breast-feeding campaign, reducing the incidence of immunizable diseases by 50%, intensifying education on AIDS prevention, reducing mortality attributable to communicable diseases, and increasing awareness of the dangers of teenage pregnancy.[77] The government has given increased attention to reproductive health matters, as demonstrated by the MOH's introduction in 1996 of the Reproductive Health Service Policy and Standards (the "Reproductive Health Service Policy").[78]

Although public and private sector expenditures are roughly equal,[79] the majority of Ghanaians depend upon the public sector for health care needs. Ghana's MOH oversees the delivery of public health care through a decentralized Primary Health Care ("PHC") delivery system, introduced in 1978,[80] designed to provide a basic package of cost-effective services that will ensure widespread access to promotive and preventive health services as well as emergency curative services.[81] The PHC concentrates its efforts in key priority areas, including: nutrition, immunization, health education, maternal and child care, family planning, sexually transmitted diseases and HIV/AIDS, and control of malaria and diarrheal diseases.[82]

Infrastructure of Health Services

Ghana's Parliament recently passed the Health Service and Health Management Bill, 1996, which provides for the establishment of the Ghana Health Service at the national, regional, and district levels.[83] This new law implements a constitutional provision that calls for the public services of Ghana to include a health service.[84] The Ghana Health Service will

be the implementing agency of the MOH and will approve national policies, increase access to health services, and manage resources for the provision of health services.[85] The Ghana Health Service is to be comprised of medical personnel already in the MOH's employ and other public officers transferred to the service, and will have national, regional, and district committees to advise and implement policy.[86] The new law also states that the Ghana Health Service will include teaching hospitals at the apex of the health system, state-owned hospitals and health stations, and will provide for the internal management of such institutions.[87]

As of 1995, Ghana's decentralized health system was comprised of approximately 177 hospitals (including two teaching hospitals, eight regional hospitals, 85 public hospitals, 41 mission hospitals, and 51 private hospitals), 733 health centers (404 of them public), and 869 clinics (267 of them public clinics).[88] As of 1995, Ghana had approximately 1,100 registered physicians and 12,600 registered nurses.[89] There is one clinic for every 10,512 persons.[90] As is the case with other government services, health care providers work at the community, subdistrict, district, regional, and national levels, depending upon the nature of the service required.[91]

Within Ghana's general health infrastructure, reproductive health services are offered at virtually every level.[92] Most small rural communities depend on traditional birth attendants ("TBAs"), who may or may not be trained. Ghana's current reproductive health policy within the PHC is described below in the section entitled "Population and Family Planning."

Cost of Health Services

Ghana's public health care services are subsidized by the government, although they are generally not offered free of charge, except for prenatal and postnatal services (excluding hospital accommodation and catering), standard immunizations, and treatment for certain communicable diseases, including venereal diseases.[93] Health care in all public health institutions also is free to indigents whose status as such has been established by social welfare officials.[94] Ghanaian law exempts indigents, students, those under 18 years who are unemployed, those over 65, and most maternity patients from payment for hospital services.[95] Consultations, laboratory tests (including pregnancy tests), minor operative procedures, minor and major surgical procedures (including all gynecological and obstetric procedures, caesarean sections, hysterectomies, and tubal ligations), drugs, and hospital accommodations, are all charged according to set rates for children and adults.[96] Significantly higher rates are charged to non-Ghanaians.[97] Ghana's ongoing structural adjustment reforms have resulted in the withdrawal of subsidies for such health care. These changes have severe repercussions in a country such as Ghana, where the majority of people cannot pay for their health needs.[98] For example, in 1992 the MOH introduced its Cash and Carry Programme to ensure the continuous supply of essential drugs at health facilities.[99] Due to the program's focus on recovering costs, many health workers have disregarded the policy provisions for free health services, resulting in serious mishandling of emergencies and cases involving indigents.[100]

Regulation of Health Care Providers

Who is legally permitted to provide what types of health care services? Are there meaningful guarantees of quality control within health care services? Because the Ghanaian government regulates these issues, reviewing relevant laws is important. Ghana has three statutory schemes creating regulatory councils to deal with qualification, registration, and disciplinary actions for: doctors and dentists;[101] nurses and midwives;[102] and pharmacists.[103]

The Medical and Dental Council (the "Medical Council") is composed of registered medical and dental practitioners, medical school representatives, distinguished non-medical members, and health services officials. It is responsible for securing, in the public interest, the highest standards in the practice of medicine and dentistry in Ghana by overseeing medical and dental study and training, establishment of professional conduct, maintenance of a registry of practitioners, and exercise of disciplinary standards.[104] Only registered physicians and dentists may practice medicine and dentistry, respectively.[105] However, the practice of "an indigenous system of therapeutics" is permitted by indigenous inhabitants of Ghana who do not perform acts dangerous to life or supply, administer, or prescribe any restricted drug.[106]

To register as a medical or dental practitioner in Ghana, an individual must hold a "primary qualification" through work in medical school, be of "good character," pass examinations, and complete a term of medical or dental residency for a period prescribed by the Medical Council with an approved hospital or institution.[107] Anyone who willfully and falsely practices, professes to practice, or receives payment for practicing medicine or dentistry without having registered or who willfully procures or attempts to procure registration by giving false information shall be guilty of an offense and subject to imprisonment not exceeding 12 months and/or a fine.[108]

Pursuant to the Nurses and Midwives Decree, nurses and midwives are governed by the Nurses and Midwives Council (the "Nurses Council"), whose function is to oversee the training, education, maintenance, and promotion of standards of professional conduct and efficiency for nurses and midwives.[109] The Nurses Council issues a certificate to an individual who "has attained the necessary standards of

proficiency" or "has acquired an adequate practical experience."[110] Such a certificate facilitates registration that entitles one to practice nursing or midwifery.[111] The Nurses and Midwives Decree establishes an offense punishable by up to 12 months imprisonment and/or a fine where an individual procures registration by false information, implies qualification to practice nursing or midwifery or practices, professes to practice, or receives compensation without being registered as a nurse or midwife.[112]

Ghana also recently promulgated the Pharmacy Act, 1994 (the "Pharmacy Act"), which regulates pharmacists through a body similar to the two councils described above, known as the Pharmacy Council.[113] The Pharmacy Council is responsible for overseeing adequate study and training in pharmacy, prescribing and enforcing standards of professional conduct, exercising disciplinary powers to ensure such standards, maintaining a register of qualified and registered pharmacists, and regulating the licensing of premises and chemical sellers to sell and distribute certain restricted drugs in the country.[114] No person may practice pharmacy nor operate a retail pharmacy unless he or she is qualified as a pharmacist, has passed the Ghana Pharmacy Professional Qualifying Examination, and has otherwise registered in accordance with the statute.[115] Moreover, no person may either describe himself or herself or hold himself or herself out to be a pharmacist, or open any premises under the description of "pharmacy," "chemist," "drug store," etc., unless a registered pharmacist is on the premises to supervise the dispensing of drugs or medication. In addition, no person may carry on a business of supplying from any premises certain classified drugs specified by law, unless that person has a valid general or limited license for such premises issued under the Pharmacy Act.[116]

While traditional health care practitioners are not yet regulated by statute in Ghana, the government has begun to recognize the need for greater integration of traditional practitioners into the health care system, particularly with respect to reproductive health. The Reproductive Health Service Policy, recently issued by the MOH, specifically includes a program of training for TBAs and other community providers and integrates them into all aspects of reproductive health services promoted through the Reproductive Health Service Policy.[117] For example, *wanzams* or "circumcisers" who practice Female Genital Mutilation ("FGM") are regarded as key players that could assist the MOH to discourage FGM.[118] Recently, the government introduced a draft proposal of a law to regulate and control the practice of traditional medicine, entitled the "Ghana Traditional Medicine Act."[119]

Patients' Rights

Laws also seek to ensure quality health services by protecting the rights of patients. Ghana's Criminal Code provides that anyone engaged in medical or surgical treatment of any person who negligently endangers that person's life is guilty of a misdemeanor[120] punishable by imprisonment of up to three years and/or a monetary fine at the court's discretion.[121] The Criminal Code also specifies that where in the course of medical or surgical treatment, any person "intentionally causes harm to a person which, in the exercise of reasonable skill and care he ought to have known to be improper, he will nonetheless be liable to punishment as if he caused the harm negligently" rather than intentionally.[122] Ghanaian law permits an aggrieved patient to bring an action in tort against a health care provider for any alleged medical malpractice.[123]

The Penal Cases Committee of the Medical Council investigates allegations of malpractice and refers cases warranting inquiry to the Disciplinary Committee of the council.[124] The Disciplinary Committee may, at its discretion, reprimand, suspend, or remove from the registry any practitioner where an inquiry merits action against him or her.[125] A practitioner may appeal any such disciplinary measure to the Court of Appeal.[126] The Disciplinary Committee may at any time restore a practitioner to the register who has been removed, although a practitioner may not apply for restoration until at least 12 months after removal from the register.[127] Similarly, disciplinary proceedings for alleged professional misconduct may be brought to the registrar against nurses or midwives under the Nurses and Midwives Decree and, at the registrar's discretion, referred to the Nurses Council's Disciplinary Committee for full inquiry.[128] The Disciplinary Committee of the Pharmacy Council inquires into matters relating to professional conduct and standards referred to it by the council.[129]

The Medical Council also has ethical guidelines stating that, in their own interests, practitioners should obtain informed consent from either the patient or a relative prior to undertaking medical or surgical procedures.[130] The regulations enacted by the Medical Council do not contain requirements relating to consent, but provide that it is the Medical Council's duty to "determine what action or course of conduct constitutes infamous conduct" in a professional respect in each disciplinary case.[131] The regulations do state that it is against professional conduct for a practitioner to disclose voluntarily, without the patient's consent, any information obtained in the course of his or her professional relationship, except that such information may be disclosed in the public interest and if the practitioner is required to do so by statute or a court of law.[132] The regulations also state that it is an offense against professional ethics "for a practitioner to abuse

his special access to a patient by way of adultery or any other improper association with the patient at the material time."[133]

B. POPULATION AND FAMILY PLANNING

The Population and Family Planning Policy

In 1969, the government issued a comprehensive policy on population entitled "Population Planning for National Progress and Prosperity: Ghana Population Policy,"[134] which stated that population control was a basic element in all developmental planning activity and identified the need to adopt measures to reduce population growth.[135] In 1992, the National Population Council ("NPC"), under the office of the president, was established to undertake the revision of the 1969 population policy with input from a wide spectrum of society,[136] and to act as adviser, promoter, and as a coordinating body to oversee population policy implementation at both the national and regional levels.[137] The NPC is appointed by the president in consultation with the Council of State and is comprised of representatives from various ministries and other private experts.[138] In 1994, because of a continuing "unacceptably high level" of population growth, the absence of a coordinated institutional machinery, and other factors such as concerns regarding HIV/AIDS and teenage pregnancy, the population policy was revised and updated after extensive debate.[139] Ghana's recent Constitution specifically refers to the state's obligation to "maintain a population policy consistent with the aspirations and development needs and objectives of Ghana"[140] as part of the Constitution's Directive Principles of State Policy.[141]

Ghana's development plans view population policy as an integral part of development. Ghana's National Development Planning Commission, which has primary responsibility for national development planning, included both medium- and long-term population objectives in its comprehensive development policy, Ghana — Vision 2020[142] ("Vision 2020"). The policy describes the "widespread failure to comprehend the negative effects of a continuing high rate of population growth and to implement effective family planning technologies" as a major constraint on development and cautions that reluctance to reduce the rate of reproduction will "prevent the achievement of the development targets proposed in this programme."[143] The long-term objective articulated in Vision 2020 is to reduce the present annual growth of 3% per annum to 2% per annum by the year 2020.[144] Vision 2020 also articulates as medium-term strategies the development of the capacity of the population to effectively exercise options to control its fertility, as well as the strengthening and enhancement of services to promote and support improved fertility management.[145]

The current National Population Policy (the "Population Policy") is primarily aimed at achieving, in the long term, a population size that is compatible with the provision of an adequate standard of living for all, and for sustainable development.[146] Other stated goals of the Population Policy include: alleviating mass poverty and enhancing the welfare of the population; reducing maternal morbidity and mortality and promoting reproductive and sexual health for all, including adolescents; enhancing the status of women in society through the elimination of discriminatory laws and cultural practices that are inimical to women's well being and self-esteem; promoting wider productive and gainful employment opportunities for women and increasing the proportion of women entering and completing at least secondary school; and examining the structure of government conditions of employment and changing them in such ways as to minimize their pronatalist effects.[147] The Population Policy seeks to achieve a number of specific objectives, many of which are set forth in quantitative terms. These targets include:[148]

- Reducing the total fertility rate from 5.5 to 5.0 by the year 2000, to 4.0 by 2010, and to 3.0 by the year 2020; and achieving a contraceptive prevalence rate of 15% for modern methods by the year 2000, 28% by 2010, and 50% by 2020;
- Reducing the present annual population growth rate of about 3.0% to 1.5% by the year 2020;
- Reducing the proportion of women who marry before the age of 18 by 50% by the year 2000 and by 80% by the year 2020;
- Reducing the proportion of women below the age of 20 and above the age of 34 bearing children by 50% by the year 2010 and by 80% by the year 2020, and achieving a minimum birth spacing interval of at least two years by 2020;
- Increasing the proportion of 15-to-19-year-old women with secondary education and above by 50% by the year 2005 and by 80% by the year 2020;
- Achieving full immunization for 80% of infants (0-to-11 months) by the year 2020;
- Reducing the infant mortality rate from its current level of about 66 infant deaths per 1,000 live births to 44 in the year 2005 and to 22 in the year 2020;
- Making family planning services available, accessible, and affordable to at least half of all adults by the year 2020; and
- Increasing life expectancy of the population from its current level of about 58 years to 65 years by the year 2010 and to 70 years by the year 2020.

The Population Policy also identifies several objectives to achieve the above goals, including: ensuring that population issues are systematically integrated in all aspects of development planning; enhancing integrated rural and urban development to improve living conditions, particularly in rural areas; providing the population, including adolescents, with the necessary information and education on the value of small family size, as well as sexual and reproductive health; ensuring accessibility to, and affordability of, family planning means and services; developing programs aimed at the empowerment of women; integrating family planning services into maternal and child health care services; educating the general public about HIV/AIDS and other sexually transmitted diseases; and ensuring that the Law Reform Commission, Parliament, and other law-making agencies are well sensitized on population issues.[149] Finally, the population policy has detailed implementation strategies in many of the principal areas addressed by the policy, including maternal and child health, family planning, health and welfare, empowerment of women, the role of men in family welfare, and children and youth.[150]

In 1996, the MOH issued the Reproductive Health Service Policy, which seeks to directly address issues affecting reproductive health care.[151] Specifically, the Reproductive Health Service Policy sets out general rules and regulations for health care providers to provide uniform policy guidance and standards concerning a wide array of reproductive health issues, recognizing that the past concentration on family planning failed to address other components of reproductive health care.[152] The Reproductive Health Service Policy thus includes the following components: safe motherhood (including antenatal, labor and delivery care, and postnatal care); adolescent reproductive health; the prevention and management of unsafe abortion; reproductive tract infections including STDs and HIV/AIDS; infertility; and the discouragement of harmful traditional reproductive health practices.[153] The Reproductive Health Service Policy endorses the principle that reproductive health care involves preventive, curative, and promotional services for the improvement of the health and well-being of the population, especially mothers, children, and adolescents. The policy states that all couples and individuals have the basic right to decide freely and responsibly about their reproductive lives and to have the information and means to do so.[154] A central objective of the Reproductive Health Policy is to provide information to enable such reproductive self-determination and to provide affordable contraceptive services, including a full range of safe and effective contraceptive methods.[155]

Government Delivery of Family Planning Services

The government provides reproductive health services at every level of its health system.[156] However, the current health system is not able to meet the needs of Ghanaians. As of 1992, there was approximately one clinic for every 10,512 persons and one hospital for every 94,224 persons in Ghana. Most of these health care facilities provide family planning services in some form.[157] These figures demonstrate that less than three fifths of the population has access to some form of modern medical facility and health service, including reproductive health care services.[158] Data also indicates that Ghanaian programs are still falling short of meeting women's demand for services.[159] According to 1993 data, just under 13% of mothers who had children in the previous three years did not receive any antenatal care,[160] 56.9% gave birth at home rather than in some type of health facility,[161] and less than 60% were assisted during deliveries by a doctor, nurse, midwife, or TBA.[162]

The fees charged for all reproductive health services, including male and female sterilizations, are mandated by the Hospital Fees Regulations.[163] In addition, clients are required to pay for contraceptive devices.[164] However, the regulations provide that no fees other than the cost of prescription drugs shall be charged to any person suffering from venereal disease, and that no fees other than hospital accommodation and catering shall be paid in any government hospital or clinic for antenatal and postnatal services and treatment at Child Welfare Clinics.[165] Treatment and services for persons with HIV/AIDS are free.[166] Prenatal, labor and delivery, and postnatal services are available in government-run hospitals and clinics, as well as in private maternity homes.[167]

Contraceptives are available through both public and private sources. The following contraceptive methods and information are available in public health care facilities: condoms, spermicides, cervical caps, diaphragms, oral contraceptive pills, injectables, lactational amenorrhoeal method ("LAM"), natural family planning methods, intrauterine devices ("IUDs"), implants, tubal ligation, and vasectomy.[168] Although 43.3% of women who are current users of modern methods obtained contraceptives from a public source, 52.2% of women users of modern methods obtained their supply from private sources, primarily pharmacies.[169] The government sector, however, is largely responsible for providing female sterilization (73%), injections (85.7%), and IUD insertions (87.1%).[170]

Ghana's Reproductive Health Service Policy also contains an information, education, and communication ("IEC") component whose principal purpose is to foster awareness, to educate, and to enable people to make informed choices and take action with respect to their reproductive health.[171] The principal IEC activities in the promotion of reproductive health include production and distribution of materials, coun-

seling, training, resource mobilization, and community involvement.[172] Specific target groups of the reproductive health IEC programs in health facilities, schools, and the community are school-aged and adolescent children, religious bodies, clients with reproductive health diseases, policy makers, and opinion leaders.[173]

C. CONTRACEPTION

Among currently married Ghanaian women, contraceptive prevalence is approximately 20%, with 10% prevalence of modern methods.[174] In 1993, the following contraceptive methods were reportedly used by married women: the pill (3.2%); IUD (0.9%); injections (1.6%); diaphragm/foam/jelly (2.2%); sterilization (0.9%); periodic abstinence (7.5%); and withdrawal method (2.1%).[175] Prevalence rates are higher for men: 33.5% report use of any method.[176]

Legal Status of Contraceptives

Ghanaian law does not restrict the use of contraceptives. The Ministry of Health's Reproductive Health Service Policy states that the government's family planning policies include the goals of providing affordable contraceptive services and a full range of safe and effective methods.[177] In general, the Reproductive Health Service Policy clearly states that spousal consent for contraceptive use is not required.[178] Doctors and pharmacists determine whether particular contraceptive methods are appropriate for particular patients.[179]

New contraceptive methods must be approved and registered by the Pharmacy Council prior to use in Ghana.[180] Several other provisions of the Pharmacy Act affect the supply of contraceptives to consumers. Because certain contraceptives are classified as "restricted drugs," there are limitations on how they may be distributed and sold. The Pharmacy Council is empowered to issue general or limited certificates regarding premises where drugs are to be sold and to revoke such certificates if the premises cease to be suitable.[181] No person may carry on a business of supplying "restricted drugs," which would include birth control pills and injections, unless that person has a valid general or limited license issued under the Pharmacy Act.[182]

Moreover, to ensure the safe supply of contraceptive and other drugs to consumers, the Pharmacy Council is empowered to revoke a license if it believes a license holder has contravened the Pharmacy Act.[183] In addition, no person may mix, compound, prepare, or supply "restricted drugs" unless that person is a pharmacist or is employed by a licensed company, or unless that person is a medical practitioner, dentist, or veterinary surgeon supplying a drug to a patient in urgent need.[184] A pharmacist or licensed company may supply "Class A" drugs, which include oral contraceptives and injections, only upon presentation of a prescription issued by a medical practitioner, dentist, or veterinary practitioner.[185] The Pharmacy Act prohibits any person from supplying a "dangerous drug" unless the drug is in a container of the prescribed description and the container bears a label indicating the prescribed particulars of its contents.[186] Condoms and spermicides are sold in pharmacies, supermarkets, and by the National Trading Corporation, which distributes them through government clinics.[187]

Regulation of Information on Contraception

In 1986, the Ghanaian government banned the advertisement of contraceptives in the mass media.[188] Moreover, although there are no laws specifically controlling information provided to clients seeking contraceptives or family planning services, the general penal laws on obscenity apply.[189] Thus, any person who publishes any "obscene" writing or representation is guilty of a misdemeanor.[190] Although obscenity is not defined, the statute provides an illustration that describes a person who publishes extracts from a medical book in a manner that gives "unnecessary prominence to indecent matters" and states that the person should be convicted if the court or jury believes that such publication "is calculated unnecessarily and improperly to excite passion, or to corrupt morals."[191] However, certain types of information regarding contraception is encouraged by the government. The Reproductive Health Service Policy requires service providers to provide clients with an array of information and counseling, including that with respect to family planning and contraception.

D. ABORTION

Although there are no official statistics on abortion in Ghana, recent studies indicate that it is a common practice, particularly among adolescents.[192] Despite the liberalization of abortion laws, illegal abortions continue to occur.[193] Moreover, most people, including health workers, are not aware that the abortion laws have been liberalized and still consider all abortions to be criminal acts.[194]

Legal Status of Abortion

Ghana's laws permit abortion in a number of circumstances. Ghana's Criminal Code provides that "[w]hoever intentionally and unlawfully causes abortion or miscarriage shall be guilty of a second degree felony"[195] and states that the offense of causing abortion or miscarriage can be committed either by the pregnant woman or by any other person.[196] Ghana clarified its criminal laws by enacting an amendment in 1985 regarding abortion (the "1985 Abortion Amendment"). The 1985 Abortion Amendment specifically defines "abortion or miscarriage" to mean "the premature expulsion or removal of conception from the uterus or womb before

the period of gestation is completed."[197] The amendment sets forth a number of conditions under which an abortion will be considered legal. An abortion is legal when the pregnancy is the result of rape, incest, or "defilement" of a mentally handicapped woman, and also if there is substantial risk that the child might suffer from or later develop a serious physical abnormality or disease.[198] It is also legal when the continuation of the pregnancy would involve a risk to the life of the pregnant woman or injury to her physical or mental health.[199] The 1985 Abortion Amendment specifically criminalizes common methods used to induce illegal abortions, thereby covering certain actions that arguably may not have been covered previously. It provides that any person who supplies or administers to a woman any "poison, drug or other noxious thing or uses any instrument or any other means" with the intent to cause or induce or abet an abortion or a miscarriage is guilty of an offense and liable to imprisonment not exceeding five years.[200] The offense of causing abortion is also committed by causing a woman to prematurely deliver a child with intent to unlawfully cause or hasten the death of the child,[201] or where intent to commit the offense is present even if the woman is not in fact pregnant.[202]

Requirements for Obtaining Abortion

As stated above, Ghanaian law not only specifies the circumstances under which an abortion may be performed, but it also states that the procedure may be legally performed only "by a registered medical practitioner specializing in gynaecology or any other registered medical practitioner in a Government hospital or in a private hospital or clinic registered under the Private Hospital and Maternity Homes Act, 1958[203] or in a place approved for the purpose."[204] No second medical opinion is required. As is the case with other surgical treatment, the pregnant woman must consent to the abortion procedure in any of the circumstances summarized above in which abortion is legal unless she lacks capacity to consent, in which case the 1985 Abortion Amendment provides that her next of kin or the person in *loco parentis* must consent in the case of rape or incest or risk to the health of the pregnant woman.[205] Spousal or partner consent is not required to obtain an abortion.[206] As is the case with other health services in Ghana, a pregnant woman must pay the applicable government fees to obtain a legal abortion unless she can demonstrate that she is indigent, in which case she would receive dispensation from payment of medical fees.

Policies Regarding Abortion

Ghana's Reproductive Health Service Policy contains specific guidelines on the "prevention and management of unsafe abortion and post abortion care."[207] Specifically, the policy defines abortion as "the loss of pregnancy before the foetus is viable,"[208] in contrast with the definition contained in the 1985 Abortion Amendment described above. It also states that the objective of unsafe abortion and post-abortion care is to manage and/or refer abortion complications, to create public awareness of the dangers of unsafe abortion, to educate clients regarding complications arising therefrom, and to prevent unwanted pregnancies through family planning.[209] The policy is targeted to all women, including adolescents, spouses and partners, and also encompasses nurses, midwives, TBAs, and physicians who provide services.[210]

Penalties

Under Ghana's Criminal Code, illegal abortions were previously considered a second-degree felony, punishable by a fine and a maximum imprisonment term of 10 years.[211] The woman who obtained an abortion, the person performing an abortion, or any other person involved may be prosecuted under the criminal statute.[212] The amendment now provides that any person who administers "any poison or noxious substance" or who "uses any instrument or any other means" to cause an abortion or who assists or encourages a woman to cause or consent to an abortion is guilty of an offense and is liable to imprisonment for a term not exceeding five years, regardless of whether the pregnant woman gives her consent.[213] Those who seek or perform abortions illegally, including health care providers, do so at their own risk. In one reported case, senior hospital nurses who had unsuccessfully attempted to procure an abortion for a pregnant nursing student who requested their assistance were convicted of a second-degree felony, with corroborating testimony provided by the nursing student they had sought to assist.[214]

Regulation of Abortion Information

Because abortion is available only in specifically prescribed circumstances at a government hospital or registered private hospital or clinic, general advertising of abortion services does not occur.[215] While not explicitly prohibited by statute, the criminal prohibition against inducing or aiding and abetting a woman to cause abortion or miscarriage may cover advertisements relating to abortion services.[216] However, Ghana's Reproductive Health Service Policy explicitly seeks "to create public awareness of the dangers of unsafe abortion and to educate clients on the complications of abortion."[217] Thus, some information regarding the hazards of abortion and the comparative benefits of family planning is communicated to clients by government providers of reproductive health services.[218] Hence, the government is increasingly aware of illegal abortions and their health implications.

E. STERILIZATION

Sterilization is not a widely used contraceptive method. In 1993, only 0.9% of currently married women reported using

female sterilization and 0.1% of currently married women reported that their husbands had been sterilized using male sterilization.[219] There are no specific laws governing sterilization in Ghana. Ghana's Criminal Code states that causing a "wound of grievous harm" does not constitute a criminal act if "undertaken in good faith for the purpose of medical or surgical treatment."[220] Moreover, the MOH's Reproductive Health Service Policy specifically states that tubal ligation and vasectomy shall be available as family planning methods[221] provided that the client is fully informed and consents in writing to the procedure. Spousal consent is encouraged but not required.[222] As with other medical care in Ghana, sterilization at public facilities and all attendant care must be paid for by the client at a prescribed rate.[223]

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

The prevalence of female genital mutilation ("FGM") — also referred to as female circumcision — in Ghana is estimated to be high. Approximately 2.325 million women have undergone this procedure.[224] The practice is common mostly in Muslim communities in the northern regions of Ghana and in the northern migrant settlement areas of the Accra metropolitan area.[225] Respondents to a study on FGM in Ghana stated that it is considered to be a precondition for marriage and is also regarded as a religious imperative.[226]

Despite its prevalence, FGM is a second-degree felony punishable by imprisonment.[227] The Criminal Code now provides that "[w]hoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person…shall be guilty of a second degree felony and liable on conviction to imprisonment of not less than three years."[228] In addition, the Constitution prohibits customary practices that harm one's physical and mental well-being and would appear to grant women de jure protection from this practice.[229]

The MOH's Reproductive Health Service Policy explicitly discourages FGM and includes discouragement of its practice as one of the eight core components of the policy.[230] The Reproductive Health Service Policy also advocates numerous strategies to discourage the practice, including integrating reproductive health activities, enforcing the law on FGM, and treating and counseling the victims of the practice.[231] For further discussion regarding FGM, see section on adolescents below.

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

Examining HIV/AIDS issues within a reproductive health framework is essential insofar as the two areas are interrelated from both a medical and public health standpoint. Hence, a full evaluation of laws and policies affecting reproductive health and rights in Ghana must examine HIV/AIDS and sexually transmitted diseases ("STDs"). MOH figures indicate that from 1986 to 1995, 17,564 AIDS cases were reported in Ghana.[232] In 1990, the MOH instituted the HIV "sentinel sero-surveillance system,"[233] which indicated that prevalence in semirural areas ranged from 0.3% to 10.5%, and in urban areas it ranged from 0.8% to 3.8%.[234] In 1993, approximately 43% of reported AIDS cases were from the central Ashanti region of Ghana.[235] Data also indicates that women comprise a disproportionately high number of all AIDS cases in Ghana.[236]

Laws Affecting HIV/AIDS

There are no laws specifically dealing with HIV/AIDS in Ghana. However, laws that generally address all sexually transmitted diseases are discussed in the following section.

Laws Affecting STDs

Few laws in Ghana specifically address STDs. Ghana's Criminal Code states that the publication of any advertisement related to "venereal disease, nervous debility, or other complaint or infirmity arising from or relating to sexual intercourse" shall constitute a misdemeanor, unless such advertisement relating to "venereal disease" is published by or with the authority of the MOH.[237] The provisions of the Pharmacy and Drugs Act, 1961, which restricted publication of descriptive matter with respect to "syphilis, gonorrhea, soft chancre and any other form of genito-urinary disease or other disease connected with the human reproductive function," as well as certain other diseases, were repealed by a later amendment.[238] To date, no other similar law has been enacted to restrict such publications.

Policies Affecting Prevention and Treatment of HIV/AIDS

The government has stated its commitment to strengthening all existing programs on AIDS and other STDs.[239] In 1986, the government set up a National AIDS Control Programme.[240] In 1990, the MOH instituted a system of HIV sero-surveillance whose objectives are to obtain information on the prevalence of HIV/STD infection in specific populations, to monitor trends in HIV infection, and to provide information for evaluating intervention programs against HIV/AIDS.[241] In 1992, the MOH published Guidelines for AIDS Prevention and Control (the "AIDS Guidelines") to assist regions and districts to integrate AIDS prevention and control activities within existing primary health care activities, to prevent the further transmission and spread of HIV, and to decrease the impact of AIDS.[242] The AIDS Guidelines also provide for psychosocial support to affected individuals, adequate clinical management to affected individuals, and information and education to strengthen the control of other STDs.[243] The

AIDS Guidelines promote safe sex, the necessity of counseling prior to and after administering HIV tests, and confidentiality with respect to all test results.[244] The AIDS Guidelines specify that no patient should be denied admission to a hospital because he or she has been diagnosed with AIDS.[245]

One of the components of Ghana's new Reproductive Health Service Policy is the prevention and management of reproductive tract infections, including HIV/AIDS.[246] Specifically, the policy seeks to prevent, control, diagnose, and treat reproductive tract infections, including HIV/AIDS, by targeting all sexually active individuals, including adolescents, all pregnant women, post-partum and post-abortion clients, and commercial sex workers. The prevention campaign features mass-media efforts, entertainment, education, promotion of condoms and interpersonal communication, family life education, and advocacy.[247] The policy specifically isolates management of HIV/AIDS patients and provides for counselors on HIV/AIDS at the regional level.[248]

Ghana's hospital fees regulations provide that no fees other than the cost of prescribed drugs are to be paid for services rendered in government hospitals to any person suffering from a "venereal disease."[249] In addition, treatment and services for HIV/AIDS are provided free of charge.[250]

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that will affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health care and her ability to make voluntary, informed decisions about such care. Laws regarding the age of first marriage can have a significant impact on a young woman's reproductive health. Furthermore, rape and other laws prohibiting sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health.

A. RIGHTS WITHIN MARRIAGE

Marriage Law

Ghana has three legal regimes governing marriage: monogamous marriage pursuant to the Marriage Ordinance, marriage (including polygamous unions) under customary law, and marriage pursuant to the Marriage of Mohammedens Ordinance.[251]

The Marriage Ordinance[252] is a statutory registration system based on monogamy and the nuclear family.[253] A registrar of marriage may not marry anyone either already married "by native law or custom to any person" or anyone under 21 years of age unless his or her parent or guardian consents in writing to the marriage.[254] Moreover, a person who is married under the Marriage Ordinance, or whose marriage is declared valid by it, is incapable of contracting a valid marriage under customary law during the continuance of the statutory marriage.[255]

The formalities and essentials of a valid customary law marriage differ slightly among different ethnic groups.[256] Customary marriage in Ghana has been defined as "principally the union of, or a contract between, a man and a woman to live as husband and wife, during which period there arises an alliance between the two family groups based on a common interest in the marriage and its continuance,"[257] and the payment of "marriage consideration" by the husband or on his behalf and its acceptance by the bride's family.[258] Yet Ghana's Criminal Code, which applies to all marriages, provides that "[w]hoever by duress causes any person to marry against his or her will, shall be guilty of a misdemeanour."[259] All customary law marriages in Ghana are potentially polygamous.[260]

In 1987, Ghana's Law Reform Commission considered the issue of reforming customary dowry payment. But it concluded that "no legislation by the Government can solve the problem" and that it would be "futile to introduce a uniform system of payment of dowry" in light of different customary practices.[261]

Under customary systems, upon marriage, the husband acquires exclusive rights over his wife. She does not, however, acquire such exclusive rights over him.[262] For example, the husband may marry additional wives without consulting his first wife.[263] If adultery is committed by a woman her husband may either divorce her and reclaim "marriage consideration" and all his expenses from her family or he may continue the marriage after collecting adultery damages from the lover and a "pacification fine" from the wife.[264] But a wife has no right in customary law to claim damages when her husband commits adultery.[265] Generally, the husband is responsible for the debts and torts of his wife during their marriage, although strictly speaking it is her family who is responsible unless the husband admits liability.[266] Ghana's Criminal Code also requires husbands to supply all "necessaries of health and life to his wife," which are defined to

include proper food, clothing, shelter, warmth, medical or surgical treatment, and any other items which are reasonably necessary for the preservation of health and life of a person.[267] A wife is expected to submit to her husband, look after children, and perform normal household duties. She has no obligation to pay his debts.[268] Widows are usually not permitted to remarry under customary law.[269]

In 1985, Ghana enacted the Customary Marriage and Divorce (Registration) Law, which provides for a uniform system of registering customary law marriages and divorces and requires that all marriages contracted and divorces effected under customary law, whether prior to or after the law's entry into effect, be registered.[270] In 1991, the law was amended to make the registration of customary marriages optional rather than mandatory.[271] Because of the continued practice of polygamy, the law does not limit the number of marriages that can be registered by any one person.[272]

The Marriage of Mohammedens Ordinance[273] was first enacted in 1907 and provides for the registration of marriages and divorces contracted under Islamic law. Every marriage celebrated under Islamic law must be registered within a week at the office of the registering agent[274] and every divorce so effected must be registered within one month.[275] It has been noted that in Ghanaian Islamic marriage, the husband pays a dowry to the wife, is entitled to marry up to four wives at one time, and to have unlimited "concubines."[276] Despite its 90-year existence, the Marriage of Mohammedens Ordinance is "hardly ever enforced," and its registration provisions "are probably not known to many Muslims."[277]

Divorce and Custody Law

Divorce, like marriage, is regulated by statutory law, customary law, and Islamic law. Statutory divorce and all ancillary relief are governed by the Matrimonial Causes Act (the "Matrimonial Act").[278] The Matrimonial Act applies to all monogamous marriages,[279] which must include all marriages under the Marriage Ordinance; and, also upon application to a court by a party to a non-monogamous marriage, the court is directed to apply the act's provisions, subject to regard for "the peculiar incidents of that marriage" in determining appropriate relief, financial provision, and child custody.[280] Subject to its discretion, a court may grant any form of relief recognized by the customary law of the parties.[281] According to the Matrimonial Act, a marriage may be dissolved at the request of either party only if a court determines that the marriage "has broken down beyond reconciliation."[282] The statute also contemplates dissolution on grounds of presumption of death or nullity.[283] A marriage may be nullified on other specific grounds.[284] Moreover, pursuant to the Matrimonial Act, the court may grant just and equitable provisional maintenance pending suit or financial provision to either party to the marriage.[285] The court may then order either party to make gross or installment payments to the other and/or convey or transfer all or a portion of movable or immovable property as settlement.[286] The court is also able to issue an order of restraint to prevent flight from the jurisdiction or harm to or interference with the spouse or a child.[287]

With respect to child custody and maintenance, the Matrimonial Act provides that, at its own or either party's initiative, as the court thinks reasonable and for a child's benefit, the court may award custody of a child to any person, regulate the right of access of any person to the child, and provide for her or his education and maintenance out of the property or income of either or both spouses.[288] In determining child custody in the case of a divorce in a polygamous marriage, the court is to consider the peculiar incidents of the marriage subject to justice, equity, and good conscience.[289] The court also has the power to prevent or rescind the disposition of assets or property (except to a purchaser in good faith for value) of either party to the marriage if such disposition has occurred prior to the settlement or to defeat the financial or property settlement.[290] Women married under the Marriage Ordinance generally have greater legal protection from arbitrary divorce and greater economic security in receiving maintenance.[291]

Although application can be made to an appropriate court to entertain suits for divorce and other matrimonial causes under the Matrimonial Act, most customary law marriages, whether or not they are polygamous, are in fact dissolved through customary law process.[292] Customary marriages are usually dissolved by negotiations between the families and both spouses.[293] If reconciliation fails, the dispute may be referred to arbitrators nominated by the families of both parties who will hear both sides formally, afford each an opportunity to cross-examine the other, and pronounce a sentence, including property settlement.[294] A wife's single act of adultery, barrenness, desertion, or "practice of witchcraft" is sufficient grounds for divorce.[295] On the other hand, customary law permits a wife to petition to divorce her husband for neglect, cruelty, impotence, desertion, and, in rare cases, persistence in pursuing numerous extramarital associations.[296] In addition, "[i]t has been held…that a husband has a lien on the ante-nuptial property and property acquired during marriage for the payment of the husband's marriage expenses. The wife, if she is lucky, is only entitled to send-off money."[297] There is generally no obligation to support an ex-wife.[298]

The Marriage of Mohammadens Ordinance, applicable to divorces pursuant to Islamic law, is silent about grounds and/or procedures for divorce. It merely provides for the registration of divorces effected under Islamic law in Ghana.[299]

Courts adjudicating a Muslim divorce are required to apply the Matrimonial Act, which states that courts are to be guided by the requirements of justice, equity, and good conscience in determining appropriate relief, financial provision, and child custody.[300]

The Maintenance of Children Decree applies with respect to many disputes regarding custody and maintenance of children regardless of whether a divorce is involved. The decree establishes family tribunals in each magisterial district consisting of three members, of whom at least one shall be a woman, to hear and determine complaints regarding paternity, custody, and maintenance of children.[301] The decree changes an earlier law by updating provisions that discriminated against fathers. For example, the decree permits an application for maintenance to be brought against any person legally liable to maintain a child, including a father, mother, or guardian, and it permits fathers, as well as mothers, to apply for the custody of a child.[302] Traditionally, among patrilineal groups such as the Ewe and the Ga, custody of children was awarded to the father. Among matrilineal groups, such as the Ashanti, the Fante, and the Nta, it was awarded to the mother.[303]

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

Ghana's Constitution declares that every person has the right to own property either alone or in association with others.[304] Although the Constitution does not explicitly apply this provision to women, it is presumed that constitutional guarantees of equality before the law and non-discrimination on the basis of gender would prohibit discrimination against women with respect to property.[305] Ghanaian women have also benefited generally from legal reform with respect to land acquisition, such as the Land Title Registration Law.[306] The main purpose of the Land Title Registration Law was to eliminate the uncertainties with respect to land title.[307] While women may indirectly benefit from greater certainty in establishing legal title to land, many women lack the education or means to undertake the land registration process to their benefit.[308]

The Constitution also explicitly provides that spouses shall have equal access to property jointly acquired during marriage and that assets acquired jointly shall be distributed equitably upon dissolution of the marriage.[309] Furthermore, the Constitution states that whether or not the deceased had a will, a spouse shall not be deprived of a reasonable provision from the estate of a deceased spouse.[310] Despite these constitutional provisions and other legal reforms described below, customary law continues to adversely affect the property rights of women in Ghana, particularly in rural areas.[311] Problems of intestate succession in Ghana have been attributed to the application of a mosaic of laws: English law of intestate succession (which occurs when an individual dies without leaving a will disposing of his or her estate, or with a will disposing of only part of the estate), patrilineal succession, matrilineal succession, the patriarchal rules of primogeniture and ultimogeniture (in which the youngest child succeeds to the estate), Islamic rules of succession, and the different marriage systems.[312] Because the customary law conception of marriage does not regard a wife as part of the husband's economic unit, a wife's claims to his property is very limited or nonexistent in contrast to that of his extended family.[313] The 1959 Ghanaian High Court ruling in *Quartey v. Martey* held that the proceeds of the joint effort of a man and his wife and/or children and any property acquired from such proceeds are by customary law the individual property of the man and not the joint property of the husband and wife.[314] By applying general rules of equity, Ghanaian courts have subsequently alleviated the situation. However, women are left "at the mercy of judges and their interpretation of case law and also their understanding of rules of equity."[315]

The Intestate Succession Law, 1985[316] (the "Intestate Law"), was enacted to remove "the anomalies in the present law relating to the intestate succession and to provide a uniform intestate succession law that will be applicable throughout the country irrespective of the class of the intestate and the type of marriage contracted by him or her."[317] The Intestate Law also sought to reverse the discrimination implicit in succession by widows and widowers, which exists under both the Marriage Ordinance and the Marriage of Mohammedens Ordinance, by repealing specific provisions of those earlier laws.[318] The 1991 Customary Marriage and Divorce (Registration) (Amendment) Law, which makes registration of customary marriages optional rather than mandatory provides that if a court is satisfied by oral or documentary evidence that a marriage was validly contracted under customary law, then the Intestate Law shall be applied.[319]

Labor Rights

All Ghanaian workers are constitutionally guaranteed the right to work under satisfactory, safe, and healthy conditions and to receive equal pay for equal work without distinction of any kind.[320] The Constitution also guarantees women equal rights to training and promotion.[321] Moreover, a right to "special care" during a reasonable period before and after childbirth, including paid leave, is also guaranteed in the Constitution.[322] Finally, the Constitution provides for the provision of child care facilities "to enable women, who have the traditional care for children, [sic] realise their full potential."[323]

Several other laws address women's labor rights. The Labour Decree, 1967, prohibits the employment of a female

in underground work in a mine and in night work in any industrial undertaking, except in exceptional circumstances with the written permission of a Labour Officer empowered pursuant to the decree.[324] In addition, the decree provides that the employer of any industrial, commercial, or agricultural undertaking shall give six weeks leave at not less than 50% pay after a female worker gives birth (eight weeks in the case of abnormal birth or multiple births) and six week's leave also at not less than 50% pay, upon medical recommendation, prior to the date a female worker is scheduled to give birth.[325] The administrative regulations of certain national institutions such as the civil service and the armed forces also have provisions treating women differently from men. For example, women in the armed forces may not have children until they have served three years, and women employed by the prison service may not marry until they have completed a period of two years' probation.[326] In his 1996 sessional address to the Parliament, the president stated that the government would soon issue a firm policy statement on affirmative action to benefit women.[327]

Rules Governing Credit

Although Ghana's Constitution explicitly guarantees women certain rights to participate in economic life,[328] it does not make specific reference to women's access to credit. Generally, Ghanaian women have very poor access to credit in light of their low level of education, social status, and inability to meet collateral requirements for the limited institutional credit made available for small scale enterprise.[329] However, certain government and international programs operating in Ghana suggest some governmental recognition of the need to improve women's access to credit.[330]

Education

In light of Ghana's gender differentials in education, it is not surprising that Ghana's Constitution grants an equal right to educational opportunities and facilities.[331] It provides that basic education shall be free, compulsory, and available to all and that secondary education shall be made generally available and accessible to all by every appropriate means and, in particular, by progressive introduction of free education.[332] The government has initiated general measures to improve the primary, secondary, and university education systems, with certain programs aimed at girls.[333] In his recent report to Parliament regarding economic and social development policies, the president also discussed the need to increase female enrollment and completion rates at all levels in the educational system.[334] For further discussion regarding education, see section on adolescents below.

Women's Bureaus

In 1975, the National Council on Women and Development ("NCWD") was established to promote the advancement of women.[335] Prior to a proposed restructuring still under consideration as of early 1997, the NCWD was under the office of the president and was composed of a 15-member council of women appointed by the government with experience in women-in-development issues and the advancement of women.[336] Since 1989, the NCWD has focused on building networks, providing training and information, monitoring, evaluating, and formulating projects with NGOs, and linking NGOs to government and external assistance.[337] The NCWD submitted its "Memorandum on Affirmative Action" policy proposal to the government, and the president announced its acceptance in principle in his January 1996 address to Parliament.[338]

C. RIGHT TO PHYSICAL INTEGRITY

Rape

A 1993 amendment of Ghana's Criminal Code provides that rape is a first-degree felony punishable by not less than three years' imprisonment and a fine, with a maximum sentence of life imprisonment.[339] Rape is defined in Ghana's Criminal Code as "the carnal knowledge of a female of any age without her consent."[340] The Criminal Code also recognizes the crime of "defilement" or statutory rape, stating that "whoever carnally knows any female under fourteen years of age, whether with or without her consent" is guilty of a second-degree felony, punishable by imprisonment for a term of between 12 months and 10 years.[341] A similar provision applies to a person who has carnal knowledge of any female "idiot," "insane person," or "patient in a lunatic asylum," whether with or without her consent, whether or not the circumstances amount to rape, provided the perpetrator knew of the woman's mental state.[342] Ghana's Criminal Code also penalizes "unnatural carnal knowledge," providing that "[w]hoever is guilty of unnatural carnal knowledge (a) of any person without his consent, is guilty of first-degree felony; (b) of any person with his consent, or of any animal, is guilty of a misdemeanor."[343]

Ghanaian law does not criminalize marital rape.[344] As described below, the Ghanaian Criminal Code provides that a married woman cannot object to the use of force by her husband because her consent to the act is presumed. For further discussion on sexual offenses against minors, see section on adolescents below.

Domestic Violence

A criminal statute prohibits wife beating.[345] Ghana has a criminal code general provision rooted in British common law

that establishes a legal defense to the use of force where the person has consented to such force being used against him or her. The provision automatically extends this consent to use of force to a married couple unless and until they are divorced or legally separated.[346] Thus, the Ghanaian Criminal Code has not to date been amended to repeal the common law marital exemption relating to the use of force, including rape.[347]

Sexual Harassment

No specific legislation relating to sexual harassment currently exists in Ghana.[348]

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

The needs of adolescents are often unrecognized or neglected. Ghana's 1993 Demographic and Health Survey showed that almost 22% of all adolescent girls aged 15-19 had already commenced childbearing at the time of the survey.[349] Moreover, given that approximately 12.5% of the Ghanaian population is between the ages of 13 and 18[350] and that approximately 43% of the country is under the age of 15,[351] it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescent rights, including those related to reproductive health, are important for women's right to self-determination as well as for their health.

Ghana's Constitution includes a provision on children's rights which defines a "child" as a person below the age of 18 and specifies certain rights of children to special care, assistance and maintenance from their natural parents, protection against physical and moral hazards, and freedom from torture or degrading treatment.[352]

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

Ghana's Population Policy seeks to reduce the proportion of women who marry before the age of 18, reduce the number of women who bear children before the age of 18, and promote education among young women between the ages of 15 and 18.[353] Ghana's Reproductive Health Service Policy specifically endorses the principle that reproductive health care services must fully incorporate adolescents.[354] All of the Reproductive Health Service Policy's substantive service components purport to incorporate all sexually active couples and individuals, without limitation on age. For example, with respect to antenatal care, the Reproductive Health Service Policy states that "[t]he beneficiaries shall be all pregnant women, including adolescents,"[355] and with respect to preventing and managing cancer of the reproductive tract, adolescents are also specifically targeted.[356] Moreover, Ghana's Reproductive Health Service Policy includes a detailed information, education, and communication policy designed to "create awareness, improve knowledge and change attitudes" in order to enable identified target groups, including adolescents, to make informed choices and decisions and to take action to improve their reproductive health status.[357]

In November 1996, the National Population Council issued its Adolescent Reproductive Health Policy (the "Adolescent Policy"), which is designed to provide a guide for policy makers to address the reproductive health needs of the large Ghanaian adolescent population.[358] The Adolescent Policy acknowledges the right to information and services of adolescents and the serious gender disparities in status, education, health, and employment.[359] It seeks to provide knowledge, skills, and services to: reduce or eliminate unintended pregnancies, reproductive tract infections, including STDs, HIV/AIDS, unsafe abortions, FGM, early marriage, and malnutrition among adolescents; improve access to education and employment opportunities; and eliminate violence against adolescents and abuses against the girl-child.[360]

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

FGM was outlawed in 1994.[361] The Reproductive Health Service Policy's FGM policy seeks to "target" various groups, including politicians and policy makers, traditional and local leaders, religious bodies, women's and men's groups, *wanzams* (circumcisers), and other groups.[362] The strategies for discouragement of harmful traditional practices include: integration of FGM-related services into all ongoing reproductive health services and activities; integration of services into the school health education program; encouraging community involvement; training reproductive health service providers; and strengthening the government's database on harmful traditional practices.[363] To combat and treat the effects of FGM, the Reproductive Health Service Policy requires enforcement of the 1994 law on FGM and the provision of full medical services, with the assistance of law enforcement officers, medical personnel, teachers, politicians, peer counselors, traditional rulers, opinion leaders, and *wanzams*.[364] The Adolescent Policy also states as an objective the reduction or elimination of FGM.[365]

C. FEMALE RELIGIOUS BONDAGE

Primarily in the southeastern Volta Region of Ghana and within certain ethnic groups, such as the Ewe, female religious slavery dating to the 17th century is still practiced.[366] Virgin girls, often under 10 years old, are given by their families to

work as slaves in religious shrines to appease the gods for crimes committed by relatives.[367] These approximately 4,500 girls and women, known as *trocosi* (slaves of the gods), are considered a priest's property and may be freed only by him, usually after the woman is no longer appealing to him because she has borne many children and been overworked. In such cases, the family must give another virgin, often in perpetuity, to atone for a serious crime.[368] These women are forced to serve their husband/master sexually and to live in deplorable conditions without adequate food, performing unpaid domestic and farm labor, deprived of education and access to health care.[369]

This traditional practice continues despite legal prohibitions. Ghana's Constitution explicitly bans slavery and forced labor[370] and prohibits customary practices that harm one's physical and mental well-being.[371] Moreover, numerous provisions of Ghana's Criminal Code are violated by this practice, including those related to rape and other sexual offenses, slavery, and forced marriage.[372]

D. MARRIAGE AND ADOLESCENTS

Recent survey data show that the median age at first marriage is 18.9 years for women in Ghana between the ages of 20 and 49.[373] But the Marriage Ordinance provides that each of the parties to a marriage must be 21 years old.[374] If either the man or the woman is below that age, a parent's or a guardian's consent is required.[375] However, the great majority of marriages are solemnized in accordance with customary law, rather than pursuant to the Marriage Ordinance. None of the customary laws applicable to various ethnic groups in Ghana specify a minimum age at which persons become legally capable of entering into marriage.[376] The Marriage of Mohammedens Ordinance applicable to Islamic marriages does not specify a minimum age for first marriage.[377] The traditional practice of forced childhood marriage still exists in Ghana,[378] despite the Criminal Code's provision voiding compelled marriage.[379]

E. EDUCATION AND ADOLESCENTS

Although the gender ratio in Ghanaian educational institutions is generally improving, significant discrepancies remain, particularly at higher levels of education. In 1987, the government initiated a program to enhance gender equity by increasing enrollment of girls in schools, and the Ministry of Education has targeted a 50:50 male/female ratio in pre-tertiary education by the year 2005.[380] The reforms are designed to improve literacy and to prepare girls for vocational and professional skills, as well as to encourage girls to pursue careers in science, engineering, and other traditionally male careers.[381] In its Vision 2020 report on economic and social development policies, the Ghanaian government also states the objective of increasing female enrollment and completion rates at all levels in the educational system.[382]

F. SEX EDUCATION FOR ADOLESCENTS

The Ghanaian government has initiated a Population Planning and Family Life Education ("POP/FLE") program for adolescents both in and out of school.[383] The POP/FLE program incorporates a broad range of topics including human reproduction, STDs and HIV/AIDS, methods of family planning, population and environmental issues, and gender issues.[384] It is still in the process of being integrated on a nationwide level into several different existing courses at the various levels of the education system, and obstacles remain.[385] The MOH's Reproductive Health Service Policy specifically targets education and counseling programs towards adolescents both in and out of school, and an effort is made to make such programs "culturally sensitive."[386] This policy's information, education, and communication program seeks to reach out to adolescents through all reproductive health facilities and schools in both the public and private sectors.[387]

G. SEXUAL OFFENSES AGAINST MINORS

As stated above, Ghana criminalizes statutory rape by establishing a second-degree felony for anyone who "carnally knows any female under fourteen years of age, whether with or without her consent."[388] This crime is punishable by imprisonment of not less than 12 months or more than 10 years.[389] However, the application of this law is weakened by Section 102 of the Criminal Code, 1960, which categorizes as a misdemeanor the "defilement" of a female between the ages of 10 and 14, but states that no prosecution for this offense may be commenced more than three months after its commission. This provision also establishes as a defense that the accused had reasonable cause to believe the girl was above 14 years of age.[390]

It is a first-degree felony for the owner or occupier of any premises to induce or "knowingly suffer" any female under 14 years of age to "carnally know" any person, whether one particular person or generally.[391] Procurement of a female under the age of 21 who is not a "common prostitute" or "of known immoral character" to have "unlawful carnal connection" is also a criminal offense under Ghanaian law, as are other actions to procure any female to become a prostitute or inmate in a brothel.[392]

ENDNOTES

1. AN OFFICIAL HANDBOOK OF GHANA 16 (1991) [hereinafter GHANA HANDBOOK].
2. THE WORLD ALMANAC AND BOOK OF FACTS 1997 768 (1996) [hereinafter WORLD ALMANAC].
3. THOMAS H. REYNOLDS & ARTURO A. FLORES, FOREIGN LAW: CURRENT SOURCES OF CODES AND LEGISLATION IN JURISDICTIONS OF THE WORLD III, GHANA 1 (1993).
4. *Id.*
5. *Ghanaians Vote for President and Parliament*, N.Y. TIMES, Dec. 7, 1996, at A8; World News Brief, *Ghana's Chief Declared Victor in Election*, N.Y. TIMES, Dec. 12, 1996, at A4 [hereinafter *Ghanaians Vote*].
6. CONST. OF THE FOURTH REPUBLIC OF GHANA (PROMULGATION) LAW, Provisional National Defense Council Law 282 (1992) [hereinafter CONST. LAW (282)].
7. *Ghanaians Vote*, *supra* note 5, at A8.
8. U.S. A.I.D. & U.S. DEP'T OF COMMERCE, WORLD POPULATION PROFILE A-6 (1996).
9. ARJUN ADLAKHA, U.S. DEP'T COMMERCE, ECONOMICS AND STATISTICS ADMINISTRATION, BUREAU OF THE CENSUS, INT'L BRIEF: POPULATION TRENDS: GHANA (July 1996).
10. GHANA STATISTICAL SERVICE, GHANA DEMOGRAPHIC AND HEALTH SURVEY 1993, at 1 (1994) [hereinafter HEALTH SURVEY].
11. *Id.*
12. CONST. LAW (282), *supra* note 6.
13. GHANA CONST. ch. 1, art. 1(2).
14. *Id.* ch. 8, art. 57(1).
15. *Id.* ch. 8, art. 66.
16. *Id.* ch. 8, art. 60.
17. *Id.* ch. 8, arts. 76, 78.
18. *Id.* ch. 8, arts. 89, 91.
19. *Id.* ch. 22, art. 270(1). The provision refers to the institution of chieftaincy, "together with its traditional councils as established by customary law" and prohibits Parliament from enacting any laws conferring on any person the right to accord or withdraw recognition to or from a chief or that detracts from the honor of the institution of chieftaincy. *Id.*
20. Specifically, the National House of Chiefs is to advise any person or authority on any matter affecting chieftaincy, undertake to study, interpret and codify customary law, evaluate traditional customs that are socially harmful and hear certain judicial appeals which may then be appealed to the Supreme Court. GHANA CONST. ch. 22, arts. 272, 273.
21. THE WORLD ALMANAC 768 (1997); REYNOLDS & FLORES, *supra* note 3, at 1.
22. GHANA CONST. ch. 20, art. 240(1).
23. *Id.* ch. 20, art. 241(3).
24. *Id.* ch. 20, art. 245.
25. *Id.* ch. 20, art. 242. Candidates seeking election to a district assembly or any lower local government unit must run as an individual and may not run under any political party, nor may political parties endorse or sponsor such a candidate in any way. *Id.* ch. 20, art. 248.
26. REYNOLDS & FLORES, *supra* note 3, at 1.
27. *Id.*
28. GHANA CONST. ch. 10, art. 93(2).
29. *Id.* ch. 10, art. 106.
30. *Id.* ch. 10, arts. 106(9), (10).
31. *Id.* ch. 4, art. 11(7).
32. *Id.* ch. 11, arts. 125(1), (3).
33. *Id.* ch. 11, art. 126(1).
34. *Id.* ch. 11, art. 128(1).
35. *Id.* ch. 11, art. 131(1)(a).
36. *Id.* ch. 11, art. 130.
37. *Id.* ch. 11, arts. 144(1), (2).
38. *Id.* ch. 11, arts. 139(1), 141(1).
39. *Id.* ch. 11, art. 137.
40. *Id.* ch. 11, art. 144(3).
41. Samuel O. Gyandoah, Jr., *The Legal System of Ghana in* MODERN LEGAL SYSTEMS CYCLOPEDIA § 1.3 (A)(4) (1982).
42. For example, the jurisdiction of the circuit courts, which hear civil matters, includes: (1) certain personal actions arising under contract or tort, (2) matters relating to minor's guardianship and custody and (3) certain probate matters for estates valued below a certain amount. *See* Courts Act (459) pt. I, § 41 (1993) (Ghana). The jurisdiction of the circuit tribunals, which hear criminal matters, includes all criminal matters arising within their territorial jurisdiction, except for treason, murder, first degree felonies, and offenses punishable by death or life imprisonment. *Id.* pt. I, § 44.
43. *Id.*, pt. II; GHANA HANDBOOK, *supra* note 1, at 37.
44. This includes Islamic law in the case of the country's small Muslim population, particularly with respect to family law matters. Gyandoah, *supra* note 41, § 1.2 (A); GOVERNMENT OF GHANA/UNFPA, 3RD COUNTRY PROGRAMME 1996-2000, U.N. Doc. DP/FPA/CP/151, at 47, ¶ 141 (1995) [hereinafter 3RD COUNTRY PROGRAMME].
45. Gyandoah, *supra* note 41, § 1.2 (A); GHANA HANDBOOK, *supra* note 1, at 36.
46. GHANA CONST. ch. 4, art. 11(1). Existing law comprises written and unwritten laws existing immediately before the coming into force of the Constitution and it is to be construed with any modifications, adaptations, qualifications and exceptions necessary to bring it into conformity with the Constitution. *Id.* ch. 4, arts. 11(4), (6).
47. Gyandoah, *supra* note 41, § 1.2(H).
48. *Id.*
49. GHANA CONST. ch. 5, art. 12(1).
50. GHANA CONST. ch. 5, art. 12(2).
51. GHANA CONST. ch. 5, art. 17. Moreover, Parliament is permitted to enact laws reasonably necessary to provide, *inter alia*, "for making different provision for different communities having regard to their special circumstances not in provision [sic] which is inconsistent with the spirit of this constitution." *Id.* ch. 5, art. 17(4)(d).
52. *Id.* ch. 5, art. 22.
53. *Id.* ch. 5, art. 27.
54. *Id.* ch. 5, art. 26(1).
55. *Id.* ch. 5, art. 26(2).
56. *Id.* ch. 6, art. 34(1).
57. *Id.* ch. 6, art. 34(2).
58. *Id.* ch. 4, art. 11(2). "Customary law" in that article means "the rules of law which by custom are applicable to particular communities in Ghana." *Id.* ch. 4, art. 11(3).
59. Gyandoah, *supra* note 41, § 11.2(I).
60. REYNOLDS & FLORES, *supra* note 3, at 2.
61. Courts Act, pt. III.
62. *Id.*; REYNOLDS & FLORES, *supra* note 3, at 2.
63. *Id.*
64. GHANA CONST. ch. 8, art. 75.
65. *Id.*
66. Memorandum from Victoria Addy, President, FIDA-Ghana, to The Center for Reproductive Law and Policy (Feb. 20, 1997) (on file with The Center for Reproductive Law and Policy) [hereinafter Addy Memorandum III].
67. *Id.* ch. 6, art. 40.
68. *Id.* ch. 6, art. 37(3).
69. Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 (*entry into force* Sept. 3, 1981) (signed by Ghana on July 17, 1980 and ratified Jan. 2, 1986).
70. International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (*entry into force* Jan. 4, 1969) (signed and ratified by Ghana on Sept. 8, 1966).
71. Convention on the Rights of the Child, Nov. 20, 1989, G.A. Res. 44/25, U.N.G.A.O.R., 44th Sess., Supp. No. 49, U.N. Doc. A/44/49, *reprinted in* 28 I.L.M. 1448 (*entry into force* Sept. 2, 1990) (ratified by Ghana on Feb. 5, 1990).
72. African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, OAU Doc. CAB/LEG/67/3/Rev 5 (1981), *reprinted in* 21 I.L.M. 59 (1982) (*entry into force* Oct. 21, 1986) (ratified by Ghana on Mar. 1, 1989).
73. *See* Presidential Report on Co-ordinated Programme of Economic and Social Development Policies, GHANA — VISION 2020 (The First Step: 1996-2000) § 5.1.5 (1995) [hereinafter GHANA VISION]; MINISTRY OF HEALTH, NATIONAL REPRODUCTIVE HEALTH SERVICE POLICY AND STANDARDS iv (Apr. 1996) [hereinafter REPRODUCTIVE HEALTH POLICY]; GHANA HANDBOOK, *supra* note 1, at 55.
74. GHANA VISION, *supra* note 73, § 2.1.5; 3RD COUNTRY PROGRAMME, *supra* note 44.
75. GHANA VISION, *supra* note 73, §§ 1.1-1.3, 3.1.5, 5.1.5 (citing National Development Policy Framework — Volume 1: Long-Term Development Objectives for Ghana — Vision 2020 and the Co-ordinated Programme of Economic and Social Development Policies (The First Step: 1996-2000)).
76. *Id.* § 5.1.5.
77. HEALTH SURVEY, *supra* note 10, § 1.4.
78. REPRODUCTIVE HEALTH POLICY, *supra* note 73.
79. WORLD BANK, WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH 210 (1993). Of the 3.5% of GDP spent on health, an estimated 1.7% was attributed to the public sector and 1.8% to the private sector. *Id.*
80. 3RD COUNTRY PROGRAMME, *supra* note 44, at 10, ¶ 34.
81. HEALTH SURVEY, *supra* note 10, at 4.
82. *Id.*

83. Health Service and Health Management Bill (1996) (Ghana) (on file with The Center for Reproductive Law and Policy) [hereinafter Health Bill].
84. Ghana Const. ch. 14, art. 190(1)(a).
85. Health Bill, *supra* note 83.
86. *Id.* § 2.
87. *Id.* §§ 29-34.
88. Republic of Ghana, Ministry of Health, The Health Sector in Ghana: Facts and Figures 12 (1996) [hereinafter Health Sector]. Hospitals are facilities that provide in- and out-patient services; health centers are facilities providing mainly out-patient and preventive services; and clinics are facilities providing one or two services. *Id.* at 13.
89. *Id.* at 14. Using 17.7 million as Ghana's estimated population, the doctor-population ratio is approximately 1 per 16,000 and the nurse population ratio is approximately 1 per 1,405. *Id.*
90. 3rd Country Programme, *supra* note 44.
91. *See* Reproductive Health Policy, *supra* note 73, at 35.
92. *See id.* at 26, 29.
93. *See* Hospital Fees Regulations, L.I. 1313 (Legislative Instrument) (1985) (Ghana) [hereinafter Hospital Fees Regulations]; *see also* Memorandum from Victoria Addy, President, FIDA-Ghana, to The Center for Reproductive Law and Policy (Feb. 1997) (on file with The Center for Reproductive Law and Policy) [hereinafter Addy Memorandum II].
94. Addy Memorandum III, *supra* note 66.
95. Hospital Fees Act (387) §§ 2-4 (1971) (Ghana) [hereinafter Hospital Fees Act].
96. *Id.*
97. *Id.*
98. 3rd Country Programme, *supra* note 44.
99. Ministry Of Health, 1993 Annual Report 18 (1994) [hereinafter MOH 1993 Annual Report].
100. *Cash and Carry Programme: Report on Programme Review* iii (Mar. 1996) (on file with The Center for Reproductive Law and Policy).
101. Medical and Dental Decree N.R.C.D. 91 (National Redemption Council Decree) (1972) (Ghana) [hereinafter Medical Decree].
102. Nurses and Midwives Decree N.R.C.D. 117 (National Redemption Council Decree) (1972) (Ghana) [hereinafter Nurses Decree].
103. Pharmacy Act, 1994 (489) (1994) (Ghana) [hereinafter Pharmacy Act, 1994].
104. Medical Decree, § 4.
105. *Id.* §§ 39, 40.
106. *Id.* § 41.
107. *Id.* §§ 21, 22.
108. *Id.* § 35.
109. Nurses Decree, §§ 2, 4.
110. *Id.* § 13.
111. *Id.* § 22.
112. *Id.* § 25.
113. Pharmacy Act, 1994, § 1.
114. *Id.* §§ 2, 27-30.
115. *Id.* §§ 15, 17 .
116. *Id.*, §§ 24, 31.
117. Reproductive Health Policy, *supra* note 73, §§ 3.5, 4.1-4.5.
118. *Id.* § 2.8.
119. *See* Addy Memorandum II, *supra* note 93.
120. Criminal Code (29) § 73(b), (c) [hereinafter Crim. Code (29), 1960].
121. Criminal Code (30) § 296 (4) [hereinafter Crim. Code (30), 1960].
122. Crim. Code (29), 1960, § 82. Causing intentional and unlawful harm is a second degree felony, punishable by up to 10 years' imprisonment, in contrast to negligently and unlawfully causing harm which is a misdemeanor, punishable by up to three years' imprisonment. *See id.*, §§ 69, 72; Crim. Code (30), 1960, § 296.
123. *See* Memorandum from Victoria Addy, President, FIDA-Ghana to The Center for Reproductive Law and Policy (Jan. 1997) (on file with The Center for Reproductive Law and Policy) [hereinafter Addy Memorandum I].
124. Medical Decree, §§ 42, 43.
125. *Id.* § 43.
126. *Id.* § 46.
127. *Id.* §§ 47, 48.
128. Nurses Decree, § 27.
129. Pharmacy Act, 1994, § 23.
130. Professional Conduct and Ethics (Guides and Regulations) ¶ 9 (Medical and Dental Council) (1975) (Ghana) [hereinafter Professional Conduct].
131. *See id.* ¶ 14.
132. *Id.* ¶ 4.
133. *See id.* ¶ 5.
134. National Population Council, National Population Policy iii (revised ed. 1994) [hereinafter Population Policy].
135. 3rd Country Programme, *supra* note 44, at 7, ¶ 23.
136. The NPC worked to initiate grassroots participation in the policy formulation of the revised population policy, a key improvement over the 1969 policy, which lacked input from implementors and different societal groups. *See* 3rd Country Programme, *supra* note 44, at 10, ¶ 31.
137. *See* National Population Council Act (435), art. 3 (1994) [hereinafter Population Act]; 3rd Country Programme, *supra* note 44, at 59, ¶ 186.
138. Population Act, *supra* note 137, art. 2.
139. Population Policy, *supra* note 134, at iii, 25; 3rd Country Programme, *supra* note 44, at 7, ¶ 24 (1995).
140. Ghana Const. art. 37(4).
141. *Id.* art. 34(1).
142. Ghana Vision, *supra* note 73.
143. *Id.* § 4.2.
144. *Id.* § 3.1.9.
145. *Id.* § 5.1.3.
146. *Id.*
147. Population Policy, *supra* note 134, § 4.2.
148. *Id.* § 4.4.
149. *Id.* § 4.3.
150. *Id.* §§ 5.1-5.20.
151. Reproductive Health Policy, *supra* note 73, at iii.
152. *See id.* at iv. In addition to general rules and regulations governing the various areas of reproductive health services, the service policy guidelines address training, components of reproductive health services, target and priority groups for service and basic information, information, education and communication eligibility for services, who will provide what services, and planning and implementation of training, logistics, supervision and evaluation activities. *Id.* The service standards set out minimum-acceptable performance levels and expectations for each component of reproductive health services, the expected functions of service providers and levels of service delivery, and the basic training content required for the performance of these functions. *Id.*
153. *Id.* at iv, § 1.3.
154. Reproductive Health Policy, *supra* note 73, § 1.1. The Reproductive Health Policy specifically adopts the reproductive health definition from the 1994 Cairo International Conference on Population and Development. *Id.* § 1.2.
155. *Id.* § 2.2.1.
156. *Id.* §§ 1.1, 1.4.
157. 3rd Country Programme, *supra* note 44, at ii.
158. *Id.* at 4, ¶ 16.
159. Health Survey, *supra* note 10, § 6.2.
160. *Id.* § 8.1.
161. *Id.*
162. *Id.*
163. Hospital Fees Regulations, *supra* note 93.
164. Report by Victoria Addy, President, FIDA-Ghana, Accra, Ghana, § 3.3.2 (Sept. 1996) (on file with The Center for Reproductive Law and Policy) [hereinafter Addy Report I].
165. Hospital Fees Regulations, *supra* note 93, §§ 2(q), 3.
166. Addy Memorandum II, *supra* note 93.
167. *Id.*
168. Reproductive Health Policy, *supra* note 73, § 2.2.5.
169. Health Survey, *supra* note 10, § 4.8.
170. *Id.*
171. Reproductive Health Policy, *supra* note 73, § 3.1.
172. *Id.* § 3.3.
173. *Id.* §§ 3.1, 3.2.
174. Health Survey, *supra* note 10, § 4.5. The number of currently married women practicing family planning in 1993 increased as compared to the 1988 demographic and health survey in which 13% of married women used family planning (5.1% using modern methods). *Id.*
175. *Id.* § 4.5. No women reported use of implants as their currently used contraceptive method. *Id.*
176. Health Survey, *supra* note 10, § 4.5.

177. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 2.2.1. Specifically, the Reproductive Health Service Policy lists condoms, spermicides, cervical caps, diaphragms, oral contraceptive pills, injectable lactational amenorrhea method, natural family planning, IUDs, implants, tubal ligation and vasectomy. *See id*.
178. *Id*. § 2.2.3.
179. Addy Memorandum III, *supra* note 66.
180. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 2.2.5.
181. Pharmacy Act, 1994, art. 27.
182. *Id*. art. 31. *See* Pharmacy and Drugs Act, 1961, 2d sched. (Class A Drugs), 3rd sched. (Class B Drugs), 4th sched. (Class C Drugs, including condoms and spermicide, primarily any proprietary drug which does not contain any Class A or Class B drugs). The Pharmacy and Drugs Act, 1961 was largely repealed pursuant to the Pharmacy Act, 1994 except for most of the First, Second, Third and Fourth Schedules which are to remain in effect until the Minister of Health on advice of the Food and Drugs Board specifies which drugs are Class A, B and C. *See* Pharmacy Act, 1994, arts. 38, 48. To date, new regulations specifying the classifications of drugs have not been issued.
183. *Id*. art. 29.
184. *Id*. art. 36.
185. *Id*. art. 35.
186. *Id*. art. 33. The Act also requires the supplier of a drug to keep certain records with respect to restricted drugs and dangerous drugs. *Id*. arts. 32, 34.
187. Addy Memorandum III, *supra* note 66.
188. *See* Ban on advertising of contraceptives, July 1986. *See also* Vol. 13, 220 CONTRACEPTION, at 23 (citing International Planned Parenthood Federation, 14 PEOPLE 32 (No. 2, 1987).
189. CRIM. CODE (29), 1960, §§ 280-81.
190. *Id*.
191. CRIM. CODE (29), 1960, § 280.
192. *See Abortion Policies: A Global Review*, U.N. Department for Economic and Social Information and Policy Analysis, at 27-29, U.N. Doc. ST/ESA/SER.A/129/Add.1 (1993) [hereinafter *Abortion Policies*]; INT'L PLANNED PARENTHOOD FEDERATION AFRICA REGION, UNSAFE ABORTION AND POST-ABORTION FAMILY PLANNING IN AFRICA 8, 28 (1994) [hereinafter UNSAFE ABORTION].
193. *Abortion Policies*, *supra* note 192, at 29.
194. UNSAFE ABORTION, *supra* note 192, at 8.
195. CRIM. CODE (29), 1960, § 58.
196. CRIM. CODE (29), 1960, § 59(1).
197. CRIMINAL CODE (Amendment), 1985 (amending CRIM. CODE (29), 1960, §§ 58 & 59) [hereinafter CRIM. CODE, 1985].
198. *Id*.
199. *Id*. § 58(2)(b).
200. *Id*.
201. *See id*. § 59(2).
202. CRIM. CODE (29), 1960, § 59(1).
203. Private Hospital and Maternity Homes Act (9) (1958) (Ghana).
204. *See* CRIM. CODE, 1985.
205. *Id*.
206. *See* Report by Victoria Addy, President, FIDA-Ghana, Accra, Ghana 7 (Jan. 1997) (on file with The Center for Reproductive Law and Policy) [hereinafter Addy Report II].
207. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 2.3.
208. *Id*. § 2.3.1.
209. *Id*.
210. *Id*. §§ 2.3.2, 2.3.5.
211. *See* CRIM. CODE (29), 1960, § 58; CRIM. CODE (30), 1960, § 296.
212. CRIM. CODE (29), 1960, § 59(1).
213. CRIM. CODE, 1985.
214. *See* Addy Report II, *supra* note 206, at 8 (describing case of State v. Chene-Kesson and Mensah, 1961 G.L.R. 708 (Ghana Sup. Ct.)).
215. *Id*. at 7.
216. *See* CRIM. CODE, 1985.
217. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 2.3.1.
218. *Id*. § 2.3.
219. HEALTH SURVEY, *supra* note 10, § 4.4.
220. United Nations Population Fund, *Survey of Laws on Fertility Control* (1979) (citing CRIM. CODE (29) § 42(c)) [hereinafter *Fertility Control*].
221. REPRODUCTIVE HEALTH POLICY, supra note 73, § 2.2.5.
222. Addy Report II, *supra* note 206, § 4.2; *see also Fertility Control*, *supra* note 220, at 14 (1979); Statement from Josephine Addy of Planned Parenthood Association of Ghana (on file with The Center for Reproductive Law and Policy).
223. Hospital Fees Regulations, pt. B. The cost listed for minor surgical operations which encompasses sterilization is 500 Cedis. *Id*.
224. NAHID TOUBIA, FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION 25 (Rainbo 1995).
225. UNICEF, CHILDREN AND WOMEN OF GHANA: A SITUATION ANALYSIS 65 (1990) [hereinafter CHILDREN AND WOMEN]; U.S. DEPT. OF STATE, 1996 HUMAN RIGHTS REPORT: GHANA § 5 (1997) [hereinafter HUMAN RIGHTS REPORT].
226. CHILDREN AND WOMEN, *supra* note 225, at 65.
227. CRIM. CODE, 1994.
228. *Id*. § 1.
229. *See* GHANA CONST. ch. 5, art. 26(2).
230. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 2.8.
231. *Id*.
232. NATIONAL AIDS/STD CONTROL PROGRAMME, AIDS SURVEILLANCE REPORT JANUARY TO DECEMBER 1995 (1996). The Ministry of Health reported 13,699 HIV-positive cases as of 1994. *See* 3RD COUNTRY PROGRAMME, *supra* note 44. The Ministry of Health estimated the percentage of the Ghanaian population that was HIV-positive in 1992 at 0.2%. *Id*. Twenty-six AIDS cases were reported in 1986 and 3,140 cases were reported as of December 1991. MINISTRY OF HEALTH, GUIDELINES FOR AIDS PREVENTION AND CONTROL ACTIVITIES AT THE REGIONAL AND DISTRICT LEVEL 1 (1992) [hereinafter AIDS GUIDELINES].
233. Sentinel surveillance involves the selection of specific sites at which a pre-determined number of people from specific population group(s) are tested in a regular and consistent way according to a pre-determined protocol. MINISTRY OF HEALTH, DISEASE CONTROL UNIT, HIV SENTINEL SURVEILLANCE I (1995) [hereinafter HIV SENTINEL].
234. *Id*. at 6.
235. MOH 1993 ANNUAL REPORT, *supra* note 99, at 8.
236. In 1992, it was estimated that women accounted for 77% of all AIDS cases. *See* 3RD COUNTRY PROGRAMME, *supra* note 44, at 46; *See also* NATIONAL COUNCIL ON WOMAN AND DEVELOPMENT, THE STATUS OF WOMEN IN GHANA (1985-1994) § 6.2.7 (1994) (citing 71%) [hereinafter STATUS OF WOMEN].
237. CRIM. CODE (29), 1960, § 284.
238. Pharmacy Act, 1961, 5th sched., *repealed by* Pharmacy Act, 1994 (489), art. 48 (1).
239. HON. KWAME PEPRAH, MINISTER OF FINANCE, THE BUDGET STATEMENT AND ECONOMIC POLICY OF THE GOVERNMENT OF GHANA FOR THE FINANCIAL YEAR 1996, at 18, ¶ 90 (Feb. 2, 1996).
240. 3RD COUNTRY PROGRAMME, *supra* note 44, at 12, ¶ 34(v).
241. HIV SENTINEL, *supra* note 233, at i.
242. AIDS GUIDELINES, *supra* note 232, at ii.
243. *Id*. at 1.
244. *Id*. §§ 4.5, 5.1. With respect to confidentiality, the AIDS Guidelines state that the test results may not be given if the person did not know she was being tested, nor may any other person be told of the results without the consent of the person tested. *Id*.
245. *Id*. § 8.1.
246. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 2.4.
247. *Id*. § 2.4.4.
248. *Id*. § 2.4.5.
249. Hospital Fees Regulations, *supra* note 93 § 2(2)(q).
250. Addy Memorandum II, *supra* note 93.
251. W.C. Ekow Daniels, *The Legal Position of Women under our Marriage Laws*, IX U. GHANA L. J. 39, 40 (1972).
252. Marriage Ordinance (127) (Gold Coast, 1951) [hereinafter Marriage Ordinance, 1951].
253. GHANA IN SISTERHOOD IS GLOBAL 255 (Robin Morgan ed., The City Univ. of N.Y., Feminist Press 1996) [hereinafter GHANA SISTERHOOD]; *See* Daniels, *supra* note 251, at 39, 40.
254. Marriage Ordinance, §§ 14(2), (4).
255. *Id*. § 44. However, nothing in the Marriage Ordinance affects the validity of any marriage contracted under or in accordance with any customary law. *Id*.
256. W.C. Ekrow Daniels, *Laws Relating to Husband and Wife in Ghana*, II U. GHANA L. J. 20, 22 (1965) [hereinafter *Laws Relating*].
257. *Id*. at 22-23. This system impliedly requires the consent of both the couple and their parents. *See* GHANA SISTERHOOD, *supra* note 253, at 255.
258. *Laws Relating*, *supra* note 256, at 23; *see also* Gordon Woodman, *Judicial Development of Customary Law: The Case of Marriage Law in Ghana and Nigeria*, XIV U. GHANA L. J. 115, 121-22 (1977).
259. CRIM. CODE (29), 1960, § 109.

260. *Laws Relating*, *supra* note 256, at 20, 22.
261. GHANA LAW REFORM COMMISSION, 12th Annual Report, at 12 (1987).
262. *Laws Relating*, *supra* note 256, at 36.
263. *Id.*
264. *Id.*; *see* Addy Report II, *supra* note 206, at 1 (citing Asumah v. Khair [1959] G.L.R. 355, 356 (1959)).
265. Daniels, *supra* note 251, at 44.
266. *Laws Relating*, *supra* note 256, at 37 .
267. CRIM. CODE (29), 1960, § 79.
268. *Laws Relating*, *supra* note 256, at 37.
269. GHANA SISTERHOOD, *supra* note 253, at 255-56.
270. Customary Marriage and Divorce (Registration) Law P.N.D.C.L. [Provisional National Defense Council Law] 112, § 1 (1985) (Ghana) [hereinafter Customary Registration Law, 1985]. Proof of customary law marriages has always been by oral testimony of the parents of the husband or wife or anyone present when the marriage was celebrated. *See* E.K. Quansah, *Updating Family Law: Recent Developments in Ghana*, 36 INT'L & COMP. L. Q. 389, 394-395 (1987).
271. Customary Marriage and Divorce (Registration)(Amendment) Law, 1991 (263) (1991)(Ghana) [hereinafter Customary Registration Law Amendment]. The amendment repeals the provision of the 1985 law that established an offense punishable by fine or imprisonment for failure to register a marriage or dissolution of a marriage. *Id.* at § 4. However, the amendment empowers the Minister of Justice to prescribe periods within which failure to register a marriage contracted before or after the date of the amendment shall be an offense. *Id.* at § 2(b). To date, the Minister of Justice has not exercised this power.
272. Quansah, *supra* note 270, at 395; Michael D. A. Freeman, *Ghana: Legislation for Today*, 11 J. FAM. L. 159, 161 (1987).
273. Marriage Ordinance, 1951.
274. Marriage of Mohammedens Ordinance, 1951 (129), § 6 [hereinafter Mohammadens, 1951].
275. Mohammedens, 1951, § 8.
276. GHANA SISTERHOOD, *supra* note 253, at 256.
277. Memorandum, Intestate Succession Law, 1985 (111) P.N.D.C.L. [Provisional National Defense Council Law] 111 (1985) (Ghana) [hereinafter Intestate Law, 1985].
278. Matrimonial Causes Act, 1971 (367) (1971) (Ghana) [hereinafter Matrimonial Causes Act].
279. *Id.* art. 41(1). However, many customary law marriages are also dissolved pursuant to customary law, rather than under the Matrimonial Act. The Matrimonial Act states that "[m]onogamous marriage does not include a potentially polygamous marriage." *Id.* at § 43.
280. *Id.* art. 41(2)(a). The formerly unwritten customary grounds for dissolution of a marriage are incorporated into the statute as nonexclusive grounds the court is to recognize in determining whether a polygamous marriage has broken down beyond reconciliation. *Id.* art. 41(3).
281. *Id.* art. 41(2). The first reported case of a dissolution of a customary marriage under the Matrimonial Act occurred in 1975 where the High Court granted the wife's petition for dissolution and ordered her husband to pay back money he had borrowed and awarded a nominal amount as customary compensation. *See* Addy Report II, *supra* note 206, at 4 (citing Mensah v. Bekow, 2 G.L.R. 347 (1957)).
282. Matrimonial Causes Act, art. 1(2).
283. *Id.* art. 13. For example, if the marriage is not consummated, if one of the parties was insane, if the woman was pregnant by another man at the time of marriage or if one of the parties was "suffering from an incurable venereal disease in a communicable form." *Id.*
284. *Id.* arts. 13, 15. The nullification proceeding must be brought within one year of the commencement of the marriage and may be brought only if marital intercourse with the petitioner's consent has not taken place since his or her discovery of the grounds for nullification. *Id.*
285. *Id.* art. 19.
286. *Id.* arts. 20, 21. The amount awarded "as a rule does not exceed one-third of the husband's income, although the court is required to consider the standard of living of the parties and their circumstances." Daniels, *supra* note 251, at 59.
287. *Id.* art. 25.
288. Matrimonial Causes Act, art. 22.
289. *Id.* art. 41(2).
290. *Id.* art. 26.
291. GHANA SISTERHOOD, *supra* note 253, at 256.
292. *See* Daniels, *supra* note 251, at 59.
293. *Id.* at 59-60; GHANA SISTERHOOD, *supra* note 253, at 256.
294. Daniels, *supra* note 251, at 60.
295. *Id*; *Laws Relating*, *supra* note 256, at 47-48.
296. *Laws Relating*, *supra* note 256, at 48-49.
297. Daniels, *supra* note 251, at 60.
298. GHANA SISTERHOOD, *supra* note 253, at 256.
299. Mohammedens, 1951, § 7, 8.
300. Matrimonial Causes Act, § 41(2).
301. Maintenance of Children Decree, S.M.C.D. 133 (Supreme Military Council Decree) pt. I (1977) [hereinafter Maintenance Decree].
302. Maintenance Decree, §§ 4, 7.
303. GHANA SISTERHOOD, *supra* note 253, at 256.
304. *See* GHANA CONST. ch. 5, art. 18.
305. *Id.* ch. 5, art. 17. Article 17(4)(d) which permits Parliament to enact laws containing "different provision for different communities having regard to their special circumstances" prohibits any such law from being inconsistent with the spirit of the Constitution. *Id.* ch. 5, art. 17(4)(d).
306. Land Title Registration Law, 1986, P.N.D.C.L. 152 (Provisional National Defense Council Law) (1986) (Ghana).
307. *See* Beatrice Duncan, *Women and Land in Ghana*, at 30-32 (unpublished paper, on file with International Human Rights Law Group, Women in the Law Project, 1995).
308. *Id.* at 31-32.
309. GHANA CONST. ch. 5, art. 22(3).
310. *Id.* ch. 5, art. 22(1).
311. *See generally* Duncan, *supra* note 307.
312. Ernest K. Bankas, *Problems of Intestate Succession and the Conflict of Laws in Ghana*, 26 INT'L L. 437 (1992).
313. E.V.O. Dankwa, *Property Rights of Widows in Their Deceased Husbands' Estate*, XVI U. GHANA L. J. 1, 2 (1982-85).
314. Quartey v. Martey, 1959 G.L.R. 377 (Ghana High Ct.); Duncan, *supra* note 307, at 7, 15.
315. Akua Kuenyehia, *Women and Family Law in Ghana: An Appraisal of Property Rights of Married Women*, XVII U. GHANA L. J. 72, 82 (1986-90).
316. Intestate Law, 1985.
317. *Id.* at i.
318. *Id.*; *see* Marriage Ordinance, 1951, § 48; Mohammedens, 1951, § 10. The Intestate Law was amended in 1991 to provide that prior to distribution of any estate, no person may eject a surviving spouse or child from the "matrimonial home," except in very limited circumstances. *See* Intestate Succession (Amendment) Law, 1991, P.N.D.C.L. 264 (Provisional National Defense Council Law) (1991) (Ghana).
319. Customary Registration Law Amendment, at 5.
320. GHANA CONST. ch. 5, art. 24(1).
321. *Id.* ch. 5, art. 27(3).
322. *Id.* ch. 5, art. 27(1).
323. *Id.* ch. 5, art. 27(2). The small percentage of women employed in the public sector receive full pay for maternity leave. *See* Memorandum from Victoria Addy, President, FIDA-Ghana, to The Center for Reproductive Law and Policy (Feb. 28, 1997) (on file with The Center for Reproductive Law and Policy).
324. Labour Decree, 1967 N.L.C.D. [National Liberation Council Decree] 157, ¶ 41 (1967).
325. *Id.* ¶ 42. Paragraph 76 provides that the Decree shall apply to employment by the Republic of Ghana. *Id.* ¶ 76. Paragraph 42 also permits new mothers to take their annual leave in conjunction with their paid maternity leave. Also, a pregnant worker may not be assigned to posts outsider her place of residence after the fourth month, nor work overtime if pregnant or with a child less than eight months old. *Id.* The decree also prohibits dismissing a female absent for maternity leave or during any illness resulting from pregnancy until her absence has exceeded a maximum period as directed by the Chief Labour Officer. *Id.* ¶ 43.
326. STATUS OF WOMEN, *supra* note 236, § 3.3.
327. President of the Republic of Ghana's Sessional Address On the Occasion of the State Opening of Parliament in Accra, at 15 (Jan. 12, 1996) (on file with The Center for Reproductive Law and Policy) [hereinafter Sessional Address].
328. GHANA CONST. ch. 5, arts. 24(1), 27(3).
329. STATUS OF WOMEN, *supra* note 236, § 5.2.
330. *See* 3RD COUNTRY PROGRAMME, *supra* note 44, ¶ 147. A project entitled Enhancing Opportunities for Women in Development (ENOWID) was commenced in 1991 as part of Ghana's Program of Action to Mitigate the Social Cost of Adjustment (PAMSCAD). The credit and training components were executed by Ghana's National Board for Small Scale Industries and the repayment rate for credit for income generating activities

was 96% from 360 women's groups. *Id.* Approximately, 45% of grants from PAMSCAD are set aside for women in both rural and urban areas. STATUS OF WOMEN, *supra* note 236, § 5.2.3.
331. Female illiteracy in 1990 was 49% compared to 30% for men. *See* STATUS OF WOMEN, *supra* note 236, § 6.1.2.
332. GHANA CONST. ch. 5, art. 25(1).
333. STATUS OF WOMEN, *supra* note 236, § 6.1.5.
334. GHANA VISION, *supra* note 73, § 3.1.3.
335. STATUS OF WOMEN, *supra* note 236, § 2.1.
336. *See* Organisational Structure of the National Council on Women and Development (1994 chart) (on file with The Center for Reproductive Law and Policy).
337. STATUS OF WOMEN, *supra* note 236, §§ 2.2, 2.3.
338. Sessional Address, *supra* note 327, at 15.
339. CRIM. CODE, 1993, § 2.
340. CRIM. CODE (29), 1960, § 98.
341. CRIM. CODE, 1993, § 2(a).
342. *Id.* § 2(a).
343. CRIM. CODE (29), 1960, § 105.
344. When Ghana's Parliament amended its rape laws in 1993, the matter of marital rape was not discussed. It has been asserted that a woman could attempt to rely on existing rape law notwithstanding the consent defense available to a husband, discussed below. *See* Addy Report II, *supra* note 206, at 10.
345. STATUS OF WOMEN, *supra* note 236, § 7.0 (1994).
346. CRIM. CODE (29), 1960, § 42(g). Section 32 of the Criminal Code does limit the legal defense of justification for force to the amount and kind of force reasonably necessary in the situation. CRIM. CODE (29), 1960, § 32.
347. *See* Beatrice Akua Duncan, *Marital Rape as a Form of Domestic Violence and the Need for Law Reform in Ghana*, at 27-29 (1994) (unpublished L.L.M. paper, Georgetown University Law Centre) (on file with The Center for Reproductive Law and Policy).
348. Addy Report I, *supra* note 164, § 9.7.4.
349. *See* HEALTH SURVEY, *supra* note 10, § 3.7.
350. ADLAKHA, *supra* note 9.
351. *Id.*
352. GHANA CONST. ch. 5, art. 28.
353. POPULATION POLICY, *supra* note 134.
354. REPRODUCTIVE HEALTH POLICY, *supra* note 73, at 2.
355. *Id.* § 2.1.1.
356. *Id.* § 2.6.
357. *Id.* § 3.1.
358. NATIONAL POPULATION COUNCIL, ADOLESCENT REPRODUCTIVE HEALTH POLICY 3 (1996) [hereinafter ADOLESCENT POLICY].
359. *Id.* at 4.
360. *Id.* at 5, 11-12.
361. CRIM. CODE, 1994.
362. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 2.8.
363. *Id.* § 2.8.2.
364. *Id.* § 2.8.4.
365. ADOLESCENT POLICY, *supra* note 358, at 11.
366. Hilary Amesika Gbedemah, *Trokosi: Twentieth Century Female Bondage, A Ghanaian Case Study* (unpublished L.L.M. paper, Georgetown University Law Centre, Apr. 1996) (on file with The Center for Reproductive Law and Policy).
367. Fitnat Naa-Adjeley Adjetey, *Reclaiming the African Woman's Individuality: The Struggle Between Women's Reproductive Autonomy and African Society and Culture*, 44 AM. U. L. REV. 1351, 1364 (1995); Howard W. French, *The Ritual Slaves of Ghana: Young and Female*, N.Y. TIMES, Jan. 20, 1997, at A1.
368. French, *supra* note 367 at A1; HUMAN RIGHTS REPORT, *supra* note 225.
369. *See* Naa-Adjeley Adjetey, *supra* note 367, at 1364; Amesika Gbedemah, *supra* note 366, at 2.
370. GHANA CONST. ch. 5, art. 16.
371. GHANA CONST. ch. 5, art. 26(2).
372. CRIM. CODE (29), 1960, §§ 97, 100, 101, 102, 106, 107, 109 & 314.
373. HEALTH SURVEY, *supra* note 10, § 5.3 (Dec. 1994). The median age has increased from 18.3 years in the 1988 Demographic and Health Survey. *Id.* In comparison, the median age for men at first marriage among men 30-59 is 25.5 years. *Id.*
374. Marriage Ordinance, 1951, § 14(2).
375. *Id.* § 14(2).
376. 3RD COUNTRY PROGRAMME, *supra* note 44, ¶ 141.
377. Mohammedens, 1951, § 6(7). The issue of whether the Quran permits child marriage has proved to be contentious. *See* ASGHAAR ENGINEER, THE RIGHTS OF WOMEN IN ISLAM 110 (1992).
378. HUMAN RIGHTS REPORT, *supra* note 225, § 5.
379. See CRIM. CODE (29), 1960, § 100.
380. 3RD COUNTRY PROGRAMME, *supra* note 44, at ¶ 144.
381. *Id.*
382. GHANA VISION, *supra* note 73, §§ 3.1.3, 5.1.7.
383. 3RD COUNTRY PROGRAMME, *supra* note 44, at ¶ 34(iv).
384. MINISTRY OF EDUCATION, POPULATION/FAMILY LIFE SKILLS EDUCATION PROGRAMME (on file with The Center for Reproductive Law and Policy).
385. *Id.*
386. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 3.2. There exist some parental and societal reservations regarding education on family life/sexuality and the provision of family planning services. *See* 3RD COUNTRY PROGRAMME, *supra* note 44, ¶ 34(iv).
387. REPRODUCTIVE HEALTH POLICY, *supra* note 73, § 3.1.
388. CRIM. CODE, 1993, § 2(a).
389. *Id.*
390. CRIM. CODE (29), 1960, § 102.
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392. *Id.* § 107.

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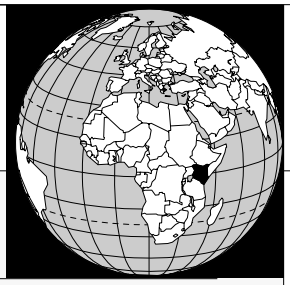
4. Kenya



Statistics

GENERAL

Population

■ The total population of Kenya is 24 million, of which slightly less than half are women.[1] The annual population growth rate is 3.4%;[2] the median age of the population is 15.1 years.[3]

■ In 1990, the proportion of the population residing in urban areas was estimated to be between 18%[4] and 24%.[5]

Economy

■ In 1993, the World Bank estimated the gross national product ("GNP") per capita to be U.S.$270.[6]

■ In 1995, the gross domestic product ("GDP") grew at an estimated rate of 5%.[7] This growth rate has significantly increased since 1992, when the GDP growth rate was 0.4%.[8]

■ The government spends approximately 2% of its GDP on health,[9] compared to the U.S., which spent approximately 12.7% of its GDP on health in 1990.[10]

Employment

■ In 1992, 2.1 million persons were employed in Kenya.[11] Women account for 25% of the total labor force.[12] In urban areas, 25% of people are unemployed.[13]

■ The average annual income of workers is Kshs. 41,196,[14] which is equivalent to approximately U.S.$752.[15]

WOMEN'S STATUS

■ The average life expectancy for women is 63 years, compared to 59 years for men. For both sexes combined, average life expectancy is 61 years.[16]

■ In Kenya, 19.5% of married women (including almost one third of women in their forties) are currently in polygynous unions.[17]

■ There is a strong gender differential in education. For example, 16.5% of males and 27.1% of females aged six and above have not received any formal education.[18]

■ Violence against women is a serious problem. Police statistics, released in 1994, showed that in 1992 there were 454 rapes, 136 attempted rapes, 343 indecent assaults, 407 cases of defilement, and 14 cases of incest. However, these statistics probably grossly underreport the true extent of the problem.[19]

ADOLESCENTS

■ Approximately 49% of the Kenyan population is less than 15 years old.[20]

■ An estimated 50% of women and girls (6.3 million) have undergone female genital mutilation ("FGM").[21]

■ The median age at first marriage for Kenyan women is 18.8 years.[22]

■ Adolescents account for about one third of hospital obstetrical cases.[23]

MATERNAL HEALTH

■ Childbearing begins early in Kenya, with the median age at first birth being 19 years.[24] The median birth interval is 30 months.[25]

■ From 1990 to 1993, the total fertility rate was 5.4 children per woman,[26] a substantial decrease from the 1979 rate of 7.9 children per woman.[27]

■ The maternal mortality rate for 1990 was estimated to be 100 deaths per 100,000 live births.[28]

■ The infant mortality rate is estimated to be between 61[29] and 64[30] per 1,000 live births. Estimates of the under-five mortality rate range between 96[31] and 102[32] deaths per 1,000 live births.

■ In Kenya, 22.6% of pregnant women receive antenatal care from doctors, while 72.3% receive antenatal care from nurses or midwives; 4.2% receive no antenatal care.[33]

■ Home deliveries account for 54.6% of births, while 44% of births are delivered in public health facilities or clinics.[34] Births are most commonly assisted by nurses or midwives (33%), followed by relatives (23%), traditional birth attendants (21%), and doctors (12%).[35]

CONTRACEPTION AND ABORTION

■ Contraception is used by 25.9% of all women, including 32.7% of married women.[36] While less than 1% of women surveyed named condoms as their method of birth control, nearly 7% of married men and nearly 12% of all men said they currently use condoms as a birth-control method.[37]

■ More than 1 in 20 married women of reproductive age in Kenya has undergone a sterilization procedure.[38]

■ Little is known about the overall incidence of abortion in Kenya.[39] However, it has been estimated that there are approximately 252,800 terminations of pregnancy among girls aged 15 to 19 each year.[40]

■ An estimated one third of maternal deaths are due to unsafe abortions. At Kenyatta Hospital, one of the largest hospitals in sub-Saharan Africa, complications from induced and incomplete abortions account for approximately 50% of gynecological admissions, totaling 6,000 admissions per year.[41]

HIV/AIDS and STDs

■ By August 1993, the Kenya National AIDS Control Programme estimated that 841,700 persons were infected with HIV.[42]

■ In June 1996, the World Health Organization reported 65,647 cases of AIDS in Kenya, including 35,428 males and 30,076 females (and 143 cases of unknown gender).[43]

■ Approximately 75% of HIV transmission occurs through heterosexual intercourse. Perinatal transmission accounts for approximately 23% of cases.[44]

■ A 1984 study conducted in a rural area in the Northern Division of Machakos District, Kenya, found that 57% of people below the age of 20 in this region had contracted a sexually transmitted disease.[45]

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24. Nat'l Council for Population & Dev., *supra* note 2, at 30.
25. *Id.* at 29.
26. *Id.* at 21.
27. National Development Plan, *supra* note 4, art. 1.84, at 27.
28. U.N., The World's Women: 1995 Trends and Statistics, at 85, U.N. Doc. ST/ESA/STAT/SER.K/12, U.N. Sales No. E.95.XVII.2 (1995).
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In 1963, Kenya gained independence from British colonial rule,[1] and a year later it became the Republic of Kenya (the "Republic"). From 1969 to 1982, the Republic was, effectively, a one-party state; in 1983, it became one legally. The only legitimate party was the Kenya African National Union (KANU).[2] However, in December 1991, a constitutional amendment reinstated a multiparty system.[3] The Republic's first multiparty elections were held in December 1992.[4]

The total population of Kenya is 24 million, of which slightly more than half are women.[5] The population is comprised of 43 ethnic groups, of which the major groups are the Embu, Kalenjin, Kamba, Kikuyu, Kisii, Luo, Luhya, Maasai, Meru, Samburu, and Taita.[6] The major religions are Christianity (66% of the population), including Roman Catholicism (28%) and Protestantism (38%), and Islam (6%). Another 26% of the population adhere to traditional religious beliefs.[7]

I. Setting the Stage: The Legal and Political Framework

To understand the various laws and policies affecting women's reproductive rights in Kenya, it is necessary to consider the legal and political systems of the country. Without this background, it is difficult to determine the process by which laws are enacted, interpreted, modified, and challenged. The passage and enforcement of law often involves specific formal procedures. Policy enactments, on the other hand, are usually not subject to such a process.

A. THE STRUCTURE OF GOVERNMENT

There are three main branches of government in Kenya — the executive, the legislative, and the judicial.[8] The executive branch of the government consists of the president, who is the head of state and commander-in-chief of the armed forces; the vice-president; and a cabinet.[9] The president is elected for a five-year term by popular vote for a maximum of two terms,[10] while the vice-president and the cabinet are appointed by the president from members of the National Assembly.[11] The attorney general serves as the principal legal advisor to the government and retains the power to institute and undertake criminal proceedings.[12] The country is administratively divided into seven provinces, each of which is governed by a provincial commissioner.[13] Provinces are subdivided into 48 districts,[14] which are governed by district commissioners,[15] and districts are further subdivided into local government areas administered by local authorities.[16]

The Constitution vests the legislative power of the Republic in the Parliament of Kenya, which consists of the president and the National Assembly.[17] The National Assembly is comprised of a minimum of 188 members directly elected by popular vote on a constituency basis,[18] with 12 additional members nominated by the president.[19] The National Assembly exercises its legislative power by passing bills, which must then be submitted to the president for assent.[20] If the president refuses to assent to legislation submitted by the National Assembly, the National Assembly may override this veto by a resolution supported by a special majority of 65% of Assembly members.[21]

Courts both create and interpret law. The judicial system can have a significant impact on legislation, including that affecting reproductive rights, because it is able to enforce the law and deal with complaints from individuals challenging the constitutionality of specific laws. The Constitution creates a hierarchical system of courts in Kenya, comprising a Court of Appeal, a High Court, *Kadhis'* courts, and other subordinate courts established by acts of Parliament.[22] The highest court in Kenya is the Court of Appeal, presided over by the chief justice and at least two other judges.[23] The Court of Appeal has jurisdiction to hear appeals from the High Court.[24] The High Court, which is presided over by the chief justice and at least 11 associate judges (referred to as "puisne" judges),[25] has jurisdiction to hear appeals from lower courts and has unlimited original jurisdiction in civil and criminal matters.[26] *Kadhis'* courts have jurisdiction to hear questions of Muslim law relating to "personal status, marriage, divorce or inheritance in proceedings in which all the parties profess the Muslim religion."[27] Resident Magistrates' courts and District Magistrates' courts, established under the Magistrates' Courts Act,[28] have limited jurisdiction in criminal and civil matters, respectively.[29]

B. SOURCES OF LAW

Domestic Sources of Law

Laws that affect women's legal status — including their reproductive rights — derive from a variety of sources. Section 3 of the Judicature Act[30] (the "Judicature Act") states that the major sources of Kenyan law include: the Constitution; other written laws; doctrines of equity and statutes of general application in force in England on August 12, 1897; the procedure and practice observed in courts of justice in England at that date; African customary law; and the common law. Customary law is of particular significance to women's rights and reproductive rights because this body of law governs personal law matters and is indicative of women's status.

The Constitution declares itself the supreme law of the land. Any law, either written or unwritten, which is inconsistent with its provisions is void to the extent that it is in conflict.[31] The Constitution explicitly states that "no law shall

make any provision that is discriminatory either of itself or in its effect."[32] However, the grounds of unacceptable discriminatory treatment enumerated in the Constitution are confined to "race, tribe, place of origin or residence or other local connexion, political opinions, colour or creed."[33] Discrimination based on gender is thus not explicitly prohibited. This nondiscrimination provision also does not apply to matters related to adoption, marriage, divorce, burial, devolution of property on death, or other matters of personal law.[34]

Other written sources of Kenyan law include enactments of the Kenyan Parliament since 1963, and subsidiary legislation in the form of orders, rules, regulations, directives, and local by-laws enacted pursuant to the authority of Acts of Parliament.[35] In addition, certain Acts of the British Parliament passed before the establishment of the Republic, which are listed in a schedule to the Judicature Act, are also sources of law in Kenya. Section 3(1) of the Judicature Act further states that the common law, doctrines of equity, and statutes of general application in force in England on August 12, 1897, apply "only so far as the circumstances of Kenya and its inhabitants permit and subject to such qualifications as those circumstances may render necessary."[36] The extent to which English common law, doctrines, and statutes are applicable in Kenya is a matter for Kenyan courts to decide based upon the facts of each case.[37] The specific legislative enactments and, where applicable, judicial decisions relating to reproductive rights are discussed in specific sections of this chapter.

The Judicature Act directs all courts in Kenya to be "guided by African customary law in civil cases in which one or more of the parties is subject to it or affected by it, so far as it is applicable and is not repugnant to justice and morality or inconsistent with any written law."[38] Courts are further directed to "decide all such cases according to substantial justice without undue regard to technicalities of procedure and without undue delay."[39] The areas of customary law that fall within the jurisdiction of the district magistrate courts include: "(a) land held under customary tenure; (b) marriage, divorce, maintenance or dowry; (c) seduction or pregnancy of an unmarried woman or girl; (d) enticement of or adultery with a married woman; (e) matters affecting status, and in particular the status of women, widows, and children, including guardianship, custody, adoption, and legitimacy; (f) and intestate succession and administration of intestate estates, so far as not governed by any written law."[40] Customary laws relating to succession have, however, been superseded in large measure by the Law of Succession Act.[41]

Until recently, the status of customary law in Kenya's legal system was unclear. In 1987, however, the landmark case of *Otieno v. Ougo*[42] provided some guidelines for the application of customary law and reaffirmed its importance in the Kenyan legal system. The *Otieno* court held that "[t]he place of customary law as the personal law of the people of Kenya is complementary to the relevant written laws."[43] The court further found that if a matter of personal law is not governed by written law, and "if there is clear customary law on this kind of matter, the common law will not fit the circumstances of people of Kenya."[44] According to *Otieno*, Kenyan courts should only resort to the English common law if in a particular instance the customs were held to be "repugnant to justice and morality."[45]

The application of customary law in Kenya continues to be complicated by the difficulty of ascertaining the content of these laws. Many of the ethno-linguistic groups in Kenya have their own systems of customary laws. Some degree of certainty was attained regarding the application of customary laws by the 1968 publication of a restatement of customary laws relating to marriage, divorce, and succession.[46] However, the restatement is not comprehensive, and the magistrate courts have statutory authority to call for and hear other evidence regarding African customary law applicable to any case before them.[47]

International Sources of Law

Because international instruments are legally binding, they create an obligation on the part of the government to undertake numerous actions, including those at the national level. Although the Judicature Act does not explicitly state that international law is a source of Kenyan law, the government is party to a number of international legal instruments,[48] including, *inter alia*: the International Covenant on Civil and Political Rights;[49] the International Covenant on Economic, Social and Cultural Rights;[50] the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW");[51] the African Charter on Human and Peoples' Rights;[52] and the Convention on the Rights of the Child.[53] International law can be an additional tool for the advancement of women's rights and reproductive rights. International legal instruments become enforceable in Kenya after they are incorporated into domestic law by implementing legislation.[54] Currently, the government has not passed any domestic legislation explicitly incorporating the international human rights instruments to which Kenya is a party.[55] Nevertheless, it has been argued that in the absence of express legislative intent to the contrary, ambiguities in domestic law should be construed to conform to international treaties to which Kenya is a party.[56]

II. Examining Reproductive Health and Rights

Issues of reproductive health and rights are dealt with in Kenya within the context of the country's health and population policies. Thus, an understanding of reproductive rights in Kenya must be based on an examination of those policies.

A. HEALTH LAWS AND POLICIES

Objectives of the Health Policy

The development of the Kenyan health sector is guided by Kenya's Health Policy Framework, which was adopted by the Ministry of Health ("MOH") in June 1994. The framework details comprehensive reform initiatives, with an overall goal to "promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable."[57] An important objective of the Health Policy Framework is to strengthen the central policy-making role of the MOH in all matters pertaining to health,[58] and to facilitate overall coordination by improving health-management information systems[59] and strengthening health research.[60] At the same time, planning, management, and resource utilization functions will be further decentralized to the district level,[61] while the MOH will encourage non-governmental organizations ("NGOs") and private-sector health service providers to offer services not available through the public sector.[62] Resources for government health services will be prioritized on the basis of their relative capacities to reduce the "burden of disease," as well as their cost effectiveness.[63] Cost sharing and other alternative health financing initiatives will also be expanded.[64] In addition, capital expenditure will be better controlled,[65] and part of the financial burden of curative care will be shifted from the MOH budget to insurance schemes.[66]

The Health Policy Framework identifies the need to continue to manage population growth as a major strategic imperative[67] and targets the HIV/AIDS epidemic as an especially severe health problem requiring urgent intervention.[68] It specifically acknowledges that the HIV/AIDS epidemic imposes a double burden on women, who are both more vulnerable to HIV infection and are adversely affected by the AIDS epidemic in their role as providers of care in the family and community.[69] The Health Policy Framework also addresses issues affecting women's health and reproductive health care. In particular, the policy intensifies and expands coverage of health care interventions through an "Essential Preventive/Primary Health Care Package" for Kenya. Components of this package include: promotion of antenatal and postnatal care; well-baby care; breast-feeding; improved diet and nutrition; health education and family planning in a comprehensive safe motherhood program; and a strengthening of basic community health care activities to enable individuals to assume responsibility for their own health.[70]

Increasing attention has been given to reproductive health matters in Kenyan health policies, and a recent report of the Kenyan Institute for Reproductive Health calls for the preparation of a comprehensive reproductive health policy by the government, together with the review, reform, and improved enforcement of laws affecting reproductive health to ensure a comprehensive package of reproductive rights and reproductive health care.[71]

Infrastructure of Health Services

While the majority of health services in Kenya are provided by the government, NGOs and the private sector provide approximately 40% of health services and 33% of in-patient care.[72] Public sector health facilities are organized in a hierarchical framework consisting of: the Kenyatta National Hospital (which is both a national referral hospital and a teaching hospital); provincial hospitals; district hospitals; health centers; health sub-centers; and dispensaries.[73] In 1992, there were 301 hospitals, 477 health centers, and 2,637 health sub-centers and dispensaries in Kenya.[74] The availability of complex diagnostic facilities and skilled specialists improves as one moves up the hierarchy. Access to treatment at higher level facilities occurs by means of a referral system.[75] Most of the public sector health care facilities are located in urban areas and are inequitably distributed among and within the country's provinces and districts.[76]

Most family planning and basic reproductive health care services are provided through either maternal and child health or family planning clinics, which have been established in all public hospitals and health centers, and in most dispensaries.[77] Other curative services for reproductive or gynecological problems are provided through maternity units, gynecology/urology units, and other outpatient clinics within hospitals and health centers.[78] While sexually transmitted diseases ("STDs") can be treated in most health facilities, only two centers in the country specialize in STD treatment.[79]

Cost of Health Services

In 1990, the government spent approximately 2.7% of its gross domestic product on health, compared to a 2.5% average spent in 1990 by the public sector in the sub-Saharan Africa region.[80] Government expenditure within the health system is characterized by large administrative expenses and a bias toward curative care at the expense of preventive care.[81] More than 70% of the public health recurrent expenditure is

allocated to staff salaries and allowances, leaving less than 30% for pharmaceutical supplies and other non-wage expenditures.[82] Further, while hospitals account for a mere 7% of total public sector health facilities, they are allocated some 69% of the recurrent health care budget.[83] Increasing attention has been given to preventive and promotive care in recent years, and the MOH has initiated a number of countrywide programs to address specific priority health issues in the country, including family planning and HIV/AIDS.[84]

Health services were provided free in public sector health facilities for many years, but user fees began to be gradually instituted in 1989. Fee exemptions and waivers are available to some people, and for certain services and illnesses.[85] Specifically, children under five and civil servants below a specified grade, as well as their spouses and unmarried dependent children, need not pay for health services. In addition, health personnel may grant waivers to patients who cannot afford the cost of treatment. Family planning counseling, antenatal and postnatal care, child welfare, and STD clinic services are all exempted from outpatient charges, as is the treatment of tuberculosis, leprosy, AIDS, and antenatal complications of pregnancy. Inpatient fees can also sometimes be exempted, especially for referrals of patients to provincial, district, and subdistrict hospitals.[86]

In 1966, in an attempt to make user charges more affordable, the government established the National Hospital Insurance Fund ("the Fund"), pursuant to the National Hospital Insurance Act (the "Hospital Insurance Act").[87] This act requires persons who earn above a specified taxable income level,[88] or their employers, to contribute toward the fund,[89] which pays for benefits such as allowances for hospital care and other medical treatments as are periodically prescribed in regulations.[90] In general, benefits paid by the fund include payment for confinement or treatment expenses necessitated by antenatal or obstetric requirements.[91]

Regulation of Health Care Providers

Who is legally permitted to provide what types of care? Are there meaningful guarantees of quality control? Because the Kenyan government regulates these issues, reviewing such laws is important. Health professionals in Kenya are regulated by three statutes, namely: the Medical Practitioners and Dentists Act[92] (the "Medical Practitioners Act"); the Nurses Act;[93] and the Pharmacy and Poisons Act[94] (the "Pharmacy Act"). The Medical Practitioners Act provides for the establishment of a Medical Practitioners and Dentists Board (the "Medical Board")[95] and for the appointment of a Registrar of Medical Practitioners and Dentists.[96] The Medical Practitioners Act also provides for the registration of medical practitioners and dentists who meet certain requirements of training and "good character."[97] Such registration entitles persons to practice medicine or dentistry only in salaried posts under government health schemes or other institutions that are approved by the Medical Board. Any practitioner who wishes to engage in private practice or to obtain compensation for her or his services is required to obtain a license issued by the Medical Board.[98] It is a criminal offense for a person to practice or profess to practice medicine, surgery, or dentistry without being registered, licensed, or otherwise granted by the Medical Board the right to render medical or dental services.[99] The Medical Board is also entitled to inquire into the conduct of practitioners registered under the Medical Practitioners Act and may cancel the registration or license of any person found guilty of "infamous or disgraceful conduct in a professional respect."[100]

The Nurses Act establishes the Nursing Council of Kenya (the "Nursing Council").[101] The Nursing Council's functions include: the establishment and improvement of standards for the nursing profession; the training of nurses; and the regulation of the conduct of nurses, including such disciplinary measures as may be necessary.[102] Provisions are made for the registration, enrollment, and licensing of nurses, midwives, community health nurses, psychiatric nurses, and pediatric nurses who meet certain requirements of "good character" and training.[103] It is an offense for any person who is not registered, enrolled, or licensed under the Nurses Act to practice as a nurse in any of the categories mentioned above. The Nursing Council has the power to suspend or cancel the registration, license, or enrollment of any person found to be guilty of negligence, malpractice, impropriety, or misconduct.[104]

Pharmacists are regulated by the Pharmacy Act, which makes provision for the establishment of a Pharmacy and Poisons Board (the "Pharmacy Board")[105] and for the appointment of a registrar who has the responsibility of keeping a register of pharmacists.[106] All persons who satisfy the Pharmacy Board that they are suitably qualified are entitled to registration.[107] It is a criminal offense for any person who is not registered to carry on the business of a pharmacist or, in the course of trade or business, to prepare or dispense a drug except under the immediate supervision of a pharmacist.[108] There are two exceptions to this rule. First, it is lawful for qualified medical practitioners, dentists, and veterinary surgeons to supply medicine in the course of legitimate treatment. Second, persons who are not registered as pharmacists may sell "non-poisonous" drugs provided that they are sold in their original condition as received from the suppliers.[109] The term "non-poisonous drug" is not defined. However, poisonous drugs are listed in a schedule to the Pharmacy Act.

Traditional healers are not regulated by Kenyan law. The government is, however, increasingly recognizing the need for greater integration of traditional healers into the health care system. For example, the draft Population Policy for Sustainable Development recognizes that "[the promotion of] women's health and safe motherhood through ante-natal, intra-natal and post-natal care programmes…should include the training and equipping of Traditional Birth Attendants."[110]

Patients' Rights

Laws also seek to ensure quality health services by protecting the rights of patients. Kenyan law requires medical practitioners to render treatment with "reasonable care" and skill, and with the informed consent of the person undergoing the procedure. Section 240 of the Penal Code provides that a person is not criminally responsible for performing, in good faith and with reasonable care and skill, a surgical operation upon any person for his or her benefit, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. Section 243(e) of the Penal Code provides that any person who renders medical or surgical treatment to any person whom he or she has undertaken to treat, "in a manner so rash or negligent as to endanger human life or to be likely to cause harm to any other person," is guilty of an offense. In the event that a medical practitioner performing a medical or surgical procedure does not use reasonable care and skill, that person "shall be deemed to have caused any consequences which adversely affect the life or health of any person by reason of any omission to observe or perform that duty."[111]

The requirement of informed consent is an established principle of the English common law, which is applied in Kenya. To constitute valid consent, the person undergoing a medical procedure must both know of the risks involved and willingly consent to undertake these risks.[112] By consenting to the procedure, the patient consents to the risks inherent in the procedure, but does not consent to negligence on the part of the surgeon.[113] A client who suffers injury due to the negligence of a medical practitioner may be able to allege a legal claim against the practitioner under tort principles of common law. To succeed in an action for negligence, the plaintiff must prove that the defendant was in breach of the duty of care owed by medical practitioners toward their clients, and that, as a result of the breach of that duty, the plaintiff suffered harm.[114] Medical procedures which are performed without a client's consent may constitute an actionable tort — "trespass" to the client's person.[115]

Finally, a client who is aggrieved by the professional misconduct of a medical practitioner may resort to the Medical Board. The Preliminary Inquiry Committee, which consists of seven elected members, is responsible for receiving and reviewing complaints against a medical practitioner and reporting to the Medical Board whether a disciplinary inquiry should be held. If the medical practitioner is, after inquiry by the Medical Board, found to have been guilty of any "infamous or disgraceful conduct" in a professional respect, the Medical Board may remove her or his name from the register and may cancel any license granted to her or him.[116]

B. POPULATION AND FAMILY PLANNING

Population and Family Planning Policy

Kenya's population policy provides the framework within which its family planning services are provided. Since the establishment of the Republic, the government has been concerned with managing population growth.[117] Shortly after Kenya's independence, the government issued a position paper entitled *African Socialism and its Application to Planning in Kenya*, which stated that a "high rate of population growth means a large dependent population, reduces the money available for development, lowers the rate of growth and makes exceedingly difficult the task of increasing social services."[118] As a result, the government committed itself to prioritizing family planning programs from its earliest days.[119] The linkages between population issues and development, and the importance of family planning in reducing population growth, have been central tenets of Kenya's population policies and programs.

In 1967, the government launched the National Family Planning Programme, through which family planning services are still provided as part of the national health-care delivery system.[120] This program was integrated with the maternal and child health division of the Ministry of Health ("MOH").[121] The growing number of agencies involved in population-related activities prompted the government to establish an umbrella body — the National Council for Population and Development ("NCPD") — to coordinate and support the activities of these agencies, and to develop an overall population policy framework. Created in 1982, the NCPD's functions include, *inter alia*:

- to determine priorities in the fields of family planning and population development activities;
- to advise the government on a national population policy;
- to plan, supervise, and coordinate an interagency multimedia information and education program;
- to promote public understanding and acceptance of family planning; and
- to promote research into contraceptive technology and into social, cultural, and economic aspects of population planning and development.[122]

In the period since 1982, the NCPD has fallen within the jurisdiction of various ministries, most recently the Office of the Vice-President and the Minister for Economic Planning and National Development.[123] Membership of the NCPD is drawn from government ministries and NGOs that deal with population programs and have an expertise in population matters.[124] The NCPD Secretariat coordinates and monitors the activities of 14 NGOs, 11 government ministries, and various other government agencies. It also collaborates with over a dozen external donor agency groups.[125]

The NCPD prepared the Population Policy Guidelines (the "Guidelines"),[126] which are the primary framework for Kenya's population policy. The Guidelines describe intersectoral programs and activities to be carried out by government agencies and NGOs under the coordination of the NCPD, clarify the leadership structure, and define the role of education, clinical services, and the mass media in promoting population policies. The Guidelines further establish demographic, educational, and clinical services goals — to guide policy and program planning subject to certain "ethical considerations." For instance, the Guidelines stipulate that no individual should be coerced to practice any family planning method contrary to his or her moral, philosophical, or religious beliefs, and that sterilizations should only be performed voluntarily and with informed consent.[127] While the Guidelines underscore the coordinating and supportive role of the NCPD in meeting these goals, they also promote the importance of decentralizing leadership and planning population activities at the community level. In accordance with a "District Focus" on rural development, the Guidelines state that leaders at the local level will be involved in population and family planning work through local development committees.[128]

The most important demographic goal identified in the Guidelines is the reduction of population growth, which is supplemented by subsidiary goals of promoting small families, reducing fertility rates and child mortality, and motivating Kenyan men to use birth control.[129] Educational goals include: improving the status of women through equal access to and opportunities for higher education; training and ensuring remunerative employment; and providing Kenyan youth with information and education concerning population matters.[130] Clinical services goals include ensuring the availability of contraceptive services and adequate counseling, examination, and follow-up.[131]

Apart from the Guidelines, various other policy documents reflect a concern for population issues. The Health Policy Framework, for instance, identifies the management of population growth as a major strategic imperative of the MOH and lists specific strategies for the MOH to undertake in order to meet this imperative. These strategies include increasing the number of family planning service delivery points, diversifying the range of available family planning services, and promoting safe motherhood and higher maternal literacy rates.[132]

Kenya's development plans[133] also reflect a concern with the relationship between population management and national development. The 1989-1993 Development Plan states that the government policy on population management rests on two premises. First, neither the absolute level of population nor its rate of growth per se is seen as the major concern; rather, the critical issue is the inability of Kenya's natural resource base and industry to sustain rapid growth of the labor force. Second, family planning activities ought to emphasize the benefits of smaller families by providing programs that offer the prospect of a better family life.[134] The 1994-1996 Development Plan confirms that the major goals of Kenya's population policy are to control population growth and distribution and to reduce the imbalance between population size and resources available to the country. It also specifically reaffirms certain principles, such as: encouraging adequate counseling for natural methods of family planning; increasing access to family planning advice and supplies in rural areas; enhancing family life programs in teacher training institutions; and reconsidering the problem of adolescent pregnancies.[135]

Most recently, the Republic of Kenya has prepared a draft National Population Policy for Sustainable Development[136] to succeed the Guidelines. The draft document addresses a wide variety of issues, including: the environment; gender; poverty; the elderly; the disabled; youth; and HIV/AIDS. It also outlines demographic,[137] health services,[138] and social services goals,[139] which are to guide the implementation of population programs until the year 2015. A notable inclusion in this draft is its emphasis on the empowerment of women, as well as on the improvement of women's social status and role in development, and the elimination of all forms of discrimination against women and girls. The draft has yet to be adopted by the government.

Government Delivery of Family Planning Services

There are currently more than 1,000 government service delivery points in Kenya providing family planning services.[140] The MOH coordinates the supply of contraceptives to service delivery points by means of the MOH logistical management system for contraceptive supplies, which is a semi-autonomous function of the Medical Supplies Coordinating Unit in Nairobi.[141] The 1993 Demographic and Health Survey found that 68.2% of current users of modern contraceptive methods — including 72.5% of pill users, 36.6% of condom users, and 70.5% of users of injectable con-

traceptives — cited government hospitals, health centers, or dispensaries as their most recent source of supply.[142] Furthermore, 63.9% of female sterilizations and 68.9% of intrauterine device ("IUD") insertions are performed in government facilities.[143] These providers have introduced fees for the provision of most types of contraceptives, although condoms continue to be distributed free of charge.[144] Male and female sterilizations are also provided free of charge in government health facilities, although legal abortions are subject to the usual fees for surgical procedures.[145] The government's National Family Planning Programme also includes an abundance of information, education, and communication ("IEC") materials and messages; however, Kenya has no comprehensive IEC policy, strategy, or program framework.[146]

C. CONTRACEPTION

The most widely used contraceptive methods in current use among women are the pill (7.5%), followed by injection (5.5%), rhythm (4.3%), female sterilization (3.9%), IUDs (2.8%), and condoms (0.9%). Less than 0.5% of women use other methods such as diaphragms, foams, jellies, NORPLANT®, natural family planning, withdrawal, or other traditional methods such as abstinence, herbs, and breast-feeding.[147] Men reported the most common methods of contraception in current use to be the rhythm method (17.3%) and condoms (11.8%).[148]

Legal Status of Contraceptives

Kenyan law does not restrict the use of contraceptives. However, several laws potentially impact the supply and manufacture of contraceptives through restrictions imposed in the interests of public health. The Pharmacy Board has primary responsibility for exercising control over pharmaceuticals within Kenya. Sections 43 and 44(1)(d) of the Pharmacy Act grant the Minister of Health wide powers to prohibit, regulate, or restrict the sale of pharmaceutical drugs and medical devices.[149] Several other provisions of the Pharmacy Act also affect the supply of contraceptives to consumers. For example, when regulating the sale and dispensing of drugs, the Pharmacy Act makes a distinction between "non-poisonous" drugs and drugs that are listed as poisons in schedules to this law. It is not unlawful for any person to sell any "non-poisonous" drug, provided that it is sold in its "original condition as received by the seller."[150] Spermicidal foams, jellies, and non-hormonal creams may therefore be sold over the counter without a prescription, as long as they have not been tampered with in any way by the seller. On the other hand, drugs that are listed in Part One of the Poisons List Confirmation Order[151] ("Part One Drugs") may only be sold by a pharmacist or other authorized dealer.[152] Part One Drugs include "steroid compounds with androgenic or estrogenic or progestational activity," as well as natural and synthetic hormones and "any preparations, admixture, extract or other substance containing any proportion of any substance having the action of any hormone." Hormonal contraceptives delivered as oral pills, implants (including NORPLANT®), or injectables (including Depo-Provera®) are considered Part One Drugs. Pharmacists may only sell these drugs to members of the public in possession of a prescription from a duly qualified medical practitioner.[153] Medical practitioners may, however, supply or dispense a Part One Drug directly to a client for the purpose of medical treatment, provided that the drug is distinctly labeled with the name and address of the person by whom it is dispensed, and that records are kept of the supply of the drug in accordance with the Pharmacy Act.[154] Furthermore, it is an offense for any person to sell a Part One Drug by means of a vending machine.[155]

A variety of other legal provisions exist to ensure the safe supply of contraceptives and other drugs to consumers. The Food, Drugs and Chemical Substances Act[156] (the "Food Act") makes it an offense for any person to sell, prepare, preserve, package, store, or convey for sale any drug or device[157] under unsanitary conditions,[158] or to sell to "the prejudice of" the purchaser any drug that is not of the nature, substance, or quality of the article demanded by the purchaser.[159] It is also an offense for any person to sell any drug that "(a) is adulterated; or (b) consists in whole or in part of any filthy, putrid, disgusting, rotten, decomposed or diseased substance or foreign matter."[160]

The Pharmacy Act requires all medicines to be clearly labeled in the manner prescribed by that law and by the rules enacted thereunder.[161] It is an offense to label, package, or sell a drug or device in a manner that is false or misleading as regards its "character," value, composition, merit, or safety.[162] Any person who sells a device that may cause injury to the health of the purchaser or user of the device when used in accordance with directions either on the label or contained in a separate document delivered with the device and under such conditions as are customary or usual is also guilty of an offense.[163]

Pursuant to Section 44(1)(d) of the Pharmacy Act, the Minister of Health may, after consultation with the Pharmacy Board, make rules with respect to prohibiting, regulating, or restricting the manufacture of drugs, pharmaceutical preparations, and therapeutic substances. For example, Rule 16, issued pursuant to Section 44(1)(d), makes it an offense to manufacture without a license a drug that will be sold and is or may be used for the treatment of any human or animal ailment. It further stipulates that in any establishment in which drugs are manufactured, the drugs must be manufactured by,

or under the supervision of, a registered pharmacist or a person with either a Fellowship or Associateship from the Royal Institute of Chemistry or an equivalent qualification recognized by the Pharmacy Board.

Finally, the MOH may, after consulting with the Pharmacy Board, make rules with respect to importation and exportation of drugs,[164] and may prohibit or control the manufacture of any secret, patent, proprietary, or homeopathic medicine, preparation, or appliance.[165] The government has promoted the supply of contraceptives for family planning activities in Kenya by means of tax exemptions on imported contraceptives. The Minister for Finance and Planning has exempted from sales tax all contraceptives (including contraceptive pills, creams, jellies, foaming tablets, foam in tubes, diaphragms, IUDs, injectables, and condoms) and pregnancy test kits imported into Kenya to be used for family planning activities.[166] Similarly, the Minister for Finance and Planning has exempted from import duty all contraceptives and pregnancy test kits imported into Kenya to be used exclusively for the purposes of family planning activities.[167]

Regulation of Information on Contraception

The dissemination of information about contraceptives, both in the form of commercial advertising and in family planning education campaigns, is subject to various legal restrictions set forth in the Pharmacy Act, the Food Act, the Penal Code, and the Films and Stage Plays Act (the "Films Act").[168]

The Pharmacy Act confers wide powers on the MOH with respect to prohibiting, regulating, or restricting the advertising of drugs and medical devices.[169] Section 39 provides that no person shall take part in the publication of an advertisement[170] referring to a drug, medicine, medical appliance, or similar article in terms that the Pharmacy Board considers to be "extravagant" and that bears little or no relation to the pharmacological properties and action of the ingredients or components thereof.

Explicit graphics or descriptions demonstrating the use of contraceptive drugs and devices are in danger of contravening the Films Act and the Penal Code. The Films Act provides for the establishment of a Board of Censors,[171] which has the power to examine films and posters to decide whether they should be approved for exhibition.[172] Section 16(4) of the Films Act provides that the Board of Censors shall not approve a film or poster that "in its opinion tends to prejudice the maintenance of public order or offend decency, or the public exhibition or display of which would in its opinion for any other reason be undesirable in the public interest."[173] Section 181(1) of the Penal Code makes it an offense for any person who "for the purpose of or by way of trade or for the purpose of distribution or public exhibition, makes, produces or has in his possession any one or more obscene writings, drawings, prints, paintings, printed matter, pictures, posters, emblems, photographs, cinematograph films or any other obscene objects, or any other object tending to corrupt morals."[174] Courts have the power to order the destruction of any obscene matter or thing to which this section relates.[175]

Finally, the Minister of Justice has the general power to prohibit the printing, publishing, importation, sale, supply, advertisement, distribution, or reproduction of any publication, if this action appears to be reasonably required in the interests of "defence, public safety, public order, public morality or public health and to be reasonably justifiable in a democratic society."[176]

D. ABORTION

Legal Status of Abortion

Although the Penal Code contains restrictive provisions relating to abortion, the scope of these laws remains unclear. Section 158 of the Penal Code states that "[a]ny person who, with intent to procure miscarriage of a woman…unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony...."[177] A similarly worded provision makes it an offense for a woman to do anything with the intent to unlawfully "procure her own miscarriage."[178] Furthermore, Section 160 makes it unlawful to "suppl[y] to or procure for any person or thing whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman."[179] The application of these criminal provisions is made uncertain by the vagueness of the "intent" requirement and by the absence of definitions for key terms such as "poison," "noxious thing," and "miscarriage."

The Penal Code provides for limited circumstances in which a pregnancy may lawfully be terminated. Section 240 of the Penal Code states that a "person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon…an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case."[180] Surgical abortions are therefore legal when the procedure is performed in good faith for the preservation of the life of the mother.

Despite the apparently limited grounds for lawful abortions provided by Section 240 of the Penal Code, legal scholars have suggested that Kenyan courts may recognize English legal practice as it existed before the passage of the Abortion Act, 1967 (England).[181] Pursuant to English legal practice at

that time, abortions could be performed either to save the life of the mother or to preserve the mental or physical health of the woman.[182]

Requirements for Obtaining Legal Abortion

Section 22(1) of the Medical Practitioners Act makes it a criminal offense for any person other than a registered or licensed medical practitioner to practice medicine or surgery in Kenya. Any lawful procedure involving the termination of a pregnancy may therefore be performed only by a medical practitioner registered or licensed under the Medical Practitioners Act. According to principles of informed consent pursuant to the English common law,[183] the woman on whom the procedure will be performed must consent to the procedure. Kenyan law does not, however, require spousal consent for abortions.

Penalties

The Penal Code prescribes severe penalties for the performance of unlawful abortions. Any person who contravenes Section 158 of the Penal Code by using any means with the intent to unlawfully procure the miscarriage of a woman is liable to imprisonment for 14 years. A person who is convicted of unlawfully supplying an abortifacient, pursuant to Section 160 of the Penal Code, may be sentenced to three years of imprisonment. These penalties apply irrespective of whether or not the woman was, in fact, pregnant. In addition, a woman convicted under Section 159 of the Penal Code of using any means to unlawfully procure her own miscarriage is liable to imprisonment for seven years.

Regulation on Abortion Information

Section 38 of the Pharmacy Act makes it an offense for any person to take part in the publication of any advertisement referring to any drug, appliance, or article in terms that are calculated to lead to the use of the drug, appliance, or article for "procuring the miscarriage of women."[184] However, such advertisements may legally appear in a publication of a technical character intended for circulation among: medical practitioners, dentists, and veterinary surgeons, or students of these professions; pharmacists or student pharmacists and authorized sellers of poisons; or persons carrying on a business that includes the sale or supply of surgical appliances.[185]

E. STERILIZATION

Kenyan law does not explicitly regulate sterilization, leaving the performance of such procedures subject to the same legal provisions that apply generally to surgical and medical procedures. For a discussion of these provisions, see the section on Patients' Rights, above. While both male and female sterilizations are provided free of charge in government health facilities,[186] the majority of female sterilizations are performed in such facilities.[187]

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

There is currently no law explicitly prohibiting female genital mutilation ("FGM") — also referred to as female circumcision. The prevalence of FGM in Kenya is estimated to be 50%.[188] In 1990, the Assistant Minister for Cultural and Social Services announced that the government had officially banned FGM,[189] although the legislature did not pass any laws prohibiting it.[190] Nevertheless, FGM may conceivably give rise to criminal actions under any one of the provisions of the Penal Code that criminalize assault or the infliction of bodily harm to any person.[191] The practice of FGM may also give rise to civil actions under the general law of tort.[192] For further discussion regarding FGM see the section on adolescents below.

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

Examining HIV/AIDS issues within a reproductive health framework is essential insofar as the two areas are interrelated from both medical and public health standpoints. Hence, a full evaluation of laws and policies affecting reproductive health and rights in Kenya must examine HIV/AIDS and sexually transmitted diseases ("STDs"). The first diagnosis of AIDS in Kenya was made in 1984. By 1993, 39,000 cases of AIDS had been reported, and it was estimated that 841,700 people in Kenya were infected with HIV.[193] In June 1996, the World Health Organization reported 65,647 cases of AIDS in Kenya, including approximately 35,428 males and 30,076 females.[194]

Laws Affecting HIV/AIDS

In July 1987, the MOH declared AIDS to be a "notifiable infectious disease,"[195] pursuant to powers conferred upon it pursuant to Section 17(2)(a) of the Public Health Act.[196] Thus, Section 18(1) of the Public Health Act imposes notification requirements on certain persons if they are inmates of any building, other than a hospital that receives patients with notifiable infectious diseases, who are suffering from a "notifiable infectious disease."[197] Any person who fails to comply with the notification requirements in this provision is guilty of an offense and is liable to be fined.[198] Although AIDS, but not HIV, has been classified as a "notifiable infectious disease," both AIDS and HIV fall within the definition of an "infectious disease" in the Public Health Act,[199] which contains potentially drastic provisions for the control of infectious diseases. Medical officers of health may enter and inspect premises in which inhabitants may have been exposed to an "infectious disease" and may medically examine persons during such inspections.[200] Medical officers of health also have

wide powers to order the cleansing and disinfecting of buildings and to direct the destruction of any building or thing that has been exposed to infection.[201] Where a medical officer of health is of the opinion that a person who is suffering from, or may be a carrier of an "infectious disease" is not being properly accommodated or treated, the person may be removed to a hospital or other place of isolation and detained there until it is determined that the person no longer constitutes a danger to the public health.[202] If a person who is suffering from an "infectious disease" willfully exposes herself or himself in public without proper precautions, or enters any public conveyance without previously notifying the owner, conductor, or driver of her or his condition, that person is guilty of an offense and is liable to a fine or to imprisonment.[203] Any owner or driver of a public conveyance who fails to immediately disinfect the vehicle after it was knowingly used to convey a person suffering from an infectious disease is guilty of an offense.[204] Similarly, it is an offense "to let for hire" any premises in which a person has been suffering from an infectious disease without first disinfecting the premises.[205]

The Penal Code also contains several other provisions that, while not directly related to HIV/AIDS, may be used to penalize the behavior of people who are infected with HIV or AIDS. Section 186 of the Penal Code makes it is an offense for any person to unlawfully or negligently undertake any act that the person knows or has reason to believe to be likely to spread the infection of any disease dangerous to life. This provision may be applied to any range of activities that might promote the spread of HIV infection, including, for example, risky sexual behavior, sharing of used hypodermic needles, or improper disposal of medical waste. Persons who know themselves to be infected with HIV but who nevertheless engage in unprotected sex, and thereby transmit the HIV virus to another person, could conceivably also be charged with manslaughter or murder pursuant to Sections 202 and 203 of the Penal Code.[206] However, since the time lag between infection with HIV and subsequent death due to AIDS-related illnesses is typically longer than one year, conviction for murder or manslaughter under these circumstances may be precluded by Section 215 of the Penal Code, which states that a "person is not deemed to have killed another if the death of that person does not take place within a year and a day of the cause of death."[207]

Laws Affecting STDs

The Public Health Act contains measures to combat the spread of the following STDs:[208] syphilis, gonorrhea, gonorrheal ophthalmia, soft chancre, venereal warts, and venereal granuloma.[209] Under the statute, every person who knows or has reason to believe that she or he is suffering from an STD must immediately consult a medical practitioner and submit to medical treatment.[210] Similarly, parents or guardians who know that their child is suffering from any such disease are legally required to ensure that the child receives medical treatment.[211] Failure to comply with the provisions of this law constitutes a punishable offense.[212]

The Public Health Act enables the Minister of Health, after receipt of a report by a medical officer, to issue an order requiring the medical examination of a person whom the Minister of Health has reason to believe is suffering from an STD.[213] Alternatively, if a government medical officer or district surgeon knows or has reason to believe that a person is suffering from an STD in a communicable form, and that the person is not under medical treatment or is not receiving treatment regularly, the officer must notify the person of the relevant requirements of the Public Health Act. If the person still does not comply with these requirements, the medical officer or district surgeon must report the matter to a magistrate.[214] On receipt of such a report, the magistrate may make or institute such inquiries, orders, or proceedings as may be necessary for the proper enforcement of the relevant provisions of the Public Health Act.[215]

In addition to the duty to seek medical treatment, persons suffering from an STD have a duty to protect other people from infection. It is an offense for a person who knows or should reasonably have known himself or herself to be suffering from an STD in a communicable form to accept or continue in employment in any capacity that entails the care of children or the handling of food or food utensils intended for consumption or use by other persons. It is also an offense for an employer to hire or continue to employ a person in such a capacity when the employer knows or should reasonably know that the employee is suffering from an STD.[216] More generally, a person who willfully or by culpable negligence infects any other person with an STD, or permits any act likely to lead to the infection of any other person, is guilty of an offense.[217]

The Public Health Act also contains various provisions that affect the dissemination of information regarding the treatment of STDs. Section 45 of the Public Health Act imposes a duty on medical practitioners to provide information to their clients regarding the nature and treatment of STDs. Pursuant to this section, medical practitioners who attend to any patient for STD-related care are required to: inform the patient of the infectious nature of the disease and of the penalties arising from infecting another person; warn the patient

against contracting marriage until cured of the disease or until it is no longer infectious; and give the patient printed information supplied to the medical practitioner by the Medical Department regarding the treatment of STDs and the duties of persons suffering from STDs.[218]

Other means of dissemination of information regarding the treatment of STDs are specifically regulated by Section 55(1) of the Public Health Act, which prohibits the publication of any advertisement or statement "intended to promote the sale of any medicine, appliance or article for the alleviation or cure of any venereal disease affecting the generative organs or functions, or of sexual impotence, or of any complaint or infirmity arising from or relating to sexual impotence."[219] This ban does not, however, apply to publications by the Medical Department or any municipal council, public hospital, or other public body in the discharge of its lawful duties. The section also does not apply to publications by any society or person acting with the authority of the MOH, or to any books, documents, or papers published in good faith for the advancement of medical science.[220]

Policies Affecting Prevention and Treatment of HIV/AIDS

In 1984, in response to the emerging HIV/AIDS epidemic, the government created a National AIDS Committee to advise it regarding the control and prevention of AIDS.[221] Three years later, the Kenya National AIDS Control Programme ("KNACP") was launched,[222] and the AIDS Programme Secretariat was created to coordinate HIV/AIDS prevention activities and manage the KNACP in accordance with five-year medium-term plans for AIDS control.[223] In early 1996, the KNACP was replaced by the National AIDS and Sexually Transmitted Diseases Control Programme.[224] A new policy paper on AIDS, which outlines future government policy and describes the roles of various agencies involved in HIV/AIDS prevention activities, has been incorporated into a sessional paper that was to be submitted to the Kenyan Parliament by December 1996.[225]

The government's HIV/AIDS policies have three primary objectives: to prevent infection, to reduce the personal and social impact of HIV infection, and to mobilize and unify national and international efforts against AIDS.[226] A variety of strategies have been identified to reduce transmission of HIV/AIDS in Kenya, including: dissemination of information regarding methods to prevent infection with HIV/AIDS; early detection and treatment of STDs; promotion of "universal precautions" among health care workers; and provision of facilities for the voluntary testing and counseling of pregnant women.[227] The government has also committed itself to providing humane care to people infected with HIV/AIDS,[228] and to ensuring that HIV/AIDS prevention programs do not stigmatize or discriminate against people infected with HIV/AIDS.[229] In addition, government policy dictates that the coverage afforded by social security and health insurance schemes to people with HIV/AIDS should be equivalent to that provided to people with other diseases.[230]

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that will affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health care and her ability to make voluntary, informed decisions about such care. Laws regarding the age of first marriage can have a significant impact on a young woman's reproductive health. Furthermore, rape laws and other laws prohibiting sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health.

A. RIGHTS WITHIN MARRIAGE

Marriage Law

Kenyan law recognizes four regimes of marriage — statutory, Islamic, Hindu, and African customary laws of marriage.[231] The various laws contain different provisions with respect to matters such as minimum age of marriage, consent, registration, and grounds for divorce.[232] Customary laws in particular have numerous variations, due to the large number of ethnic groups.

Statutory marriages are governed by the Marriage Ordinance[233] and the African Christian Marriage and Divorce Ordinance[234] (the "African Christian Marriage Ordinance"). The Marriage Ordinance stipulates that a statutory marriage is invalid if either party is already married by customary law to any person other than the person with whom the statutory marriage is contracted.[235] In addition, a person who is married under statutory law cannot enter into a customary marriage for the duration of the statutory marriage.[236] However, Section 37 of the Marriage Ordinance recognizes customary marriages by providing that "nothing in this Ordinance

contained shall affect the validity of any marriage contracted under or in accordance with any native law or custom, or in any manner apply to marriages so contracted."[237] The African Christian Marriage Ordinance provides for the marriage of African Christians and for the dissolution of such marriages. This ordinance allows persons already married by customary law to convert their union into a statutory marriage.[238] The African Christian Marriage Ordinance also provides that any African woman married under this ordinance or under the Marriage Ordinance is deemed to have attained "majority" status upon widowhood and has a right to receive support for herself and her children from the brother or other relative of her deceased husband without having to cohabit with that person.[239]

Other religious marriages are also recognized. Marriages performed according to Hindu rites and ceremonies are recognized by the Hindu Marriage and Divorce Ordinance [240] (the "Hindu Marriage Ordinance"), whose general effect is to confer upon Hindu marriages substantially the same status as a monogamous marriage under the Marriage Ordinance.[241] Hindu marriages may not be solemnized if either party is already married.[242] The Mohammedan Marriage, Divorce and Succession Ordinance[243] (the "Mohammedan Marriage Ordinance") provides for the recognition of marriages contracted under Islamic law,[244] while the Mohammedan Marriage and Divorce Registration Ordinance[245] (the "Mohammedan Marriage Registration Ordinance") makes provision for the registration of such marriages. It is a criminal offense for a person to contract an Islamic marriage while that person is already married in accordance with the Marriage Ordinance, the law of any Christian country, or African customary law.[246] There is, however, no statutory restriction against polygamous marriages conducted under Islamic law.

Marital customs and practices vary among the more than 40 ethnic groups in Kenya. In order for a marriage to be validly constituted, the customary laws of every ethnic group require the bridegroom to make payments of livestock or other property to the father or guardian of the bride.[247] All systems of customary law permit men to enter into any number of marriages simultaneously, while prohibiting women from entering into a subsequent marriage during the continuance of a prior marriage.[248] While the prior consent of both spouses is now essential to the validity of marriage under all systems of customary law, the consent of the first or senior wife is not required before the husband takes a subsequent wife.[249] Special types of marriage, including levirate unions[250] and widow inheritance,[251] are still practiced among some ethnic groups.[252] For a discussion on marriage and adolescents see section on adolescents below.

Divorce and Custody Law

Like marriage, divorce is regulated by various laws. The Matrimonial Causes Ordinance[253] governs the dissolution of statutory marriages. According to this Ordinance, a person may only petition a court for divorce after three years of marriage, except in the case of "exceptional hardship" or when her or his spouse has been guilty of "exceptional depravity."[254] After three years of marriage, either spouse may petition for divorce on the grounds of: adultery; desertion without cause for at least three years immediately preceding the petition; cruelty; or incurable unsoundness of mind.[255] In addition, the wife may petition for divorce on the ground that her husband has, since the celebration of the marriage, been guilty of "rape, sodomy, or bestiality."[256] The Matrimonial Causes Ordinance also makes provision for decrees of judicial separation or nullity of a marriage in specified circumstances.[257] A husband may, in a petition for divorce or separation, claim damages from any person on the ground of adultery with his wife,[258] but no similar relief is available to wives whose husbands have committed adultery.

Parties to a Hindu marriage may petition for divorce on any of the grounds listed above, together with certain additional grounds peculiar to Hindu marriages. A petition for divorce may, for example, be presented to the court on the grounds that the respondent has converted to another religion or has "renounced the world" by entering and remaining in a religious order "apart from the world" for at least three years immediately preceding the petition.[259] Petitions may also be made under the Hindu Marriage Ordinance for decrees of judicial separation or to nullify a marriage.[260]

Islamic divorces are governed by Islamic law,[261] although the Mohammedan Marriage Registration Ordinance makes provision for the registration of such divorces.[262] In a suit for divorce, the burden of proof of the applicable principles of Islamic law rests on the party bringing the action.[263] The principal forms of Islamic divorce are *talaq*, the unilateral repudiation of the marriage by a husband, and *khula*, the seeking of marital dissolution by a wife by giving consideration to her husband for her release.[264]

A divorce under customary law may be granted either by the elders of the community with the assistance of the families of the spouses or by a court.[265] Customary law typically does not enumerate a fixed list of grounds for divorce, although it is possible to identify certain matters that normally constitute grounds for divorce.[266] Among Kikuyu and Luo people, for instance, divorce is typically granted to either spouse due to: refusal of sexual intercourse without just cause; witchcraft; habitual theft; willful desertion; incest; or excessive

physical cruelty.[267] Among the Luo, a man may divorce his wife for her "habitual adultery" with any man, although a wife may divorce her husband for his "habitual adultery" only if the woman with whom the husband had adulterous relations was married.[268] Among the Kikuyu, even a single act of adultery by the wife is a ground for divorce by the husband, while adultery is never a ground for divorce by the wife.[269] Among both the Luo and the Kikuyu, the impotence or infertility of a husband may be grounds for divorce by the wife, while a wife's barrenness is not a ground for divorce by the husband.[270]

Child custody and maintenance following the dissolution of a marriage are addressed by a number of statutes, including the Matrimonial Causes Ordinance,[271] the Guardianship of Infants Ordinance[272] (the "Guardianship Ordinance"), and the Subordinate Courts (Separation and Maintenance) Ordinance[273] (the "Separation and Maintenance Ordinance"). In a judicial separation granted under the Separation and Maintenance Ordinance,[274] the court may make an order granting legal custody of any children of the marriage under 16 years of age to the wife.[275] In proceedings for divorce, judicial separation, or nullity, Section 30 of the Matrimonial Causes Ordinance provides that the court may make such provision regarding the custody of children as it considers just.[276] In making an order as to custody of and access to children of the marriage, the welfare of the child is always the first and paramount consideration.[277] The court must also consider the parents' conduct and wishes.[278] While both parents have equal rights to apply for custody,[279] in practice the court normally awards custody of children below the age of seven to the mother on the basis that mothers are best able to look after young children who are still wholly dependent on adults for survival.[280] Where the court awards custody of a child to the mother, it may order the father to pay to her such weekly or other periodical sum as the court, having regard to the means of the father, considers reasonable for maintenance of the child.[281] In addition, in any suit for divorce, judicial separation, or nullity, the court may order that the husband pay the wife such annual, monthly, or weekly sum of money for any term, not exceeding her life, as the court may deem reasonable.[282]

Custody of Hindu children is governed by the statutory law described above,[283] as are issues of maintenance.[284] Rules of custody differ among various schools of Islamic law, although custody of boys under seven and girls under nine is generally with the mother, and above those ages with the father.[285] Upon divorce, a Muslim wife is only entitled to maintenance for the period of her *iddat*,[286] which is normally three months.[287] Under customary law, the father is normally entitled to custody,[288] and wives are not usually entitled to maintenance upon separation or divorce.[289]

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

The Registered Lands Act[290] and the Law of Succession Act[291] (the "Succession Act") are the primary statutes governing ownership and use of agricultural land in Kenya.[292] Once title to a portion of land has been registered, the Registered Lands Act vests absolute title to that property in the registered owner, while removing all other claims to the land that might exist.[293] Although this statute grants women an equal right to register title to land, the law was enacted in a context in which women traditionally could not own land and inheritance of land occurred by male lineage.[294] When the Registered Lands Act was passed men rushed to register land,[295] and the passage of the statute did not permit subsequent alteration of the register, thereby precluding many women from changing the register to accommodate their interests.[296]

The Succession Act,[297] which took effect in 1981, sought to provide uniformity to an area of law that had been governed according to four legal regimes[298] — African customary law, statutory law, Hindu law, and Islamic law. Two elements of the statute — an exemption for Muslims[299] and a provision stating that the inheritance of livestock and agricultural lands continue to be governed by customary law[300] — have undermined the attempt to achieve uniformity. In addition, although Section 35 grants the surviving spouse a life interest in an intestate estate, that right terminates for a widow upon remarriage;[301] no similar restriction is placed on the rights of widowers. (This provision remains somewhat of an anomaly in a statute that also grants women the same capacity to make a will as men,[302] and grants men and women equal rights to inherit from a parent or sibling.)

Despite the removal of formal legal impediments to equal inheritance rights for women, as a consequence of testamentary freedom, the Succession Act imposes no obligation on fathers to provide for their daughters. Fathers continue the customary practice of transferring land to their sons on the assumption that a daughter will marry and gain access to land through her status as a wife.[303] Furthermore, customary laws of inheritance, which preclude a daughter's right to inherit land, are still highly respected even though they are not legally enforceable.[304] These practices are able to continue because most inheritance issues do not come before the courts,[305] or court opinions are not available. Furthermore, current property laws continue to be interpreted and applied in a conservative manner.[306] In the case of *Estate of Njeru Kamanga*, for instance, the daughters of the deceased were disinherited by the magistrate, who felt that they had no right to the father's property because they were married — despite the unequivocal provisions of the Succession Act.[307]

Labor Rights

The Employment Act,[308] the primary statute governing employment in Kenya, has been criticized for failing to address issues of gender inequality and job discrimination on the basis of sex, including sexual harassment.[309] The Employment Act also contains certain provisions that, although designed to protect women, also restrict their employment opportunities. Subject to certain exceptions,[310] women may not be employed in industrial undertakings at night.[311] Women are also generally prohibited from being employed in underground work in a mine.[312] The Minister of Labor also has the power to prohibit the employment of women in any other specified trade or occupation.[313] The position of women in the workplace is further compromised by restrictive provisions regarding maternity leave. While Section 7(2) of the Employment Act provides that women employees are entitled to two months maternity leave with full pay, this provision is subject to the restriction that a woman who has taken two months maternity leave shall forfeit her annual leave for that year.[314] Furthermore, in 1985, the president of Kenya announced that no civil servant who had more than four children would be eligible for paid maternity leave.[315]

Various other legal restrictions affect the financial security of women employees. Kenyan pension law provides that a widow loses her work pension upon remarriage, whereas a man does not.[316] Furthermore, the terms of civil service for women state that they are not entitled to a housing allowance.[317]

Rules Governing Credit

Although Kenyan law does not restrict women's access to credit services, most credit institutions require collateral in the form of immovable property.[318] This mandate greatly restricts the number of women who qualify for loans, considering that women have traditionally been excluded from land ownership.[319] In addition, most banks require women borrowing money to have a male guarantor or their husband's permission.[320] In recognition of the difficulties that women experience in gaining access to credit, the 1994 to 1996 National Development Plan commits the government to promoting agricultural production through the establishment of special credit schemes for women who belong to women's groups.[321]

Access to Education

Kenyan law does not explicitly restrict women's access to education. At higher levels of education, however, significant discrepancies remain in the ratio of male to female students.[322] The 1994 to 1996 National Development Plan recognizes that women continue to be disadvantaged in education and outlines steps to remedy the problem.[323] For a further discussion regarding education, see section on adolescents below.

Women's Bureaus

Women's issues are addressed officially under the auspices of the Women's Bureau within the Ministry of Culture and Social Services.[324] The main functions of the Women's Bureau are to: assist women to improve their economic status; create an awareness of women's contributions to development; promote women's interests in the design and implementation of development projects; and conduct research on women.[325] Since its establishment in 1975,[326] the Women's Bureau has facilitated the creation of about 250 women's NGOs and agencies, which serve more than 17,000 women's groups.[327]

C. RIGHT TO PHYSICAL INTEGRITY

Rape

The Penal Code prescribes severe penalties for persons convicted of rape and other forms of non-consensual sexual intercourse.[328] The Penal Code states that a person is guilty of rape if he has sexual intercourse with a woman or girl without her consent, or if she is coerced or deceived in some way into giving her consent.[329] Despite the seemingly broad language of the Penal Code, it has traditionally been accepted that husbands cannot be convicted of raping their wives, as consent to sexual intercourse is considered to be implied in marriage; if the parties are judicially separated, the husband may be convicted of rape.[330] The penalty for both rape and attempted rape is life imprisonment with hard labor, with or without corporal punishment.[331] Any person who has sexual intercourse with a woman or girl knowing that she is an "idiot or imbecile" is liable to imprisonment with hard labor for 14 years, with or without corporal punishment.[332]

Various other sexual offenses are contained in Chapter XV of the Penal Code, including *inter alia*: abduction of a woman of any age against her will for the purposes of marriage or sexual relations;[333] "indecent assault" of any woman or girl;[334] procurement of women or girls for the purpose of prostitution;[335] inducement of sexual intercourse through duress, fraud, or the administration of overpowering drugs;[336] and detention of any woman against her will for the purposes of sexual intercourse.[337] Chapter XV also identifies several offenses in relation to unlawful sexual intercourse with minors. In particular, Section 145 of the Penal Code provides that unlawful sexual intercourse with any girl under the age of 14 years constitutes an offense, irrespective of whether or not she consented to sexual intercourse.[338] It is, however, sufficient defense to such a charge of statutory rape that the accused had reason to believe, and did in fact believe, that the girl was 14 years or older, or that the girl was his wife.[339] For further discussion on sexual offenses against minors, see the section on adolescents below.

Domestic Violence

Wife-beating is fairly prevalent in Kenya.[340] The continuation of this practice may be attributable to the fact that every regime of customary law in Kenya grants husbands the right to "chastise" their wives for "misconduct."[341] Under Kenyan customary laws, only "unjustified or excessive beating" by the husband would be sufficient ground for divorce or for the wife to return to her family.[342] Nonetheless, violence against a wife might constitute an offense under any one of the provisions of the Penal Code criminalizing assault, which is defined as the unlawful infliction of bodily harm to any person or the intent to unlawfully harm another person.[343] Assault or battery may also be grounds for civil actions in tort.[344]

Sexual Harassment

Both physical and verbal sexual harassment constitute criminal offenses under Section 144 of the Penal Code. An act of physical sexual harassment may constitute an offense under Section 144(1) of the Penal Code, which provides that any person who "unlawfully and indecently assaults any woman or girl" is guilty of a felony punishable by imprisonment with hard labor for five years, with or without corporal punishment.[345] A Kenyan court made the following significant observations in relation to what constitutes "indecent assault": "An assault accompanied by utterances suggestive of sexual intercourse is an indecent assault, as also an assault by touching…The simple issue usually is whether the assault was intentional and whether it was indecent. Utterances suggestive of sexual intercourse could change an otherwise simple assault into an indecent assault…"[346] Verbal sexual harassment may also be grounds for a criminal charge pursuant to Section 144(3) of the Penal Code, which provides that any person who, "intending to insult the modesty of any woman or girl, utters any word, makes any sound or gesture or exhibits any object, intending that the word or sound shall be heard, or that the gesture or object shall be seen, by the woman or girl, or intrudes upon the privacy of the woman or girl," is guilty of a misdemeanor.[347]

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

The needs of adolescents are often unrecognized or neglected. Given that approximately 26% of the Kenyan population is between the ages of 10 and 19,[348] it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescent rights, including those related to reproductive health, is important for women's right to self-determination, as well as for their health.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

Although Kenya's laws and policies do not explicitly restrict the provision of services to adolescents, the government does not provide reproductive health programs or services specifically geared towards their needs.[349] Kenya's Health Policy Framework does, however, identify the need for "[p]romotion of fora to examine the sensitive issue of youth contraceptives...."[350]

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

Despite repeated condemnation by the executive branch of government in recent years, the practice is still as prevalent in Kenya today as it was at the beginning of the century.[351] In 1982, President Moi issued an official statement against FGM after the deaths of 14 girls from complications of excision[352] and instructed the police to pursue murder charges against people who carry out the procedure with fatal results.[353] The Director of Medical Services also ordered that no health official should carry out the procedure without the office's specific permission.[354] In December 1989, President Moi called upon Kenyan communities who still practice FGM to stop the practice immediately.[355] Six months later, the Assistant Minister for Cultural and Social Services announced that the government had officially banned female genital mutilation.[356] Despite this commitment of the executive to outright prohibition of FGM, the legislature has not been forthcoming in passing any laws banning the practice.[357] In November 1995, a proposal to outlaw the practice was defeated in the Kenyan Parliament.[358] It is conceivable, however, that FGM may be reported as a criminal action pursuant to any one of the provisions of the Penal Code that bar assault or the infliction of bodily harm to any person.[359] It may also give rise to civil actions under tort law.

C. MARRIAGE AND ADOLESCENTS

The minimum age at which persons may be married in Kenya differs according to the marital regime under which the marriage is solemnized. The Marriage Ordinance requires parties to a statutory marriage to be at least 16 years of age.[360] If either party, other than a widow or widower, is under 21 years of age, the legal guardian of that party is required to give her or his written consent to the marriage.[361] Under Hindu law, the minimum age for marriage is 18 for the bridegroom and 16 for the bride.[362] Women who wish to marry between the ages of 16 and 18 require the consent of a guardian.[363] Neither the Mohammedan Marriage Ordinance nor the Mohammedan Marriage Registration Ordinance specifies a minimum age for first marriage for persons married in Kenya

under Islamic law, and the issue of whether the Quran permits child marriage has proved to be contentious.[364] Nevertheless, it appears that, while Muslim girls may be given in marriage by their guardians even before puberty, they have the option of accepting or rejecting the marriage upon reaching puberty.[365] None of the customary laws in Kenya specify a minimum age at which persons become legally capable of entering into marriage. In general, however, female genital mutilation is a prerequisite to marriage, although many ethnic groups no longer apply this requirement. Certain ethnic groups, including the Kikuyu, also require women to have passed their first menstrual period before marriage.[366]

D. EDUCATION AND ADOLESCENTS

The gender ratio of female to male students in educational institutions has generally improved in recent years, although significant discrepancies remain at higher levels of education. In primary schools, the female-to-male ratio has increased from 75 to 100 in 1972 to 97 to 100 in 1992. Female-to-male enrollment ratios in secondary schools rose from 45 to 100 in 1972 to 75 to 100 in 1992, while the ratio for first-year intake in universities dropped from 42 to 100 in 1989 to 37 to 100 in 1992.[367] Women's access to education is not limited by legislation, but rather by limited opportunities due in part to customs, social attitudes, and financial constraints.[368]

The 1994 to 1996 National Development Plan recognizes that "females are disadvantaged at all levels of education in terms of access, participation, completion and performance."[369] The Development Plan therefore outlined remedial steps, which include: improved collection of data regarding the educational status of girls in Kenya; "community mobilization and sensitization in support of the Girl Child"; follow-up with adolescent mothers who leave school, to facilitate their return to school; gradual removal of sexual stereotyping of gender roles in educational materials; and improvement of the learning environment of girls.[370] The government has also stated its intention to introduce a bursary program directed toward girls at primary school level in rural and low-income areas.[371]

E. SEX EDUCATION FOR ADOLESCENTS

Sex education is not explicitly included in school curricula in Kenya, although issues of sex and sexuality are addressed in subjects such as social ethics, biology, anatomy, and physiology.[372] The government has also acknowledged the need for teachers, parents, and community leaders to reinforce "traditional health promoting values and policies," particularly in the light of the HIV/AIDS epidemic.[373]

F. SEXUAL OFFENSES AGAINST MINORS

Various provisions of the Penal Code address the issue of sexual offenses committed against young persons. Section 145 of the Penal Code makes it an offense to commit, or attempt to commit, unlawful sexual intercourse with any girl under the age of 14 years, irrespective of whether or not she consented.[374] Sections 144 and 164 criminalize indecent assault committed on girls and boys under the age of 14 years, respectively.[375] For a girl under 14 years old, consent is no defense for indecent assault or sexual intercourse, unless the accused had reason to believe, and did in fact believe, that the girl was 14 years or older, or that the girl was his wife.[376]

Sections 149 and 166 of the Penal Code contain provisions that affect girls under the age of 13 years.[377] Section 149 makes it a felony for the owner, occupier, or manager of premises to induce or knowingly permit any girl under the age of 13 years to be upon the premises for the purpose of sexual intercourse with any man.[378] While the penalty for incest is ordinarily imprisonment for five years, Section 166(1) of the Penal Code increases this penalty to life imprisonment if the incest is committed with a girl under the age of 13 years.[379]

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29. *Id.* §§ 4, 9.

30. Laws of Kenya, Ch. 8, § 3.
31. *Id*. § 3.
32. *Id*. § 82 (1).
33. *Id*. § 82 (3).
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35. Mwalimu, *supra* note 13, at 23.
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37. Eugene Cotran, *The Future of Customary Law in Kenya*, *in* The S.M. Otieno Case 148, 149 (Jackton B. Ojwang & Jesse Ndwiga Kanyua Mugambi eds.).
38. Laws of Kenya, Ch. 8, § 3(2).
39. *Id*.
40. Laws of Kenya, Ch. 10, § 2.
41. Laws of Kenya, Ch. 160, § 2.
42. Otieno v. Ougo, Civil Appeal No. 31 of 1987, *reported in* Eugene Cotran, Casebook on Kenya Customary Law 331 (1987). The *Otieno* case involved the burial of a prominent Nairobi lawyer. The deceased's eldest brother claimed that the body should be buried on the land of his patrilineal Luo ancestors, in accordance with Luo customary law. The deceased's widow contended that the body should be buried near Nairobi, in accordance with the wishes of the deceased, expressed while he was alive. The court found in favor of the deceased's brother, and denied the widow the right to dispose of the body. *Id*. at 332.
43. *Id*. at 339.
44. *Id*. The court also stated that, at present, "there is no way in which an African citizen of Kenya can divest himself of the association with the tribe of his father if those customs are patrilineal." *Id*. at 336.
45. *Id*. at 339.
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51. Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13, (*entry into force* Sept. 3, 1981) (ratified by Kenya on March 9, 1984).
52. African Charter on Human and Peoples' Rights, *adopted* June 26, 1981, OAU Doc. CAB/LEG/67/3/Rev. 5 (1981), *reprinted in* 21 I.L.M. 59 (1982) (*entry into force* Oct. 21, 1986) (ratified by Kenya on Feb. 10, 1992).
53. Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, G.A. Res. 44/25, U.N.G.A.O.R., 44th Sess., Supp. No. 49, U.N. Doc. A/44/49, *reprinted in* 28 I.L.M. 1448 (*entry into force* Sept. 2, 1990) (ratified by Kenya on July 30, 1990).
54. *See* Mathangani, *supra* note 48, at 191.
55. Memorandum from Jane Kiragu, Project Manager, International Federation of Women Lawyers (FIDA) Kenya Chapter (Sept. 20, 1996) (on file at The Center for Reproductive Law and Policy).
56. Mathangani, *supra* note 48, at 191.
57. Ministry of Health, Gov't of Kenya, Kenya's Health Policy Framework 26 (1994).
58. *Id*. at 31-33.
59. *Id*. at 45-47.
60. *Id*. at 48.
61. *Id*. at 35-36.
62. *Id*. at 36-37.
63. *Id*. at 33-34.
64. *Id*. at 38.
65. *Id*. at 39.
66. *Id*. at 39-40.
67. *Id*. at 28.
68. *Id*. at 42.
69. *Id*. at 17.
70. *Id*. at 34.
71. See Japeth K. Mati, Strategy For Reproductive Health Care In Kenya: A Consultant Report (Third Draft) (Feb. 1996) (Unpublished report on file at The Center for Reproductive Law and Policy) (noting a commitment to an integrated approach to avoid a duplication of services).
72. National Development Plan for the Period 1994 to 1996, art. 11.39, at 231 (Republic of Kenya 1994).
73. Agenda '94: People, Economic Affairs and Politics 253-54 (Institute of Economic Affairs [Kenya] 1994) [hereinafter Agenda '94].
74. National Development Plan for the Period 1994 to 1996, *supra* note 72, art. 1.102, at 33.
75. Agenda '94, *supra* note 73, at 254.
76. *Id*.
77. Republic of Kenya, National Population Policy for Sustainable Development 13 (Oct. 1995) (Draft on file with The Center for Reproductive Law and Policy) [hereinafter National Population Policy].
78. *Id*. at 14.
79. *Id*.
80. World Development Report 1993: Investing In Health, tbl. A.9, at 210 (World Bank 1993).
81. National Development Plan for the Period 1994 to 1996, *supra* note 72, art. 11.35, at 230 (Republic of Kenya 1994).
82. Agenda '94, *supra* note 73, at 254.
83. *Id*.
84. Population and Human Resources Div., World Bank, Report No. 13152-KE, Kenya Poverty Assessment 75 (1995).
85. *Id*. at 82.
86. *Id*.
87. Laws of Kenya, Ch. 256.
88. Persons over the age of 18 years are liable to pay the standard monthly contribution if their income exceeded 1,000 shillings in the preceding month, 3,000 shillings in the preceding three months, or 12,000 shillings in the preceding 12 months. Laws of Kenya, Ch. 255, § 5(3).
89. *Id*. §§ 5-6.
90. *Id*. § 10(1).
91. However, no benefits shall be payable for these purposes if the expenses arose within six months of the date of payment of the first contribution for a year, unless the contributor had contributed to the Fund throughout the entire preceding year. Laws of Kenya, Ch. 255 [Subsidiary], Reg. 9.
92. Laws of Kenya, Ch. 253.
93. Laws of Kenya, Ch. 257.
94. Laws of Kenya, Ch. 244.
95. Laws of Kenya, Ch. 253, § 4(1).
96. *Id*. § 5.
97. *Id*. § 11(1).
98. *Id*. §§ 15(1), 17.
99. *Id*. § 22(1).
100. *Id*. § 20(1).
101. Laws of Kenya, Ch. 257, § 3.
102. *Id*. § 9.
103. *Id*. §§ 12-17.
104. *Id*. § 25.
105. Laws of Kenya, Ch. 244, § 3.
106. *Id*. § 5.
107. *Id*. § 8.
108. *Id*. §§ 19(1)-(2).
109. *Id*. §§ 19(4)-(5).
110. National Population Policy, *supra* note 77, at 28.
111. Laws of Kenya, Ch. 63, § 218.
112. Tudor Jackson, The Law of Kenya: An Introduction 185 (2nd ed. 1978).
113. *Id*.
114. *Id*. at 208.
115. See *id*. at 197 (discussing "trespass to the person" generally).
116. Laws of Kenya, Ch. 253, § 20(1); see also *supra* notes 92-110 and accompanying text (regulation of health personnel).
117. Census data were collected even before independence. The first complete census was conducted in 1948, with censuses being conducted regularly every 10 years since then. U.N. Dep't Of Int'l Economics & Social Affairs, II World Population Policies 103, U.N. Doc. ST/ESA/SER.A/102/Add.1, Sales No. E.89.XIII.3 (1989). The most recent census was conducted in 1989. UNFPA, *supra* note 5, at 11.
118. African Socialism and its Application to Planning in Kenya Nairobi ¶ 86, at 31 (Republic of Kenya 1965).

119. *Id.*
120. DEVELOPMENT PLAN 1989–1993, art 9.14 (Republic of Kenya 1989), *in* 18 ANN. REV. OF POPULATION L. 230, 232 (Reed Boland & Jan Stepan eds., 1993).
121. NAT'L COUNCIL FOR POPULATION & DEV., *supra* note 4, at 3.
122. NAT'L COUNCIL FOR POPULATION & DEV., *Population Policy Guidelines, Jan.* 1986, THE WEEKLY REVIEW [NAIROBI], 24 Jan. 1986, at 17, Appendix I, *in* 13 ANN. REV. OF POPULATION L. 269, 280-81 (Reed Boland & Jan Stepan Eds., 1989) [hereinafter *1986 Population Policy Guidelines*].
123. NATIONAL POPULATION POLICY, *supra* note 77, at 33.
124. U.N. DEP'T OF INT'L ECONOMICS & SOCIAL AFFAIRS, *supra* note 119, at 103.
125. UNFPA, *supra* note 5.
126. 1986 Population Policy Guidelines, *supra* note 122.
127. *Id.* art. 7.3(e), at 280.
128. *Id.* art. 7.1(d), at 279.
129. *Id.* art. 5.1, at 271.
130. *Id.* art. 5.2, at 271.
131. *Id.* art. 5.3.
132. MINISTRY OF HEALTH, *supra* note 57, at 28.
133. A formal system of development planning has existed since 1965. U.N. DEP'T OF INT'L ECONOMICS & SOCIAL AFFAIRS, *supra* note 117. The most recent plan is the Development Plan covering the period 1994 to 1996. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72.
134. The 1989-1993 Development Plan also commits the government to expanding antenatal care to enable expectant mothers to attend at least one prenatal health session before the birth of each new baby and to providing postnatal care, including infant immunization, education on the use of oral rehydration salts, and nutrition monitoring. DEVELOPMENT PLAN 1989-1993, *supra* note 120, art 9.14, at 233.
135. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, art. 10.37, at 212.
136. NATIONAL POPULATION POLICY, *supra* note 77.
137. Specific demographic targets are envisaged for reduction of rates of infant mortality, child mortality, maternal mortality, crude death, total fertility, and population growth, as well as for increases in life expectancy and contraceptive prevalence rates. *Id.* at 20-21.
138. Health service targets are envisaged for immunization coverage, professionally attended deliveries, and primary health care coverage. *Id.* at 21-22.
139. Social service targets call for increases in literacy rates, educational attainment levels for both sexes, and availability of sanitary facilities. *Id.* at 22.
140. MATI, *supra* note 71, at 1. There are also approximately 800 NGO and private service delivery points in Kenya. *Id.* The Family Planning Association of Kenya ("FPAK") accounts for about 60% of the oral contraceptives reported to have been distributed through community-based distribution services. UNFPA, *supra* note 5, at 50.
141. UNFPA, *supra* note 5, at 48.
142. NAT'L COUNCIL FOR POPULATION & DEV., *supra* note 4, at 49.
143. *Id.*
144. Memorandum from Jane Kiragu, *supra* note 55.
145. *Id.* (citing interview with Claire Obare, Programme Officer, *Association of Voluntary Surgical Contraception, Nairobi Office*).
146. UNFPA, *supra* note 5, at 12.
147. NAT'L COUNCIL FOR POPULATION & DEV., *supra* note 4, at 39-40.
148. *Id.* at 147.
149. LAWS OF KENYA, Ch. 244, §§ 43, 44(1)(d).
150. *Id.* § 19(5).
151. The Poisons List Confirmation Order is attached as a schedule to the Pharmacy Act.
152. *Id.* § 25(2)(a).
153. *Id.* § 29(2)(a).
154. *Id.* § 31(1).
155. *Id.* § 35.
156. LAWS OF KENYA, Ch. 254.
157. "Device" is defined in section 2 of the Food, Drugs and Chemical Substances Act to mean "any instrument, apparatus or contrivance, including components, parts and accessories thereof, manufactured, sold or represented for use in the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state, or the symptoms thereof, in man or animal." *Id.* § 2.
158. *Id.* §§ 12, 19.
159. *Id.* § 11.
160. *Id.* § 8.
161. LAWS OF KENYA, Ch. 244, § 41.
162. LAWS OF KENYA, Ch. 254, §§ 9, 17.
163. *Id.* § 16.
164. LAWS OF KENYA, Ch. 244, § 44(1)(fa).
165. *Id.* § 43(1). Contraceptive devices, including IUDs, are appliances, and would therefore fall within this provision.
166. The Sales Tax (Remission) Order, No. 17 (1984).
167. The Customs and Excise (Remission) Order, No. 19 (1984).
168. LAWS OF KENYA, Chs. 63, 222, 244, 254.
169. LAWS OF KENYA, Ch. 244, §§ 43(1), 44(1)(d).
170. "Advertisement" is defined broadly in section 2 of the Pharmacy and Poisons Act to include "a notice, circular, label wrapper or other document, and an announcement made orally or by means of producing or transmitting light or sound." *Id.* § 2.
171. LAWS OF KENYA, Ch. 222, § 11(1).
172. *Id.* § 15.
173. *Id.* § 16(4).
174. LAWS OF KENYA, Ch. 63, § 181(1).
175. *Id.* §§ 181(3), (4).
176. LAWS OF KENYA, Ch. 244, § 52; *see also* LAWS OF KENYA, Ch. 63, § 53 (making it a crime to possess such publications).
177. LAWS OF KENYA, Ch. 63, § 158.
178. *Id.* § 159.
179. *Id.* § 160.
180. *Id.* § 240.
181. U.U. UCHE, LAW AND POPULATION GROWTH IN KENYA, MONOGRAPH SERIES NO. 22, at 17 (1974).
182. *Id.* at 17 (citing R. v. Bourne [1938] 3 A11 E.R. 615, [1939] 1 K.B. 687).
183. JACKSON, *supra* note 112, at 185.
184. LAWS OF KENYA, Ch. 244, § 38.
185. *Id.* § 40(3)(b).
186. Memorandum from Jane Kiragu, *supra* note 55.
187. NAT'L COUNCIL FOR POPULATION & DEV., *supra* note 4, at 49.
188. NAHID TOUBIA, FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION 25 (Rainbo 1995).
189. Sharon Ladin, International Women's Rights Action Watch (IWRAW), *Kenya, in* 1993 IWRAW TO CEDAW COUNTRY REPORTS 11, 12 (1992).
190. JACQUELINE SMITH, VISIONS AND DISCUSSIONS ON GENITAL MUTILATION OF GIRLS: AN INTERNATIONAL SURVEY 119 (1995).
191. LAWS OF KENYA, Ch. 63, §§ 231, 234, 250, 251.
192. For a general discussion of tort law in Kenya, *see* JACKSON, *supra* note 112, at 182-225.
193. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, at 261.
194. WORLD HEALTH ORG., WHO AIDS SURVEILLANCE REPORT: KENYA (June 18, 1996) (unpublished document on file at The Center for Reproductive Law and Policy).
195. Notice of the Minister of Health (July 23, 1987), Gazette Notice No. 3539, THE KENYA GAZETTE, July 31, 1987, at 1110.
196. LAWS OF KENYA, Ch. 242.
197. LAWS OF KENYA, Ch. 244, § 18(1). Where a medical practitioner has not attended to the patient, either the head of the patient's family, a relative, or an occupier of the building must notify the nearest medical officer of health that the person is suffering from a notifiable infectious disease. In any case in which a medical practitioner has been called in to attend to the patient, that practitioner is required to submit to the nearest medical officer of health a certificate detailing particulars of the case. The medical practitioner must also inform the head of the household, or the occupier of the premises, or any person in attendance on the patient, of the infectious nature of the disease and the precautions to be taken to prevent its conveyance to others. Similar notification requirements apply to medical practitioners who become aware that a person has died of an infectious disease. *Id.*
198. LAWS OF KENYA, Ch. 244, § 18(2). Medical practitioners in private practice have an added incentive to comply with the notification requirements because Kenyan health authorities are required to pay them a fee of four shillings for each certificate duly sent by them in accordance with the provisions of the PUBLIC HEALTH ACT. *Id.* § 19.
199. Section 2 of the Public Health Act defines "infectious disease" to mean "any disease (not including any venereal disease except gonorrheal ophthalmia) which can be communicated directly or indirectly by any person suffering therefrom to any other person." *Id.* § 2.
200. *Id.* § 21.
201. *Id.* §§ 22, 23.
202. *Id.* §§ 26, 27.

203. *Id.* § 28(a).
204. *Id.* § 29.
205. *Id.* § 30(1).
206. Section 202(1) of the Penal Code provides that "[a]ny person who by an unlawful act or omission causes the death of another person is guilty of the felony termed manslaughter." LAWS OF KENYA, Ch. 63, § 202(1). Section 203 of the Penal Code provides that "[a]ny person who of malice afterthought causes the death of another person by an unlawful act or omission is guilty of murder." *Id.* § 203.
207. *Id.* § 215(1); *see also* Robert P. Wasson, Jr., *The Aids Crisis As An Impetus to Law Reform in the United States and Kenya*, 17 SUFFOLK TRANSNATIONAL LAW REVIEW 1, 45-46 (1994).
208. STDs are referred to as "venereal diseases" in the Public Health Act.
209. LAWS OF KENYA, Ch. 242. § 43. All references to STDs in the discussion of the provisions of the PUBLIC HEALTH ACT below refer to these six diseases.
210. *Id.* § 44(1).
211. *Id.* § 46(1).
212. *Id.* §§ 44(2), 46(2).
213. *Id.* § 51(1).
214. *Id.* § 48(1).
215. *Id.* § 48(2). An order made by the magistrate may require the person to furnish a medical certificate stating whether or not the person is suffering from an STD, or to submit to medical treatment at a specified time or place. The magistrate may also order the detention of the person in a special hospital for the duration of treatment. *Id.* § 48(3).
216. *Id.* § 47.
217. *Id.* § 49.
218. *Id.* § 45.
219. *Id.* § 55(1). For the purposes of § 55 of the Public Health Act, "advertisement" and "statement" include any paper, document, or book containing any advertisement or statement prohibited under the section. *Id.* § 55(3).
220. *Id.* § 55(4).
221. MINISTRY OF HEALTH, REPUBLIC OF KENYA, AIDS CONTROL PROGRAMME, 1987-1991 MEDIUM TERM PLAN: END OF TERM REVIEW 8 (1992).
222. *Id.*
223. *Id.* Two five-year medium term plans for AIDS control have been implemented since then: a 1987-1991 Plan and a 1992-1996 Plan. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, Arts. 12.11, 12.15, at 263-64.
224. Memorandum from Jane Kiragu, *supra* note 55.
225. *Id.*
226. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, art. 12.16, at 264.
227. *Id.* arts. 12.19, 12.21, 12.27, 12.28, at 265-70.
228. *Id.* art. 12.29, at 268.
229. *Id.* art. 12.24, at 266.
230. *Id.* art. 12.29, at 268.
231. MWALIMU, *supra* note 13, at 28.
232. RESTATEMENT I, *supra* note 46, at 8.
233. LAWS OF KENYA, Ch. 150.
234. LAWS OF KENYA, Ch. 151.
235. LAWS OF KENYA, Ch. 150, § 35(1).
236. *Id.* § 37.
237. *Id.*
238. LAWS OF KENYA, Ch. 151, § 9 (1).
239. *Id.* § 13 (1).
240. LAWS OF KENYA, Ch. 157.
241. JACKSON, *supra* note 112, at 46.
242. LAWS OF KENYA, Ch. 157, § 3 (1)(a).
243. LAWS OF KENYA, Ch. 156.
244. *Id.* § 3(1).
245. LAWS OF KENYA, Ch. 155.
246. LAWS OF KENYA, Ch. 156, §§ 5, 6.
247. *See, e.g.*, RESTATEMENT I, *supra* note 46, at 13, 26, 38 (discussing the practice among the Kikuyu, Meru and Tharaka).
248. *See, e.g.*, *id.* at 16, 28-29, 40-41.
249. *See, e.g.*, *id.* at 23, 35.
250. When a husband dies, his widow may remain living at his home and have sexual relations with a male relative of the deceased — usually the younger brother of the deceased who is next in order of seniority — in order to have children. This is termed a "levirate union." *Id.* at 13.
251. The widow may choose to be inherited by a brother or other male relative of the deceased and become his wife for all purposes. *Id.*
252. For a detailed restatement of the customary law of marriage and divorce of each ethnic group of Kenya, *see id.*
253. LAWS OF KENYA, Ch. 152.
254. *Id.* § 6(1).
255. *Id.* § 8(1).
256. *Id.*
257. *Id.* §§ 13-19.
258. *Id.* § 23.
259. LAWS OF KENYA, Ch. 157, § 10.
260. *Id.* §§ 11-12.
261. LAWS OF KENYA, Ch. 156, § 3(1).
262. LAWS OF KENYA, Ch. 155, § 9.
263. LAWS OF KENYA, Ch. 156, § 3(4).
264. UCHE, *supra* note 181, at 24-25.
265. MWALIMU, *supra* note 13, at 32.
266. See, e.g., RESTATEMENT I, *supra* note 46, at 20, 43 (discussing the Kikuyu, Meru and Tharaka).
267. *Id.* at 20, 179.
268. *Id.* at 179.
269. *Id.* at 20.
270. *Id.* at 20, 179.
271. LAWS OF KENYA, Ch. 152.
272. LAWS OF KENYA, Ch. 144.
273. LAWS OF KENYA, Ch. 153.
274. An order for judicial separation may be granted to a wife pursuant to the provisions of this Ordinance if the husband: has been convicted of committing one of various offenses against her; the husband deserted her; was guilty of persistent cruelty to her or her children, or has neglected to maintain them; insisted upon having sexual intercourse with her while knowing that he had a sexually transmissible disease; compelled her to submit herself to prostitution; or is a habitual drunkard or habitual drug-taker. *Id.* § 3(1).
275. *Id.* § 4(b).
276. LAWS OF KENYA, Ch. 152, § 30(1).
277. LAWS OF KENYA, Ch. 144, § 17.
278. *Id.* § 7(1).
279. *Id.* § 6.
280. JANET KABEBERI, THE CHILD: CUSTODY, CARE AND MAINTENANCE 22 (1990); *see also* Githunguri V. Githunguri (1982-88) 1 KAR 9 (1979).
281. LAWS OF KENYA, Ch. 144, § 7(3).
282. LAWS OF KENYA, Ch. 152, § 25.
283. KABEBERI, *supra* note 280, at 27.
284. LAWS OF KENYA, Ch. 157, § 7(4).
285. REPORT OF THE COMMISSION ON THE LAW OF MARRIAGE AND DIVORCE, 114 (Republic of Kenya 1968).
286. "Iddat" means "[t]he period counted by a divorcee or a widow from the termination of marriage through divorce or death, during which she cannot re-marry." JAMAL J. NASIR, THE STATUS OF WOMEN UNDER ISLAMIC LAW AND UNDER MODERN ISLAMIC LEGISLATION 144 (1990).
287. REPORT OF THE COMMISSION ON THE LAW OF MARRIAGE AND DIVORCE, *supra* note 285, at 107.
288. *Id.* at 114.
289. *Id.* at 107.
290. LAWS OF KENYA, Ch. 300.
291. LAWS OF KENYA, Ch. 160.
292. Mumbi Mathangani, *The Triple Battle: Gender, Class and Democracy in Kenya*, 39 HOW. L.J. 287, 301 (1995) (discussing the Registered Lands Act, LAWS OF KENYA, Ch. 300).
293. LAWS OF KENYA, Ch. 300, §§ 27, 28.
294. Mathangani, *supra* note 292, at 302.
295. Ladin, *supra* note 189, at 13.
296. Perpetua W. Karanja, *Women's Land Ownership Rights in Kenya*, *in* THIRD WORLD LEGAL STUDIES-1991: REALIZING THE RIGHTS OF WOMEN IN DEVELOPMENT PROCESSES: WOMEN'S LEGAL ENTITLEMENTS TO AGRICULTURAL DEVELOPMENT AND FINANCIAL ASSISTANCE 109, 130-31.
297. LAWS OF KENYA, ch. 160.
298. THE LAW OF SUCCESSION IN KENYA: GENDER PERSPECTIVES IN PROPERTY MANAGEMENT AND CONTROL 15-22 (Patricia Kameri-Mbote, ed. 1995).
299. *Id.* at 22 (citing Act No. 21 (1990), which came into effect in January, 1990). Muslims successfully argued for this exemption on the basis that the Act infringed upon their freedom of religion as embodied in § 78 of the Constitution. *Id.* at 23.

300. LAWS OF KENYA, Ch. 160, §§ 32, 33.
301. *Id.* § 35(1).
302. *Id.* § 5(2).
303. Karanja, *supra* note 296, at 131.
304. *Id.* at 128.
305. U.S. Dep't of State, *Kenya Human Rights Practices, 1994*, 1994 HUMAN RIGHTS REPORT (1995), *available in* LEXIS, World Library.
306. Karanja, *supra* note 296, at 130.
307. Succession Case No. 93 of 1991 (Maina 1992), *unreported case cited in* THE LAW OF SUCCESSION IN KENYA: GENDER PERSPECTIVES IN PROPERTY MANAGEMENT AND CONTROL, *supra* note 298, at 27. The government has recognized that the problem of discriminatory inheritance practices persists and has committed itself to take measures to address the problem. The 1994 to 1996 National Development Plan states that "[o]wing to land inheritance patterns which favour males over female offsprings [sic], policy measures will be taken to encourage joint decision making on land utility and its accruing benefits between spouses." NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, at 254.
308. LAWS OF KENYA, Ch. 226.
309. Mathangani, *supra* note 48, at 185.
310. Between the hours of 6:30 pm and 6:30 am women may only be employed where: there was an unforeseeable emergency; the work involves perishable goods that would certainly perish if left overnight; the work is not normally manual and is of a managerial nature or otherwise involves health and welfare services; special permission is granted by the Minister of Labor; or the Minister of Labor suspends the restrictions in the public interest during an emergency. LAWS OF KENYA, Ch. 226, §§ 28, 29.
311. *Id.* § 28(1).
312. *Id.* § 30. Exceptions to this rule include where the work entails non-manual management services, health or welfare services, or a period of training in the course of studies. *Id.*
313. *Id.* § 56(1)(j).
314. *Id.* § 7(2).
315. 12 ANN. REV. OF POPULATION L., 1985, at 101 (Reed Boland & Jan Stepan eds., 1988).
316. U.S. Dep't of State, *supra* note 305.
317. Memorandum from Jane Kiragu, Project Director, International Federation of Women Lawyers (FIDA) Kenya Chapter, March 23, 1996 (on file at The Center for Reproductive Law and Policy), *citing* Pub. Serv. Dept., Personnel Guide.
318. WAHIDO SHAH, KENGO POLICY STUDIES SERIES NO. 3, COMMUNITY PROBLEM SOLVING FOR SUSTAINABLE DEVELOPMENT: A REVIEW OF KENYAN GRASSROOTS WOMEN'S INITIATIVES 30.
319. Mathangani, *supra* note 292, at 309.
320. *Id.*
321. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, art. 7.59, at 128.
322. *Id.* art. 1.98, at 33.
323. *Id.* arts. 11.161-11.163, at 255-56.
324. Mathangani, *supra* note 48, at 186 n.44.
325. A GUIDE TO POPULATION ACTIVITIES IN KENYA (Abigail Krystal & Anne Schneller eds., 1987) (unpublished report on file at The Center for Reproductive Law and Policy).
326. *Id.*
327. UNFPA, *supra* note 5, at 13.
328. LAWS OF KENYA, Ch. 63, §§ 140-167.
329. *Id.* § 139.
330. JACKSON, *supra* note 112, at 114. In April 1994 the Attorney General remarked that Kenyan men who have non-consensual sexual intercourse with their wives could soon be charged with rape. this remark was made in the Attorney General's opening address at a Gender Violence Workshop, hosted by the Kenya Chapter of the International Federation of Women Lawyers: THE STANDARD NEWSPAPER, Apr. 19, 1994, at 1.
331. LAWS OF KENYA, Ch. 63, §§ 140, 141.
332. *Id.* § 146.
333. *Id.* § 142.
334. *Id.* § 144(1).
335. *Id.* § 147.
336. *Id.* § 148.
337. *Id.* § 151 (1).
338. *Id.* § 145.
339. *Id.*
340. Ladin, *supra* note 189, at 11.
341. *See, e.g.*, RESTATEMENT I, *supra* note 46, at 28, 41.
342. *See, e.g.*, *id.*
343. LAWS OF KENYA, Ch. 63, §§ 231, 234, 250, 251.
344. Jackson, *supra* note 112, at 197.
345. LAWS OF KENYA, Ch. 63, § 144(1).
346. Gitau v. Republic, (1982-1988) 1 KAR 148, 149 (1983). On the facts in this case, the Court of Appeal found that the act of stripping a woman naked constitutes indecent assault, and marching a woman naked in a street aggravated the indecent assault.
347. The penalty for this misdemeanor is imprisonment for one year. LAWS OF KENYA, Ch. 63, § 144(3).
348. Approximately 16% of the population is between 10 and 14, and 10% is between 15 and 19. NAT'L COUNCIL FOR POPULATION & DEV., *supra* note 4, at 7.
349. Memorandum from Jane Kiragu, Project Director, International Federation of Women Lawyers (FIDA) Kenya Chapter, June 17, 1996 (on file at The Center for Reproductive Law and Policy).
350. Ministry of Health, *supra* note 57, at 28.
351. Smith, *supra* note 190, at 119. It is believed that more than three quarters of the ethnic groups in Kenya practice FGM. MAENDELEO YA WANAWAKE ORGANIZATION, A REPORT ON HARMFUL TRADITIONAL PRACTICES THAT AFFECT THE HEALTH OF THE WOMEN AND THEIR CHILDREN IN KENYA 2 (unpublished report on file at The Center for Reproductive Law and Policy).
352. Hope Lewis, *Between IRUA and "Female Genital Mutilation": Feminist Human Rights Discourse and the Cultural Divide*, 8 HARV. HUM. RTS. J. 1, 40 (1995).
353. 13 ANN. REV. OF POPULATION L., 1986, at 225 (Reed Boland & Jan Stepan eds., 1989).
354. *Id.*
355. *Moi: Stop Girl Circumcision*, KENYA TIMES, Dec. 30, 1989, at 1.
356. Ladin, *supra* note 189, at 12.
357. SMITH, *supra* note 190, at 119.
358. *Bid to outlaw female circumcision defeated*, DAILY NATION, Nov. 14, 1996, at 16 (Kenya).
359. LAWS OF KENYA, Ch. 63, §§ 231, 234, 250, 251.
360. LAWS OF KENYA, Ch. 150, § 35(2).
361. *Id.* § 19. In the absence of a person having lawful custody residing in Kenya and capable of consenting to the marriage, substitute consent may be given by the Minister, a judge of the Supreme Court, or a Provincial Commissioner. *Id.* § 21. If any person whose consent to a marriage is required refuses to consent, the Supreme Court may, on application being made, consent to the marriage. *Id.* § 22.
362. LAWS OF KENYA, Ch. 157, § 3(1)(c).
363. *Id.* § 3(1)(d).
364. ASGHAR ENGINEER, THE RIGHTS OF WOMEN IN ISLAM 110 (1992).
365. *Id.* at 110-11.
366. RESTATEMENT I, *supra* note 46, at 10.
367. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, arts. 1.92, 1.94, 1.98, at 30-31, 33.
368. Florida A. Karani, *Educational Policies and Women's Education*, *in* WOMEN AND LAW IN KENYA 23, 27 (Mary Adhiambo Mbeo & Oki Ooko-Ombaka eds., 1989). Some of the reasons advanced for the low rate of girl's secondary school enrollment include: child marriage; adolescent pregnancy; a failure of most technical facilities to provide boarding facilities for women; school fees at secondary level, which often exceed the income of the average family; and household responsibilities. *Id.* at 26; Ladin, *supra* note 189, at 12.
369. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, art. 11.162, at 255.
370. *Id.* art 11.163, at 255-56.
371. GOV'T OF KENYA, ECONOMIC REFORMS FOR 1996-1998: THE POLICY FRAMEWORK PAPER 35-36 (1996).
372. Memorandum from Jane Kiragu, *supra* note 349.
373. NATIONAL DEVELOPMENT PLAN FOR THE PERIOD 1994 TO 1996, *supra* note 72, art. 12.20, at 266.
374. LAWS OF KENYA, Ch. 63, § 145. A person convicted of unlawful intercourse with a girl under the age of 14 years is liable to imprisonment with hard labor for 14 years together with corporal punishment, while a person who attempts to have unlawful sexual intercourse with a girl under the age of 14 years is liable to imprisonment with hard labor for five years, with or without corporal punishment. *Id.*
375. *Id.* §§ 144, 164.
376. LAWS OF KENYA, Ch. 63, §§ 144(2), 145(2).
377. *Id.* §§ 149, 166.
378. *Id.* § 149. A similar offense committed against a girl above the age of 13 and under the age of 16 years constitutes a misdemeanor. *Id.* § 150.
379. *Id.* § 166(1).

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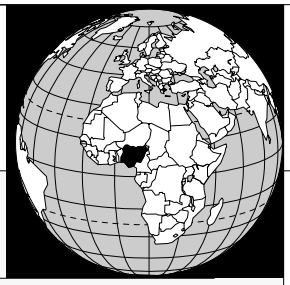
5. Nigeria



Statistics

GENERAL

Population

■ Nigeria, the most populous nation in Africa, has an estimated 112 million people, of which approximately 53.8 million are women.[1] The average annual population growth rate is 2.9%.[2]

■ About 48% of the population is below the age of 15.[3]

■ In 1993, 38% of Nigerians resided in urban areas, and the urban growth rate from 1980 was 5.5%.[4]

Economy

■ The estimated annual gross national product ("GNP") per capita for 1993 was U.S.$300.[5] From 1980 to 1993 the average annual GNP growth rate was -0.1%, and the average annual rate of inflation was 20.6%.[6]

■ From 1980 to 1993 the average annual growth rate of the gross domestic product ("GDP") was 2.7%, about half what it was during the 1970s.[7]

■ From 1970 to 1993, Nigeria's expenditure of the GDP on industry rose from 14% to 43%, while its expenditure on agriculture declined from 41% to 34%.[8]

■ Nigeria's expenditure of the total budget on health in 1987 was 0.8%.[9]

Employment

■ In 1993, the labor force was estimated to be 45.6 million people, of which 34.3% were women.[10]

■ The unemployment rate for the total population was estimated at 28% for 1992.[11] The overall unemployment rate reported by the Nigerian government for the middle of 1995 was 1.8%.[12] The majority of the unemployed are between the ages of 15 and 24.[13]

WOMEN'S STATUS

■ In 1996, life expectancy was projected to be 55 years for women and 53 years for men.[14]

■ Polygamy is common. Approximately 42.6% of all married women are in polygamous unions and 56.7% are in monogamous unions.[15]

■ According to 1990 estimates, literacy rates were between 31%[16] and 39% for women, and 51% for the total population.[17]

■ The number of prison admittances for sex offenses in 1993 was 430, a significant decrease from the 1,201 admittances in 1990.[18]

ADOLESCENTS

■ In 1988, only 76% of girls and 74% of boys reached grade four in school.[19] An estimated 76% of primary school–aged children were actually enrolled, with only 67% of girls enrolled. These figures decline drastically by secondary school, to a total enrollment of 20% and a female enrollment of 17%.[20]

■ The average age at first sexual intercourse for all women is 15.9 years.[21]

■ The median age at first marriage is 16 years.[22]

■ Half of all women have children by the age of 20,[23] and 17% of all births in 1993 were to women under the age of 20.[24]

■ Approximately 40% to 50% of Nigerian women have undergone FGM.[25]

MATERNAL HEALTH

■ In 1992, it was estimated that each Nigerian woman would have an average of six children during her lifetime.[26]

■ Maternal mortality estimates for Nigeria are among the highest in the world. Studies indicate maternal mortality rates ranging from 800 to 1,500 deaths per 100,000 live births.[27]

■ The infant mortality rate is approximately 83 deaths per 1,000 births.[28]

CONTRACEPTION AND ABORTION

■ Total contraceptive prevalence is 7.5% and the use of modern contraceptive methods is 3.8%.[29]

■ Among women who use contraception, the most common modern methods of contraception are the pill (29.7%) and injectables (24.3%).[30]

■ A community based study in 1987 revealed that 34.8% of women who underwent abortion were married, and 52.2% had two or more children.[31]

■ Of the estimated annual 50,000 maternal deaths, approximately 20,000 result from the complications of unsafe induced abortions.[32] Complications from illegal abortions account for approximately 50% of all maternal deaths.[33]

HIV/AIDS AND STDs

■ In a study of three cities in Nigeria, the four most common STDs were non-specific genital infection (59.4%), gonorrhea (19.2%), candidiasis (10.5%), and trichomoniasis (10.5%).[34]

■ As of June 1996, there were 5,500 reported cases of AIDS.[35] Sero-prevalence rates for HIV were estimated in 1994 to be 3.8% of the general population; however, these figures are thought to be underreported.[36]

■ Of the total number of Nigerians who test positive for HIV, 96% are adults (over age 20) and 67% are males.[37]

ENDNOTES

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2. World Bank, World Development Report 1995: Workers in an Integrating World 210 (1995) [hereinafter World Development Report 1995].
3. U.N. Population Fund (UNFPA), Programme Review and Strategy Development Report: Nigeria 7 (1991) [hereinafter Nigeria/UNFPA].
4. World Development Report 1995, *supra* note 2, at 222.
5. World Bank, World Tables 1995, at 513 (1995) [hereinafter World Tables 1995].
6. World Development Report 1995, *supra* note 2, at 162.
7. *Id*. at 164.
8. *Id*. at 166.
9. *Nigeria Country Report, supra* note 1, at 65.
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13. *Id*.
14. PPF Country Programme, *supra* note 1, at tbl. A1.
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19. World Development Report 1995, *supra* note 2, at 218.
20. *Id*. at 216.
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26. NDHS 1990, *supra* note 1, at 23.
27. Chinyelu B. Okafor and Rahna R. Rizzuto, *Women's and Health-Care Providers' Views of Maternal Practices and Services in Rural Nigeria*, 25 Studies in Family Planning 353 (1994).
28. World Tables 1995, *supra* note 5, at 515.
29. PPF Country Programme, *supra* note 1, at 147.
30. *Id*. at 148.
31. International Planned Parenthood Federation, Unsafe Abortion and Post-abortion Family Planning in Africa: The Mauritius Conference at 9 (1994).
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33. World Health Organization, Maternal Health and Safe Motherhood Programme, Abortion: A Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion 33 (2d ed. 1994).
34. Bamikale Feyisetan, Prevalence of Sexually Transmitted Diseases in Nigeria: Background Paper 10 (1994) (unpublished paper on file with The Center for Reproductive Law and Policy) [hereinafter Prevalence of STDs].
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36. *Id*.
37. Prevalence of STDs, *supra* note 34, at 22.

In 1960, the Federal Republic of Nigeria ("Nigeria") achieved independence within the British Commonwealth. In 1963, the country assumed a representative form of government.[1] Following a military coup in 1966, Nigeria was governed by a succession of military regimes, only broken by a brief return to civilian rule from 1979 to 1983.[2] After canceling the results of elections held in 1993, the current military regime led by General Sani Abacha has indefinitely postponed the return to civilian government.[3]

Nigeria is Africa's most populous nation, with an estimated 112 million inhabitants, including approximately 53.8 million women.[4] Nigeria is comprised of over 300 ethnic groups.[5] The dominant tribes are the Hausa and Fulani in the northern regions, the Yoruba in the southwest, and the Ibos in the southeast.[6] Christianity and traditional beliefs predominate in the south, while much of the northern population is Muslim.[7] Over 200 regional languages and dialects are spoken in Nigeria.[8] The official languages are English, Hausa, Yoruba, and Ibo.[9]

I. Setting the Stage: The Legal and Political Framework

To understand the various laws and policies affecting women's reproductive rights in Nigeria, it is necessary to consider the legal and political systems of the country. Without this background, it is difficult to determine the manner in which laws and policies are enacted, interpreted, modified, and challenged. The passage and enforcement of law often involves specific formal procedures. Policy enactments, however, are not subject to such a process.

A. THE STRUCTURE OF GOVERNMENT

Nigeria is a federation of 36 states and one Federal Capital Territory (Abuja).[10] The states are further subdivided into 589 local government areas.[11] The Nigerian government is thus structured in three tiers: federal, state, and local. The federal government defines and monitors national policy, while state and local governments are charged with implementing such policies.[12] Traditional rulers provide essential support to state and local governments in the implementation of national policy in Nigeria.[13] The 1979 Constitution (the "Constitution") establishes state Councils of Chiefs to advise state governments on cultural and customary legal issues and to assist in the processes of government.[14]

The Nigerian government is under centralized military administration. Although the Constitution provides for three independent branches of government — the executive, legislative, and judicial — the military regime has suspended the legislature's activities by decree and limited the scope of the judiciary's power, especially with regard to the review of constitutional issues and the protection of human rights.[15] Under the present government, the executive is controlled by the president, who heads the military government and is commander in chief of the armed forces.[16] The civilian cabinet was dissolved in 1995. Currently, a Provisional Ruling Council ("PRC"), formerly the Armed Forces Ruling Council, has assumed the legislative function.[17] At the state level, the executive and legislative functions are performed by military governors, who have been installed by the central military regime.[18] All acts of the military regime, including the promulgation of decrees, are not subject to review by the courts.[19]

Courts both create and interpret law. The judicial system can have significant impact on legislation, including that affecting reproductive rights, because it is able to enforce the law and deal with complaints from individuals challenging the constitutionality of specific laws. However, with the current system of military decrees, the power of the court system is significantly weakened.

The Supreme Court of Nigeria is the highest court in the federal system. It has original jurisdiction over disputes between states and between states and the federal government, and appellate jurisdiction over cases appealed from the lower federal courts and the highest state courts.[20] Each state has its own court system, which include Magistrates' or District Courts as the courts of first instance in civil and criminal cases, and a High Court with original and appellate jurisdiction.[21] Pursuant to the Constitution, states may also establish lower and appellate customary courts with limited jurisdiction over civil disputes.[22] In the northern states, separate Sharia courts hear appeals involving Islamic personal law.[23] Judges in the state and federal court system, including justices of the Supreme Court, do not have secured tenure and are removable at the will of the federal government, as is also the case with other civil service officers.[24]

B. SOURCES OF LAW

Domestic Sources of Law

Laws that affect women's legal status — including their reproductive rights — derive from a variety of sources. In Nigeria, military decrees determine the validity of all laws, including the Constitution.[25] The Nigerian legal system is based on English common law, statutory law, Islamic law, and tribal customary law.[26] Pursuant to state and federal legislation, courts may not enforce customary laws that are "repugnant to natural justice, equity and good conscience," "incompatible

either directly or by implication with any law…in force," or "contrary to public policy."[27] Two sets of criminal laws are in force in Nigeria: the Criminal Code,[28] which applies to the southern states of Nigeria, and the Penal Code,[29] applicable in the northern states. Although the two codes are similar in content, the Penal Code reflects the values of the predominantly Muslim population of the north.[30]

International Sources of Law

Because international instruments are legally binding, they create an obligation on the part of the government to undertake numerous actions, including those at the national level. A number of international human rights treaties, particularly the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), recognize and promote specific reproductive rights. The government of Nigeria is a party to various international legal instruments, including, *inter alia*: the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights;[31] the CEDAW;[32] the International Convention on the Elimination of All Forms of Racial Discrimination;[33] the Convention on the Rights of the Child;[34] and the African Charter on Human and Peoples' Rights.[35]

II. Examining Reproductive Health and Rights

Issues of reproductive health and rights are dealt with in Nigeria within the context of the country's health and population policies. Thus, an understanding of reproductive rights in Nigeria must be based on an examination of those policies.

A. HEALTH LAWS AND POLICIES

The Nigerian government estimates that 40% of the population has access to health facilities.[36] In 1992, there was roughly one doctor for every 3,867 people.[37] Approximately one third of all births are attended by a doctor, nurse, trained midwife, or traditional birth attendant.[38]

Objectives of the Health Policy

The Federal Ministry of Health (the "Federal MOH") is responsible for establishing health policies.[39] In 1988, the Nigerian government adopted the National Health Policy and Strategy To Achieve Health for All Nigerians (the "National Health Policy"), which articulates the goal of enabling all Nigerians to achieve socially and economically productive lives.[40] According to the National Health Policy, health is an "essential component of social and economic development as well as being an instrument of social justice and national security."[41] The policy seeks to equitably distribute health care and to disseminate information to underserved communities.[42]

Since 1975, the Nigerian government has utilized a Primary Health Care ("PHC") approach to the provision of national health care.[43] PHC is defined in the National Health Policy in accordance with World Health Organization guidelines to include general health services, preventive, curative, promotive, and rehabilitative care.[44] Although the National Health Policy does not specifically provide for reproductive health care, PHC encompasses basic treatment, maternal and child health ("MCH") and family planning services, the prevention and control of infectious diseases, and the provision of essential drugs and supplies.[45] The National Health Policy establishes PHC as an "integral part of the national health system" and a priority for national development.[46] In 1992, the importance of the PHC system was reinforced by the establishment of the National Primary Health Care Development Agency ("the Agency").[47] The Agency seeks to implement the National Health Policy by revising existing health policies where necessary, translating policies into feasible strategies, and providing technical support to the management of the PHC system.[48]

The National Health Policy assigns responsibility for the implementation of health policies to the Federal MOH and state Ministries of Health ("State MOHs").[49] The Federal MOH oversees national strategies for the provision of health care, directing federal resources for health programming, drafting national health legislation, and monitoring the health status of citizens.[50] State MOHs control state funds and resources, and draft enabling legislation at the state level.[51]

Infrastructure of Health Services

Since 1946, the Nigerian government has been involved in the provision of health care.[52] The Federal MOH establishes service delivery guidelines and coordinates the efforts of state governments and the private sector.[53] However, the actual provision of basic health care is assigned to local governments under the supervision of State MOHs.[54] The Nigerian health system consists of over 12,000 health care institutions, nonprofit service providers, and for-profit medical providers, as well as commercial pharmaceutical outlets and traditional medical practitioners.[55] The Nigerian public health care system provides health care at three levels.

The primary level of care in Nigeria provides a range of medical services through the PHC program.[56] PHC services are administered by local governments and delivered by 1,071 local government and private health centers, clinics, dispensaries, first aid stations, and maternity centers.[57] These service centers offer basic care, health education, simple laboratory tests, and preventive care services. MCH services offered by such centers as part of the primary level of care include: prenatal and postnatal care for mothers; family planning; immu-

nization for children; oral rehydration therapy; nutritional education; and treatment of minor childhood ailments.[58] Traditional healers and trained community health workers also provide essential care, minimal or traditional family planning, and MCH services.[59] Primary level service providers are the "entry point" into the Nigerian health care system, referring patients to institutions at the secondary and tertiary levels of care for specialized services.[60]

There are two additional levels of health care — secondary and tertiary. The secondary level of care, based at the state level, is provided by 119 district hospitals and 780 general hospitals.[61] Secondary level care providers offer comprehensive community-based health care with greater laboratory and facility support than at the primary level.[62] State institutions provide models for the delivery of PHC services and supervise primary care provision within the local government areas.[63]

The Federal MOH is responsible for policy formulation, technical assistance, and provision of services in tertiary health institutions.[64] Highly specialized services, mainly focusing on curative care, are available at 13 teaching hospitals and other tertiary health institutions, which are primarily based in urban areas.[65]

Cost of Health Services

Nigeria has no social security system.[66] The National Health Policy commits state and local governments to the provision of health subsidies for preventive care and additional public assistance for low-income individuals.[67] In its 1996-97 budget, the federal government allocated N 30 billion (approximately U.S.$380 million) of a special petroleum trust to fund improvements in roads and the supply of basic medicines in rural areas.[68] In 1987, the last year for which full budget figures were available, health expenditures comprised 0.8% of the national budget compared to a 2.5% average spent in 1987 by the public sector in sub-Saharan Africa.[69]

Regulation of Health Care Providers

Who is legally permitted to provide what types of care? Are there meaningful guarantees of quality control? Because the Nigerian government regulates these issues, reviewing such laws is important. The medical and dental professions are regulated by the Medical and Dental Practitioners Decree of 1988[70] (the "1988 Decree"). Pursuant to the 1988 Decree, all medical and dental practitioners must be registered in Nigeria.[71] The 1988 Decree establishes a regulatory council (the "Medical and Dental Council"), which is responsible for determining standards for the training and qualifications of health providers in Nigeria.[72] In addition, the Medical and Dental Council is responsible for the preparation and review of a professional code of conduct reflecting current standards of practice.[73] The 1988 Decree also establishes a disciplinary tribunal and an investigating panel that may initiate an inquiry into the conduct of any registered health professional.[74] The provisions of the 1988 Decree do not affect the nonsurgical practices of traditional medical practitioners who have received community recognition as practitioners trained in "the system of therapeutic medicine traditionally in use."[75] However, any unregistered person who performs an "activity involving an incision in human tissue" in return for a fee or reward is subject to a fine up to N 10,000 (U.S.$127).[76]

The practice of nursing and midwifery is regulated by the Nursing and Midwifery (Registration, etc.) Decree of 1979[77] (the "1979 Decree"). The 1979 Decree establishes a Nursing and Midwifery Council that determines standards for professional qualifications and conduct and oversees internal disciplinary procedures.[78] All nurses and midwives in Nigeria must be registered with the Nursing and Midwifery Council.[79] Pharmacists are regulated under the Pharmacists Council of Nigeria Decree of 1992.[80]

Patients' Rights

Nigerians have access to limited legal protection against medical malpractice. Medical practitioners may incur civil liability for professional negligence or malpractice.[81] In addition, criminal laws seek to protect individuals against "grievous harm."[82] While there is no significant body of law protecting patients' rights, a few policies seek to ensure quality health services by protecting the rights of patients. The Medical and Dental Council of Nigeria has published ethical guidelines governing professional conduct, the violation of which may result in disciplinary action by the council or suspension from practice.[83] The guidelines prohibit public disclosure of patient information relating to "criminal abortion, veneral [sic] disease, attempted suicide, concealed birth and drug dependence" unless required by law.[84] The council guidelines also state that medical practitioners "must desist from compulsory treatment of a patient in the absence of illness…[and] must always obtain consent of the patient or the competent relatives or seek another professional opinion, before embarking on any special treatment procedures with determinable risks."[85]

B. POPULATION AND FAMILY PLANNING

The Population and Family Planning Policy

Nigeria's population policy provides the framework within which its family planning services are provided. In 1988, in response to the perceived adverse socioeconomic consequences of rapid population growth, the government adopted the National Policy on Population for Development, Unity, Progress and Self-Reliance[86] (the "National Policy on Population"). This policy is designed to achieve the primary

goals of decelerating the rate of population growth and improving standards of living.[87] This voluntary policy is predicated upon the principle that couples and individuals have the right to determine the number and the spacing of their children.[88] The National Policy on Population identifies several objectives, including: promoting awareness of population problems and the effects of rapid population growth on development; providing information on the benefits of reasonable family size; making family planning services easily accessible to all couples and individuals at an affordable cost; and educating youth on matters relating to sexuality, fertility regulation, and family planning.[89]

The National Policy on Population seeks to achieve a number of specific objectives, many of which are set forth in quantitative terms. These targets include:[90]

- Reducing the proportion of women who marry before the age of 18 by 50% by 1995, and by 80% by 2000;
- Reducing the number of children a woman bears over her lifetime from the prevailing average of above six children to an average of four children;
- Reducing the proportion of women bearing more than four children by 50% by 1995, and by 80% by 2000;
- Reducing the present rate of population growth from about 3.3% per year to 2.5% by 1995, and to 2.0% by 2000;
- Extending the family planning coverage to 50% of women of childbearing age by 1995, and to 80% by 2000;
- Reducing the infant mortality rate to 50 per 1,000 live births by 1990, and to 30 per 1,000 live births by 2000;
- Reducing the crude death rate to 100 per 1,000 by 1990, and to 80 per 1,000 by 2000; and
- Providing 50% of rural communities with basic social amenities by 1990, and 75% by 2000, to stimulate and sustain self-reliant development.

The policy also contains non-numerical targets such as ensuring access to services for high-risk clients, including women under the age of 18 or over the age of 35, those with four or more children, or those with chronic illnesses that increase the health risk of pregnancy.[91] In addition, the policy seeks to expand family life education and programming to increase the use of family planning services by men and adolescents.[92]

Nigeria's population policy identifies a number of strategies with which to meet its objectives. One strategy is to embark on an aggressive information and communication campaign to educate individuals about the importance of maintaining a reasonable family size both for personal and national welfare.[93] The policy also proposes to encourage the use of family planning methods by raising the status of women and easing their employment burden.[94] These measures include: the establishment of day care centers; the promulgation of legislation to eliminate discrimination against women in education and employment; and educational efforts to increase the age of marriage to 18 years.[95]

The National Policy on Population devotes an entire section to the implementation of national MCH programming. The objective of the policy in this section is to "reduce the current high childhood and maternal morbidity and mortality rates, especially in the rural and suburban areas."[96] Several strategies to improve maternal and child health are set forth: increasing the emphasis on MCH care within the PHC system, as well as the promotion of breast-feeding, nutrition, clean water, sanitation, immunizations, birth spacing, fertility regulation, and family planning services; reducing the incidence of high-risk births, which include births to women below the age of 18 or over the age of 35, births at intervals of less than two years, and more than four births to one woman; and promoting research into traditional health care methods.[97]

The National Policy on Population is primarily administered by the Federal MOH.[98] The Department of Population Activities ("DPA") is responsible for planning most of the activities at the federal level and ensuring adequate coordination of population programs at all levels.[99] The National Consultative Group on Population for Development and the Population Working Group assist in the implementation of population programming.[100] Family planning has been introduced into state health care delivery systems, resulting in 1987 in the creation of a family planning coordinator in each state.[101]

Pursuant to the Constitution,[102] the federal government established a National Population Commission to monitor the national population policy, provide information and data on population to facilitate national development planning, and advise the federal government on population-related programming.[103]

Government Delivery of Family Planning Services

From 1983 to 1989, the nation's first public family planning program was implemented.[104] Family planning services are provided through the PHC system and are available at approximately 20% to 25% of MCH facilities.[105] Although the National Health Policy defines family planning to include education, counseling, the provision of information on child spacing, and fertility treatment, most government facilities only distribute contraceptives.[106] Government providers supply approximately 37% of modern contraceptives in

Nigeria, including condoms, spermicides, intrauterine devices ("IUDs"), injectables, and the pill.[107] Government family planning clinics require a N 50 (approximately U.S.$0.63) fee for registration and N 100 (approximately U.S.$1.25) for disbursement of the contraceptive.[108] Despite governmental efforts, there is often a shortage of contraceptives at health clinics.[109] Furthermore, because the PHC system is primarily located in urban and semirural areas, the availability of modern contraceptives in rural areas is extremely limited.[110]

C. CONTRACEPTION

Total contraceptive prevalence is 7.5%, and the use of modern methods is 3.8%.[111] Among married women, the most common modern methods of contraception are the pill (29.7%) and injectables (24.3%). The private sector is the primary source of contraceptives for women in Nigeria.[112]

Legal Status of Contraceptives

There is no law that explicitly regulates the sale or use of contraceptive drugs and devices. However, the National Policy on Population states that "[n]ational family planning programmes shall make available a variety of methods of fertility regulation to ensure free and conscious choice by all couples."[113] The availability of contraceptives at government distribution centers indicates that contraceptive use and distribution is legal in Nigeria. In fact, a wide assortment of contraceptive devices and procedures, including pills, injectables, IUDs, diaphragms, foams, jellies, condoms, and female and male sterilization are available.[114]

The Nigerian government does not have a policy directed specifically at the safety requirements of contraceptive drugs and devices. However, the Food and Drugs Act prohibits misleading labeling and advertising practices.[115] This act authorizes the Minister of Health to require manufacturers of drugs to furnish information on a drug's chemical composition, its intended use, the results of clinical investigations, and any adverse effects on health.[116] Devices or drugs may not be imported into Nigeria unless they are accompanied by a certificate that guarantees that they comply with Nigerian standards and the standards of the country in which they are manufactured.[117] Any person who contravenes the requirements of the Food and Drugs Act is subject to imprisonment for two years or to a fine.[118]

Regulation of Information on Contraception

No law prohibits the advertising of contraceptives or the distribution of contraceptive information. However, advertisements or other published material concerning contraceptive use must not contravene laws prohibiting the publication or distribution of "obscene" materials. Materials which "tend to deprave and corrupt" may be deemed obscene and prohibited.[119]

D. ABORTION

Legal Status of Abortion

The performance of an abortion in Nigeria is a criminal offense unless it is performed to save a pregnant woman's life. As stated earlier, criminal law in Nigeria is bifurcated. The Criminal Code applies to the southern states and the Penal Code applies to the northern states.[120] The Criminal Code and the Penal Code provisions treating the subject of abortion are similar and refer to the inducement or procuration of a "miscarriage."[121] Abortions are illegal regardless of duration of pregnancy; the laws prohibit abortions performed at all stages of fetal or embryonic development from the time of fertilization.[122]

The Penal Code regards the performance of most abortions as a criminal act. It states that any person who "voluntarily causes a woman with child to miscarry"[123] may be punished by imprisonment. A woman who causes herself to miscarry is considered to be within the meaning of the provision.[124] Under the Penal Code, a woman must actually be pregnant for the crime of abortion to have occurred. In contrast, under the Criminal Code the crime of abortion only requires intent to commit the act.[125] Nigerian law permits the performance of an abortion only if it is necessary to save a woman's life. The Criminal Code stipulates that a person "is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation…upon an unborn child for the preservation of the mother's life."[126] Similarly, the Penal Code permits an abortion to save the life of a woman.[127] However, the laws do not clearly distinguish between abortions performed by registered medical practitioners and unregistered medical practitioners, and do not stipulate the kind of facility in which abortions may take place.[128]

Laws cover other abortion-related offenses. For example, in southern Nigeria the Criminal Code provides that it is illegal to supply materials knowing that they may be used unlawfully to "procure the miscarriage of a woman."[129] The Penal Code provides that any person who, with intent to cause a "miscarriage," undertakes any act that causes a woman's death is subject to imprisonment for 14 years.[130] It also makes it unlawful for a person to "use force to any woman and thereby unintentionally caus[e] her to miscarry."[131]

Requirements for Obtaining Legal Abortion

Spousal consent is not a requirement for operations necessary to save a woman's life, but it is commonly required by medical establishments in Nigeria.[132] The government does not subsidize abortion services and abortions are not available in most public health facilities.[133]

Penalties

Both the Criminal Code and the Penal Code impose a penalty of 14 years of imprisonment for the performance of an abortion. In addition, upon conviction for the performance of and abortion, a medical practitioner may have his or her license suspended or may be subject to other disciplinary action.[134] Under the Criminal Code, a woman who consents to the performance of an illegal abortion or attempts to self-induce an abortion may be punished by seven years of imprisonment.[135]

E. STERILIZATION

Sterilization is legal in Nigeria. Although "emasculation" is regarded as a "grievous harm" in the Penal Code, the law exempts surgical operations that are performed in good faith and with reasonable care from prosecution as a crime.[136] The Criminal Code contains similar provisions.[137] In 1992, the government confirmed in a report to the United Nations Population Fund that sterilization in Nigeria is legal if performed for life, health, eugenic, or contraceptive purposes.[138] Sterilization is not a common method of contraception in Nigeria; women who have elected female sterilization comprise fewer than four percent of female contraceptive users.[139]

Requirements

Sterilization is available in government health institutions and teaching hospitals.[140] In addition, missionary organizations such as the Nongo U Kristu U Ken Sudan Hen Tiv ("NKST") provide family planning services, including sterilization, in rural health facilities.[141] All surgical operations must be performed by registered practitioners in Nigeria.[142] It is common for Nigerian medical practitioners to require spousal consent for female sterilizations.[143]

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

The practice of female genital mutilation ("FGM") — also referred to as female circumcision — is prevalent among most major ethnic groups in Nigeria, affecting approximately half of Nigerian women.[144] Several forms of FGM are common in Nigeria, including scarification, infibulation, and introcision (involving cuts into the vaginal wall).[145] An estimated 85% of FGM operations are performed by traditional birth attendants, barbers, or traditional medical practitioners.[146]

Currently, there is no law in Nigeria that prohibits FGM.[147] Although the Constitution recognizes the "sanctity of the human person" and prohibits torture and inhuman or degrading treatment, there has been no constitutional challenge the the customary practice of FGM.[148] Prior to 1987, federal and state governments did not even address the issue of FGM. At that time, the National Association of Nigerian Nurses and Midwives ("NANNM") launched a 10-year campaign to educate and mobilize women health professionals and other non-governmental organizations with regard to the health consequences of FGM. The campaign set as its goals the achievement of an 80% reduction in FGM prevalence by 1997, and complete eradication by the year 2002.[149] The NANNM project has also instigated the revision of medical and nursing school curricula, as well as training material for midwives, to include information about FGM.[150] For further discussion regarding FGM, see section on adolescents below.

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

Examining HIV/AIDS issues within a reproductive health framework is essential insofar as the two areas are interrelated from both a medical and public health standpoint. Hence, a full evaluation of laws and policies affecting reproductive health and rights in Nigeria must examine HIV/AIDS and sexually transmitted diseases ("STDs").

AIDS was first reported in Nigeria in 1986.[151] In 1994, the prevalance rate for HIV was reported to be 3.8% of the population; as of June 1996, government authorities had confirmed 5,500 cases of AIDS.[152] The prevalence of STDs is generally not reported in Nigeria, especially among women.[153] There are no governmental mandates or policies regarding such prevalence.[154] Moreover, studies have indicated that the high cost of health care in Nigeria and regional disparities with regard to access to health facilities significantly affects levels of self-reportage and participation in treatment programs.[155]

Laws Affecting HIV/AIDS and STDs

Currently, no laws deal specifically with AIDS, HIV, or STD transmission.[156]

Policies Affecting Prevention and Treatment of HIV/AIDS and STDs

Nigeria has not been able to address the AIDS epidemic in a significant manner.[157] Since 1986, the country has, however, attempted to coordinate governmental responses to the epidemic, and has implemented HIV, AIDS, and STD prevention activities pursuant to its National AIDS and STD Control Program ("NASCP"). NASCP's Second Medium-Term Plan sets forth four strategic objectives: prevention of HIV infection; reduction of the personal and social impact of HIV/AIDS in HIV-positive individuals and their families; reduction of the impact of HIV/AIDS on society; and the mobilization of efforts and resources to combat HIV/AIDS.[158]

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that will affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health care and her ability to make voluntary, informed decisions about such care. Laws regarding age of first marriage can also have a significant impact on a young woman's reproductive health. Furthermore, rape and other laws prohibiting sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health.

A. RIGHTS WITHIN MARRIAGE

Marriage law

Three types of marriage — customary, Islamic, and civil — are recognized in Nigeria. Marriages adhering to customary or civil law are legally valid throughout the country.[159] In the northern states, marriages under Islamic law are also legally recognized.[160] Pursuant to customary and Islamic law, marriages may be polygamous; Islamic law in Nigeria permits a man to have up to four wives.[161]

Under customary law, marriages are arranged between families, and the prospective suitor is often required to pay a bride-price to the bride's family.[162] Within customary marriages, traditions requiring women to undergo harsh and burdensome rites at widowhood, and the periodic ritual seclusion of women, are prevalent.[163] Under Islamic law in northern Nigeria, the father of a woman retains the "right" (*ijbar*) to arrange the marriage of his virgin daughter, regardless of her age and without her consent.[164] Islamic law marriage involves a dower paid directly to the woman to be married.[165] In the northern states, the customary seclusion of women is particularly rigorous and may restrict women's movement outside of their homes even in emergency situations.[166]

Under civil law, marriage must be monogamous, and, unlike the other two types of marriage, it must be registered.[167] In a civil or customary marriage, the spouses have a reciprocal duty to maintain each other as well as any children of the union.[168] Valid civil marriages in Nigeria must be voluntarily entered into by both parties.[169] In southern Nigeria, forced marriage under any system of law is formally prohibited by law as a criminal offense, punishable by imprisonment for up to seven years.[170] Despite this prohibition, women in the southwestern regions may be compelled to marry the local *oba* (king).[171] Arranged marriages are also common in rural areas of the south.[172]

For a discussion on marriage and adolescents, see section on adolescents below.

Divorce and Custody Law

Like marriage, divorce is regulated by various laws. The dissolution of civil marriages is governed by the 1970 Matrimonial Causes Act[173] (the "1970 Act"). Pursuant to the 1970 act, a civil divorce may only be granted on the ground that the marriage has broken down "irretrievably."[174] An exclusive list of situations satisfy this condition: the willful and persistent refusal to consummate the marriage;[175] adultery that is "intolerable";[176] the absence of consortium for two or more years;[177] desertion lasting at least one year;[178] and marital behavior such that "the petitioner cannot reasonably be expected to live with the respondent."[179] The 1970 Act states that unreasonable marital behavior includes the failure to pay maintenance for at least two years and the commission of sexual assault, including rape.[180]

Customary and Islamic law marriages, which are not governed by the 1970 Act, may be dissolved either nonjudicially in accordance with customary law or in Sharia courts.[181] In northern Nigeria, a man married under Islamic law may divorce his wife unilaterally by repeating the phrase "I divorce you" three times (the *talaq*). Such action is not available to women.[182] However, Islamic law does provide that a woman may divorce her husband with his consent if she returns the dower payment to him.[183] In considering the grounds for divorce, Sharia courts may take into account, *inter alia*, any failure to pay maintenance, a prolonged absence, or the infliction of harm.[184] Available grounds for divorce are not defined under non-Islamic customary law.[185] Many customary law courts will consider as relevant: adultery; cruelty; desertion; and impotence, sterility, or the presence of any reproductive health problem.[186] At the dissolution of a customary law marriage, the parties must refund a portion of the bride-price or dower payments that were made.[187]

Pursuant to the 1970 Act, courts may determine custody and maintenance disputes within civil, customary, and Islamic marriages.[188] In any custody dispute, the 1970 Act provides that the interests of the child shall be paramount.[189] In determining responsibility for spousal and child maintenance, courts may consider the "means, earning capacity and

conduct" of each party, as well as "all other relevant circumstances."[190] However, irrevocable divorce under Islamic law and any divorce under customary law terminates all rights of spousal maintenance.[191]

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

There are no formal laws restricting women's rights to own property in Nigeria.[192] An 1882 law in force in many Nigerian states affirms the capacity of a married woman to hold, acquire, and dispose of property.[193] Because property acquired during a marriage is often presumed to belong to the husband or male head of the household, a woman often cannot demonstrate her rights in property without documentation of ownership or proof of her contribution to the purchase of the property.[194]

State laws and common law provisions governing intestate inheritance rights do not discriminate against women.[195] Moreover, under customary law, daughters may inherit from their parents' estates.[196] However, most systems of Nigerian customary law exclude widows from inheriting property in their own right, and widows often must enter into leviratic arrangements (in which the widow marries a member of her husband's family, such as a brother) to ensure the continuing support of their husband's family.[197] Under Islamic inheritance laws as practiced in northern Nigeria, one eighth of a man's estate is allocated to his surviving wife or wives.[198] The remainder of the estate is distributed so that male heirs receive twice the share of any female heirs.[199]

Labor Rights

The Constitution recognizes the principle of "equal pay for equal work without discrimination on account of sex" and seeks to eliminate discrimination "on any ground" in employment matters.[200] However, Nigerian women encounter informal discrimination in employment and often do not receive wages commensurate with those received by male coworkers.[201] Moreover, the Labour Act contains some provisions that — although designed to protect women — prohibit women from engaging in certain areas of employment, such as working at night or underground.[202] In 1990, less than 10% of Nigerian women were employed in nonagricultural jobs.[203] The Constitution also seeks to ensure working conditions that are "just and humane" and do not endanger worker health, safety, or welfare.[204] By law, all women are entitled to 12 weeks' maternity leave, during which period they must receive, at minimum, 50% of their regular wages.[205] In addition, the labor laws require employers to provide women workers with at least one hour each day to nurse their children.[206]

Access to Credit

No specific laws limit women's access to credit.[207] However, several obstacles exist for women who attempt to obtain credit in Nigeria that are attributable to discriminatory customary laws relating both to women's right to own property and the prevailing attitudes of major financial institutions and investors toward female applicants.[208] Women tend not to own real property that could serve as collateral for their loan applications.[209] Moreover, financial houses currently require married women to obtain their husband's support for their credit applications.[210]

Access to Education

The Constitution states that a fundamental objective of state policy is the provision of educational opportunity at all levels of schooling.[211] In its 1981 revised National Policy on Education, the government of Nigeria perceived an "imbalance" in female enrollment levels, and committed state and local governmental authorities to programming intended to encourage female attendance, particularly in primary, secondary, and technical schools.[212] The federal government has allocated funds to establish women's education centers in each local governmental area to promote educational opportunities for women.[213] For further discussion regarding education, see section on adolescents below.

C. RIGHT TO PHYSICAL INTEGRITY

Rape

Both Nigerian criminal codes define rape in similar terms. In southern Nigeria, the criminal code defines rape as "unlawful carnal knowledge of a woman or girl, without her consent."[214] Unlawful intercourse with a woman's consent also constitutes rape if the consent is obtained by force, fraud, threats, or "intimidation of any kind."[215] The laws in southern Nigeria also proscribe attempted rape as an offense.[216] In northern Nigeria, the Penal Code defines rape to be sexual intercourse with a woman against her will or without her consent, or sexual intercourse with a girl under the age of 14.[217] Furthermore, the Penal Code criminalizes consensual intercourse if the woman's consent was obtained through the use of threats to her life or threats of physical harm.[218] The punishment for rape under both codes is imprisonment for life.[219] "Carnal knowledge" and sexual intercourse are defined for the purposes of both codes as acts of penetration.[220] This definition excludes other sexual offenses, such as sodomy or the insertion of foreign objects into a woman's vagina, from the definition of rape.[221] Such acts may be prosecuted under the laws prohibiting "unnatural" sexual offenses,[222] assault,[223] "indecent assault,"[224] or acts of "gross indecency."[225]

In general, both criminal codes in Nigeria provide little protection against marital rape. Under the Criminal Code in southern Nigeria, intercourse between a husband and wife can never constitute rape.[226] Pursuant to the Penal Code in northern Nigeria, the definition of rape explicitly excludes the marital rape of a woman who has attained the age of puberty.[227] Women may receive limited protection from marital rape under the prohibitions against assault. In addition, the above provisions that preclude prosecution of marital rape do not apply to the rape of an estranged spouse.[228] For further discussion on sexual offenses against minors, see section on adolescents.

Domestic Violence

Incidents of domestic violence may be prosecuted under general criminal code provisions penalizing assault.[229] In northern Nigeria, it is permissible for husbands to "correct" their wives with physical punishment if it is lawful under the system of customary law to which the spouses adhere, and if the punishment is not "unreasonable in kind or in degree" or "does not amount to the infliction of grievous hurt."[230] In all states in Nigeria, a woman may use domestic violence as a ground for divorce if her husband has been convicted of grievously injuring her or attempting to seriously injure or kill her.[231]

Sexual Harassment

No laws deal explicitly with sexual harassment in Nigeria. However, criminal law in Nigeria prohibits "indecent assault," which is defined as an act of "gross indecency" committed against a person, without consent or by use of force or threats.[232] But pursuant to the Criminal Code, indecent assault committed against a woman is a lesser offense than indecent assault of a man, and the crime carries lower penalties.[233]

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

The needs of adolescents are often unrecognized or neglected. Given that approximately 22% of the Nigerian population is between the ages of 10 and 19,[234] it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescent rights, including those related to reproductive health, is important for women's right to self-determination as well as for their health.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

Adolescents are not legally restricted from access to contraceptives, but informal restrictions operate to limit contraceptive use.[235]

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

No laws in Nigeria either prohibit or explicitly address FGM. Yet several different forms of FGM are prevalent in Nigeria, and the age at which the operation may be performed varies. In some regions, the ritual is performed on children one week or a few years old; in other areas, young women may undergo FGM at marriage, during pregnancy, or at the birth of their first child.[236] Among these groups, excision or clitoridectomy of the pregnant woman is believed to protect the child during birth.[237] FGM may also be performed on young girls as part of traditional puberty rites.[238] As a result of educational and mobilization campaigns conducted by organizations of women health professionals and other non-governmental organizations, secondary school curricula have recently been revised to include information about the health consequences of FGM.[239]

C. MARRIAGE AND ADOLESCENTS

The average age at first marriage in Nigeria is 16.[240] Child marriage is particularly common in the north, where the majority of girls are married between the ages of 12 and 15.[241] The National Policy on Population discourages early marriage and states that parents should not arrange marriages for girls below the age of 18.[242]

A variety of conflicting laws relate to the age at first marriage. The eastern states of Nigeria have enacted legislation that prohibits marriage contracts between parties under the age of 16 and declares any such marriage legally unrecognizable.[243] In addition, for the remainder of the states, the civil law provides that parties to a valid civil marriage be "of marriageable age." Although the term "marriageable age" is not defined,[244] adolescents under the age of 21 cannot marry without parental consent under the civil law.[245] Yet customary law provides that children can marry when they have attained puberty, usually at age 14 for boys and age 12 for girls.[246] Under Islamic law as practiced in northern Nigeria, on the other hand, there is no minimum age for marriage.[247]

D. EDUCATION AND ADOLESCENTS

State and local governmental authorities are responsible for the provision and maintenance of primary educational facilities.[248] Some Nigerian states have established scholarship funds for female students and made school attendance mandatory, prohibiting the withdrawal of female students for the purposes of marriage.[249]

E. SEX EDUCATION AND ADOLESCENTS

The National Social Development policy gives primary importance to the role of family life education in achieving

"planned parenthood."[250] Family life education is defined to include child spacing and family planning information, and may also include sex education and AIDS prevention information.[251] This information is presently a component of secondary school curricula.[252] The National Policy on Population seeks to incorporate this information, including education on issues related to fertility, into community programming and the curricula of training and vocational schools.[253]

F. SEXUAL OFFENSES AGAINST MINORS

Under the Penal Code in northern Nigeria, children under the age of 14 are incapable of providing consent, including consent to sexual acts.[254] In addition, a child under the age of 16 is presumed incapable of consent to any act of "gross indecency" with an adult in a position of authority, such as a teacher or guardian.[255]

In southern Nigeria, the Criminal Code prohibits statutory rape.[256] Sexual intercourse with a girl under the age of 13 is punishable by life imprisonment, with or without caning, and sexual assault of a girl under the age of 13 is punishable by imprisonment of up to three years.[257] Assaults committed against girls between the ages of 13 and 16, including statutory rape, are punishable by imprisonment for up to two years.[258]

In both southern and northern Nigeria, the criminal laws also contain specific prohibitions against the "procuration" or employment of a minor child in prostitution.[259]

ENDNOTES

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7. NDHS, *supra* note 4, at 1.
8. *Id*.
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10. NDHS, *supra* note 4, at 2; Memorandum from Theresa Akumadu, Head, Women's Right Project, Civil Liberties Organisation (Mar. 12, 1997) (on file at The Center for Reproductive Law and Policy).
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16. Walden Reports, *supra* note 4; *Geography and History*, *supra* note 2.
17. *Nigeria Country Report*, *supra* note 4. *See* NIGERIA CONST. (Suspension and Modification) (Amendment) Decree 1985, ch. I, § 2(6), Sched. 3-C [hereinafter NIGERIA CONST.].
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19. Ambrose O. O. Ekpu, *Judicial Response to Coup D'Etat: A Reply to Tayyab Mahmud (From a Nigerian Perspective)*, 13 ARIZ. J. INT'L & COMP. L. 1, 23 (1996).
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21. REYNOLDS & FLORES, *supra* note 1, at 5-6. In the northern states, Magistrates' Courts have jurisdiction over criminal cases and District Courts have jurisdiction over civil cases. *See id*.
22. NIGERIA CONST. (1979), § 245.
23. *Id*. § 240; REYNOLDS & FLORES, *supra* note 1, at 6.
24. Ekpu, *supra* note 19, at 26-27.
25. *Id*. at 21.
26. Akumadu, *supra* note 15, at 1.
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60. HEALTH POLICY, *supra* note 40, at 12.
61. NDHS, *supra* note 4, at 117; Delano, *supra* note 57, at 25.
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72. *Id*. §§ 1(2)(a), 9(1)(a)-(c), (2).
73. *Id*. § 1(2)(c); *see generally* MEDICAL AND DENTAL COUNCIL OF NIGERIA, RULES OF PROFESSIONAL CONDUCT FOR MEDICAL AND DENTAL PRACTITIONERS IN NIGERIA (1995) [hereinafter RULES].
74. Medical Decree, *supra* note 70, § 15.
75. *Id*. § 17(6).
76. *Id*. §§ 17(1)(a), (5), (7).
77. Decree No. 89, Nursing and Midwifery (Registration, Etc.) (1979) [hereinafter Nursing Decree].
78. *Id*. §§ 1(2), 17.
79. *Id*. § 1(2).
80. Decree No. 91, Pharmacists Council of Nigeria Decree (1992).
81. Akumuda, *supra* note 15, at 10-11; RULES, *supra* note 73, at 16-18.
82. For example, § 332 of the Penal Code provides imprisonment for life to any person who with the intent to disfigure or disable another "unlawfully wounds or does any grievous harm." PEN. CODE § 332. Section 241 of the Penal Code criminalizes the act of voluntarily causing "grievous hurt." *See* PEN. CODE § 241. However, it is not an offense if the act is likely to cause injury but is performed without criminal intent and with the aim of benefitting the injured person. *See* PEN. CODE § 49.
83. RULES, *supra* note 73, at 16.
84. *Id*. at 21-22.
85. RULES, *supra* note 73, at 12-13.
86. FEDERAL REPUBLIC OF NIGERIA, NATIONAL POLICY ON POPULATION FOR DEVELOPMENT, UNITY, PROGRESS AND SELF-RELIANCE 1 (1988) [hereinafter NAT'L POLICY].
87. *Id*. at 12.
88. *Id*. at 2.
89. *Id*. at 12-13.
90. *Id*. at 13-14.
91. *Id*. at 14.
92. *Id*. at 13-14.
93. *Id*. at 15-17.
94. *Id*. at 20.
95. *Id*. at 20-22.
96. *Id*. at 18.
97. *Id*. at 18.
98. UNFPA, *supra* note 5, at 21-22.
99. *Id*. at 21.
100. *Id*. at 21-22.
101. Bamikale J. Feyisetan & Martha Ainsworth, *Contraceptive Use and the Quality, Price, and Availability of Family Planning in Nigeria*, *in* THE WORLD BANK, INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT, Living Measurement Study Working Paper No. 108, at 4 (1994).
102. NIGERIA CONST. ch. VI, pt. III(A), § 211.
103. Decree No. 23, National Population Commission Decree (1989) (Nig.).
104. Makinwa-Adebusoye, Levels of Contraceptive Knowledge and Use in Nigeria 1 (1992) (unpublished paper, on file with The Center for Reproductive Law and Policy).
105. UNFPA, *supra* note 5, at 12, 33.
106. *Id*. at 34; HEALTH POLICY, *supra* note 40, at 9-10.
107. Planned Parenthood, *supra* note 4, at 147; UNFPA, *supra* note 5, at 36.
108. Akumadu, *supra* note 15, at 9.
109. Feyisetan & Ainsworth, *supra* note 101, at 4-5.
110. UNFPA, *supra* note 5, at 12.
111. Planned Parenthood, *supra* note 4, at 147.
112. *Id*.
113. NAT'L POLICY, *supra* note 86, § 5.1.7, at 16.
114. NDHS, *supra* note 4, at 37.
115. Food and Drugs Act, § 5(a), ch. 150 (1990). This law, as well as other industry regulations, is not well enforced. *See generally* H.D. KAYIT, PHARMACISTS COUNCIL OF NIGERIA: RESPONSIBILITIES AND CONSTRAINTS, PHARMACY LAWS AND PRACTICE IN NIGERIA (1995).
116. Food and Drugs Act, § 4.
117. *Id*. § 8(2).
118. *Id*. § 17.
119. CRIM. CODE §§ 233C(1), 233d; PEN. CODE § 202 (also covering "willful exhibition" of obscene matter).
120. KARIBI-WHYTE, *supra* note 30, at 212-13.
121. CRIM. CODE § 228; *see* PEN. CODE § 232. The criminal code provision is based on the Offences Against the Persons Act 1861, § 58. See T.B.E. Ogiamien, *A Legal Framework to Liberalize Abortion in Nigeria*, NIG. CURRENT L. REV. 107, 111 (1988-91). The Criminal Code also proscribes the "killing of an unborn child," which under English law was criminalized as "child destruction." *See* CRIM. CODE § 228. The offense criminalizes any deliberate act or omission when a woman is about to give birth which prevents the child from being born alive, encompassing "the wilful [sic] infliction of ante-natal injuries on a child in order to cause its death before it has an independent existence of its mother." CRIM. CODE §§ 328, 309; *see* EMMANUEL OLAWUYI FAKAYODE, THE NIGERIAN CRIMINAL CODE COMPANION 391, ¶ 64 (1977). This offense is punishable by life imprisonment. However, any operation performed for the preservation of a woman's life is excluded from prosecution under this provision. *See* CRIM. CODE § 297. The Penal Code contains a similar provision which criminalizes the intentional performance of an act "preventing [a] child from being born alive or causing it to die after its birth…" but does not limit the applicability of this offense to situations where a woman is about to give birth. PEN. CODE § 235.
122. The definition of pregnancy utilized in the Nigerian laws on abortion is derived from developed English law. *See* I.E. Adi, *The Question of Abortion*, NIG. CURRENT L. REV. 191, 192 (1982).
123. PEN. CODE § 232.
124. *Id*.
125. Ogiamien, *supra* note 121, at 119; FAKAYODE, *supra* note 121, at 395, ¶ 65.
126. CRIM. CODE § 297. The ground of preservation of the mother's life may include consideration of risks posed by the pregnancy to the mother's physical or mental health, as defined by developed law following the English case of R. v. Bourne [1939] 1 K.B. 687 (Ireland); *see* Ogiamien, *supra* note 121, at 121.

127. PEN. CODE § 235.
128. *See Abortion in Nigeria: What the Law Says and What it Doesn't Say*, CAMPAIGN AGAINST UNWANTED PREGNANCY NEWSLETTER (Campaign Against Unwanted Pregnancy), June 1993, at 3-4.
129. CRIM. CODE § 230.
130. PEN. CODE § 233.
131. *Id.* § 234.
132. Akumadu, *supra* note 15, at 10.
133. *Id.*; Delano, *supra* note 57, at 25.
134. RULES, *supra* note 73, § 39.
135. CRIM. CODE § 228.
136. *See* PEN. CODE § 54.
137. CRIM. CODE § 297.
138. *Sterilization Laws, Practices, Policies and Conditions in Africa*, at 17 (1994) (unpublished paper, on file with The Center for Reproductive Law and Policy).
139. Planned Parenthood, *supra* note 4, tbl. B, § 2.8 (female sterilization as a form of contraception estimated at 3.9%); *see generally* Akumadu, *supra* note 15, at 10.
140. Akumadu, *supra* note 15, pt. III; DHS *Regional Analysis Workshop for Anglophone Africa*, Fertility Trends and Determinants in Six African Countries, at 70 (1994) [hereinafter *DHS Analysis*].
141. *DHS Analysis*, *supra* note 140, at 70.
142. Medical Decree, *supra* note 70, §§ 17(1)(a), (5), (7).
143. Akumadu, *supra* note 15, at 10.
144. NAHID TOUBIA, FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION 25 (Rainb♀ 1995); Mairo U. Mandara, *Prevalence Of Female Genital Mutilation In Zaria: A Critical Appraisal*, *in* DISCUSSING REPRODUCTIVE RIGHTS IN NIGERIA at 29, 36 (1995).
145. Mandara, *supra* note 144, at 30-31.
146. Christine Adebajo, *Female Genital Mutilation Educational Approach*, *in* RESEARCH ACTION & INFORMATION NETWORK FOR THE BODILY INTEGRITY OF WOMEN AND COLUMBIA SCHOOL OF PUBLIC HEALTH, CENTER FOR POPULATION AND FAMILY HEALTH, REPORT OF THE GLOBAL ACTION AGAINST FEMALE GENITAL MUTILATION FIRST INTER-AGENCY WORKING GROUP MEETING 5 app. IV (1994).
147. *Id.* at 8, app. IV.
148. NIGERIA CONST. 1985 §§ 17(2)(b), 31(1)(a); Skumadu, *supra* note 15, at 17.
149. Adebajo, *supra* note 146, at 2.
150. *Id.* at 8.
151. NATIONAL AIDS/STD CONTROL PROGRAMME, FACT SHEET ON AIDS (1996) [hereinafter FACT SHEET].
152. *Id.*
153. VOICES, supra note 37, at 106-07.
154. Feyisetan & Ainsworth, *supra* note 101, at 9.
155. VOICES, *supra* note 37, at 106-07; FACT SHEET, *supra* note 151.
156. Akumadu, *supra* note 15, app., ¶ 3.
157. TONY BARNETT & PIERS BLAIKIE, AIDS IN AFRICA: ITS PRESENT AND FUTURE IMPACT 636 (1992).
158. Feyisetan & Ainsworth, *supra* note 101, at 1.
159. *See* LESLYE OBIORA ET AL., WHAT EVERY WOMAN IN NIGERIA SHOULD KNOW 1-3 (1986).
160. *Id.* at 2.
161. *Id.*
162. VOICES, *supra* note 37, at 72, 115. A bride-price payment may range between N 10-N 25, approximately U.S.$0.12-$0.31. *See Id.* at 115.
163. *Id.* at 78-83, 119-20. In the southwest, a woman is commonly assumed to be responsible for her husband's death, and may be required "to sit on the floor, have no bath, wear the same clothes [and] eat with unwashed left hand throughout the mourning…period," lasting from three to seven days. *Id.* at 81.
164. Akumadu, *supra* note 15, at 12. However, the father may lose this right if he has given his daughter an option to choose among suitors. See Yakubu v. Paiko; CA/K/80s/85, at 18-19, 24 (Kaduna Ct.App. 1985) (noting also that fathers that choose to exercise this right should consult the wishes of their daughters if they are over 14 years old); Auwalu H. Yadudu, *Colonialism and the Transformation of the Substance and Form of Islamic Law in the Northern States of Nigeria*, 9 J.L. & RELIGION 17, 43 (1991).
165. VOICES, *supra* note 37, at 72, 115.
166. *Id.* at 120-21.
167. MARRIAGE ACT [Chapter 218], §§ 11(1)(d), 30, 33, 35, 39, 46-47 (1971) (Nig.) (stating the penalties for contravention of these provisions). In practice, the requirement of monogamy in civil marriage has not invalidated subsequent customary law marriages. *See* OBIORA, *supra* note 159, at 2.
168. OBIORA, *supra* note 159, at 6.
169. *Id.* at 4.
170. CRIM. CODE. § 361 (punishing "[a]ny person who, with intent to marry or carnally know a female of any age, or to cause her to be married…takes her away, or detains her against her will").
171. VOICES, *supra* note 37, at 23.
172. *Id.* at 72.
173. MATRIMONIAL CAUSES ACT [Chapter 220] (1970) (Nig.).
174. *Id.* § 15(1).
175. *Id.* § 15(2)(a).
176. *Id.* § 15(2)(b). A woman petitioning for divorce on the ground of adultery may receive damages from her spouse. See E.N.U. Uzodike, *A Decade of the Matrimonial Causes Act* 1970, NIG. CURRENT L. REV. 55, 56 (1983).
177. MATRIMONIAL CAUSES ACT § 15(2)(e)-(h).
178. *Id.* § 15(2)(d).
179. *Id.* § 15(2)(c).
180. *Id.* § 16. A petitioner does not have to provide proof of the respondent's conviction of rape, but must merely "satisf[y] the court that…respondent has committed rape." *See id.* § 16(1)(a). It is unclear if marital rape would qualify. However, conviction for a spousal assault involving the intentional infliction of grievous harm is an adequate ground for divorce. *See id.* § 16(1)(e).
181. OBIORA, *supra* note 159, at 11; Akumadu, supra note 15, at 13.
182. *Id.*
183. *Id.*
184. OBIORA, *supra* note 159, at 12.
185. Akumadu, *supra* note 15, at 13.
186. *Id.*; OBIORA, *supra* note 159, at 13.
187. VOICES, *supra* note 37, at 77.
188. Akumadu, *supra* note 15, at 13; *see generally* MATRIMONIAL CAUSES ACT §§ 3(a)(i), 25.
189. MATRIMONIAL CAUSES ACT § 71(1).
190. *Id.* § 70(1). In addition, the criminal laws in the south require heads of households to maintain their legitimate children. *See* CRIM. CODE § 301. The head of a household is usually considered to be the father. *See* O.A. Ipaye, *Custody and Child-Support Laws in Nigeria*, NIG. CURRENT L. REV. 67, 75 (1988-91).
191. OBIORA, *supra* note 159, at 25; VOICES, *supra* note 37, at 78.
192. UNITED STATES DEPARTMENT OF STATE, NIGERIAN HUMAN RIGHTS PRACTICES 1995 (1996) [hereinafter NIGERIAN PRACTICES 1995].
193. Akumadu, *supra* note 15, at 14. The law is not in force in the Oyo, Ondo, Ogun, Osun, Edo, and Delta states. *See id.*
194. *Id.* However, courts have discretion in distributing marital property upon dissolution of a marriage. For further discussion, *see* section on divorce and custody law.
195. *See id.*; Administration of Estates, Distribution of Residuary Estate, pt. VI, § 49.
196. Akumadu, *supra* note 15, at 14. Less than five percent of Nigerians provide for the distribution of their property by will. *See id.*
197. *See* Suberu v. Sunmonu, 2 F.S.C. 33, 34 (1957) (Jibown, F.J.) (holding that a Yoruba widow was not entitled to inherit from her husband's estate because she herself was inherited by her husband's family); Abdulmalik Bappa Mahmud, *Succession under the Sharia in Nigeria*, NIG. CURRENT L. REV. 121, 131 (1982); Ebeku, *supra* note 27, at 49-50.
198. Mahmud, *supra* note 197, at 126.
199. *Id.*; Akumadu, *supra* note 15, at 15.
200. NIGERIA CONST. ch. II, §§ 17(3)(a), (e).
201. Akumadu, *supra* note 15, at 15; NIGERIAN PRACTICES 1995, *supra* note 192.
202. *See* LABOUR ACT §§ 55-58. Nurses and women in managerial positions are exempt from some of these provisions. *See id.*
203. U.S. DEPARTMENT OF STATE, NIGERIAN HUMAN RIGHTS PRACTICES, 1993 (1994) [hereinafter NIGERIAN PRACTICES 1993].
204. NIGERIA CONST. ch. II, §§ 17(3)(b)-(c).
205. LABOUR ACT § 54.
206. *Id.*
207. Akumadu, *supra* note 15, at 15.
208. *Id.*
209. *Id.*
210. *Id.*
211. NIGERIA CONST. § 17(3)(e).
212. UNITED NATIONS ECO COMMISSION FOR AFRICA, ADVANCES OF AFRICAN WOMEN: FORGING A STRATEGY FOR THE 1990S, NIGERIA 4.11 (1990).
213. UNFPA, *supra* note 5, at 53.

214. CRIM. CODE § 357. Under Nigerian law, a mistake regarding the woman's consent may be a defense to a charge of rape. However, it is unclear if the mistaken belief must be both honest and reasonable. *See* CRIM. CODE § 25; ISABELLA OKAGBUE, THE REFORM OF SEXUAL OFFENCES IN NIGERIAN CRIMINAL LAW 7 (1991).
215. CRIM. CODE § 357. Under the criminal code's definition of rape, the use of economic threats or the threat of social injury may vitiate a woman's consent. *See* OKAGBUE, *supra* note 214, at 7.
216. CRIM. CODE § 359. Attempted rape is punishable by 14 years of imprisonment, with or without caning. *See id.*
217. PEN. CODE §§ 282(1)(a)–(b), (e).
218. *Id.* § 282(1)(c). A woman's consent is vitiated by fear of "hurt," which is defined as the fear of bodily pain, disease or infirmity. *See id.* § 240. In addition, a woman who is intoxicated may be incapable of validly consenting to intercourse. *See id.* § 39(b).
219. CRIM. CODE § 358 (imposing a penalty of life imprisonment, with or without caning); PEN. CODE § 283 (imposing a penalty of life imprisonment, with or without a fine).
220. PEN. CODE § 282 (explanation) (stating that "[m]ere penetration is sufficient to constitute the sexual intercourse necessary to the offense of rape"); CRIM. CODE § 6 (defining "carnal knowledge" and "carnal connection"). Under the Criminal Code, males under the age of 12 are presumed incapable of sexual intercourse. *See* CRIM. CODE § 6.
221. OKAGBUE, *supra* note 214, at 6; PEN. CODE § 282 (using the term "sexual intercourse" to define rape), § 284 (using the term "carnal intercourse" to define "unnatural" sexual offences); *see also* FAKAYODE, *supra* note 121, at 430, ¶ 71 (defining "carnal knowledge" and "carnal connection").
222. PEN. CODE. § 284. Section 214 of the criminal code contains a similar provision but also penalizes a woman who "permits a male person to have carnal knowledge of…her against the order of nature." CRIM. CODE § 214. Under both codes, conviction of an unnatural sexual offence is punishable by 14 years of imprisonment. *See id.* § 214.
223. Assault with intent to commit an unnatural offence is punishable by 14 years of imprisonment. See CRIM. CODE § 352.
224. CRIM. CODE §§ 353, 360. Under these provisions, indecent assault on a woman is punishable by two years of imprisonment, while indecent assault of a man is punishable by three years of imprisonment. *See* OKAGBUE, *supra* note 214, at 6.
225. PEN. CODE § 285. This provision criminalizes acts of "gross indecency" committed upon the person of another without that person's consent, or through the use of threats or force. *See id.* The offence is punishable by seven years of imprisonment, with or without a fine. children under 16 years of age in certain relationships are presumed incapable of consenting for the purposes of this section. *See infra* text accompanying notes 254–59 (under the heading "*Sexual Offences against Minors*").
226. CRIM. CODE § 6.
227. PEN. CODE § 282(2).
228. OKAGBUE, *supra* note 214, at 9.
229. Akumadu, *supra* note 15, at 14.
230. PEN. CODE §§ 55(1)(d), 56. "Grievous hurt" is defined exclusively under the penal code to be: "emasculation; permanent deprivation of sight, hearing or speech; loss of a limb or permanent impairment to the use of a limb; permanent disfigurement of the head or face; the fracture or dislocation of a bone or tooth; or harm that is life-threatening, or which causes the victim to suffer for 20 days either incapacitated or in severe physical pain...." PEN. CODE § 241.
231. MATRIMONIAL CAUSES ACT §§ 5(2)(c), 16(1)(e); *see also* PEN. CODE § 241 (defining "grievous hurt"). The Act provides that a conviction for attempted murder or the infliction of grievous harm is "sufficient" evidence of marital behavior such that "the petitioner cannot reasonably be expected to live with the respondent."
232. *See* CRIM. CODE §§ 353, 360; PEN. CODE § 285. Under the criminal code, an indecent assault is defined to be an assault accompanied by an act that is "depraved, outrageous or scandalous[,] e.g., exposing the body or the male organ in public." FAKAYODE, *supra* note 121, at 71.
233. Indecent assault of a man is a felony offense punishable by three years of imprisonment while indecent assault of a woman is classified as a misdemeanor punishable by two years of imprisonment. *See* CRIM. CODE §§ 353, 360.
234. Planned Parenthood, *supra* note 4, tbl A.
235. Akumadu, *supra* note 15, app.
236. NIGERIAN PRACTICES 1993, *supra* note 203.
237. Adebajo, *supra* note 146, at 5.
238. NIGERIAN PRACTICES 1993, *supra* note 203; Adebajo, *supra* note 146, at 5, app IV.
239. Adebajo, *supra* note 146, at 8.
240. Akumadu, *supra* note 15, at 13.
241. VOICES, *supra* note 37 at 118.
242. NAT'L POLICY, *supra* note 86, at 14.
243. AGE OF MARRIAGE LAW [Chapter 6] §§ 2-4, 6 (Eastern Region 1956).
244. *Id.* § 3(1)(e); OBIORA, *supra* note 159, at 4. English common law doctrine set a minimum age for marriage at 14 for boys and 12 for girls. *See* Harrod v. Harrod, 69 E.R. 344, 349 (1954).
245. MARRIAGE ACT §§ 18–20, 48 (proscribing penalties for contravention of these provisions).
246. OBIORA, *supra* note 159, at 3–4. In the eastern states, the minimum age for customary marriages is set by law at 16. *See* Akumadu, *supra* note 15, at 12.
247. Sarah Y. Lai & Regan E. Ralph, *Female Sexual Autonomy and Human Rights*, 8 HARV. HUM. RTS. J. 201, 219 (1995).
248. NIGERIA CONST., 4th Sched., § 2(a).
249. UNFPA, *supra* note 4, at 4.
250. FEDERAL REPUBLIC OF NIGERIA, SOCIAL DEVELOPMENT POLICY FOR NIGERIA 21 (1989).
251. NIGERIAN EDUCATIONAL RESOURCE AND DEVELOPMENT COUNCIL, POPULATION EDUCATION DEPARTMENT, POPULATION AND FAMILY LIFE EDUCATION SUPPLEMENTARY TEACHER'S GUIDE ON INTEGRATED SCIENCE FOR JUNIOR SECONDARY SCHOOLS (1990).
252. *Id.*
253. NAT'L POLICY, *supra* note 86 at 22-23.
254. PEN. CODE § 39; *see also* PEN. CODE § 282(1)(b).
255. *Id.* § 285.
256. CRIM. CODE §§ 218, 221. Any prosecution for statutory rape under the criminal code must be brought within two months after the offense was committed. *See id.*
257. *Id.* §§ 218, 222. Attempted statutory rape of a girl under the age of 13 is punishable by imprisonment up to 14 years, with or without caning. *See id.*
258. *Id.* §§ 221, 222.
259. *See* PEN. CODE §§ 275, 276, 278, 281; CRIM. CODE §§ 219, 223, 224.

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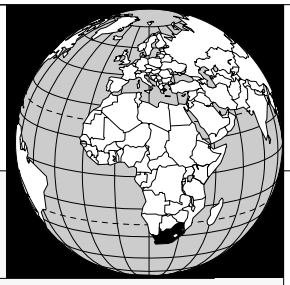
6. South Africa



Statistics[1]

GENERAL

Population

■ The official 1995 mid-year estimate of the total South African population is 41.24 million.[2]

■ In 1994, the racial composition of the population was 76.1% African, 12.8% white, 8.5% colored,[3] and 2.6% Indian.[4] In each racial group, slightly more than half the population is women.[5]

■ The total national average annual population growth rate for 1991 to 1994 was 2.1%, which reflected a population growth rate of 2.5% for Africans, 0.7% for whites, and 1.5% for coloreds and Indians.[6]

■ In 1994, the birth rate was 23.4 per 1,000, compared to the death rate of 9.4 per 1,000.[7]

■ In 1994, 48.8% of the population lived in urban areas.[8]

Economy

■ In 1993, South Africa's Gross National Product ("GNP") per capita was $2,980.[9] In 1991, the per capita income of whites was 12.3 times higher than the per capita income for Africans.[10]

■ The 1996-97 health budget was U.S.$3.62 billion (R 17.2 billion), which comprised 9.9% of total estimated government expenditure.[11]

Employment

■ Women comprise approximately 36% of the total work force in South Africa.[12] In 1994, African women constituted 18% of the labor force and 48% of the unemployed. In comparison, white men constituted 14% of the labor force and a mere 1% of the unemployed.[13] A white man was 5,000 times as likely to be in top management as a black woman.[14]

WOMEN'S STATUS

■ In 1990, overall life expectancy at birth is estimated to be 62 years for males and 68 years for females. By racial category, the respective life expectancies for males and females are: 60 and 67 among Africans, 69 and 76 among whites, 59 and 65 among coloreds, 64 and 70 among Indians.[15]

■ In 1994, police statistics indicated that 32,107 cases of rape were reported.[16] However, it is estimated that only one in 36 women reported being raped to the police.[17] Less than one third of all reported cases are prosecuted; of the cases which are prosecuted, only half result in convictions.[18]

■ Of the four racial categories, Africans marry youngest at an average of 18.9 years, while whites marry the latest at an average age of 20.9 years.[19]

■ Women account for 53.4% of persons aged 16 to 24 who are not attending school and have not yet obtained the highest level of school (Standard 10).[20]

ADOLESCENTS

■ In 1995, children under the age of 15 years accounted for 37.1% of the population, while 4.5% of the population was 65 years and older.[21]

■ In 1995, the teenage pregnancy rate was estimated to be 330 per 1,000 women under the age of 19 years.[22]

MATERNAL HEALTH

■ In 1995, the total fertility rate was estimated to be 4.1.[23]

■ The official national average maternal mortality rate is 32 deaths per 100,000 live births, including rates of 5, 8, 22 and 58 among Indians, whites, coloreds and Africans, respectively.[24]

■ The 1995 infant mortality rate is estimated to be 46 per 1,000 live births.[25] Although information regarding racial differential is not available for 1995, it is known that, in 1992, the infant mortality rate for the entire South African population was estimated to be 48.9 deaths per 1,000 live births, including rates of 7.3, 9.9, 36.3 and 54.3 for whites, Indians, coloreds, and Africans respectively.[26]

■ In 1994, in rural areas, 15.6% of people live within one kilometer (km) of a health facility, while 55.9% of people live five km or more from health facilities. The corresponding percentages for people in urban areas are 43.6% and 13.3%, respectively.[27]

CONTRACEPTION AND ABORTION

■ In 1994, contraceptive prevalence rates among women were 66% for Africans, 74% for coloreds, 77% for Indians, and 80% for whites.[28]

■ In 1995, the overall contraceptive prevalence rate was 53%, including 51.7% of the population using modern methods, and 1.3% using traditional methods.[29]

■ Injectable contraceptives are the most common method of contraception among African women, while the oral pill is the method used most extensively among the other racial groups.[30]

■ In 1992, condoms were used by between 10% and 25% of men.[31]

■ It is estimated that 200,000 unsafe abortions are performed in South Africa each year. Each year, approximately 45,000 women with spontaneous miscarriages or illegally induced abortions are admitted to South African hospitals, of whom about 400 die from septic abortions.[32]

HIV/AIDS AND STDs

■ It is estimated that, in the beginning of 1995, between 1.8 and 2 million South Africans were infected with HIV, and that between 12,000 and 15,000 people had AIDS.[33]

■ In 1995, at least 10% of the population had ulcerative infections caused primarily by syphilis and chancroid. The median prevalence rate of gonorrhea and chlamydia is 8% and 11% respectively.[34]

ENDNOTES

1. Because inefficient methods of data collection have been employed until recently and because many estimates have only recently taken account of the former "homelands," comparative chronological data on population-related issues in South Africa is often not entirely reliable. MINISTRY FOR WELFARE AND POPULATION DEVELOPMENT, A GREEN PAPER FOR PUBLIC DISCUSSION: POPULATION POLICY FOR SOUTH AFRICA (Apr. 1995) [hereinafter GREEN PAPER].
2. Central Statistical Services (visited Dec. 20, 1996), http://www.css.gov.za/releases/demograp/y91_95/p0302.html.
3. People of mixed race, who live predominantly in the Western Cape.
4. HEALTH SYSTEMS TRUST: DURBAN & HENRY J. KAISER FAMILY FOUNDATION, SOUTH AFRICAN HEALTH REVIEW 1995 5 (1995) [hereinafter HEALTH REVIEW].
5. *Id.*
6. *Id.*
7. GREEN PAPER, *supra* note 1, at 7.
8. HEALTH REVIEW, *supra* note 4, at 6.
9. THE WORLD BANK, WORLD DEVELOPMENT REPORT 1995: WORKERS IN AN INTEGRATING WORLD 163 (1995).
10. HEALTH REVIEW, *supra* note 4, at 230.
11. HEALTH SYSTEMS TRUST: DURBAN & HENRY J. KAISER FAMILY FOUNDATION, SOUTH AFRICAN HEALTH REVIEW 1996 76 (1996).
12. HUMAN RIGHTS WATCH WOMEN'S RIGHTS PROJECT, VIOLENCE AGAINST WOMEN IN SOUTH AFRICA: THE STATE RESPONSE TO DOMESTIC VIOLENCE AND RAPE 1 (1995) [hereinafter HUMAN RIGHTS WATCH].
13. DEPARTMENT OF LABOUR, GREEN PAPER POLICY PROPOSALS FOR A NEW EMPLOYMENT AND OCCUPATIONAL EQUITY STATUTE, General Notice No. 804, Table 1 in Appendix to Chapter 2 (July 1, 1996).
14. *Id.* at ¶2.2.7.
15. HEALTH REVIEW, *supra* note 4, at 12.
16. HUMAN RIGHTS WATCH, *supra* note 12, at 51.
17. HEALTH REVIEW, *supra* note 4, at 181.
18. HUMAN RIGHTS WATCH, *supra* note 12, at 17.
19. HEALTH REVIEW, *supra* note 4, at 10.
20. GREEN PAPER, *supra* note 1, at 9.
21. *Id.* at 7.
22. *Id.*
23. *Id.*
24. These estimates exclude the former "independent homelands" — some of the most impoverished areas of the country — and it is believed that maternal mortality rates in these areas are considerably higher than the official statistics. HEALTH REVIEW, *supra* note 4, at 177-8.
25. GREEN PAPER, *supra* note 1, at 7.
26. HEALTH REVIEW, *supra* note 4, at 235.
27. GREEN PAPER, *supra* note 1, at 8.
28. HEALTH REVIEW, *supra* note 4, at 10.
29. GREEN PAPER, *supra* note 1, at 8.
30. HEALTH REVIEW, *supra* note 4, at 11.
31. *Id.* at 174.
32. *Id.* at 178.
33. *Id.* at 171.
34. *Id.* at 44.

South Africa was first populated by Khoisan people, in approximately 20,000 BC.[1] In approximately 500 AD, significant numbers of Bantu-speaking groups[2] migrated to the region from the north.[3] In 1652, the first Dutch settlers arrived in the Cape — the southwest tip of the country — and gradually developed their own social identity and language, Afrikaans.[4] In the early 1800's they were followed by English settlers and, in the late 1800's, by Indian traders and indentured Indian laborers who settled in Natal on the east coast.[5] In 1910, the Union of South Africa was founded, marking the unification of four former colonies — Cape, Natal, Orange Free State, and Transvaal.

After 1948, when the National Party came to power, the South African government attempted to enforce apartheid — a system of complete geographical, social, and political segregation between white and black people.[6] In 1960, South Africa withdrew from the British Commonwealth and became the Republic of South Africa.[7] Apartheid officially ended in April 1994, when the African National Congress ("ANC") won South Africa's first completely multi-racial election, and Nelson Mandela became the first black president of South Africa.[8] The ethnic makeup of the current South African population of 41.24 million[9] is: African (76.1%); colored[10] (8.5%); Indian (2.6%); and white (12.8%).[11] There are 11 official languages at the national level.[12] The major religions are Christianity, Hinduism, and Islam.[13]

Before 1994, South Africa was administratively divided into four provinces[14] and 10 black "homelands," including four "independent" states[15] and six "self-governing territories."[16] In 1994, these administrative divisions were consolidated into nine provinces: Eastern Cape; Free State; Gauteng; KwaZulu-Natal; Mpumalanga; Northern Cape; Northern Province; North West; and Western Cape.[17]

I. Setting the Stage: The Legal and Political Framework

To understand the various laws and policies affecting reproductive rights in South Africa, it is necessary to consider the legal and political systems of the country. Without this background, it is difficult to determine the manner in which laws and policies are enacted, interpreted, modified, and challenged. The passage and enforcement of law in particular often involves specific formal procedures.

A. THE STRUCTURE OF GOVERNMENT

The Constitution of the Republic of South Africa 1996 (the "Constitution")[18] creates three "spheres of government" — national, provincial, and local — which are "distinctive, interdependent and interrelated."[19] There are nine provinces in the country. Local level government consists of municipalities,[20] which have the right to govern the local government affairs of their communities, subject to national and provincial legislation.[21]

The Executive Branch

National executive power is vested in the president,[22] who is elected by the National Assembly from among its members[23] as head of state and of the national executive.[24] The president exercises executive power together with the other members of the cabinet,[25] which consists of the president, as head of the cabinet, a deputy president, and ministers who are appointed by the president.[26] Members of the cabinet are collectively and individually accountable to the Parliament for the performance of their functions.[27]

The executive authority of a province is vested in the premier of that province,[28] who is elected by the provincial legislature from among its members.[29] The premier exercises executive power together with the other members of the provincial Executive Council,[30] which is comprised of the premier, as head of the council, and between five and 10 members appointed by the premier from among the members of the provincial legislature.[31] The provincial executive must act in accordance with the Constitution and, if a constitution has been passed for that province, the provincial constitution.[32]

The executive authority of a municipality is vested in its Municipal Council,[33] which consists mainly of members elected in accordance with national legislation.[34] National and provincial government may not thwart the capacity of a municipality to exercise its powers or to perform its functions.[35]

The Legislative Branch

National legislative authority is vested in the Parliament,[36] which consists of the National Assembly and the National Council of Provinces.[37] The National Assembly consists of between 350 and 400 members elected by popular vote[38] for a term of five years.[39] The National Assembly is elected to represent the people of the Republic of South Africa (the "Republic") and to ensure government in accordance with the Constitution by selecting the president, providing a forum for public consideration of issues, enacting legislation, and overseeing executive action.[40] The National Council of Provinces has 90 members, comprised of 10 delegates from each of the nine provinces.[41] It represents provincial interests in the national sphere of government by participating in the national legislative process and by providing a national forum for public consideration of matters affecting the provinces.[42] The legislative authority of a province is vested in its provin-

cial legislature,[43] which consists of between 30 and 80 members[44] elected for a term of five years.[45] A provincial legislature may pass a constitution for its province[46] and may also pass legislation for its province with respect to any matter within a "functional area" listed in Schedule 4 or 5 of the Constitution, or any other matter expressly assigned to the provincial legislature by national legislation.[47]

Schedule 4 of the Constitution provides Parliament concurrent jurisdiction with provincial legislatures to enact legislation regarding specified "functional areas,"[48] which include, *inter alia*: health services, population development, education at all levels except tertiary education, welfare services, and indigenous and customary law. Where national legislation and provincial legislation falling within a "functional area" listed in Schedule 4 are in conflict, national legislation that applies uniformly with regard to the country as a whole prevails over provincial legislation if it meets one of several specified criteria.[49] Schedule 5 lists the "functional areas," such as provincial planning and ambulance services, in which Parliament may pass legislation for specified national interests only when such intervention is necessary.[50]

The legislative authority of a municipality is vested in its Municipal Council.[51] A municipality may adopt bylaws for the effective administration of the matters which it has the right to administer,[52] provided that any bylaw that conflicts with national or provincial legislation is invalid.[53]

The Judicial Branch

Courts both create and interpret law. The judicial system can have a significant impact on legislation, including legislation affecting reproductive rights, because courts are able to enforce the law and deal with complaints from individuals challenging the constitutionality of specific laws.

The Constitution vests national judicial authority in the courts, which are "independent and subject only to the Constitution and the law, which they must apply impartially and without fear, favour or prejudice.[54] The Constitution lists the courts to include: the Constitutional Court; the Supreme Court of Appeal; the High Courts, including any high court of appeal established by an act of Parliament to hear appeals from High Courts; the Magistrates' Courts; and any other court established or recognized by an act of Parliament.[55] High Courts are structured in a series of provincial and regional (or "local") divisions, while Magistrates' Courts operate within magisterial districts, which do not necessarily coincide with local government areas.[56]

Each court within the South African judicial system has a specific jurisdiction. The Constitutional Court is comprised of a president, a deputy president, and nine other judges.[57] The jurisdiction of the Constitutional Court is confined to issues involving the interpretation, protection, or enforcement of the Constitution.[58] The Constitutional Court makes the final decision as to the constitutionality of a national or provincial statute or the conduct of the president of South Africa, and it must confirm any order of invalidity made by any court with jurisdiction to decide on constitutional matters before that order has any force.[59] The Supreme Court of Appeal is the highest court of appeal in all matters other than constitutional matters.[60] High Courts may decide on any matter not assigned to another court by statute, including any constitutional matter, except where that matter falls within the exclusive jurisdiction of the Constitutional Court or has been assigned to another court by an act of Parliament.[61] Courts of a status lower than a High Court may not decide upon the constitutionality of any legislation or the president's conduct.[62] Magistrates' Courts and other lower courts may decide on any other matter determined by an act of Parliament.[63]

The Republic has a single national prosecuting authority, which is comprised of a national director of public prosecutions, other directors of public prosecutions, and prosecutors.[64] The prosecuting authority has the power to institute criminal proceedings for the state.[65]

B. SOURCES OF LAW

Domestic Sources of Law

Laws that affect women's legal status, including their reproductive rights, derive from a variety of sources. Domestic sources of law in South Africa include the Constitution, Roman-Dutch law, English law, legislation, judicial precedent, and African customary law.

The Constitution is the supreme law of the Republic;[66] laws or conduct inconsistent with its principles are invalid.[67] Chapter Two of the Constitution contains the Bill of Rights, which applies to all law and binds the legislature, the executive, the judiciary, and all "organs of state."[68] These rights may be limited only by a "law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom."[69] A competent court may grant appropriate relief, including a declaration of rights, to any person who alleges that a right in the Bill of Rights has been infringed or threatened.[70] When interpreting the Bill of Rights, courts are required to consider international law and to "promote the values that underlie an open and democratic society based on human dignity, equality and freedom," and they are permitted to consider foreign law.[71] When interpreting legislation, and when developing the common law or customary law, courts must "promote the spirit, purport, and objects of the Bill of Rights."[72]

Several provisions of the Bill of Rights directly affect the status of women and reproductive rights. For example, the Bill of Rights provides that neither the state nor any other person may "unfairly discriminate directly or indirectly" against anyone on any of the grounds listed in that section, which include, *inter alia*, gender, sex, pregnancy, marital status, and sexual orientation.[73] The Bill of Rights further grants everyone the right to bodily and physical integrity, which includes the right "to make decisions concerning reproduction,"[74] and the right of access to health care services, including reproductive health care.[75]

Another major source of South African law is Roman-Dutch law — the law that was applied and developed in Holland in the seventeenth and eighteenth centuries.[76] Roman-Dutch law in large measure still governs — or forms the basis for legislation governing — personal law, contracts, and tort law.[77] English law is applied only in very limited circumstances. For instance, it is applied with respect to certain areas of evidence, intellectual property, and bankruptcy law.[78]

The application of African customary law, which is largely uncodified, is currently governed in South Africa by Section 1 of the Law of Evidence Amendment Act, 1988.[79] This section provides that any court may apply "indigenous law"[80] if it "can be ascertained readily and with sufficient certainty"[81] and is not "opposed to the principles of public policy or natural justice."[82] While this section grants courts discretion to apply either customary or civil law, the overall choice of law must be guided by a determination of which legal system the parties "might reasonably have been expected to apply in the context of the case."[83] In making such a determination of which legal system the parties would have expected to apply, courts may take into account a variety of factors including: express or implied agreement between the parties; the nature of prior transactions between the parties; the subject matter and environment of a transaction; the form of a transaction; and the lifestyle of the parties.[84] Customary law has only been codified in the former province of Natal, by the Natal Code of Zulu Law (the "Natal Code"),[85] and in the formerly self-governing territory KwaZulu by the KwaZulu Act on the Code of Zulu Law (the "KwaZulu Code").[86] Pursuant to the Constitution, these codes continue to have the same territorial application as they had before the previous Constitution took effect on April 27, 1994, and they continue in force in these areas subject to amendment or repeal, and to consistency with the Constitution.[87] However, since the amalgamation of Natal and KwaZulu into the province of KwaZulu-Natal, there has not yet been any determination of how differences between the Natal and KwaZulu codes are to be reconciled.[88]

The continued application of African customary law is ensured by the Constitution, which stipulates that when customary law applies to a case, courts must apply it, subject to the Constitution and any other legislation that specifically deals with customary law.[89] Traditional authorities, such as chiefs and headmen, who observe systems of customary law, may also function subject to any applicable legislation and customs.[90] To deal with matters of customary law and traditional leadership, the Constitution provides that national or provincial legislation may establish "houses of traditional leaders" and that national legislation may establish a "council of traditional leaders."[91] Furthermore, the clause of the Bill of Rights that guarantees the right to freedom of religion, belief, and opinion, states that the Constitution should not be construed to preclude legislation that recognizes systems of personal and family law under any tradition or marriages concluded under any tradition or system of religious, personal, or family law, provided that such recognition is consistent with the provisions of the Constitution.[92]

International Sources of Law

Many international human rights treaties recognize and promote specific reproductive rights. Because they are legally binding on governments, these international instruments impose specific obligations to protect and advance these rights. International agreements become legally binding within the Republic once they are signed by the national executive[93] and approved by resolution in both the National Assembly and the National Council of Provinces.[94] In general, international agreements must be enacted into law by national legislation, but "self-executing" provisions of agreements that have been approved by Parliament become law unless they conflict with the Constitution or an act of Parliament.[95] In addition to international agreements, customary international law also constitutes law in the Republic of South Africa unless it conflicts with the Constitution or an act of Parliament.[96] The South African government has ratified certain human rights treaties,[97] including: the Convention on the Elimination of All Forms of Discrimination Against Women;[98] and the Convention on the Rights of the Child.[99] However, South Africa has neither signed nor ratified a number of significant human rights treaties,[100] such as: the International Covenant on Economic, Social and Cultural Rights;[101] the International Covenant on Civil and Political Rights;[102] the African Charter on Human and Peoples' Rights;[103] and the Convention on the Elimination of All Forms of Racial Discrimination.[104]

II. Examining Reproductive Health and Rights

Issues of women's health and reproductive rights are dealt with in South Africa in the context of the country's health and population policies. The Health Act, 1977 (No. 63 of 1977), which previously regulated health services in South Africa, is currently in the process of being substantially revised. The new act is likely to be comprehensive, encompassing matters such as the restructuring of the national health system, district health development, hospitals, medicines, and health information systems. In the meantime, the development of the health sector is being guided by numerous policy documents issued by the national and provincial health departments.[105] Thus, an understanding of reproductive rights in South Africa must be based upon an examination of those policies.

A. HEALTH LAWS AND POLICIES

Objectives of the Health Policy

The government is currently engaged in a "complete transformation" of the health care delivery system.[106] In 1994, when the ANC came to power, it inherited a public sector health system characterized by fragmentation, geographical maldistribution of resources, inefficiency, and an overemphasis on hospital-based care.[107] Furthermore, the private sector consumes a disproportionate share of resources in relation to the size of the population that the health system serves,[108] and the private sector is characterized by soaring expenditures.[109] Transformation of the health care delivery system is oriented towards the provision of primary health care services — an approach that emphasizes community participation, intersectoral collaboration, and cost-effective care, and in which preventive, promotive, curative, and rehabilitative services are integrated.[110] Priorities in this restructuring process include: cost-containment in both the public and private sectors; improved access to care and better quality of services, especially at the primary care level; redistribution of public sector resources among the levels of care; and greater accessibility of private sector resources to a larger portion of the population.[111]

Infrastructure of Health Services

The health system is being restructured around three levels of health authorities. At the national level, a unified Department of Health has been established. Its responsibilities include: providing overall leadership in the formulation of health policy and legislation; developing the capacity of provincial health departments to provide effective health services; and ensuring equity in the allocation of resources to the provinces.[112] Pursuant to the Constitution, provincial health departments are responsible for providing and regulating health services in their respective provinces, within the framework of national policies and guidelines formulated by the national Department of Health.[113] At the primary care level, the organization of provincial health systems is centered around health districts.[114] Primary health care and hospital services in each health district will be administered by District Health Authorities — unified, integrated health management structures at the local level.[115] All residents of each district will have access to district health services, provided by a team of staff specializing in various components of primary health care.[116] District Health Authorities will be able to supplement the services provided to health system users by entering into contractual arrangements with private sector providers, thus making resources currently available within the private sector more accessible to the broader population.[117] Services provided within the publicly funded primary health care system include family planning services, HIV/AIDS education and counseling, and maternal and child health services such as antenatal care, deliveries, postnatal, and neonatal care.[118]

Cost of Health Services

The government's 1996-97 health budget was U.S.$4.2 billion (R 17.2 billion),[119] comprising 9.9% of total estimated government expenditure.[120] The increasing emphasis on primary health care is reflected in the increased expenditure on primary health care from an estimated 29% of total public health expenditure in 1995-96 to a projected 36.5% in 2000-01.[121] Government commitment to increasing access to primary health care is also evidenced by the expanding range of free health services provided by government. Until 1994, health services were subject to user charges, with few exceptions.[122] Services exempt from user charges in the public sector included sterilization, general family planning services, and the examination of victims of rape and other assaults.[123] As of June 1, 1994, free health services were extended to children under 6 years of age and to all pregnant women, for the period from the diagnosis of pregnancy until 42 days after termination of pregnancy, or until any complications that have developed from the pregnancy are cured or stabilized.[124] From April 1, 1996, the free health care policy was extended to include all patients at the primary health care level.[125]

Regulation of Health Providers

Before 1995, the conduct and practice of South African health professionals was regulated by a plethora of statutory bodies operating in the Republic and in the former "independent homelands."[126] In 1995, the laws pursuant to which these bodies were constituted were amended so as to consolidate them into four statutory councils: the Interim National

Medical and Dental Council of South Africa, the South African Interim Nursing Council, the Interim Pharmacy Council of South Africa, and the Chiropractors, Homeopaths and Allied Health Service Professions Interim Council.[127] These councils were created for a period of two years, during which time they are required to make recommendations to the Minister of Health concerning their reconstitution, and to advise the Minister of Health about amending the legislation pursuant to which they were established so as to place "greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement."[128]

Traditional healers are not regulated within this framework of statutory councils. Nevertheless, the national Department of Health has recognized the importance of traditional practitioners and traditional birth attendants as being instrumental in promoting primary health care.[129] It has therefore recommended that provincial governments should consider the regulation and control of traditional healers, both to legally empower them and to ensure that adequate standards are observed in traditional medical practice.[130]

Patients' Rights

South African law provides users of the health system with certain safeguards against abuse by health care providers. For instance, the South African common law imposes a legal duty on medical practitioners to respect the confidentiality of their patients.[131] A violation of this duty is likely to give rise to a tort action based on invasion of privacy.[132] Similarly, medical practitioners are not permitted to treat patients without their consent. Violation of this rule could be regarded as a serious assault on the patient.[133] The patient's consent may only be dispensed with in very limited circumstances, including where statutory authority exists for such intervention in the interests of public health, and where a patient requires emergency treatment but is temporarily unable to provide consent due to shock, unconsciousness, or intoxication.[134] More generally, the statutory councils described in the preceding section may investigate complaints of any improper or disgraceful conduct of health professionals, and may exercise disciplinary powers in respect of persons found guilty of such misconduct.[135]

The rights of health service users are likely to receive considerably greater priority in the emerging National Health System. The government has stated that a fundamental principle of this system is that the needs and rights of users should be respected, and that individual users and communities should be empowered to participate in the governance of the health system.[136] In accordance with this principle, the national Department of Health has recommended the creation of a Charter of Community and Patients' Rights, in consultation with health service providers and users.[137]

B. POPULATION AND FAMILY PLANNING

Population and Family Planning Policy

In 1984, the former South African government established a Population and Development Programme ("PDP"), with the goal of achieving a lower population growth rate capable of being sustained by South Africa's economic and natural resources.[138] The PDP was premised upon the notion that a lower population growth rate should be achieved through socioeconomic development, particularly in areas of education, primary health care, economic development, employment opportunities, and housing.[139] The agencies responsible for implementing the PDP included an Interdepartmental Committee and a Chief Directorate of Population Development (which is currently within the Department of Welfare).[140] The Chief Directorate of Population Development established "population units" in all the provinces. These population units were initially formed to support community development, but later shifted their priorities toward information, education, and communication ("IEC") campaigns, particularly targeted to groups such as youth and women. The objective of these activities was to encourage smaller families.[141]

The new South African government's socioeconomic development policies are articulated in the Reconstruction and Development Programme,[142] which has effectively replaced the PDP.[143] Furthermore, pursuant to the Constitution, population development is now a legislative and executive responsibility of provincial government, although the national government has concurrent jurisdiction to enact laws on population development when national interests are at stake.[144] In light of these developments, the Department of Welfare is reassessing the role of the national population units.[145] The Ministry for Welfare and Population Development also recently released a discussion document inviting public comment on the possible content of a population policy for South Africa.[146] This "Green Paper on Population Policy" was intended to stimulate debate on the relationship between population issues and development in South Africa.[147] In this discussion document, it is acknowledged that a development and population policy should deal not only with population trends, but also with the environment, resources, production, and patterns of consumption.[148] The Green Paper on Population Policy raises a variety of issues requiring public comment, including, for example, whether or not South Africa should set specific goals in relation to the average number of children a woman or man should have,[149] and what mechanisms, if any, should be available for coordinating activities aimed at women's empowerment.[150]

Government Delivery of Family Planning Services

Since 1974, family planning services have been provided

free of charge in government facilities.[151] The distribution of services has, however, been inadequate and inequitable.[152] For example, services in predominantly white areas were better than services in predominantly black areas.[153] Many women in rural areas and informal settlements only had access to injectable contraceptives, and rural clinics often lacked facilities for inserting intrauterine devices ("IUDs").[154] Furthermore, barrier methods of contraception, such as condoms and diaphragms, were not widely promoted despite their potential to prevent sexually transmitted diseases ("STDs").[155] Family planning services have now been identified as one of the services to be provided by District Health Authorities in community hospitals, clinics, and community health centers,[156] which should substantially increase the accessibility of these services. In some provinces, there are stand-alone family planning clinics. In 1995, in Kwazulu-Natal, for example, there were 25 family planning clinics. However, efforts are currently being made to integrate these clinics with facilities that provide a broader range of primary health care services.[157] In addition, a major component of the new Department of Health's interventions against the human immunodeficiency virus ("HIV") and acquired immune deficiency syndrome ("AIDS") has been to increase condom distribution.[158] The Department of Health has also recently introduced the female condom, and has trained primary health care and family planning staff on its application.[159]

C. CONTRACEPTION

In 1995, the overall contraceptive prevalence rate was 53%, with 51.7% of the population using modern methods and 1.3% using traditional methods.[160] African women most commonly use injectable contraceptives, while the oral pill is the method used most extensively among the other racial groups.[161] Between 10% and 25% of men use condoms.[162]

Legal Status of Contraceptives

The Medicines and Related Substances Control Act, 1965 (the "Medicines Act"),[163] provides for the registration and control of medicines and medical devices, including contraceptive drugs and devices. The Medicines Act categorizes medicines and certain medical devices in a series of schedules. The preconditions for the sale or supply of medicines or devices vary according to the schedule in which the particular medicine or device is located.

Oral contraceptives containing only progestogen are listed in the second schedule of the Medicines Act. Schedule 2 substances may be sold only by a pharmacist, or by a trainee pharmacist or pharmacist assistant under the personal supervision of a pharmacist. The pharmacist must record the particulars of every sale of a Schedule 2 substance in a book maintained for this purpose. These medicines may only be sold to a person under the age of 16 years if the sale is made pursuant to a prescription issued by a medical practitioner or pursuant to a written order disclosing the purpose for which the substance will be used and signed by someone whom the seller knows to be over the age of 16 years.[164]

Hormones intended for oral contraception, except oral contraceptives containing only progestogen, are listed in the third schedule of the Medicines Act. Schedule 3 medicines may also be sold only by a pharmacist, or by a trainee pharmacist or pharmacist assistant under the personal supervision of a pharmacist, and the details of such sales must be recorded in a book maintained for this purpose. Schedule 3 substances must be sold on the written prescription or oral instructions of a medical practitioner, regardless of the age of the purchaser.[165] Schedule 4 of the Medicines Act lists IUDs. The sale of Schedule 4 substances and devices is subject to the same requirements as the sale of Schedule 3 substances. However, if the sale is made on the oral instructions of a medical practitioner, these verbal instructions must be confirmed by a written prescription within seven days.[166]

In addition, the Medicines Act prohibits the sale of any medicine or scheduled substance unless it bears a label stating particulars prescribed by regulation.[167] The Medicines Act further grants the Minister of Health extensive powers to make regulations on matters such as: packaging; the composition, therapeutic suitability, effect, purity, or other properties of medicines; and the importation, transportation, storage, or disposal of medicines and scheduled substances.[168]

Regulation of Information on Contraception

The Medicines Act prohibits the publication or distribution of any false or misleading advertisement concerning any medicine, including contraceptives.[169] Contraceptive advertisements or educational publications that contain explicit sexual content may also, pursuant to the provisions of the Films and Publications Act, 1996 (the "Films Act"), potentially be subject to age restrictions or other restrictions relating to distribution.[170] The Films Act was enacted to replace the earlier Publications Act, 1974 (No. 42 of 1974), which had been challenged as unconstitutional.[171] The Films Act is based on the principle that adults should enjoy the optimum amount of freedom, and that children should be protected against materials which are harmful or disturbing.[172] The Films Act establishes a Film and Publications Board,[173] with powers to regulate the distribution of certain publications and films, primarily by means of classification, the imposition of age restrictions, and the rendering of consumer advice.[174] Persons aggrieved by a decision of the Film and Publications Board may appeal the decision to a Film and Publications Review Board.[175]

D. ABORTION

Legal Status of Abortion

On November 12, 1996, South Africa enacted the Choice on Termination of Pregnancy Act, 1996 (the "Choice Act").[176] This act repealed the provisions related to abortion contained in the Abortion and Sterilization Act, 1975.[177] Section 2(1) of the Choice Act now defines the circumstances in which pregnancies may lawfully be terminated[178] to be:

(a) upon request of a woman[179] during the first 12 weeks of the gestation period[180] of her pregnancy;

(b) from the 13th week up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that —

(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy:

(i) would endanger the woman's life;

(ii) would result in severe malformation of the fetus; or

(iii) would pose a risk of injury to the fetus.

Requirements for Obtaining Legal Abortion

The Choice Act sets forth three major requirements for the performance of a legal abortion. First, the informed consent of the pregnant woman is required. Second, the law states that, depending upon the stage of pregnancy, the abortion must be performed either by a medical practitioner or a registered midwife. Finally, the Choice Act specifies the type of facilities in which such a procedure must occur.

The Choice Act requires the informed consent of the pregnant woman for the termination of her pregnancy.[181] In almost all circumstances, no consent other than that of the pregnant woman is required.[182] Where the pregnant woman is under 18 years of age, the Choice Act requires a medical practitioner or registered midwife to advise the woman to consult with her parents, guardian, family members, or friends prior to the procedure being performed. However, a woman may not be refused access to a termination of pregnancy because she chose not to consult with other individuals.[183] The only exceptions to the requirement of the pregnant woman's consent apply in the case of a woman who is either so severely mentally disabled that she is "completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy" or who is in a state of continuous unconsciousness with no reasonable prospect of regaining consciousness in time to request and to consent to the termination of her pregnancy.[184] If those conditions are met, the woman's guardian, spouse, or "curator" may request and consent to the termination of her pregnancy during the first 12 weeks of the gestation period, or from the 13th week up to and including the 20th week on the grounds set forth in Section 2(1)(b). However, the additional consent of two medical practitioners, or a medical practitioner and a registered midwife, is also required.[185] Alternatively, the pregnancy of such a woman may be terminated at the behest of two medical practitioners, or a medical practitioner and a registered midwife, in one of two circumstances. During the period up to and including the 20th week of the woman's gestation period, such practitioners may supply the necessary authorization if they are of the opinion that the continued pregnancy would pose a risk of injury to the woman's physical or mental health, or if there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality. After the 20th week of gestation, such practitioners may supply the requisite consent if they are of the opinion that the continued pregnancy would endanger the woman's life, result in a severe malformation of the fetus, or pose a risk of injury to the fetus.[186]

The Choice Act also stipulates the persons able to perform a legal abortion and the facilities where such a procedure can occur. Abortions performed at the request of a woman during the first 12 weeks of the gestation period may be carried out either by a medical practitioner or by a registered midwife who has completed the prescribed training course.[187] All other pregnancy terminations may be performed only by a medical practitioner.[188] In addition, surgical abortions may only be performed at a facility designated by the Minister of Health for that purpose.[189] Persons in charge of such facilities are required to keep records of all abortion procedures performed in their facilities, and must forward this information, while maintaining confidentiality regarding the woman's identity, to the Director-General of Health.[190] The Choice Act provides that the identity of women who have requested or obtained a termination of pregnancy must remain confidential at all times.[191]

Penalties

Section 10 of the Choice Act prescribes penalties for persons who contravene the requirements of this law. Any person who performs an abortion procedure and does not meet the professional qualifications required by the Choice Act is guilty of an offense and is liable upon conviction to a fine or to imprisonment for a period up to 10 years.[192] Persons who are

required to maintain and furnish records pursuant to the Choice Act but fail to do so are liable to be fined or to be imprisoned for a period not exceeding six months.[193] Furthermore, it is an offense for any person to prevent the lawful termination of a pregnancy or to obstruct access to a facility for the termination of a pregnancy. Any person found guilty of this offense is liable to a fine or to imprisonment for a period not exceeding 10 years.[194]

Regulation of Abortion Information

When a woman requests a termination of pregnancy from a medical practitioner or registered midwife, the Choice Act requires that practitioner to inform the woman of her rights pursuant to this law.[195] The Choice Act also places an obligation on the state to "promote the provision of non-mandatory and non-directive counseling, before and after the termination of pregnancy."[196]

E. STERILIZATION

There are no specific laws in South Africa regarding the performance of sterilizations upon persons capable of consenting. Sterilization is predominantly governed by South African statutory law as well as by the common law that applies to the performance of general surgical procedures.[197] The Child Care Act, 1983,[198] provides that any person over the age of 18 years is competent to consent, without the assistance of her or his guardian, to the performance of any operation upon herself or himself.[199] Thus, a mentally competent, consenting adult may freely choose sterilization as her or his preferred method of contraception.[200] Legal scholars in South Africa have differed on the issue of whether or not the sterilization of a married person requires the consent of that person's spouse.[201] The argument for spousal consent is based on an alleged legally protected interest of a person in the reproductive capacity of her or his spouse.[202] Nevertheless, it may be argued that the provision in the Constitution which guarantees that everyone has the right to make decisions concerning reproduction and control over his or her body[203] denies any right which persons may previously have had to refuse consent to the sterilization of their spouses.

The Abortion and Sterilization Act governs the sterilization of any person who for any reason is incapable of consenting, or who is legally incompetent to consent, to the operation.[204] In these circumstances, a sterilization may only be performed once three requirements have been met. First, two medical practitioners must certify in writing that the person concerned is suffering from a hereditary condition which would cause her or his child to suffer from a serious physical or mental disability, or that the person concerned is unable, due to permanent physical or mental disability, to comprehend the consequences of, or bear parental responsibility for, "the fruit of coitus."[205] Secondly, a magistrate or the person who is normally entitled to consent to an operation upon the person concerned — for example, the parent or guardian of a minor, or the curator of a mentally ill person under curatorship[206] — must consent to the operation.[207] Thirdly, the Minister of Health, or a medical officer of the Department of Health so authorized by the Minister of Health, must grant written authority for the sterilization.[208] Any person who performs a sterilization upon a person who was unable to consent, other than in accordance with the procedure described above, is guilty of a criminal offense punishable by a fine not exceeding U.S.$1,220.00 (R 5000), or to imprisonment for a period not exceeding five years, or to both the fine and imprisonment.[209]

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

Female genital mutilation ("FGM") — also referred to as female circumcision — is not practiced to a significant extent in South Africa,[210] and there is no legislation that explicitly addresses this practice. A person who subjected another person to FGM would, however, in all likelihood be liable to be charged with the common law offense of assault, which is the unlawful and intentional application of force or threat of force against another person.[211]

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

The HIV/AIDS epidemic has a significant impact on women's health and gives rise to important issues pertaining to reproductive rights. A full evaluation of laws and policies affecting reproductive health and rights in South Africa must therefore examine issues of HIV/AIDS and sexually transmitted diseases ("STDs"). The Department of Health has estimated that, in the beginning of 1996, 1.8 million South Africans were infected with HIV.[212] This number represents a tenfold increase over the past five years.[213] Overall, 10% of woman attending antenatal clinics are HIV-positive,[214] although in some urban areas this figure is as high as 30%.[215] At present, the primary mode of HIV transmission in South Africa is heterosexual intercourse — a radical change from the earlier phase of the epidemic from 1982 to 1986 when HIV infection and AIDS were mainly restricted to gay men.[216] South Africa is also in the midst of an epidemic of STDs.[217] At least 10% of the population have ulcerative infections caused by syphilis and chancroid, while the median prevalence rates of chlamydia and gonorrhea are 11% and 8%, respectively.[218]

Policies Affecting HIV/AIDS and STDs

In November 1988, the former South African government established AIDS Training and Information Centres in

strategic locations around the country and set up an AIDS Unit and National AIDS Advisory Group within the Department of Health.[219] In 1992, the AIDS Unit was replaced by a more "community-sensitive" AIDS Programme, within the Primary Health Care Directorate of the Department of Health.[220] Since 1994, the new Government has made AIDS a high priority within its programme of socioeconomic development.[221] The status of the AIDS Programme has been elevated to a Directorate within the Department of Health, and its sphere of operation has been expanded to include STDs.[222] The Department of Health has adopted five key approaches in a "medium term" strategy to combat the HIV and STD epidemics:

- life skills and responsible sex education programs in schools and youth centers;
- mass communication strategies to popularize methods of prevention;
- increased access to barrier methods of contraception, including male and female condoms;
- more effective and more appropriate management of STDs; and
- establishment of norms, standards, and guidelines for the care of patients suffering from AIDS.[223]

Laws Affecting HIV/AIDS

Although the South African Law Commission has recommended the passage of an "HIV and AIDS Act," there is at present no comprehensive statute dealing with issues relating to HIV/AIDS in South Africa.[224] Rather, South African law affecting AIDS currently derives from a variety of sources, including the common law, statutory law, and ethical guidelines and practice rules prepared by the South African Medical and Dental Council ("SAMDC"),[225] which specify the acts or omissions that may give rise to disciplinary action by the SAMDC.[226] It is also to be noted that all existing laws and policies are now subject to scrutiny in terms of the Bill of Rights enshrined in the Constitution, which binds not only the state, but also natural and juristic persons to the extent that particular provisions of the Bill of Rights are applicable.[227]

The most far-reaching protection that the Constitution provides to people with HIV or AIDS is contained in Section 9, which guarantees that everyone has the right to equal protection and benefit of the law, and which prohibits unfair discrimination by the state or any other person against anyone on various grounds, including disability.[228] Other provisions that provide potentially important protections to people with HIV or AIDS include, *inter alia*: the right to have one's dignity respected and protected;[229] the right to bodily and psychological integrity;[230] the right to privacy;[231] the right to freedom of movement;[232] the right to choose one's trade, occupation, or profession freely;[233] the right to fair labor practices;[234] the right to have access to health care services;[235] the right to basic education;[236] the right of access to information;[237] and the right to administrative action that is lawful, reasonable, and procedurally fair.[238]

Laws to Control HIV Transmission

Neither HIV nor AIDS has been declared to be a "notifiable medical condition"[239] such that health care workers are required to report cases to the local authorities. Rather, medical practitioners voluntarily supply information regarding all new cases of AIDS to the Department of Health while maintaining the anonymity of the person infected with HIV.[240] However, AIDS is listed as a "communicable disease" for the purposes of the Communicable Disease Regulations, which set forth far-reaching measures to contain the spread of communicable diseases in the event that such diseases constitute a real danger to health.[241] These measures include: the closure of teaching institutions and public places of entertainment; quarantine of persons carrying communicable diseases or of persons who have come into contact with such carriers; and the compulsory medical examination of persons suspected of being carriers of communicable disease and who constitute a danger to the public health.[242] The inclusion of AIDS as a "communicable disease" for the purposes of these regulations has been widely criticized, and draft regulations have been published for comment which would exclude AIDS from the application of these provisions.[243]

Criminal law has not been used as a measure to combat HIV transmission in South Africa.[244] However, it is possible that persons infected with HIV who knowingly or negligently engage in acts which could lead to the transmission of HIV to another person, may be liable to prosecution for crimes such as murder, attempted murder, culpable homicide, or assault.[245]

HIV/AIDS and Health Care

HIV-positive persons who seek medical treatment need special protection from health care providers who may not be sensitive to the special needs of these patients. The important question arises, for instance, of whether or not medical practitioners should be compelled to treat patients whom they know to be HIV-positive. In addition, it may be critical to ensure that a patient consents to HIV testing and that medical practitioners respect the confidentiality of their patients. South African law addresses several of these concerns.

The South African Medical and Dental Council Guidelines state that "[n]o health worker may ethically refuse to treat any patient solely on the grounds that the patient is, or may be, HIV seropositive."[246] The SAMDC Guidelines further state that "[n]o doctor may withhold normal standards of

treatment from any patient solely on the grounds that the patient is HIV seropositive, unless such variation of treatment is determined to be in the patient's interest."[247] However, the duty to treat as set forth in the SAMDC Guidelines is merely an ethical duty, rather than a legal one.[248] Under common law, a doctor in private practice may decide not to treat a patient for any reason — including the HIV status of the patient — except in an emergency or where the physician has already embarked on treatment of the patient.[249] On the other hand, medical practitioners who are employed by hospitals or by the state are bound by their conditions of service, which generally oblige such medical practitioners to treat all patients referred to them in the course of their employment.[250] In light of the constitutional prohibition of unfair discrimination[251] and its guarantee of a right of access to health care services,[252] it is likely that any refusal by a medical practitioner — whether in private or public sector practice — to provide care to HIV-positive persons could be challenged as a violation of the Constitution.

Testing the HIV-serostatus of a patient should only be performed with the informed consent of that patient.[253] This principle derives from the South African common law,[254] and has been confirmed by SAMDC Guidelines, which describe the types of information that must be given to patients.[255] The consent of a patient to an HIV test must be expressly given, as tacit consent is not considered sufficient under these circumstances.[256] The consent requirement may only be dispensed with in the event of an emergency.[257] Furthermore, substitute consent — such as from a "curator," guardian, or family member — may be obtained for HIV testing of mentally ill persons or persons below the age of 14 years.[258]

Medical practitioners have a duty to respect the confidentiality of their patients. This is a legal duty recognized by the common law, which has been reiterated in the rules of the SAMDC.[259] In *Jansen Van Vuuren and Another NNO v. Kruger*,[260] the court stated that the fact that "AIDS is a dangerous condition…on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards."[261] Disclosure of medical information is permissible only in limited circumstances, including: where the patient has consented to disclosure; where disclosure is required by law; or where disclosure is in the public interest.[262] However, disclosure of such information to sexual partners of the patient and to health care workers exposed to the blood or other bodily fluids of an HIV-infected patient may be justified as being in the public interest.[263] In such circumstances, SAMDC Guidelines prescribe that the medical practitioner should first attempt to obtain the patient's consent before making such disclosure.[264]

SAMDC Guidelines place no obligation on medical practitioners to undergo testing for HIV, or to inform patients of their HIV status. However, the SAMDC Guidelines set forth detailed instructions on "universal precautions" which should be used by health care workers to prevent transmission of HIV from health care workers to patients and vice versa.[265] Employers of health care workers have a legal duty to provide the necessary equipment and facilities for such universal precautions, pursuant to Section 8(1) of the Occupational Health and Safety Act,[266] which provides that "[e]very employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees."

HIV/AIDS and Education

Measures for the control of communicable diseases in schools are set forth in Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions[267] (the "Communicable Disease Regulations"). AIDS, but not HIV, is listed as a communicable disease in Annexure I of these regulations. The Communicable Disease Regulations require a school principal who is aware or has reason to suspect that a pupil is suffering from a communicable disease or was in contact with such a person to notify the relevant health or local government authorities without delay.[268] The principal may not allow a pupil suffering from AIDS to enter the school unless authorized thereto by a medical certificate to this effect.[269] A parent who knows that her or his child is suffering from AIDS or was in contact with such a person must inform the principal of the school of this.[270] The Communicable Disease Regulations have been widely criticized, and draft regulations that would expressly prohibit principals from refusing to allow students to attend schools on the basis that they are HIV-positive have been published for public comment.[271] In any event, the existing Communicable Disease Regulations may be in conflict with the Constitutional protection against unfair discrimination and the guarantee that everyone has the right to a basic education.[272]

HIV/AIDS and Employment

Under common law, employers have the right to freely decide whom they wish to employ and may therefore require prospective employees to undergo an HIV test prior to employment.[273] However, the recently promulgated Labour Relations Act, 1995,[274] contains a "transitional" provision protecting both employees and applicants for employment from unfair discrimination — direct or indirect — on any arbitrary ground, including disability.[275] Pursuant to the

common law, employers may not require an employee to undergo HIV testing against his or her will, as this would amount to unilateral alteration of the employment contract.[276] HIV-positive employees also have no legal duty to inform their employers of their HIV serostatus, unless that person poses a threat to the health of other employees or she or he becomes so ill as to be unable to properly fulfill the employment obligations.[277] Dismissal solely on the grounds of HIV infection is likely to be regarded as automatically unfair. Section 187(1)(f) of the Labor Relations Act provides that a dismissal is "automatically unfair if… the reason for the dismissal is…that the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, including, but not limited to…disability."

HIV/AIDS and Life Insurance

HIV testing for the purposes of life insurance is not regulated by South African law. Rather, the Life Offices Association ("LOA") — an association of life assurance companies[278] — has entered into an agreement (the "LOA Agreement") that is binding on all its members and which sets forth minimum standards regarding the insurance of HIV-positive persons.[279] Pursuant to this agreement, a negative HIV test result is a precondition for the issuance of life policies worth U.S.$48,780 (R 200,000) or more, or for disability policies of U.S.$488 (R 2,000) per month or more.[280]

Laws Affecting STDs

South African law does not specifically prescribe measures to be taken for the prevention and control of STDs. STDs have neither been declared "communicable diseases" for the purposes of the Communicable Disease Regulations[281] nor have they been declared "notifiable medical conditions" pursuant to the powers conferred on the Minister of Health by the Health Act, 1977.[282] The control of STDs does, however, fall within the broad powers conferred on local authorities by the Health Act to render services for the prevention of communicable diseases.[283]

H. ARTIFICIAL INSEMINATION

The Human Tissue Act, 1983,[284] and detailed regulations issued thereunder,[285] regulates the conditions in which persons may be artificially inseminated in South Africa. Artificial insemination may be performed only upon a married woman — including a woman married under customary law — and only with the written consent of her husband.[286] A child born as a consequence of artificial insemination is regarded by law as the legitimate child of the woman giving birth and her husband.[287] The South African Law Commission has also recently proposed a Bill on Surrogate Motherhood, which would regulate the artificial insemination of women acting as surrogate mothers.[288] The provisions of the bill, however, must be scrutinized for compliance with the Constitution before it can be enacted into law.[289]

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's legal status within society. Not only do laws relating to women's legal status reflect societal attitudes that affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the frustration of a woman's access to reproductive health care and her ability to make voluntary and informed decisions about such care. Laws regarding age of first marriage can also have a significant impact on a young woman's reproductive health. Furthermore, laws relating to rape, sexual assault, and domestic violence present significant rights issues and can have direct consequences for women's health.

At the outset of this discussion, it is important to note that several structures have been established to ensure that issues of women's health and gender equality are adequately addressed by the government. A national Maternal, Child and Women's Health Directorate has been established within the Department of Health, and directorates or subdirectorates for Maternal, Child and Women's Health have been set up in most of the provinces.[290] Furthermore, the Constitution mandates the establishment of a Commission for Gender Equality to promote respect for gender equality and for the protection, development, and attainment of gender equality.[291] Pursuant to this Constitutional mandate, the Commission on Gender Equality Act, 1996,[292] was enacted to provide for the composition, powers, functions, and functioning of the Commission for Gender Equality.[293] The functions of the Commission for Gender Equality are extensive and include, *inter alia*: monitoring and evaluating the policies of governmental or private bodies; making recommendations in respect of any law which may potentially affect gender equality or the status of women, or new legislation which would promote gender equality; investigating gender-related issues with a view to resolving disputes or rectifying acts or omissions; and monitoring compliance with international legal instruments related to the objects of the Commission.[294] In exercising these functions,

members of the Commission have wide powers, including limited powers of entry, search, and seizure.[295]

A. RIGHTS WITHIN MARRIAGE

Marriage Law

In South African law, marriage is defined as "the legally recognized voluntary union of one man and one woman to the exclusion of all others while it lasts."[296] To enjoy full legal recognition, marriages must be solemnized by a duly authorized marriage officer[297] in accordance with the provisions of the Marriage Act, 1961.[298] Unless the parties to the marriage specified otherwise in an "antenuptial contract," parties to civil marriages contracted before November 1, 1984, were married "in community of property,"[299] and wives were subject to the "marital power" of their husbands such that a wife was unable to contractually bind the joint household without her husband's consent. A husband, however, could even alienate the marital home without his wife's consent.[300] The Matrimonial Property Act, 1984,[301] abolished "marital power" in respect of all marriages entered into after November 1, 1984,[302] and, in the absence of an antenuptial contract specifying otherwise, made all marriages subject to community property principles with "accrual," whereby husband and wife are joint administrators of the joint estate for the duration of the marriage and share equally in the profits accrued during the marriage on its dissolution.[303] "Marital power" was finally abolished in all civil marriages by the General Law Fourth Amendment Act, 1993.[304] The effect of the abolition of "marital power" in civil marriages is to eliminate the restrictions on a wife's capacity to contract and to litigate.[305] Hence, these reforms have given wives legal equality with their husbands.[306]

Marriages of men and women pursuant to African customary law do not constitute legally valid marriages because they are potentially polygamous and are not solemnized by designated marriage officers according to the formalities set forth in the Marriage Act.[307] In several statutes, however, customary marriages are accorded the same legal consequences as legally valid marriages for certain specific purposes,[308] including for the purposes of maintenance.[309] The basic requirements for a customary marriage include:[310] payment of bridewealth by the prospective husband or his family to the family of the woman he intends to marry; consent of the bride and bridegroom; and consent of the bride's guardian, although such consent may not be "unreasonably" withheld.[311] The Black Administration Act, 1927,[312] provides that black women who are partners in customary unions and living with their husbands are legally considered to be "minors" under the guardianship of their husbands.[313]

The Marriage Act makes provision for Islamic and Hindu religious leaders to be designated marriage officers for the purpose of solemnizing marriages according to "Mohammedan rites or the rites of any Indian religion."[314] Hindu marriages are legally recognized as valid marriages only if solemnized by a duly designated marriage officer in accordance with the provisions of the Marriage Act.[315] Marriages performed according to Muslim law are not valid, however, because they are "potentially polygamous,"[316] although they are afforded some limited statutory recognition similar to those afforded to customary marriages.[317] For a discussion on marriage and adolescents, see the section on adolescents below.

Divorce and Custody Law

The Divorce Act, 1979,[318] provides that a court may grant a divorce on one of two grounds — the "irretrievable breakdown of marriage" and the mental illness or continuous unconsciousness of a party to the marriage.[319] "Irretrievable break-down of marriage" refers to a marriage that "has reached such a state of disintegration that there is no reasonable prospect of the restoration of a normal marriage relationship."[320] There are no restrictions on the types of facts or circumstances which may be indicative of an irretrievable breakdown of marriage,[321] and the blameworthiness of the spouses' conduct is irrelevant to granting a divorce.[322] The court may, however, postpone the divorce proceedings to enable the parties to attempt reconciliation, if it is of the opinion that the spouses may be reconciled.[323]

When granting a divorce, a court may make an order regarding the custody of any children of the marriage.[324] In making such an order, courts must be guided primarily by the best interests of the child, taking account of all relevant circumstances.[325] Ultimately the court must decide which of the parents will better fulfill the child's multiple needs.[326] In general, custody of young children and daughters of any age is awarded to the mother,[327] while custody of older boys is awarded to the father.[328] Where the court grants custody to one parent, the other parent retains a right of reasonable access to the children.[329] The Divorce Act further provides that a court may make an order regarding the guardianship[330] of the child, including an order granting sole guardianship to either of the parents.[331] The Guardianship Act, 1993,[332] grants guardianship of minor children born of a marriage to the mother, in the absence of a court order to the contrary.[333] Furthermore, a court granting a decree of divorce may make any order which it considers appropriate with regard to the maintenance of a dependent child of the marriage.[334] Courts may order one spouse to pay maintenance to the other in accordance with a written agreement between them.[335] Maintenance orders are enforced by maintenance courts, pursuant to the provisions of the Maintenance Act, 1963.[336]

In customary law marriages, the failure of either spouse to perform her or his duties in marriage may be sufficient reason for divorce.[337] Wives generally have sufficient reason for divorce if their husbands failed to support them or if their husbands exceeded the "right of moderate chastisement."[338] Grounds for dissolution of customary marriages in KwaZulu-Natal are enumerated by the Natal and KwaZulu Codes. These codes provide that either partner to a customary marriage may bring an action for divorce on any of the following grounds: adultery; continued refusal of the other party to engage in sexual intercourse; desertion; "continued gross misconduct"; imprisonment of the partner for a period not less than five years; or the existence of conditions which "render the continuous living together of the partners insupportable or dangerous."[339] In addition, wives may bring an action for divorce by reason of "gross cruelty" or ill-treatment by the husband, or accusations of witchcraft or other "serious allegations" made against them by their husbands.[340]

In the absence of agreement to the contrary between the spouses' families, customary law entitles the husband and his family to full parental rights in respect of children born of a marriage, if bridewealth has been paid.[341] However, despite this rule of customary law, courts apply common law principles to custody insofar as they award custody to the parent who is better able to serve the best interests of the child.[342] In customary law, the closest analogy to maintenance is *isondlo*, which is a onetime payment that may be claimed by any person who has raised a child, if the parent claims custody of that child.[343] In fact, statutory law is now typically applied to maintenance claims.[344] The Natal and KwaZulu Codes provide that, upon the dissolution of a customary marriage, courts may make any order regarding maintenance of minor children that it considers "just and expedient."[345]

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

While customary law places restrictions on women's entitlement to land ownership,[346] women gain access to land through the general duty of support owed to them by the male head of the family. Pursuant to this duty, the family head allots to wives pieces of land on which to support themselves and their children.[347] The discriminatory effects of customary law in this regard are compounded by Section 11(3)(b) of the Black Administration Act,[348] whereby women in customary unions are considered minors and are subject to the guardianship of their husbands. Hence, husbands in customary marriages are given legal control of everything owned or acquired by their wives.[349] Some of the harsher effects of this law have been mitigated to some extent by Section 11A of the Black Administration Act, which exempts black women from black law and custom insofar as it affects the acquisition or disposal of a "right of leasehold, sectional leasehold or ownership," or the borrowing of money on the strength of that right, or the defense of that right in a court of law.[350] While Section 11A has been lauded as a "victory for African women,"[351] it has also been criticized for providing "limited formal equality" which "does not reflect social reality."[352]

Customary laws that restrict women's access to property appear to be in violation of Section 9 of the Constitution, which provides that everyone is equal before the law and prohibits unfair discrimination on the basis of gender or sex.[353] These laws also appear to be in direct violation of Section 25(1) of the Constitution, which provides that "no law may permit arbitrary deprivation of property."[354] The Ministry of Land Affairs has recognized the unconstitutionality of laws that prejudice the ability of women to own land and has articulated its commitment to eradicate gender discrimination in land allocation and ownership.[355] In pursuing this objective, the government has identified the need to remove all legal restrictions on women's access to land and to ensure that land assets are registered in the names of beneficiary members of a household, rather than solely in the name of the head of the household.[356]

Labor Rights

The South African government has articulated its commitment to ensuring that all workers have equal rights.[357] The government has already made significant strides toward protecting the rights of women employees by passing the Labour Relations Act, 1995.[358] The Labour Relations Act provides that every employee has the right not to be unfairly dismissed.[359] Dismissals are "automatically unfair" in certain circumstances, such as where the reason for the dismissal is the employee's pregnancy, intended pregnancy, or any related reason, or where the dismissal occurred because the employer "unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground," including, *inter alia*: gender, sexual orientation, marital status, or "family responsibility."[360]

The Minister of Labour has commissioned the drafting of a new employment standards law.[361] The Department of Labour subsequently published for public comment a set of preliminary policy proposals concerning the possible content of the new statute (the "Employment Standards Policy").[362] The Employment Standards Policy takes note of certain areas of South African employment law that need to be revised in the new employment standards law because they provide inadequate protection to women workers. First, farm workers, domestic workers, and part-time workers — a high proportion of whom are women[363] — are excluded from certain

protections, including minimum wages, the right to unpaid leave, and sick pay, all available to other workers.[364] The Employment Standards Policy proposes that such workers be given the protection of the new employment standards law.[365] Secondly, the Employment Standards Policy recognizes the need for reconsidering the existing regulation of maternity leave and maternity pay, and the need for legislation to provide for a short period of paid paternity leave.[366] Currently, the Basic Conditions of Employment Act prohibits women from working for four weeks before and eight weeks after childbirth, unless they are granted a special exemption.[367] Employees have no general entitlement to maternity pay, although the Unemployment Insurance Act allows contributors to the Unemployment Insurance Fund to receive 45% of their wages for up to six months.[368] The Unemployment Insurance Act, 1966,[369] however, entitles women who adopt a child under two years of age to maternity leave.[370] Thirdly, the Employment Standards Policy proposes that special protection should be given to pregnant employees engaged in night work, and that pregnant women and nursing mothers who normally engage in work that might place their health at risk should be offered suitable alternative work without loss of salary.[371]

The Ministry of Labor has also published policy proposals for a new Employment and Occupational Equity Statute.[372] This law will implement measures to eradicate discrimination in employment practices, prevent harassment in the workplace (including sexual harassment), and enable the Department of Labour to require companies to develop employment equity plans.[373] Other measures to ensure equal treatment of employees will be implemented through codes of practice and subsidiary legislation.[374]

Access to Credit

Gender equality is a major objective of the current government's economic policy.[375] Within this policy, the government has identified the need to address the problem of credit constraints for women with limited collateral through, for example, increasing training opportunities for women, improving credit subsidies, and encouraging innovative credit schemes.[376]

Access to Education

The educational system in South Africa is characterized by significant disparities in educational levels on the basis of both race and gender. The new South African government has articulated policy and implemented structures specifically to eradicate these disparities and to ensure equal access to education for all. For a discussion of these measures, see the section on adolescents below.

C. RIGHT TO PHYSICAL INTEGRITY

Rape

Rape is defined as "intentional, unlawful sexual intercourse with a woman without her consent."[377] The offense of rape requires penetration of the penis into the vagina. Non-consensual oral sex, anal sex, or insertion of foreign objects into the vagina constitute the offense of "indecent assault" rather than rape.[378] In 1993, the Prevention of Family Violence Act[379] was enacted, which provides that a husband may be convicted of the rape of his wife.[380] Sexual intercourse with a girl under 16 years of age, regardless of her consent, constitutes statutory rape.[381] For a further discussion of statutory rape and other sexual offenses against minors, see the section on adolescents below.

Prosecution in rape cases is complicated by certain rules of evidence that favor the defendant. In rape cases, South African courts are guided by a "cautionary rule" of evidence, which requires additional care to be taken when accepting the uncorroborated testimony of women who have been raped.[382] In effect, the cautionary rule results in an additional burden of proof for the prosecution beyond the ordinary standard of proof beyond a reasonable doubt applied to other assault crimes.[383] Furthermore, the rule of evidence barring introduction of a victim's earlier sexual history during a rape trial is waived if the complainant previously had a relationship with the defendant.[384] While the judicial process is often a harrowing experience for rape survivors,[385] the creation of a Sexual Offences Court in Wynberg, Western Cape, represents a promising initiative to address this problem, albeit on a limited scale. The Wynberg Sexual Offenses Court, established in 1992, employs women assessors and specially trained prosecutors with lighter caseloads to better prepare for cases. Separate waiting rooms are provided for the plaintiffs and defendants. Furthermore, police officers from each of the Criminal Investigation Units in the surrounding areas have been trained as police rape specialists.[386]

Domestic Violence

South African criminal law does not recognize domestic violence as a specific crime, although women may charge abusive husbands or partners with the common law offense of assault.[387] The principal civil law remedy available to victims of domestic violence is an interdict issued pursuant to the Prevention of Family Violence Act.[388] The remedy is available between "a man and a woman who are or were married to each other according to any law or custom and also a man and a woman who ordinarily live or lived together as husband and wife, although not married to each other."[389] In the interdict, a judge or magistrate may enjoin the alleged abuser from

committing any act including, but not limited to: assaulting or threatening the complainant or a child living with one or both of the parties; entering the matrimonial home or other place where the complainant resides; or preventing the complainant or a child who ordinarily lives in the matrimonial home from entering that home.[390] The interdict is accompanied by a warrant for the arrest of the alleged abuser, which is suspended subject to compliance with the interdict.[391] A partner arrested for noncompliance with such an interdict must be brought before a judge or magistrate within 24 hours of the arrest.[392] The penalty for failure to comply with an interdict issued pursuant to this act is a fine or imprisonment for a period not exceeding 12 months, or both the fine and imprisonment.[393]

Sexual Harassment

South Africa has no legislation which specifically addresses sexual harassment. Nevertheless, the problem of sexual harassment in the workplace is receiving increasing attention by the courts and by the Ministry of Labour. In 1989, a sexual harassment suit was brought before a South African court for the first time.[394] In this case, the court found a senior executive guilty of touching a woman co-worker inappropriately, and held that employers had a duty to ensure that their employees were not subjected to sexual harassment in the workplace.[395] In 1995, the Minister of Labour, Tito Mboweni, issued a statement expressing the Ministry's concern regarding the extent of sexual harassment in South African workplaces and pledging the full support and cooperation of the Ministry and Department of Labour for initiatives aimed at eliminating sexual harassment.[396] The Minister of Labour indicated that the Directorate for Equal Opportunities, established within the Department of Labour, would address issues of sexual harassment in the workplace.[397] In addition, the recently promulgated Labour Relations Act, 1995,[398] established a Commission for Conciliation, Mediation and Arbitration.[399] One of the functions of this Commission is to provide employees, employers, and employees' or employers' organizations with advice or training concerning the prevention of sexual harassment in the workplace.[400]

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

The needs of adolescents are often unrecognized or neglected. Given that 37.1% of the South African population is under the age of 15,[401] it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescent rights, including those related to reproductive health, are important for women's right to self-determination as well as for their health.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

Issues of adolescent health, including reproductive health, fall within the responsibilities of the Maternal, Child and Women's Health Directorate of the Department of Health.[402] Until now, adolescents have typically not been provided with access to the full range of reproductive health services, such as education and counseling about sexuality and adolescent health. Few centers have existed that specialize in adolescent health, and these have largely been confined to the main cities.[403] Furthermore, the Child Care Act, 1983 (Act No. 74 of 1983), provides that persons of 14 years or younger require the assistance of their parent or guardian to obtain medical treatment.[404] In effect, this means that children under the age of 15 years cannot legally have access to contraceptive measures without the consent of their parent or guardian.[405] The Department of Health has set the goal of providing all health workers with training in the field of adolescence by the year 1998.[406]

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

As mentioned above, FGM is not practiced to any significant extent in South Africa.[407]

C. MARRIAGE AND ADOLESCENTS

The Marriage Act requires minors — persons under the age of 21[408] — who have not previously contracted a valid marriage to obtain the consent of their parents or guardians as a prerequisite for marriage.[409] However, boys under the age of 18 years and girls under the age of 15 years may not enter a valid marriage except with the permission of the Minister of Home Affairs or other authorized officer.[410] Customary law regimes do not specify a minimum age for first marriage, but rather require only that the spouses have reached puberty, the age of which varies from person to person.[411]

D. EDUCATION AND ADOLESCENTS

The South African educational system is characterized by significant disparities in educational levels between men and women, and among the various racial groups. In 1993, 99% of white South Africans were literate, as compared to 84% of Indians, 66% of coloreds, and 54% of Africans.[412] Women account for 53.4% of persons aged 16 to 24 who are not attending school and have not yet obtained Standard 10 (the highest level of schooling).[413] Black women were doubly disadvantaged by apartheid policies of the former South African government, which sought to exclude black children from

educational opportunities that would allow them to engage in higher education and higher-skilled careers, and by socioeconomic pressures which resulted in many girls having to leave school prematurely.[414]

The new South African government has demonstrated a firm commitment to eradicating these disparities in access to education. The National Education Policy Act, 1996,[415] provides that national education policy must advance the right of every person to basic education and equal access to education institutions,[416] and must be directed toward "achieving equitable education opportunities and the redress of past inequality in education provision, including the promotion of gender equality and the advancement of the status of women."[417] The government has already announced its intention to provide free and compulsory education for all children from a "reception year" up to grade nine.[418] On January 1, 1995, the government commenced implementation of the "ten years free and compulsory education" policy by enrolling all six-year-olds in Grade One.[419] The policy is expected to be phased in over several years.[420]

The Ministry of Education has also announced its intention to establish a fulltime Gender Equity Commissioner and a permanent Gender Equity Unit within the Department of Education.[421] The functions of the Gender Equity Unit will be to advise the Director-General of Education on all aspects of gender equity in the education system, including, for example: possible mechanisms to correct gender imbalances in enrollment, subject choice, career paths, and employment; responses to sexism in curricula, textbooks, teaching, and guidance; and strategies to eliminate sexism, sexual harassment, and violence throughout the educational system.[422]

E. SEX EDUCATION FOR ADOLESCENTS

Education of adolescents on issues of STDs and HIV/AIDS is one of the key strategies of the Department of Health's HIV/AIDS and STD Programme.[423] Education on these issues will form part of a broader program that will encompass matters such as nutrition, substance abuse, and environmental awareness.[424] In 1997, a comprehensive package on health, including sexual health, will be incorporated into school curricula for the first time.[425]

F. SEXUAL OFFENSES AGAINST MINORS

Section 14(1) of the Sexual Offenses Act, 1957,[426] makes it an offense for any man to have or attempt to have sexual intercourse with a girl under 16 years of age, or to commit or attempt to commit an "immoral or indecent act" with a boy or girl under the age of 19 years, or to solicit such an act.[427] The Sexual Offenses Act specifies two defenses which may be raised to charges pursuant to this section.[428] The first such defense incorporates three components, each of which must be present for the defense to succeed, namely: at the time of the offense, the girl was a prostitute; the accused was under the age of 21 years at the time of the offense; and the accused had not previously been charged with a similar offense.[429] The second defense is that the girl, or the person in whose charge she was, deceived the accused into believing that she was over the age of 16 years at the time of the offense.[430] The consent of the minor is not a defense to a charge pursuant to this section.

ENDNOTES

1. The S. Afr. Found., *South Africa: The Land and its People* (visited Feb. 12, 1997) <http://www.satcis.co.za/002.saoverview/001.safhtml/001.info_on_sa/003.landandpeople.html>.
2. The Nguni (Xhosa, Zulu, Swazi, Ndebele), Sotho (North, South and Tswana), Venda, Lemba and Shangaan-Tsonga.
3. The S. Afr. Found., *supra* note 1.
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. *Central Statistical Services* (visited Feb. 19, 1997) <http://www.css.gov.za/releases/demograp/y91_95/p0302.htm>.
10. People of mixed race who live predominantly in the Western Cape.
11. SOUTH AFRICAN HEALTH REVIEW 1995, at 5 (Health Sys. Trust [Durban] & Henry J. Kaiser Family Found. 1995).
12. Afrikaans, English, isiNdebele, Sesotho sa Leboa, Sesotho, siSwati, Xitsonga, Setswana, Tshivenda, isiXhosa, and isiZulu. S. AFR. CONST. § 3(1).
13. The S. Afr. Found., *South Africa: Briefly* (visited Feb. 19, 1997) <http://www.satcis.co.za/002.saoverview/002.sa_briefly/rsa_info.html>.
14. Cape, Natal, Orange Free State, and Transvaal.
15. The so-called TBVC states: Transkei, Bophutatswana, Venda, and Ciskei.
16. Gazankulu, Kangwane, KwaNdebele, KwaZulu, Lebowa, and QwaQwa.
17. S. AFR. CONST. § 103(1).
18. The negotiations process which commenced in February 1990 between the former South African government and liberation movements culminated in an agreement on a two-stage transition of governmental power. Initially, the country would be governed by an interim government comprising a coalition of the major political parties. The interim government would be established under an interim constitution agreed to by the negotiating parties, while a transitional national legislature, elected by universal adult suffrage, would be responsible for drafting a new Constitution. CONSTITUTIONAL COURT OF SOUTH AFRICA, CERTIFICATION OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996, Case CCT 23/96; *decided on* September 6, 1996, ¶ 12. In accordance with this agreement, the Constitution of the Republic of South Africa Act No. 200 of 1993 (the "Interim Constitution") became effective on April 27, 1994. On December 10, 1996, the final Constitution was signed into law. This act is entitled the CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA ACT, 1996.
19. S. AFR. CONST. § 40(1).
20. *Id.* § 151(1).
21. *Id.* § 151(3).
22. *Id.* § 85(1).
23. *Id.* § 86(1).
24. *Id.* § 84(1).
25. *Id.* § 85(2).
26. *Id.* § 91(2).
27. *Id.* § 92(2).
28. *Id.* § 125(1).
29. *Id.* § 128(1).
30. *Id.* § 125(2).
31. *Id.* § 132.
32. *Id.* § 125(6).
33. *Id.* § 151(2).

34. *Id.* § 157.
35. *Id.* § 151(4).
36. *Id.* § 43.
37. *Id.* § 42(1).
38. *Id.* § 46(1).
39. *Id.* § 49(1).
40. *Id.* § 42(3).
41. *Id.* § 60(1).
42. *Id.* § 42(4).
43. *Id.* § 104(1).
44. *Id.* § 105(2).
45. *Id.* § 108(1).
46. *Id.* § 104(1). Section 143 of the Constitution provides that a provincial constitution must not be inconsistent with the Constitution, and may provide for provincial legislative or executive structures and procedures, and also for the institution, role, authority and status of a traditional monarch. Furthermore, provincial constitutions must comply with principles of cooperative government and may not confer on provincial government powers beyond those provided for by the Constitution.
47. S. AFR. CONST. § 104(1).
48. *Id.* § 44(1).
49. *Id.* § 146(2). The criteria include, *inter alia*: the national legislation deals with a matter that cannot be regulated effectively by provincial legislation; national interests require uniformity provided by legislation which establishes norms and standards, frameworks or national policies; or the national legislation is necessary for the maintenance of national security, the maintenance of economic unity, the promotion of equal opportunity or equal access to government services, or the protection of the environment. In addition, § 146(3) of the Constitution states that national legislation pertaining to a matter listed in Schedule 4 prevails over provincial legislation if the national legislation aims to prevent unreasonable provincial action that prejudices the economic, health or security interest of another province or the whole country, or which obstructs the implementation of national economic policy.
50. Such intervention is permissible to maintain national security, economic unity, or essential national standards, to establish minimum standards required for the rendering of services, or to prevent unreasonable provincial action which is prejudicial to the interest of another province, or to the whole country. S. AFR. CONST. § 44(2).
51. *Id.* § 151(2).
52. *Id.* § 156(2). A municipality has the right to administer any matter assigned or delegated to it by national or provincial legislation, as well as matters listed in Part B of Schedule 4 (including, *inter alia*, child care facilities and municipal health services) and in Part B of Schedule 5 (including, *inter alia*, local amenities and control of public nuisances).
53. S. AFR. CONST. § 156(3).
54. *Id.* § 165.
55. *Id.* § 166.
56. Telephone interview with Michael Jennings, Attorney of the Supreme Court of South Africa (Jan. 31, 1997).
57. S. AFR. CONST. § 167(1).
58. *Id.* §§ 167(3), 167(7).
59. *Id.* § 167(5).
60. *Id.* § 168(3).
61. *Id.* § 169.
62. *Id.* § 170.
63. *Id.*
64. *Id.* § 179(1).
65. *Id.* § 179(2).
66. *Id.* § 2.
67. *Id.*
68. *Id.* § 8(1).
69. *Id.* § 36(1).
70. *Id.* § 38. This section provides that persons who may approach the court for such relief are: anyone acting in her or his own interest; anyone acting on behalf of another person who cannot act in his or her own name; anyone acting as a member of, or in the interest of, a group or a class of persons; anyone acting in the public interest; and an association acting in the interest of its members.
71. S. AFR. CONST. § 39(1).
72. *Id.* § 39(2).
73. *Id.* § 9.
74. *Id.* § 12(2).
75. *Id.* § 27(1). Section 27(2) provides that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of this right.
76. 3 THOMAS H. REYNOLDS & ARTURO A. FLORES, FOREIGN LAW: CURRENT SOURCES OF CODES AND LEGISLATION IN JURISDICTIONS OF THE WORLD SA 3 (1993).
77. *Id.* at SA 5.
78. *Id.*
79. LAW OF EVIDENCE AMENDMENT ACT 45 of 1988.
80. "Indigenous law" is defined in subsection (4) to mean "the black law or customs as applied by the black tribes in the Republic or in territories which formerly formed part of the Republic."
81. Subsection (2) allows parties to a suit to adduce evidence of the substance of customary laws.
82. Subsection (1) includes a proviso that it shall not be lawful to declare that the custom of bridewealth is repugnant to principles of public policy or natural justice.
83. T. W. BENNETT, A SOURCEBOOK OF AFRICAN CUSTOMARY LAW FOR SOUTHERN AFRICA 53 (1991).
84. *Id.* at 124–28.
85. THE NATAL CODE OF ZULU LAW P151 of 1987.
86. KWAZULU ACT ON THE CODE OF ZULU LAW, ACT 16 OF 1985.
87. S. AFR. CONST. art. 2, sched. 6.
88. T.W. BENNETT, HUMAN RIGHTS AND AFRICAN CUSTOMARY LAW UNDER THE SOUTH AFRICAN CONSTITUTION 58 (1995).
89. S. AFR. CONST. § 211(3).
90. *Id.* § 211(2).
91. *Id.* § 212(2).
92. *Id.* § 15(3).
93. *Id.* § 231(1).
94. *Id.* § 231(2). International agreements signed by the national executive which are of a technical, administrative or executive nature, or which otherwise do not require ratification or accession, are legally binding without approval by the National Assembly and the National Council of Provinces, but must be tabled in both houses of Parliament within a reasonable time. S. AFR. CONST. § 231(3).
95. *Id.* § 231(4).
96. *Id.* § 232.
97. I. Currie, *List of Human Rights Treaties Acceded to or Ratified by South Africa* (visited Feb. 19, 1997) <http://pc72.law.wits.ac.za/docs/ratlist.html>.
98. Convention on the Elimination of All Forms of Discrimination against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 14 (*entry into force* Sept. 3, 1981) (signed by South Africa on Jan. 29, 1993 and ratified in 1995).
99. Convention on the Rights of the Child, G.A. Res 640 (VII), 7 U.N. GAOR, Supp. (No. 20) at 27, U.N. Doc. A/2361 (1952) (*entry into force* July 7, 1954) (signed by South Africa on Jan. 29, 1993 and ratified in 1995).
100. CURRIE, *supra* note 97.
101. International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, 993 U.N.T.S. 3 (*entry into force* Sept. 3, 1976).
102. International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, 999 U.N.T.S. 171 (*entry into force* March 23, 1976).
103. African Charter on Human and Peoples' Rights, *adopted* June 26, 1981, OAU Doc. CAB/LEG/67/3/Rev. 5 (1981) *reprinted* in 21 I.L.M. 58 (1982) (*entry into force* Oct. 21, 1986).
104. International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (*entry into force* Jan. 4, 1969).
105. SOUTH AFRICAN HEALTH REVIEW 1996, at 197 (Health Sys. Trust [Durban] & Henry J. Kaiser Family Found. 1996).
106. AFR. NAT'L CONGRESS, THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME ¶ 2.12.5.2 (1994) [hereinafter RECONSTRUCTION AND DEVELOPMENT PROGRAMME 1994].
107. *Id.* ¶ 2.12.1; *see also* Dep't of Health, *Restructuring of the National Health System for Universal Primary Health Care* ¶ 2 (1996) (visited Feb. 19, 1997) <http://www.aztec.co.za/biz/dgreen/nhipart1.htm> [hereinafter *Restructuring of the National Health System*].
108. Private sector employment accounts for 59% of physicians, 93% of dentists, 89% of pharmacists, and 60% of supplementary health personnel. However, only an estimated 23% of South Africans have regular access to private sector health care. *Restructuring of the National Health System*, *supra* note 107, ¶ 2.2.
109. *Id.* ¶ 2.4.
110. RECONSTRUCTION AND DEVELOPMENT PROGRAMME 1994, *supra* note 106, ¶ 2.12.5.8.

111. *Restructuring of the National Health System, supra* note 107, ¶ 2.5.
112. Dep't of Health [S. Afr.], Towards a National Health System 7-10 (1995) [hereinafter Towards a National Health System].
113. S. Afr. Const. §§ 104(1), 125(2), *read with* S. Afr. Const. sched. 4; Towards a National Health System, *supra* note 112, at 15.
114. Towards a National Health System, *supra* note 112, at 15.
115. *Restructuring of the National Health System, supra* note 107, ¶ 4.3.2.
116. Id. ¶ 4.3.5.1.
117. *Id.* ¶ 4.3.4.
118. *Id.* ¶ 4.2.1.
119. One U.S. dollar is worth approximately 4.10 South African Rands. Thomas Cook Foreign Exchange (Feb. 24, 1997).
120. South African Health Review 1996, *supra* note 105, at 76.
121. *Restructuring of the National Health System, supra* note 107, ¶ 5.
122. South African Health Review 1995, *supra* note 11, at 165.
123. *Id.* at 194.
124. Services provided to pregnant women pursuant to this policy include all available health services, and are not limited to services for conditions related to the pregnancy. Government Gazette Notice 657(1994), *as reproduced in* South African Health Review 1996, *supra* note 105.
125. *Id.* at 162.
126. South African Health Review 1995, *supra* note 11, at 195.
127. These amendments were effected by: the Medical, Dental and Supplementary Health Service Professions Amendment Act No. 18 of 1995; Nursing Amendment Act No. 5 of 1995; Pharmacy Amendment Act No. 6 of 1995; and the Chiropractors, Homeopaths and Allied Health Service Professions Amendment Act No. 40 of 1995.
128. Medical, Dental and Supplementary Health Service Professions Amendment Act No. 18 of 1995, § 4; Nursing Amendment Act No. 5 of 1995, § 4; Pharmacy Amendment Act No. 6 of 1995, § 4; and Chiropractors, Homeopaths and Allied Health Service Professions Amendment Act No. 40 of 1995, § 4.
129. Towards a National Health System, *supra* note 112, at 40.
130. *Id.*
131. Stephen Harrison, Review and Reform of South African Health Legislation 116 (1995) (unpublished L.L.M. dissertation, University of Cape Town).
132. *Id.*
133. *Id.* at 118.
134. *Id.*
135. *See, e.g.*, §§ 41 and 42 of the Medical, Dental and Supplementary Health Service Professions Act No. 56 of 1974.
136. *Restructuring of the National Health System, supra* note 107, ¶ 4.1, § 8.
137. Towards a National Health System, *supra* note 112, at 46.
138. Ministry for Welfare & Population Dev., A Green Paper for Public Discussion: Population Policy for South Africa 14 (1995) [hereinafter Green Paper on Population Policy].
139. *Id.*
140. *Id.*
141. *Id.* at 14-15.
142. Reconstruction and Development Programme 1994, *supra* note 106.
143. Green Paper on Population Policy, *supra* note 138, at 15.
144. S. Afr. Const. §§ 104(1), 125(2), read with S. Afr. Const. sched. 4. *See infra* discussion of Setting the Stage: the Legal and Policy Framework.
145. Green Paper on Population Policy, *supra* note 138, at 15.
146. *Id.* at 5.
147. *Id.*
148. *Id.* at 18.
149. *Id.* at 27.
150. *Id.* at 32.
151. Women's Health Project, *Women's Health Conference Policy on Contraception* (1994).
152. *Id.*
153. *Id.*
154. *Id.*
155. *Id.*
156. Towards a National Health System, *supra* note 112, at 18-19.
157. Telephone interview with Dr. David Harrison, Health Systems Trust, Durban (Feb. 2, 1997).
158. South African health Review 1996, *supra* note 105, at 169.
159. *Id.* at 169.
160. Green Paper on Population Policy, *supra* note 138, at 7-8.
161. South African Health Review 1995, *supra* note 11, at 11.
162. *Id.* at 174.
163. Medicines and Related Substances Control Act No. 101 of 1965.
164. *Id.* § 22A(4).
165. *Id.* § 22A(5).
166. *Id.* § 22A(6).
167. *Id.* § 18(1).
168. *Id.* § 35(1).
169. *Id.* § 20.
170. Films and Publications Act No. 65 of 1996.
171. Republic of S. Afr., *Report of the Task Group: Film and Publication Control, presented to* Dr. M.G. Buthelezi (Minister of Home Affairs), Dec. 1, 1994, at 1.
172. *Id.* p. 20.
173. Films and Publications Act No. 65 of 1996, § 3.
174. *Id.* § 2.
175. *Id.* § 20(1).
176. Republic of S. Afr., Choice on Termination of Pregnancy Act No. 92 of 1996 [hereinafter Choice Act].
177. *Id.* The Abortion and Sterilization Act, 1975, severely restricted access to abortions by prescribing detailed procedural requirements which had to be met before abortions could be performed, and by limiting the grounds for legal abortions to situations where pregnancy: endangered the life of the pregnant woman or constituted a serious threat to her physical health; constituted a serious threat to the woman's mental health; posed a serious risk that the child to be born would be seriously disabled; or was the result of "illegitimate carnal intercourse" with a woman with permanent mental disability. Abortion and Sterilization Act No. 2 of 1975, §3.
178. "Termination of pregnancy" is defined in § 1 of the Choice Act to mean "the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman."
179. "Woman" is defined in § 1 of the Choice Act to mean "any female person of any age."
180. "Gestation period" is defined in § 1 of the Choice Act to mean "the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last."
181. Choice Act, *supra* note 176, § 5(1).
182. *Id.* § 5(2).
183. *Id.* § 5(3).
184. *Id.* § 5(4).
185. *Id.*
186. *Id.* § 5(5).
187. *Id.* § 2(2).
188. *Id.*
189. *Id.* § 3.
190. *Id.* § 7(3).
191. *Id.* § 7(5).
192. *Id.* § 10(1).
193. *Id.* § 10(2).
194. *Id.* § 10(1)(c).
195. *Id.* § 6.
196. *Id.* § 4.
197. Harrison, *supra* note 131, at 140.
198. Child Care Act No. 74 of 1983.
199. *Id.* § 39(4)(a).
200. Harrison, *supra* note 131, at 140.
201. J. C. Sonnekus, *Sterilisasie — toestemming deur nie-pasiënt-gade?*, De Rebus 369, 373 (Aug. 1986).
202. *Id.* at 371.
203. S. Afr. Const. § 12(2).
204. Abortion and Sterilization Act No. 2 of 1975, § 4(1).
205. *Id.* § 4(1)(a).
206. Sonnekus, *supra* note 201, at 369.
207. Abortion and Sterilization Act, No. 2 of 1975, § 4(1)(b).
208. *Id.* § 4(1)(c).
209. *Id.* § 10(1).
210. Nahid Toubia, Female Genital Mutilation: A Call for Global Action (Rainbo, 1995).

211. Telephone interview with Michael Jennings, *supra* note 56.
212. South African Health Review 1996, *supra* note 105, at 165.
213. *Id.* at 27.
214. *Id.*
215. *Id.* at 166.
216. Aspects of the Law Related to Aids 13 (S. Afr. L. Comm'n Working Paper No. 58, Project 85, 1995).
217. South African Health Review 1995, *supra* note 11, at 44.
218. *Id.*
219. *Id.* at 174.
220. *Id.*
221. *Id.* at 175.
222. *Id.*
223. South African Health Review 1996, *supra* note 105, at 169-70.
224. Aspects of the Law Related to Aids, *supra* note 216, annex. A.
225. The SAMDC was the predecessor to the Interim National Medical and Dental Council of South Africa, discussed above.
226. Aspects of the Law Related to Aids, *supra* note 216, at 33.
227. S. Afr. Const. § 8.
228. *Id.* § 9. It is still unclear whether HIV-infection would constitute disability for the purposes of this provision. *Id.* § 25.
229. *Id.* § 10.
230. *Id.* § 12.
231. *Id.* § 14.
232. *Id.* § 21.
233. *Id.* § 22.
234. *Id.* § 23.
235. *Id.* § 27.
236. *Id.* § 29.
237. *Id.* § 32.
238. *Id.* § 33.
239. Aspects of the Law Related to Aids, *supra* note 216, at 150.
240. *Id.*
241. Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, No. R. 2438 annex. 1 (1987).
242. *Id.* regs. 2, 14.
243. Aspects of the Law Related to Aids, *supra* note 216, at 144.
244. *Id.* at 162.
245. Ann Strode, AIDS and the Law: Maintaining the Balance (A Paralegal Manual) 85-86 (1995); Aspects of the Law Related to Aids, *supra* note 216, at 162.
246. SAMDC Guidelines 2, *as cited in* Aspects of the Law Related to Aids, *supra* note 216, at 39.
247. *Id.*
248. Aspects of the Law Related to Aids, *supra* note 216, at 39.
249. *Id.* at 38.
250. *Id.*
251. S. Afr. Const. § 9(3).
252. *Id.* § 27(1).
253. Strode, *supra* note 245, at 14.
254. *Id.* at 14.
255. SAMDC Guidelines 4-5, *as cited in* Aspects of the Law Related to Aids, *supra* note 216, at 43.
256. Strode, *supra* note 245, at 14.
257. *Id.* at 17.
258. *Id.* at 18-19.
259. Jansen van Vuuren and Another NNO v. Kruger 1993 (4) SA 842, 850.
260. 1993 (4) SA 842.
261. 1993 (4) SA at 856.
262. Aspects of the Law Related to Aids, *supra* note 216, at 52.
263. *Id.*
264. SAMDC Guidelines 4,5 & 6, *as cited in* Aspects of the Law Related to Aids, *supra* note 216, at 54-55.
265. SAMDC Guidelines 3 & 6, *as cited in* Aspects of the Law Related to Aids, *supra* note 216, at 63-64.
266. Occupational Health and Safety Act No. 85 of 1993.
267. Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, No. R. 2438, *reprinted in* Government Gazette No. 11014 of October 30, 1987 [hereinafter Regulations Relating to Communicable Diseases 1987].
268. *Id.* reg. 7(1)(a).
269. *Id.* reg. 7(1)(b).
270. *Id.* reg. 7(2).
271. Draft Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, Notice No. 703 of 1993 § 67, *reprinted in* Government Gazette No. 15011 of July 30, 1993.
272. S. Afr. Const. §§ 9, 29.
273. Aspects of the Law Related to Aids, *supra* note 216, at 131-32. This law may be subject to challenge pursuant to the prohibition against unfair discrimination in the Constitution. S. Afr. Const. § 9.
274. Labour Relations Act No. 66 of 1995.
275. *Id.* sched. 7 (§§ 2(1), 2(2)). This transitional protection of applicants for employment is likely to be replaced by comprehensive legislation in the near future. Aspects of the Law Related to Aids, *supra* note 216, at 139.
276. *Id.* at 132.
277. *Id.* at 133.
278. Strode, *supra* note 245, at 99.
279. Aspects of the Law Related to Aids, *supra* note 216, at 120.
280. *Id.* at 121.
281. Regulations Relating to Communicable Diseases 1987, *supra* note 267, annex. 1.
282. Health Act No. 63 of 1977. *See* 21 Joubert (ed.), Laws of South Africa (LAWSA), ¶ 288.
283. Health Act No. 63 of 1977, § 20(1)(d).
284. Human Tissue Act No. 65 of 1983.
285. Regulations Regarding the Artificial Insemination of Persons, and Related Matters No. R. 1182, *reprinted in* Government Gazette No. 10283 of June 20, 1986.
286. *Id.* reg. 8(1).
287. Children's Status Act No. 82 of 1987, § 5.
288. Draft Bill on Surrogate Motherhood *proposed by* South African Law Commission, General Notice 512 of 1995 *reprinted in* Government Gazette No. 16479 of June 14, 1995.
289. R. Pretorius *Surrogate Motherhood: A Detailed Commentary on the Draft Bill*, De Rebus 114 (Feb. 1996).
290. South African Health Review 1996, *supra* note 105, at 182.
291. S. Afr. Const. §§ 181(1), 187.
292. Commission on Gender Equality Act No. 39 of 1996.
293. *Id.*
294. *Id.* § 11
295. *Id.* § 13.
296. Joubert, *supra* note 282, at 16.
297. Marriage Act No. 25 of 1961, § 11(1).
298. Marriage Act No. 25 of 1961.
299. A property regime whereby the estates of the husband and wife were merged into a joint estate, administered by the husband.
300. Human Rights Watch Women's Rights Project, Violence Against Women in South Africa: The State Response to Domestic Violence and Rape 28 (1995). A somewhat different property regime applied in respect to civil marriages entered into between Africans, which were governed by the Black Administration Act 38 of 1927. These marriages excluded community of property, but wives were still subject to their husbands' marital power. However, the Matrimonial Property Law Amendment Act No. 3 of 1988 resulted in African marriages contracted after December 2, 1988, being subject to "community of property" and excluding marital power.
301. Matrimonial Property Act No. 88 of 1984.
302. *Id.* § 11.
303. Human Rights Watch Women's Rights Project, *supra* note 300, at 28; Joubert, *supra* note 282, at 83.
304. General Law Fourth Amendment Act No. 132 of 1993, § 29.
305. Matrimonial Property Act No. 88 of 1984, § 12.
306. Joubert, *supra* note 282, at 121.
307. *Id.* at 18.
308. *Id.*
309. Maintenance Act No. 23 of 1963, § 5(6). Other examples of such limited recognition of customary unions may be found in: Black Laws Amendment Act 76 of 1963, § 31; Income Tax Act 58 of 1962 § 1; and Insolvency Act 24 of 1936, § 21(13).

310. Legal Resources Centre, Handbook of Public Interest Law 177 (year not available).
311. Section 38(2) of both the KwaZulu Code and the Natal Code, however, require a guardian's consent only if either party is under 21 years of age.
312. Black Administration Act No. 38 of 1927.
313. Black Administration Act No. 38 of 1927, § 11(3)(b), *reproduced in* K. Robinson *The Minority and Subordinate Status of African Women under Customary Law* 11(3) 457 South African Journal on Human Rights 461 (1995).
314. Marriage Act No. 25 of 1961, § 3(1).
315. Human Rights Watch Women's Rights Project, *supra* note 300, at 30.
316. *Id.* at 30.
317. *Id.*
318. Divorce Act No. 70 of 1979.
319. *Id.* § 3.
320. *Id.* § 4(1).
321. Section 4(2) of the Divorce Act does, however, describe certain types of circumstances which may be considered as evidence of the "irretrievable break-down of marriage" including: the parties have not lived together as husband and wife for a continuous period of one year immediately preceding the institution of the divorce action; adultery by the defendant which the spouse finds irreconcilable with a continued marital relationship; and the defendant has been sentenced as an "habitual criminal" and is undergoing imprisonment as a result of that sentence.
322. Joubert, *supra* note 282, at 208.
323. Divorce Act No. 70 of 1979, § 4(3).
324. *Id.* § 6(3).
325. Joubert, *supra* note 282, at 198.
326. *Id.* at 198.
327. *Id.* at 221.
328. *Id.* at 198.
329. *Id.* at 222.
330. Whereas custody involves the care and control of the child's person — including the duty to supply the child with sufficient accommodation, food, education, clothing and health care — guardianship entails the right to administer the child's property and affairs. *Id.* at 189.
331. Divorce Act No. 70 of 1979, § 6(3).
332. Guardianship Act No. 192 of 1993.
333. *Id.* § 1(1).
334. Divorce Act No. 70 of 1979, § 6(3).
335. *Id.* § 7(1).
336. Maintenance Act No. 23 of 1963. Section 2 of this act provides that every magistrates' court shall be a maintenance court for the purposes of this section.
337. Bennett, *supra* note 83, at 248.
338. *Id.* at 247.
339. Natal and KwaZulu Codes § 48.
340. *Id.* § 48(2).
341. Bennett, *supra* note 83, at 289.
342. *Id.* at 292.
343. *Id.* at 278.
344. *Id.* at 282. Section 5(6) of the Maintenance Act states that "[f]or the purposes of determining whether a black…is legally liable to maintain any person, he shall be deemed to be the husband of any woman associated with him in a customary union."
345. Natal and KwaZulu Codes §§ 53, 54.
346. Bennett, *supra* note 88, at 137.
347. *Id.*
348. Robinson, *supra* note 313.
349. *Id.*
350. Black Administration Act, § 11A, *reprinted in* 14 Ann. Rev. of Population L., 1987, at 152 (Reed Boland & Jan Stepan eds., 1990).
351. Robinson, *supra* note 313, at 462.
352. *Id.* For example, it has been observed that while this section allows women in customary marriages to enter into property ownership agreements, they are unable to independently use and enjoy that property because it becomes "house property" subject to their husbands' control.
353. S. Afr. Const. § 9.
354. *Id.* § 25(1).
355. Ministry of Land Affairs, Republic of S. Afr., *Green Paper on Land* (visited on Feb. 19, 1997) <http://wn.apc.org/dla/4execsum.htm>.
356. *Id.*
357. Reconstruction and Development Programme 1994, *supra* note 106, ¶ 482.
358. Labour Relations Act No. 66 of 1995.
359. *Id.* § 185.
360. Labour Relations Act No. 66 of 1995, § 187(1).
361. Ministry of Labor, *Employment Standards Statute: Policy* Proposals, General Notice No. 156 of 1996, *reprinted in* Government Gazette No. 17002 of 1996, Feb. 23, 1996, art 1 [hereinafter Ministry of Labor General Notice No. 156].
362. The Employment Standards Policy has, however, not been endorsed by the Cabinet, and so does not represent official government policy. *Id.* at 15.
363. *Id.* at 25. Women constitute 89% of domestic workers: Human Rights Watch Women's Rights Project, *supra* note 300, at 17.
364. *See* Wage Act No. 5 of 1957; Ministry of Labor General Notice No. 156, *supra* note 361, at 16; The Basic Conditions of Employment Act No. 3 of 1983; Ministry of Labor General Notice No. 156, *supra* note 361, at 26.
365. *Id.* at 23, 26.
366. Ministry of Labor General Notice No. 156, *supra* note 361, chp. G.
367. *Id.* at 59.
368. These benefits are not available to domestic workers or to employees earning above a certain income level. *Id.* at 60.
369. Unemployment Insurance Act No. 30 of 1966.
370. Ministry of Labor General Notice No. 156, *supra* note 361, at 61.
371. *Id.* at 54, 61.
372. Department of Labour, *Green Paper: Policy Proposals for a New Employment and Occupational Equity Statute* General Notice No. 804 of 1996, July 1, 1996.
373. *Id.* ¶¶ 4.3.2 and 4.4.1.
374. *Id.* ¶ 4.3.1.
375. Republic of South Africa, White Paper on Reconstruction and Development: Government's Strategy for Fundamental Transformation ¶ 3.2.8 (1994) [hereinafter White Paper on Reconstruction and Development].
376. *Id.* ¶ 3.2.8.
377. Human Rights Watch Women's Rights Project, *supra* note 300, at 89.
378. *Id.*
379. Prevention of Family Violence Act No. 133 of 1993.
380. *Id.* § 5.
381. Sexual Offenses Act No. 23 of 1957, § 14(1).
382. Human Rights Watch Women's Rights Project, *supra* note 300, at 101.
383. *Id.* at 102.
384. *Id.* at 106.
385. *Id.* at 103-07.
386. *Id.* at 119.
387. *Id.* at 62.
388. Prevention of Family Violence Act No. 133 of 1993.
389. *Id.* § 1(2). Victims of abuse by relatives or by homosexual partners must still rely on the more expensive and complex High Court interdicts. Human Rights Watch Women's Rights Project, *supra* note 300, at 69.
390. Prevention of Family Violence Act No. 133 of 1993, § 2(1).
391. *Id.* § 2(2).
392. *Id.* § 3(2).
393. *Id.* § 6.
394. J v. M Ltd., 10 I.L.J. 755 (1989), *discussed in* A. K. Wing and E.P. de Carvalho, *Black South African Women: Toward Equal Rights*, 8 Harvard Human Rights Journal 57, 69 (Spring 1995).
395. *Id.* at 69.
396. Tito Mboweni, Minister of Labour, *Sexual Harassment in the Workplace*, Statement to the Imago Conference (May 16, 1995) (visited on Feb. 12, 1997) <gopher://gopher.anc.org.za:70/00/govdocs/pr/1995/harass.mol)>.
397. *Id.*
398. Labour Relations Act No. 66 of 1995.
399. *Id.* § 112.
400. *Id.* § 115(3)(i), *as amended by* Labour Relations Amendment Act No. 42 of 1996, § 31(b)(i).
401. Green Paper on Population Policy, *supra* note 138, at 7.
402. South African Health Review 1995, *supra* note 11, at 182.
403. Telephone interview with Dr. David Harrison, *supra* note 157.
404. Child Care Act No. 74 of 1983, § 39(4).
405. Harrison, *supra* note 131, at 141.

406. SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 11, at 183.
407. TOUBIA, *supra* note 210.
408. AGE OF MAJORITY ACT 57 OF 1972, § 1.
409. MARRIAGE ACT NO. 25 OF 1961, § 24(1); JOUBERT, *supra* note 282, at 32. If a minor has no parent or guardian or is for any good reason unable to obtain the consent of a parent or guardian to marry, a commissioner of child welfare may grant consent to the marriage. If a parent, guardian or commissioner of child welfare refuses to consent to the marriage, a High Court may supply the requisite consent to the marriage if it is of the opinion that the refusal of consent was without adequate reason and was not in the interests of the minor. MARRIAGE ACT NO. 25 OF 1961, § 25.
410. *Id.* § 26(1).
411. BENNETT, *supra* note 83, at 174.
412. SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 11, at 234.
413. GREEN PAPER ON POPULATION POLICY, *supra* note 138, at 9.
414. WING and CARVALHO, *supra* note 394, at 70-72.
415. NATIONAL EDUCATION POLICY ACT NO. 27 OF 1996.
416. *Id.* § 4(a)(ii).
417. *Id.* § 4(c).
418. WHITE PAPER ON RECONSTRUCTION AND DEVELOPMENT, *supra* note 375, ¶ 2.
419. *Id.* ¶ 45.
420. *Id.*
421. *Id.* ¶ 66.
422. *Id.*
423. DEP'T OF HEALTH, THE SOUTH AFRICAN GOVERNMENT'S HIV/AIDS AND STD PROGRAMME: STRATEGY, BUSINESS AND STRUCTURE PLANS 1995-1996, at 4.
424. *Id.* at 4.
425. HEALTH SYSTEMS TRUST, HST UPDATE, Issue 16, at 15 (1996).
426. SEXUAL OFFENSES ACT NO. 23 OF 1957.
427. *Id.* § 14(1). Similarly, § 14(3) of this act makes it is an offense for any woman to have or attempt to have sexual intercourse with a boy under 16 years of age, or to commit or attempt to commit an immoral or indecent act with a boy or girl under the age of 19 years, or to solicit such an act.
428. SEXUAL OFFENSES ACT NO. 23 OF 1957, § 14(2).
429. *Id.* § 14(2)(a).
430. *Id.* § 14(2)(c).

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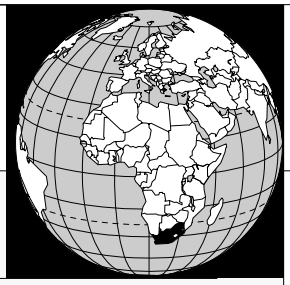
7. Tanzania



Statistics

GENERAL

Population

■ The total population of Tanzania is approximately 29 million,[1] of which slightly over half are women.[2]

■ In 1996, the proportion of the population residing in urban areas was 21%.[3] However, the urban growth rate of over 6% per year is one of the highest in the world, and it is estimated that in the next 15 years "86 percent of the total population growth [will] occur in urban areas, causing the urban population to nearly double its size."[4]

■ The median age is 15.4 years, with 49% of the population below the age of 15.[5]

Economy

■ In 1993, the World Bank estimated the gross national product ("GNP") per capita to be U.S.$90, a per capita decrease of U.S.$210 since 1983.[6] From 1980 to 1993, the average annual growth rate of the GNP per capita was 0.1%, while the annual average rate of inflation was 24.3%.[7]

■ In the late 1980s the average annual growth rate of the gross domestic product ("GDP") was 3.8%, a significant recovery from the early 1980s when the GDP grew at an estimated 1%.[8]

■ In 1993, agriculture made up 56% of the GDP.[9] However, this figure does not take into account subsistence farming, where agricultural output is either not exchanged or not exchanged for money.[10]

Employment

■ About 90% of the able-bodied population is engaged in agriculture, of which 54%[11] to 75%[12] are women. Women make up less than 25% of the total number of workers in paid wage employment.[13]

■ In 1993, the labor force was estimated to be 13.7 million people, of which 47.2% were women.[14] In 1995 the labor force participation rate for girls aged 10 to 19 was 46%.[15]

■ The average annual income in Tanzania is U.S.$110.[16]

WOMEN'S STATUS

■ The average life expectancy for women is 53, while for men it is 50.[17]

■ A 1990 survey showed that 90% of women in Tanzania are battered or have experienced violence in some form.[18]

■ According to the Ministry of Community Development, in 1991 there were 1,525 assaults and 497 rapes reported; in 1992 there were 1,541 assaults and 736 rapes reported; and in 1993 there were 2,094 assaults and 721 rapes reported.[19]

■ As students progress toward higher education, the percentage of women drastically decreases. While in 1992 females made up about 48% of the primary school population, they only comprised about 18% of the undergraduate university population.[20]

ADOLESCENTS

■ In 1990, there were an estimated 96 girls per 100 boys in primary school; this number significantly declined to 77 girls per 100 boys in secondary school. It is estimated that while 68% of all children attend primary school, only 5% attend secondary school, with the numbers for girls only slightly lower. [21]

■ An estimated 10% of Tanzanian women and girls have undergone FGM, with clitoridectomy reported only among the Christian Chagga groups near Mt. Kilimanjaro.[22]

■ The median age at first marriage for women is 17 years, and by the age of 20 years over 95% have been married at least once.[23]

MATERNAL HEALTH

■ In 1995 the total fertility rate was 5.8 children per woman.[24]

■ The infant mortality rate is estimated to be between 84.2[25] and 104.3[26] per 1,000 live births. The under-5 mortality rate for 1993 was 167 deaths per 1,000 live births.[27] Malnutrition is the primary cause in more than 50% of deaths of children aged 1-4.[28]

■ The U.N. Population Division estimates that in 1993 17% of all births were to women under 20; 69% of the births were to women between the ages of 20 and 35.[29]

■ According to hospital records from 1992, which cover about half of all births, maternal mortality is estimated at 200-400 per 100,000 births per year.[30] It is estimated that 40% to 60% of all pregnant women are malnourished.[31]

■ An estimated 40% of deliveries in rural areas and 20% of deliveries in urban areas are attended by traditional birth attendants or midwives.[32]

■ About 80% of expecting mothers attend antenatal clinics at least once during their pregnancies.[33]

CONTRACEPTION AND ABORTION

■ In 1994, nearly 18% of all women aged 15 to 49 used contraception of any kind. Of these women, 26% used the pill, 12% relied on injections, 14% used condoms with their partners, 9% were sterilized, and 4% used an IUD; traditional methods were used by 36% of women, with 14% of women choosing the calendar rhythm/safe period method.[34]

■ In a 1983 national study, abortion accounted for an estimated 17% of all maternal deaths. In a 1990 study in one hospital in the capital of Dar-es-Salaam, 47% of admittances for abortion complications were due to induced abortions.[35]

HIV/AIDS AND STDs

■ The number of estimated AIDS cases by December 1994 was 250,000. Estimated HIV infection rates based on blood donor prevalence show that 1 to 1.5 million Tanzanians were infected by 1995.[36] Heterosexual intercourse accounts for 80% of the transmission of HIV.[37]

■ Women are disproportionately at risk for HIV infection. The infection rate is 5.4% for males and 7.0% for females.[38] In addition, the peak infection age for women is from 20 to 24, while for men it is from 25 to 35.[39]

■ HIV infection among pregnant women ranges from 2.3% in rural areas to more than 30% in urban clinics. About 30% of HIV infected pregnant women will vertically transmit HIV to their babies who will die in infancy or early childhood.[40]

ENDNOTES

1. The World Almanac and Book of Facts 1997, at 824 (1996) [hereinafter World Almanac].
2. Arjun Adlakha, U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census, International Brief: Population Trends: Tanzania 4 (Sept. 1995) [hereinafter Population Trends: Tanzania].
3. World Almanac, *supra* note 1, at 824.
4. Population Trends: Tanzania, *supra* note 2, at 3.
5. U.N. Population Fund (UNFPA), Programme Review and Strategy Development Report: United Republic of Tanzania vii, U.N. Doc. E/850/1994 (1991) [hereinafter Tanzania/UNFPA].
6. World Bank, World Tables 1995, at 657 (1995) [hereinafter World Tables 1995].
7. World Bank, World Development Report 1995: Workers in an Integrating World 162 (1995) [hereinafter World Development Report 1995].
8. President's Office Planning Commission, National Population Policy iv (United Republic of Tanzania, 1992) [hereinafter National Population Policy].
9. World Development Report 1995, *supra* note 7, at 166.
10. *Id.* at 232.
11. Ministry of Community Development, Women Affairs and Children, Tanzanian Women: Country Report to 4th World Conference on Women Beijing 51 (United Republic of Tanzania, 1995) [hereinafter Tanzanian Women: Country Report].
12. Ministry of Community Development, Women Affairs and Children, Policy on Women in Development in Tanzania 2 (United Republic of Tanzania, 1992).
13. World Development Report 1995, *supra* note 7, at 51.
14. World Tables 1995, supra note 6, at 659.
15. World Development Report 1995, *supra* note 7, at 146.
16. Tanzanian Women: Country Report, *supra* note 11, at 36.
17. World Development Report 1995, *supra* note 7, at 218.
18. Tanzanian Women: Country Report, *supra* note 11, at 15.
19. *Id.* at 16.
20. *Id.* at 22, 23.
21. World Development Report 1995, *supra* note 7, at 218.
22. Nahid Toubia, Female Genital Mutilation: A Call for Global Action 25 (Rainbo 1995).
23. National Population Policy, *supra* note 8, at 2.
24. Population Trends: Tanzania, *supra* note 2, at 4.
25. World Tables 1995, *supra* note 6, at 659.
26. Population Trends: Tanzania, *supra* note 2, at 4.
27. World Development Report 1995, *supra* note 7, at 214.
28. National Population Policy, *supra* note 8, at 7.
29. World Development Report 1995, *supra* note 7, at 212.
30. Report by Dr. Janet Kabeberi-Macharia, Women and Law in East Africa, Nairobi, Kenya (1996) at p. 4 (on file with The Center for Reproductive Law and Policy)(*citing* Bureau of Statistics, Women and Men of Tanzania, Dar-es-Salaam 23 (1992)).
31. Tanzania/UNFPA, *supra* note 5, at 57.
32. *Id.* at 57.
33. Ministry of Health, National Health Policy 4 (United Republic of Tanzania, 1990).
34. Population Trends: Tanzania, *supra* note 2, at 2.
35. World Health Organization, Maternal Health and Safe Motherhood Programme, Abortion: A Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion 28 (2d ed. 1994).
36. Ministry of Health, National Policy on HIV/AIDS/STD 1 (United Republic of Tanzania, 1995).
37. Tanzanian Women: Country Report, *supra* note 11, at 32.
38. *Id.* at 33.
39. *Id.* at 32.
40. *Id.* at 33.

In 1964, the United Republic of Tanzania ("Tanzania") was established pursuant to the union of two countries — Tanganyika and Zanzibar[1] — that had recently gained independence from Britain.[2] Tanganyika became independent in 1961; Zanzibar attained independence in 1963.[3] The former nation of Tanganyika that is now a part of Tanzania is hereinafter referred to as Mainland Tanzania; the Island of Zanzibar is referred to as Zanzibar. In 1965, an interim Constitution was established for Tanzania. On April 25, 1977, the permanent Constitution of Tanzania (the "Constitution") came into effect.[4] Although Mainland Tanzania and Zanzibar are united as one nation, each maintains separate executive, legislative, and judicial institutions. As will be explained below, the Constitution specifies the laws that are applicable to both regions. It is noteworthy that the health and population policies of the country apply to both Mainland Tanzania and Zanzibar.[5]

The total population of Tanzania is estimated to be 29,058,470.[6] Women make up 51% of the population.[7] Approximately 45% of the population is Christian; another 35% are Muslim and located primarily in Zanzibar; and 20% adhere to traditional beliefs.[8] Tanzania has approximately 120 ethnic groups. Although many languages are spoken in Tanzania, the principal and official languages are Swahili and English.[9]

I. Setting the Stage: The Legal and Political Framework

To understand the various laws and policies affecting women's reproductive rights in Tanzania, it is necessary to consider the legal and political systems of the country. Without this background, it is difficult to determine the manner in which laws and policies are enacted, interpreted, modified, and challenged. The passage and enforcement of law often involves specific formal procedures. Policy enactments, however, are not subject to such a process.

A. THE STRUCTURE OF GOVERNMENT

From 1977 until 1992, Tanzania was a one-party state in which all political and governmental activity in the country was carried out, directed, and supervised by one party — the Chama Cha Mapinduzi ("CCM").[10] In 1990, the CCM reconsidered its one-party policy, and in 1991 President Mwinyi appointed a 22-member commission to study the feasibility of introducing a multiparty system in Tanzania and its possible impact on the "unity, peace and concord amongst all Tanzanians regardless of tribe, creed, race or gender."[11] In the midst of the debate regarding the impact of a multiparty system, the CCM loosened its monopoly over the exercise of state power. In 1992, this commission recommended the introduction of multiparty politics; this view was affirmed by the National Executive Committee of the CCM.[12] Hence, in 1992 an amendment was made to the Constitution permitting multiple-party politics.

Although Tanzania has several features of a federal state, it does not follow a complete federal model. The country is divided into 25 regions, of which five are on the islands of Zanzibar and Pemba. Most regions are further divided into four or five districts. But Mainland Tanzania and Zanzibar have separate legislative, executive, and judicial institutions; however, there are certain specified "union" institutions that exercise jurisdiction over matters relating to both Mainland Tanzania and Zanzibar. Union matters are defined under the first addendum to the Constitution to include, *inter alia*: foreign affairs; defense and security; police; authority on matters related to a state of emergency; citizenship; immigration; loans and international business; all matters related to coins and money for the purpose of all legal payments; banks and all activities of the banks; foreign currency and the administration of the Department of Customs; communications; higher education; and some issues related to natural resources.

The highest executive function in the nation lies with the president of the United Republic of Tanzania. The president is the head of state, head of government, and commander-in-chief of the armed forces.[13] The president selects a prime minister, who has the responsibility of "controlling, and supervising the day to day functions of all matters and activities of the Union Republic."[14] The person chosen to be prime minister is also to serve as one of the two vice-presidents called for in the Constitution.[15] The head of the government of Zanzibar acts in a dual capacity as both president of Zanzibar and as the other vice-president of the United Republic of Tanzania.[16] Each one of the vice-presidents is "chief assistant" to the president on all "Union matters."[17]

The two primary legislative bodies in Tanzania are the Parliament of Tanzania, situated in Mainland Tanzania, and the Council of Representatives located in Zanzibar.[18] The responsibilities of the Parliament include legislating on "Union matters" of Tanzania and on all matters relating to Mainland Tanzania.[19] The Council of Representatives, on the other hand, legislates for Zanzibar on "non-Union" matters.[20] As a result of the 1992 constitutional changes, women must occupy 37 seats in Parliament, which has a membership of 275 members.[21]

Courts both create and interpret laws. The judicial system can have a significant impact on legislation, including that affecting reproductive rights, because it is able to enforce law and deal with complaints from individuals challenging the

constitutionality of specific laws. The present Tanzanian court system, established in 1963 by the Magistrates Courts Act,[22] ended a dual system of courts (previously one system administered common law and the other customary law), and created a hierarchy of courts. There are lower courts (referred to as Primary Courts) in each of the 25 administrative regions.[23] Primary Courts have jurisdiction in all procedures of a civil nature: where the law applicable is customary and Islamic law (except in matter relating to the Land Registration Ordinance) for the recovery of civil debts (with a monetary restriction); for the recovery of debts arising out of a contract; in all matrimonial proceedings related to civil and Christian marriages; and in all other proceedings in which jurisdiction is granted to primary courts by the Magistrates' Court Act or any other law.[24] The second level of courts are the District Courts, followed by the Resident Magistrates Court and the High Court. The Court of Appeal is the supreme court of Tanzania. The chief justice of the Court of Appeal is the head of the judiciary. Zanzibar also has a High Court. The chief justice of the High Court of Zanzibar is the head of the judiciary of Zanzibar.

B. SOURCES OF LAW

Domestic Sources of Law

Laws that affect women's legal status — including their reproductive rights — derive from a variety of sources. These sources are: the Constitution of Tanzania, which declares itself the supreme law of the land; [25] written laws, which are based on English legislation from the last half of the nineteenth century; a number of codes and acts developed by British drafters and legislators for India that were revised by local Tanganyikan legislators to conform to local needs; numerous customary laws; and Islamic law.[26]

Article 9(1)(g) of the Constitution states that the authority of the state must ensure that "the Government and all its instruments of the people offer equal opportunities for all citizens, men and women, regardless of color, tribe, religion, or creed." Furthermore, the Bill of Rights also prohibits discrimination; however, it fails to list gender as one of the grounds of unacceptable discrimination.[27] All rights and freedoms guaranteed by the Bill of Rights are subject to restrictions on the grounds of "interests of the public," [28] as well as "to ensure that justice and freedom of others"[29] and the "interests of the nation." [30] Violation of these rights and freedoms are not illegal during an emergency or in ordinary times when the security of the nation is in danger.[31]

Customary law is effective primarily in the realm of personal relations. Although Tanzania has about 120 ethnic groups, each with its own laws and customs, an attempt was made through the passage of the Local Customary Laws Declaration Order No. 4 to codify customary laws to bring some unity and predictability to existing laws. This declaration attempts to eliminate outdated customs in a number of family matters, including succession, payment of bridewealth, divorce, child custody, and maintenance. It is estimated that this law applies to approximately 80% of all communities in Tanzania.[32]

International Sources of Law

A number of international human rights treaties recognize and promote specific reproductive rights. Because international instruments are legally binding, they create an obligation on the part of the government to undertake numerous actions, including those at national levels. The government of Tanzania has ratified various human rights instruments, including: the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the International Convention on the Elimination of All Forms of Racial Discrimination; 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.[33]

II. Examining Reproductive Health and Rights

Issues of reproductive health and rights are dealt with in Tanzania within the context of its health and population policies, which apply to both Mainland Tanzania and Zanzibar. Thus, an understanding of reproductive rights in Tanzania must be based on an examination of those policies.

A. HEALTH LAWS AND POLICIES

Objectives of the Health Policy

In 1990, the Ministry of Health ("MOH") released a National Health Policy[34] (the "Health Policy"), which aims at "improving the health status of all people wherever they are, in urban and rural areas, by reducing morbidity and mortality and raising life expectancy."[35] The policy defines good health as physical, mental, and social well-being.[36] The overall objective of the Health Policy is to improve the health and well-being of all Tanzanians, with a focus on those who are most at risk, and to encourage the health system to be more responsive to the needs of people.[37] The specific objectives of this health policy include: reducing infant and maternal morbidity and mortality; increasing life expectancy through the provision of "adequate and equitable maternal and child health services"; "promotion of adequate nutrition, control of communicable diseases and treatment of common

conditions"; ensuring that health services are accessible to all; and sensitizing the community to common preventable health problems and improving the capabilities at all levels of society to assess and analyze problems and to "design appropriate action through genuine community involvement."[38]

The provision of Primary Health Care ("PHC") services is a primary strategy for realizing the government's Health Policy.[39] The Health Policy also sets forth basic requirements for PHC services, including community involvement, cooperation with other sectors, and decentralization of regions and districts.[40] The Health Policy identifies maternal and child health, including family planning, as being a necessary element of PHC services.[41]

Infrastructure of Health Services

Between 1972 and 1987, the government of Tanzania established a comprehensive health infrastructure system[42] such that, in 1987, approximately 70% of the population lived within five kilometers of a health facility.[43] Health care facilities within this system include village health services, dispensary services, health center services, district hospitals, regional hospitals, and referral/consultant hospitals.[44] This system is currently comprised of 152 hospitals, 250 health centers, and over 2,600 dispensaries.[45] The village health service is the "lowest level of Health Care delivery in the country."[46] The Health Policy calls for the establishment of a village health post in all villages by the year 2000.[47] A village health service center is only required to have an office for storage of medicines and equipment.[48] They are not located in permanent buildings; instead, village health service centers provide essentially preventive services that can be offered in the homes of individuals.[49] Two village health workers are required for each village, one of them to deal with maternal-child problems and the other with environmental sanitation.[50]

The dispensary services center is the second level of health services.[51] The long-term objective of the Health Policy is to have one dispensary for each village,[52] and for each dispensary to cater to 6,000 to 10,000 people and supervise all the village health posts in its ward.[53] Each dispensary is to have facilities for out-patients, a maternity room with at least two beds, bathrooms for women and men, and rooms for the dispensary staff.[54] Each health center, the next level of health care, is expected to cater to 50,000 people, approximately the population of one administrative division.[55] The services offered by the health centers are similar to those offered by the dispensary, except that the health centers offer more specialized services[56] and serve as supervisors of the dispensaries.[57]

Hospitals are expected to provide the highest levels of health care. The Health Policy calls for each district to have a district hospital,[58] which, on average, has between 60 and 150 beds.[59] For those districts that do not have such hospitals, the government is to negotiate with religious organizations to designate voluntary hospitals as district hospitals.[60] The next level of hospital care is provided for at the regional hospitals. These hospitals are to have specialists in various fields, and offer additional services not provided at district hospitals,[61] as well as to have on average between 200 and 400 beds.[62] There is one regional hospital in each of Tanzania's 25 regions.[63] The highest level of hospital service in the country is provided by the referral/consultant hospitals.[64] These hospitals are supposed to be equipped with sophisticated modern medical equipment in order to handle cases that are now referred abroad.[65] Each referral hospital is to have between 400 and 600 beds. In 1990, they had between 423 and 1,423 beds.[66] As of 1990, there were four referral hospitals in Tanzania.[67] The Health Policy aims to establish six such referral hospitals.[68]

The MOH oversees the delivery of health care at the national level.[69] To decentralize health care, the policy at the regional and district levels will be supervised by the regional and district authorities according to guidelines issued by the MOH.[70] The policy further provides that implementation of the policy will be coordinated by the MOH in conjunction with the ministries responsible for water, agriculture, and education, non-governmental organizations ("NGOs"), international organizations, political parties, and the private sector.[71]

Cost of Health Services

Tanzania has a comprehensive health coverage system in which services are available free of charge.[72] The only exceptions are for patients in special or private wards at referral and regional hospitals, for dental appointments, and for travel-related immunization.[73] Health services are financed by the government in two ways.[74] First, the MOH provides funds to the referral hospitals, medical schools,[75] "parastatals" such as the Muhimbili Medical Centre and the National Institute for Medical Research,[76] and hospitals that belong to religious organizations.[77] Second, the prime minister's office provides funds to administer the regional and district hospitals.[78] Similarly, the government gives subsidies to the local councils for the salaries of personnel at the health centers and dispensaries.[79] Local governments are responsible for running the dispensaries and health centers in the rural areas,[80] and obtain their funds from government subsidies and local taxes.[81]

Regulation of Health Providers

Who is legally permitted to provide what type of care? Are there meaningful guarantees of quality control? Because the Tanzanian government regulates these issues, reviewing such laws is important. Health professionals in Tanzania are regulated by three statutes: the Medical Practitioners and Dentists Ordinance[82] (the "Medical Practitioners Ordinance"); the

Nurses and Midwives Registration Ordinance[83] (the "Nurses Ordinance"); and the Pharmacy and Poisons Ordinance[84] (the "Pharmacy Ordinance").

The Medical Practitioners Ordinance provides for the establishment of a medical board called the Tanganyika Medical Council (the "Medical Council"). The Medical Practitioners Ordinance requires all medical practitioners to be registered. A medical practitioner is defined in the ordinance as "any person professing to practise medicine or surgery, or holding himself out as ready and willing to give medical or surgical treatment to patients for gain."[85] A dentist is defined as "any person professing to practise dentistry or holding himself out as ready and willing to give dental treatment to patients for gain."[86] A person is entitled to register under the Medical Practitioners Ordinance if he or she is the holder of a diploma that is recognized for the "time being" by the Council as furnishing a sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of medicine, surgery, or midwifery, and if he or she has compiled the additional requirements relating to the acquisition of practical experience in medicine, surgery, midwifery, or in any one or more such disciplines as the Minister of Health may by rule prescribe.[87] If an unregistered person provides medical treatment or holds himself or herself out as a medical practitioner, that person is guilty of an offense and will be liable upon conviction to a fine not exceeding S 10,000 (U.S.$17)[88] or to imprisonment for a term not exceeding five years, or both.[89] The Medical Practitioners Ordinance also states that nothing in the ordinance is to be construed as prohibiting or preventing the "bona fide practice of systems of therapeutics" according to "native methods" by persons recognized by the community to which they belong, as long as such practice is not or is not likely to be dangerous to life.[90]

The other general functions of the Medical Council are to carry out the provisions of the Medical Practitioners Ordinance. In particular, the Medical Council maintains the register of medical practitioners and dentists; publishes in the official gazette the name, address, and registered qualifications of each medical practitioner and dentist duly registered; cautions, censures, or orders the suspension from practice, or directs the erasure from the register of the name of any medical practitioner or dentist convicted of any felony or misdemeanor, or who after due inquiry by the Medical Council is deemed to have been guilty of "infamous conduct" in any professional respect; decides which medical diplomas and which diplomas in dentistry may be recognized as furnishing a sufficient guarantee that the holder possesses the requisite knowledge and skill for medical practice; and approves hospitals or other institutions and posts therein for the purpose of enabling persons provisionally registered under the Medical Practitioners Ordinance to obtain the experience necessary to enable them to register.[91]

The Nurses Ordinance establishes the Nurses and Midwives Council (the "Nurses Council"),[92] which undertakes functions similar to the Medical Council. The activities of the Nurses Council include: keeping and maintaining a register of nurses and midwives; prescribing and regulating syllabi of instruction and courses of training for nurses and midwives; prescribing and conducting examinations for nurses and midwives; and cautioning, censuring, ordering the suspension from practice, or the removal from the register the name of any registered nurse or registered midwife for malpractice, negligence, or misconduct; deciding upon the termination of any period of suspension; and the restoration to the register of any name removed.[93] To be entitled to register under the Nurses Ordinance, a person must fulfill one of four requirements, all of which seek to ascertain that a person has been trained as a nurse.[94] The requirements for midwives are almost the same.[95] Any person who is not a registered nurse or midwife, or has been suspended from practice, who habitually or for gain practices as a nurse or attends women in childbirth, shall be guilty of an offense and shall be liable upon conviction to a fine not exceeding S 1,000 (U.S.$1.70).[96]

Pharmacists are regulated by the Pharmacy and Poisons Ordinance, which makes provisions for the establishment of a Pharmacy and Poisons Board (the "Pharmacy Board"),[97] and for the appointment of a registrar with the responsibility of keeping a register of pharmacists.[98] All persons who satisfy the requirements set forth in the Pharmacy Ordinance are entitled to registration.[99] It is a criminal offense for any person who is not registered to carry on the business of a pharmacist or, in the course of business, to prepare or dispense a drug, except under the immediate supervision of a pharmacist.[100] There are two exceptions to this rule. First, it is lawful for qualified medical practitioners, dentists, and veterinary surgeons to supply medicine in the course of medical, dental, or animal treatment, respectively. Second, persons who are not registered as pharmacists may sell "non-poisonous" drugs, provided that they are sold in their original condition as received by the seller.[101] The Pharmacy Ordinance does not define "non-poisonous," but it calls for the Pharmacy Board to create a list of substances that are to be treated as poisons for the purpose of the ordinance.[102]

Patients' Rights

Some laws also seek to ensure quality health services by protecting the rights of patients. Tanzanian law requires medical practitioners to render treatment with "reasonable care" and skill and with the informed consent of the person under-

going the procedure.[103] The Penal Code provides that a person is not criminally liable for performing, in good faith and with reasonable care and skill, a surgical operation upon any person for his or her benefit if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case.[104] In addition, Section 233(e) of the Penal Code provides that any person who, "in a manner so rash or negligent as to endanger human life or to be likely to cause harm to any other person," renders medical or surgical treatment to any person whom he or she has undertaken to treat, is guilty of a misdemeanor.

B. POPULATION AND FAMILY PLANNING

The Population and Family Planning Policy

Tanzania's population policy provides the framework within which its family planning services are provided. The main goal of the National Population Policy (the "Population Policy"),[105] adopted in 1992, is "to extend the horizon of the country's development plans whose principal objective is to move Tanzanians away from poverty and extend their horizon of standard of living."[106] The policy sets forth as its primary concerns safeguarding, as much as possible, the satisfaction of the basic needs of "vulnerable groups" in the population, and developing human resources for current and future national socioeconomic progress.[107] The Population Policy sets forth the following objectives:

- improving the demographic knowledge database (i.e., data collection, processing, analysis, and projections and research on population and development);
- enhancing the desire of leaders and the public at large to be aware of various problems related to population and development;
- establishing information, education, and communication ("IEC") systems, which, among other things, will encourage the provision and use of services related to family planning and responsible parenthood, such as directing a significant part of family planning programs to include men so that eventually couples are able to decide and plan the size of their family;
- making family planning means and services easily accessible, so as to reduce maternal and child mortality;
- preparing young people, before marriage, to become responsible parents through proper upbringing and the provision of family life education;
- educating the public on the benefits of women marrying and bearing children after the age of 18 years; and
- improving the status of women in society by reviewing existing laws in areas where their rights and those of children are undermined.[108]

Other goals of the Population Policy include: providing women with adequate education and appropriate technology to lessen their daily workload and assuring them equal opportunity; developing the labor force and emphasizing its proper use by reviewing the existing employment policies; preparing and implementing coordinated development plans to reduce the rate of rural to urban migration; and preventing further degradation of the environment.[109] The Population Policy makes specific reference to the role of women in the implementation of development programs.[110] Activities include increasing employment opportunities for women at all levels, reviewing and amending laws — especially those relating to marriage, family, property, and employment — that inherently discriminate on the basis of gender, raising the minimum age of marriage for girls to 18 years, promoting women's education at the post-primary level, and increasing the number of women in decision-making positions.[111]

To attain its goals, the Population Policy sets forth the roles of different agencies in the implementation of the integrated maternal and child health/family planning programs ("MCH/FP"). All agencies are to be involved in strengthening the capacity to deliver maternal and child health services through appropriate training of personnel, upgrading and equipping health facilities for the delivery of MCH/FP services, utilizing IEC programs to promote various family planning methods, and establishing an MCH/FP service statistics system for monitoring and evaluation purposes. Other issues that the program will focus on are: taking appropriate measures in the spheres of law, education, and social services to protect and promote the goals of the MCH/FP program; encouraging and assisting NGOs to continue with their contribution in this area; and reducing the incidence of pregnancies of women below the age of 18 years and over the age of 35 years, as well as reducing the number of pregnancies at intervals of less than two years.[112]

Implementing Agencies

The Population Policy states that the implementation of the MCH/FP program will be carried out by the MOH, the Tanzania Food and Nutrition Center, and the Attorney General's office.[113] The Women in Development program is to be carried out by numerous agencies, which include: the Planning Commission; the Zanzibar Planning Commission; the Ministry responsible for Education and Culture; the Institute of Adult Education; and the Ministry responsible for Community Development, Women's Affairs, and Children.[114]

Government Delivery of Family Planning Services

In 1994, the MOH published the National Policy Guidelines and Standards for Family Planning Services Delivery and Training (the "Family Planning Guidelines").[115] These

guidelines reiterate the government's commitment to family planning, as well as to providing comprehensive health services equitably to all citizens.[116] They also set forth the eligibility requirements for government family planning services. The Family Planning Guidelines state that "[a]ll males and females of reproductive age, including adolescents irrespective of their parity and marital status, shall have the right of access to family planning information, education and services."[117] Furthermore, it provides that any woman or man shall be provided with a family planning method of her or his choice after appropriate and adequate counseling without requiring the consent of a spouse.[118] The guidelines also state that family planning services are to be provided through government, non-government, and private health facilities, such as Maternal and Child Health ("MCH") clinics, family planning clinics, and community based programs.[119]

The Family Planning Guidelines set forth standards for family planning services. This policy addresses issues of counseling and screening of clients, instructions and follow-up schedules for contraceptive use, family planning methods to be provided at various delivery points, and eligibility by type of method. IEC materials are to be available at each site[120] for the following contraceptive methods: "hormonal method" (oral contraceptives, injectables, and implants);[121] intrauterine devices ("IUDs");[122] "voluntary surgical contraception" (tubal ligations[123] and vasectomies[124]);"barrier methods" (condoms and diaphragms);[125] lactational amenorrhoea method;[126] and natural family planning methods.[127]

C. CONTRACEPTION

The current contraceptive prevalence rate in Tanzania is estimated to be below 10% among women aged 15 to 49.[128] In 1990-91, the most prevalent contraceptives were pills (49.6%), female sterilization (26.3%), condoms (13.4%), IUDs (5.9%), injections (4.4%), diaphragms (0.2%), and male sterilization (0.2%).[129]

Legal Status of Contraceptives

Only contraceptive products registered and approved by the MOH are made available for use.[130] The Family Planning Guidelines indicate that the MOH is to ensure the availability and accessibility of a wide range of family planning methods to facilitate wider choice for the user. Furthermore, the methods available should include those that offer temporary, long-term, and permanent contraception.[131]

Regulation of Information on Contraception

There are no laws that explicitly regulate information on contraception in Tanzania.

D. ABORTION

Legal Status of Abortion

Tanzanian law severely restricts women's ability to obtain abortions. The only circumstance under which an abortion is legal is when it is necessary to preserve a woman's life. Tanzania's criminal law punishes both the pregnant woman as well as any other individual who may assist her in the termination of her pregnancy. A pregnant woman "who with intent to procure her own miscarriage unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever" is guilty of a felony.[132] Similarly,"[a]ny person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means" is guilty of a felony.[133] Furthermore, any person who unlawfully supplies "any thing whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman," is guilty of a felony.[134]

The Penal Code provides for limited circumstances in which a pregnancy may be lawfully terminated. Section 230 of the Penal Code states that a "person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical procedure upon…an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all circumstances of the case."

Requirements for Obtaining Legal Abortion

An abortion is only legal if it is performed to preserve the life of the mother. This law, however, is subject to "reasonable" interpretation.[135] In *Rev v. Baurul*,[136] a 14-year-old girl was pregnant as a result of a rape, and the surgeon performed an abortion on the grounds that allowing the infant to be born would be seriously detrimental to the girl's health. The court acquitted the surgeon of the criminal charge of having caused a termination of pregnancy.[137]

Penalties

A woman convicted pursuant to Section 151 of the Penal Code of using any means to "procure her own miscarriage" is liable to imprisonment for seven years. Any person who contravenes Section 150 of the Penal Code by using "any means" with the intent to unlawfully "procure the miscarriage" of a woman is liable to imprisonment for 14 years. Furthermore, a person convicted of unlawfully supplying "anything whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman," may be sentenced to three years of imprisonment pursuant to Section 152 of the Penal Code. All these penalties apply irrespective of whether or not the woman was in fact pregnant.

Regulation on Abortion Information

Section 38 of the Pharmacy Ordinance makes it an offense for any person to take part in the publication of any advertisement referring to any drug, appliance, or article in terms that are calculated to lead to the use of the drug, appliance, or article for "procuring the miscarriage of women."[138] However, such advertisement may legally appear in a publication of a technical character intended for circulation among: medical practitioners, dentists, and veterinary surgeons or students of these professions; pharmacists or student pharmacists and authorized sellers of "poisons"; or persons "carrying on a business which includes the sale or supply of surgical appliances."[139]

E. STERILIZATION

Women and men are eligible for sterilization if they have attained their desired family size.[140] "Any woman or man shall be provided with a family planning method of her/his choice after appropriate and adequate counseling without requiring the consent of the spouse."[141] A number of tests are required prior to the performance of a female sterilization.[142] No special tests are required for vasectomies.[143] According to the Family Planning Guidelines, sterilization need not be available at dispensaries.[144] Sterilizations are to be available at health centers so long as the health provider is properly trained and the facility has the required equipment and supplies.[145] Hospitals are to offer sterilization.[146]

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

Female genital mutilation ("FGM") — also referred to as female circumcision — is practiced by communities in several regions of Tanzania and by Somali immigrants.[147] It is estimated that 10% of Tanzanian women undergo FGM.[148] Although there is no law that specifically mentions FGM, in 1990 a National Committee on Traditional Practices was created to work toward creating awareness about FGM and improving the status of women in general.[149] For further discussion regarding FGM and adolescents, see section on adolescents below.

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

Examining HIV/AIDS issues within the reproductive health framework is essential insofar as the two are interrelated from both a medical and public health standpoint. Hence, a full evaluation of laws and policies affecting reproductive rights in Tanzania must examine HIV/AIDS and sexually transmitted diseases ("STDs"). In December of 1994 the total number of estimated AIDS cases in Tanzania was approximately 250,000.[150] Estimates based on blood donors indicate that, by 1995, about 1 to 1.5 million Tanzanians may have been infected with HIV.[151] In 1995, the MOH estimated that if current trends continue, the number of people infected with HIV might rise to 2.4 million by the year 2000.[152]

Laws Affecting HIV/AIDS and STDs

Although there are no laws that specifically address HIV/AIDS or STDs, the Penal Code contains a provision that could be used to penalize the behavior of people who are infected with HIV/AIDS. Section 179 of the Penal Code makes it an offense for any person to unlawfully or negligently undertake any act that is, and that the person knows or has reason to believe to be, likely to spread the infection of any disease "dangerous to life."[153]

Policies Affecting Prevention and Treatment of HIV/AIDS and STDs

In September 1995, the MOH released a National Policy on HIV/AIDS and STDs (the "National AIDS Policy"). The National AIDS Control Programme was charged with the control and prevention of HIV/AIDS and STDs in the country.[154] The overall goal of the policy is to "mobilize and sensitize the community to become actively involved in preventing further transmission of HIV and to cope with the social and economic consequences of AIDS."[155] The specific objectives of the National AIDS Policy are:

- increasing the community's awareness of HIV/AIDS and its consequences;
- preventing further transmission of HIV/AIDS through use of preventive measures such as safer sex, testing, and counseling;
- providing infected persons and those who care for them with appropriate support through the existing health care system and home-based care;
- safeguarding the rights and interests of infected persons by preventing discrimination in employment, housing, treatment, education, and other social services;
- safeguarding the rights of the community as a whole against infection with HIV/AIDS and STDs;
- supporting and promoting activities geared to strengthening national efforts toward control and prevention of HIV/AIDS and STDs; and
- creating a national institutional framework that will coordinate the mobilization of financial, human, and material resources for AIDS prevention and control.[156]

The national strategy for AIDS control and prevention focuses on the following areas: education and information; prevention; treatment, care and counseling; access and participation (i.e. maintaining quality of life for infected persons by preventing discrimination); and research.

The National AIDS Policy also sets forth policies for HIV testing.[157] Individuals requesting HIV testing in voluntary counseling and testing sites may be required to pay for the full or part of the cost of counseling and testing. However, the cost of HIV testing in hospitals and other treatment centers for sick patients will depend on the policy of the facility.[158] Testing is not to be mandatory for any marriage, or for travelers or migrants into or out of the country.[159]

The National Policy addresses the issue of care for people with HIV/AIDS and STDs.[160] The stated goal is "to provide optimal humane and supportive care for the patients and their dependants."[161] This care is to preserve confidentiality, avoid discrimination, and allow a patient to live as normal and productive a life as possible.[162] Addressed under the section on care for people with HIV/AIDS and STDs are the issues of: institutional care; management of STDs (including that provision shall be made for STD patients to have free treatment); community-based support services; protection of health care workers; and the plight of widows and orphans due to AIDS.[163] Prevention of sexual transmission, as well as prevention of transmission through blood transfusion, invasive skin piercing, and prenatal transmission are also dealt with in the National AIDS Policy.[164] In addition, the policy states that HIV testing shall not be allowed as a pre-employment condition[165] and that HIV infection shall not be a cause for termination of employment.[166]

The National AIDS Policy also sets forth the rights of persons with HIV and AIDS. "Persons with HIV infection with or without AIDS shall be guaranteed all basic rights, such as the right to protection of privacy, to employment, to education in schools, to have use of public transport and housing."[167] Furthermore, "persons receiving advice, counseling, and treatment for AIDS will be assured of the same rights to privacy and confidentiality as persons receiving treatment for any other disease."[168] HIV-infected persons shall also have, according to the policy, the right to insurance.[169] However, the policy stresses the importance of confidentiality in testing, as well as the need for pre- and post-test counseling.[170] The policy also calls for the punishment of HIV-infected individuals "aware of their being infected who indulge in unprotected sex with other(s) thus putting their partners at risk of HIV infection (without their partners [sic] informed consent)."[171] In addition, the policy encourages the criminalization of the willful spread of HIV/AIDS and STDs.[172]

Finally, the National AIDS Policy focuses on issues of gender.[173] The policy calls for the community to be educated on the consequences of multiple partners and high-risk sexual behavior. Specifically, it calls for women of all ages to be "provided with basic education about their own bodies and about human sexuality, as well as specific information about HIV/AIDS/STDs."[174] STD services are to be made accessible to women through the MCH/FP clinics, and HIV-transmission protective devices for women are to be promoted and provided.[175]

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's legal status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that will affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health care and her ability to make voluntary, informed decisions about such care. Laws regarding age of first marriage can have a significant impact on a young woman's reproductive health. Furthermore, rape and other laws prohibiting sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health.

A. RIGHTS WITHING MARRIAGE

Marriage Laws

Marriage in Mainland Tanzania is governed by the Law of Marriage Act (the "Marriage Act") of 1971.[176] The Marriage Act recognizes marriages contracted in a civil form in accordance with the rites of religion (Christian, Hindu, or Islamic) to which both parties belong, as well as marriages contracted under customary law when both parties belong to a community that follows customary law. However, except where the Marriage Act specifically permits the application of customary law or Islamic law, it deems such laws inapplicable in all the matters it covers.[177] The Marriage Act regulates numerous activities relating to marriages, including the forms and registration of marriages, the procedures for marriage and divorce (including custody issues), and relations between the spouses. Provisions included in the Marriage Act are rules regarding the consent of both parties to a marriage,[178] minimum age at the time of marriage,[179] property rights between spouses,[180] and the duties of each spouse to maintain the other.[181] Consent by both parties must be given "freely and

voluntarily," which is defined as not being influenced by coercion or fraud, or mistaken as to the nature of the ceremony. Furthermore, consent is not valid if either party is suffering from any mental disorder, or was intoxicated, and thus could not fully understand the nature of the ceremony.[182] The minimum age of marriage is 18 for males and 15 for females.[183] During the marriage, a husband has a duty to maintain his wife or wives and to provide them with such accommodation, clothing, and food as may be reasonable with regard to his means.[184] Women have a similar duty to provide for their husbands, but this duty occurs only if the husband is incapacitated, wholly or partially, from earning a livelihood by reason of mental or physical injury or ill health.[185]

The Marriage Act contains many provisions that seek to protect women's rights within marriage. For example, the Marriage Act reinforces the capacity of married women to enter into contracts[186] and enables women to continue to own their own property by stating that, subject to any agreement to the contrary, a marriage shall not operate to change the ownership of any property previously owned by either husband or wife.[187] Furthermore, where the matrimonial house is owned by one of the parties, neither party may alienate it while the marriage continues.[188] The Marriage Act, however, also maintains certain gender discriminatory practices. For example, Section 15(3) of the Marriage Act prohibits a woman who is married from contracting another marriage during the period that she is married. A man, on the other hand, is allowed under the law to contract more than one marriage at a time. The Marriage Act also states that a man can marry at the age of 18; however, the minimum age of first marriage for a woman is 15.[189] For further information regarding marriage and adolescents, see section on adolescents below.

Divorce and Custody Law

The law of divorce and custody is also governed by the Marriage Act. Any married person may petition the court for a decree of separation or divorce on the ground that his or her marriage has "broken down."[190] However, no decree will be granted unless the court is satisfied that the breakdown is "irreparable."[191] Furthermore, no person can petition for divorce until he or she has been married for a period of two years, unless it is shown that exceptional hardship is being suffered by the person applying for the divorce.[192] Also, before petitioning for divorce, a person must first refer the matrimonial difficulty to a Marriage Conciliatory Board and this board must certify that it has failed to reconcile the parties.[193] In deciding whether or not a marriage has "broken down," a court is to consider all relevant evidence regarding the conduct and circumstances of the parties. The court may accept one or more of a number of specified situations as evidence that a marriage has "broken down," but proof of any such matter shall not automatically entitle a party to a divorce decree. Relevant evidence of the "breakdown" of a marriage includes: mental or physical cruelty, willful neglect, desertion, voluntary separation, and change of religion where both parties had followed the same faith at the time of the marriage and where, according to the laws of the faith, a change of religion dissolves the marriage.[194] The Marriage Act also revokes the right of a Muslim husband to repudiate his marriage unilaterally.[195]

The Marriage Act provides for the division of matrimonial property and the payment of maintenance. It states that in exercising its powers, a court shall have regard to: the customs of the community to which the parties belong; the contributions made by each party in the form of money, property, or work towards the acquisition of such property; any debts owed by either party which were incurred for their joint benefit; and the needs of any infant children[196] of the marriage.[197] The intent of the Marriage Act was to ensure that women who did not contribute to the purchase of the matrimonial property were not denied a share of that property.[198] A court may order a man to pay maintenance to his wife or former wife in a limited number of circumstances. Such situations include those in which a man has refused or neglected to provide for his wife, deserted his wife, or married his wife pursuant to Islamic law, which requires maintenance for a customary period[199] following the date on which the divorce occurs.[200] A woman may also be required to pay maintenance to her husband in a situation where he is incapacitated and is not able to earn a living.[201]

The Marriage Act governs matters regarding the custody and guardianship of infant children. The governing principle in matters of custody and guardianship is that the welfare of the infant is of first and paramount consideration.[202] The Marriage Act provides that in making a determination concerning the custody of an infant, a court shall consider the wishes of the parents, the wishes of the infant if he or she is in a position to give an independent opinion, and the customs of the community to which the parents belong.[203] Furthermore, a court is to take into consideration criteria such as the economic situation of the parents, the housing possibilities of each parent, and the behavior of the mother in terms of whether she has contributed to the termination of the marriage. There is a rebuttable presumption that an infant under the age of seven should be cared for by the mother.[204] If there is more than one child from a marriage, a court is not bound to place all the children with one parent; the court is to consider the welfare of each child independently.[205]

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

The Tanzanian Constitution states that "[w]ithout jeopardising applicable laws of the land, every one has the right to own property and the right to keep his property in accordance with the law."[206]

Succession Laws

Succession laws in Mainland Tanzania are governed by the four competing legal systems under which an estate may be administered.[207] These systems of law are statutory law, customary law, Islamic law, and Hindu law. A person's "ethnicity, religious affinity or race" determines which of these regimes apply.[208] However, the existence of such diverse legal systems does raise the issue of which legal regime would apply in a particular situation. Two different tests are employed to determine the choice of law to be applied — the "mode of life test" and the "intention of the deceased."[209] When the question is whether to choose between the application of statutory law or customary law, courts employ "the mode of life test." Under this test, courts use the reasoning that, generally, customary law is applicable to a person who is or was a member of a community in which rules of customary law relevant to the matter are established and accepted. To determine if customary law should be applied to an individual case, the court must examine whether the deceased's manner of life indicates that the estate should be regulated "otherwise than by customary law."[210] The "intention of the deceased test" is to be applied when an African is also Muslim and there is a question as to whether to apply either customary law or Islamic law. To apply this test, a court will examine the intentions of the deceased by reviewing either written or oral declarations.[211]

The law to be applied can have a significant impact on the distribution of an estate. For example, under customary law a widow whose spouse dies intestate does not obtain a share of her husband's estate if there are children from the marriage.[212] Meanwhile, under the "statute law," when a person dies intestate the widow or widower receives one third of the estate's property, and the remaining two thirds goes to lineal descendants.[213] Thus, the four legal systems in force in Mainland Tanzania can produce divergent results when a person dies intestate, or even if a person dies with a will. Probate and administration of estates are also dealt with differently under all four systems.

Labor Rights

Only a fraction of women in Tanzania (3%) are employed in the formal sector. The vast majority of Tanzanian women are engaged in either domestic work or in the informal sector.[214] Hence, many of the labor laws described below are generally not applicable to the majority of the female work force.

The Constitution grants all persons in Tanzania the right to work, as well as the right to equal pay for equal work.[215] In addition, the Employment Ordinance of 1956 (the "Employment Ordinance"),[216] the 1975 amendments to the ordinance, and the Security of Employment Act of 1964[217] all regulate employment in Tanzania. The Employment Ordinance, however, contains certain provisions that restrict employment opportunities for women. Women are prohibited from working between the hours of 6 p.m. and 6 a.m. in any industrial undertaking unless there is an unforeseeable emergency or the work involves goods that would perish if left overnight, or if the women are holding responsible positions in management and are not engaged in manual work,[218] or if the Labour Commissioner has suspended this restriction.[219] A woman may also not be employed in underground work in any mine except in limited circumstances.[220] After considering the advice of the Labour Advisory Board, the president may make regulations that further prohibit the employment of women.[221]

Laws do provide women with some maternity benefits. Pursuant to the Amended Employment Ordinance, women are "entitled to prenatal maternity leave of 42 days, which may be taken at any time after the completion of the seventh month of pregnancy and before delivery," or "before the completion of the seventh month of pregnancy if a medical officer recommends that such leave is necessary or desirable in the interest of the employee's health."[222] Furthermore, women are entitled to 42 days leave commencing from the day of delivery.[223] Maternity leave is to be with full pay and at the expense of the employer.[224] However, a female employee is not entitled to any maternity leave under this provision if she has taken maternity leave within the previous three years.[225] If any of the allotted time has been taken, the entire leave is deemed to have been taken.[226] Furthermore, in any calendar year in which a female employee has taken maternity leave, she forfeits her annual leave; if she has already taken her annual leave, she forfeits the next year's annual leave.[227]

Access to Credit

Credit reform, initiated in 1981 in conjunction with a series of three-year-recovery programs, has hardly affected women.[228] Women continue to lack collateral, information, and knowledge on how to process and obtain loans.[229]

Access to Education

Tanzanian law does not explicitly restrict women's access to education. However, women have had less access to educational facilities, particularly at higher levels of education.[230] Completion and enrollment rates at all levels are lower for women than for men, and dropout rates for women are high-

er at all levels.[231] For further discussion regarding education, see the section on adolescents below.

Women's Bureaus

The Population Policy states that its plans relating to the promotion of women's rights will be implemented by the following institutions: the Ministry of Community Development, Women Affairs and Children; the Ministry of Labour and Youth Development; the Department of Women's Affairs in the Chief Minister's Office; Women's Organizations; Parents' Organizations; and the Attorney General's Office.[232] The Ministry of Community Development, Women Affairs and Children issued a "Policy on Women in Development in Tanzania."[233] The purposes of the Policy on Women in Development include: providing a "correct interpretation of the concept of women in development," so as to assist in overcoming "customs and traditional practices that militate against women"; "to ensure that society recognizes and appreciates the various activities performed by women"; "to establish concrete gender sensitive plans with equitable distribution of resources"; and to ensure the full participation and involvement of women in national development programs.[234]

C. RIGHT TO PHYSICAL INTEGRITY

Rape

The Penal Code states that a person is guilty of rape if he "has unlawful carnal knowledge of a woman or a girl, without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representations as to the nature of the act, or, in the case of a married woman, by impersonating [sic] her husband."[235] In addition, any person "who attempts to commit rape is guilty of a felony."[236] Rape and attempted rape are punishable by imprisonment for life, with or without corporal punishment.[237]

Various other sexual offenses are recognized by the Penal Code. They include the "abduction" of a woman of any age against her will for the purpose of marriage or sexual relations,[238] the "indecent assault" of any woman or girl,[239] the "procurement" of women or girls for the purpose of prostitution,[240] the inducement of sexual intercourse through duress, fraud, or the administration of overpowering drugs,[241] and the detention of any woman against her will for the purpose of sexual relations.[242] For a discussion of sexual offenses against minors, see the section on adolescents below.

Domestic Violence

Wife battering is common in Tanzania.[243] A 1990 survey showed that 90% of women are battered or have experienced violence in some form.[244] The Marriage Act prohibits violence against the spouse. Section 66 of the Marriage Act states: "For the avoidance of doubt, it is hereby declared that, notwithstanding any custom to the contrary, no person has any right to inflict corporal punishment on his or her spouse."[245] Although the Penal Code does not address specifically violence between spouses, criminal penalties for "unlawful assault,"[246] "assault occasioning actual bodily harm,"[247] "unlawful wounding,"[248] and "grievous harm"[249] are available. Under the Criminal Procedure Act, all the above offenses, except the crime of "common assault," do not require an arrest warrant.[250] Any person convicted of assault is liable to imprisonment for one year,[251] "assault occasioning actual bodily harm" is punishable by imprisonment for five years,[252] and any person convicted of "unlawfully wounding another" is liable to imprisonment for three years.[253] Once an act of violence has been reported, the police are responsible for the arrest of the accused[254] and for the prosecution of the case.[255] The woman only remains as the complainant and may assist in the prosecution as a witness.[256] This is true despite the fact that the criminal provisions under which domestic violence may be prosecuted are under the jurisdiction of the Primary Courts, where it is the complainant who is supposed to prosecute the case.[257] Also, when the court imposes a sentence in cases of domestic violence, it may take into account a number of factors including the age of the defendant, character, previous history, and the health or mental condition of the accused.[258]

Sexual Harassment

Some protection against sexual harassment in the workplace can be found in the Security of Employment Act.[259] Generally, this statute seeks to prevent the arbitrary dismissal of employees. However, it does not provide a definition of harassment.

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

The needs of adolescents are often unrecognized or neglected. Given that approximately 45% of the population is below the age of 15[260] and that for every six people in the country one is a youth between the ages of 15 and 24,[261] it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescent rights, including those related to reproductive health, are important for women's right to self-determination as well as for their health.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

The Family Planning Guidelines state that all males and females of reproductive age, including adolescents, are entitled

to family planning information, education, and services. In addition, the guidelines provide that adolescents are entitled to counseling on family planning information and that those who are sexually active are to be counseled on access to methods that are suitable to them.[262]

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

Partial removal of the labia minora is practiced by some tribes in the Morogoro and Iringa regions, and infibulation is practiced by Somali ethnic groups who live in the Arusha region.[263] No laws specifically address FGM, which is practiced in a number of regions in Tanzania, including Dodoma, Singida, Arusha, Kilimanjaro, and Mara.[264] In 1990, a National Committee on Traditional Practices was created to work toward creating awareness about FGM and improving the status of women in general.[265]

C. MARRIAGE AND ADOLESCENTS

There appear to be a number of conflicting laws regarding the age of first marriage and majority. A minor is defined by the Age of Majority Ordinance as a person of either sex who is not yet 18 years old.[266] Yet, pursuant to the Marriage Act, a man can marry upon attaining 18 years of age, and a woman may marry upon attaining 15 years of age.[267] The Penal Code also states that "any person of African or Asiatic descent" may "marry or permit the marriage of a girl under the age of twelve years in accordance with the custom of the tribe or religion" as long as it is not intended that the marriage be consummated before the girl is 12 years old.[268] In addition, a court may grant leave for a marriage to occur when the future spouses are younger than the minimum age, so long as they are not younger than 14 years old and the court is satisfied that there are special circumstances which make the proposed marriage desirable.[269] Furthermore, it is not an offense to give or receive money or presents in consideration or on the occasion of such a marriage.[270]

Laws do seek to ensure that provisions regarding the age of first marriage are enforced. The Marriage Act provides that "any person who is party to a ceremony purporting to be a marriage knowing or having reason to believe that the other party is below the minimum age for marriage [is] guilty of an offense and [is] liable upon conviction to imprisonment for three years."[271] Furthermore, it also states that "any person who participates in any such ceremony knowing or having reason to believe that either party is below the minimum age for marriage [is] guilty of an offense and [is] liable upon conviction to imprisonment for a term not exceeding two years."[272]

Tanzania's criminal laws also discourage early marriage. Section 138 of the Penal Code provides that any person married to a girl under the age of 12 years who has or attempts to have "carnal knowledge" of the girl, with or without her consent, before she has attained the age of 12 years is guilty of a misdemeanor punishable by five years imprisonment. Similarly, if the parent of the girl "parts with the possession, or otherwise disposes, of the girl with the intention that the girl shall, while still under the age of twelve years and whether with or without her consent, be carnally known by her husband or knowing it to be likely that the girl will, while under the age of twelve years, be so carnally known, is guilty of a misdemeanour, and is liable to imprisonment for two years."[273]

D. EDUCATION AND ADOLESCENTS

Although primary education in Tanzania is both universal and compulsory,[274] Tanzania's education system provides few education and training opportunities to youth beyond that level.[275] For example, in 1988 only 10.5% of students leaving primary school entered a secondary school.[276] In addition, "female access to higher education in Tanzania is extremely marginal."[277] From 1980 to 1981, female students constituted approximately 26% of all undergraduate university students. Since then, this proportion has been declining.[278] The Education Act attempts to "protect students, particularly girls, who are prevented from going to school by their parents or guardians or who are treated in a way which obliges them to leave school."[279]

E. SEX EDUCATION FOR ADOLESCENTS

No law specifically regulates sex education. The IEC component of the National Family Planning Program has introduced family planning education into nonschool/information programs.[280]

F. SEXUAL OFFENSES AGAINST MINORS

The Penal Code recognizes several offenses relating to unlawful sexual intercourse with minors. Any person who "carnally knows any girl under the age of fourteen years is guilty of a felony and is liable to imprisonment for life, with or without corporal punishment."[281] "Any person who attempts to have carnal knowledge of a girl under the age of fourteen years is liable to imprisonment for fourteen years, with or without corporal punishment."[282] It is, however, a sufficient defense to such a charge if the accused had reason to believe, and did in fact believe, that the girl was 14 years old or older.[283] Furthermore, this provision of the Penal Code does not apply when the accused is married to the girl.[284]

ENDNOTES

1. Union of Tanganyika and Zanzibar, Cap. 557, Supp. 64 (1967).
2. THE WORLD ALMANAC AND BOOK OF FACTS 1997 824 (1996).
3. *Id.*
4. CONSTITUTION OF THE UNITED REPUBLIC OF TANZANIA, *reprinted in* 29 CONSTITUTIONS OF THE COUNTRIES OF THE WORLD 6 (Albert P. Blaustein & Gisbert H. Flanz eds.,1986) [hereinafter TANZ. CONST]. Although amendments have been made to the constitution since 1986, such amendments are currently only available in Swahili.
5. Telephone interview with "Information," Tanzanian Embassy in Washington, D.C. (Feb. 12, 1997).
6. THE WORLD ALMANAC AND BOOK OF FACTS, *supra* note 2, at 824.
7. WOMEN AND MEN IN TANZANIA 3 (Bureau of Statistics, Dar es Salaam, 1992).
8. THE WORLD ALMANAC AND BOOK OF FACTS, *supra* note 2, at 824.
9. *Id.*
10. TANZ. CONST., preamble, ¶¶ 3(3), 10.
11. John Quigley, *Perestroika African Style: One-Party Government and Human Rights in Tanzania*, 13 MICH. J. INT'L L.VOL. 611, 635 (1992).
12. *Id.* at 651.
13. TANZ. CONST., ¶ 33.
14. *Id.* ¶¶ 51, 52.
15. *Id.* ¶ 47(4).
16. *Id.* ¶ 47(3).
17. *Id.* ¶ 47(2).
18. *Id.* ¶ 4(2).
19. *Id.* ¶ 64(1).
20. *Id.* ¶ 64(2).
21. Colin Darch, *Introduction to Tanzania*, 54 WORLD BIBLIOGRAPHICAL SERIES 4 (1996). The number increased from 15. TANZ. CONST., ¶ 66(1)(c); Telephone interview with "Information," Tanzanian Embassy in Washington, D.C. (Feb. 28, 1997), *citing Speaker's Inauguration Speech*, BUNGE NEWS, Apr. 1996, at 9.
22. The Magistrates' Courts Act of 1963 was later repealed and re-enacted with some modifications. Magistrate Courts Act, Gazette of the United Republic of Tanzania, Apr. 13, 1984, Act Supp. No. 2.
23. THOMAS M. REYNOLDS & ARTURO A. FLORES, TANZANIA IN FOREIGN LAW: CURRENT SOURCES OF CODES AND LEGISLATION IN JURISDICTIONS OF THE WORLD 2-3 (1993).
24. Magistrate Courts Act, Gazette of the United Republic of Tanzania, Apr. 13, 1984, Act Supp. No. 2.
25. TANZ. CONST., ¶ 64(5).
26. REYNOLDS & FLORES, *supra* note 23, at 2-3.
27. TANZ. CONST., ¶¶ 13(4), 13(5).
28. *Id.* ¶ 30(1).
29. *Id.* ¶ 30(2)(a).
30. *Id.* ¶ 30(2)(f).
31. TANZ. CONST., ¶ 31.
32. Report from Janet Kabeberi-Macharia, Women & Law in East Africa 1 (1996) (on file with The Center for Reproductive Law and Policy) (citing M. Rwebangira & C. Mukoyogo, THE LAW OF INHERITANCE IN TANZANIA: A STATUS REPORT, NAIROBI 5 (1995)).
33. International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, 999 U.N.T.S. 171 (*entry into force* Mar. 23, 1976) (ratified by Tanzania on June 11, 1976); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, 993 U.N.T.S. 3 (*entry into force* Sept. 3, 1976) (ratified by Tanzania on June 11, 1976); International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (*entry into force* Jan. 4, 1969) (ratified by Tanzania on Oct. 27, 1972); Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 (*entry into force* Sept. 3, 1981) (signed by Tanzania on July 17, 1980 and ratified on Aug. 20, 1985); Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, G.A. Res. 44/25, U.N. G.A.O.R., 44th Sess., Supp. No. 49, art. 9, at 165, U.N. Doc. A/44/49, *reprinted in* 28 I.L.M. 1448 (1989) (*entry into force* Sept. 2, 1990) (ratified by Tanzania on June 10, 1991); and African Charter on Human and Peoples' Rights, *adopted* June 26, 1981, OAU Doc. CAB/LEG/67/3/Rev. 5 (1981), *reprinted in* 21 I.L.M. 58 (1982) (*entry into force* Oct. 21, 1986) (ratified by Tanzania on Mar. 9, 1984).
34. UNITED REPUBLIC OF TANZ. MINISTRY OF HEALTH, NATIONAL HEALTH POLICY (1990) [hereinafter HEALTH POL.]. Before the implementation of the 1990 National Health Policy, health services planning in Tanzania was considered part of broader national development, which had generally been articulated in a series of five year plans. *See id.* at 1-5.
35. *Id.* at 1.
36. *Id.*
37. *Id.*
38. *Id.* at 5-6.
39. *Id.* at 7.
40. *Id.* at 7-9.
41. *Id.* at 12-13.
42. UNITED REPUBLIC OF TANZANIA, NATIONAL POPULATION POLICY, PRESIDENT'S OFFICE, THE PLANNING COMM'N 13 (1992) [hereinafter POP. POL.].
43. *Id.* at 13-14.
44. HEALTH POL., *supra* note 34, at 21-30.
45. POP. POL., *supra* note 42, at 13-14.
46. HEALTH POL., *supra* note 34, at 21.
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.* at 22.
52. *Id.*
53. *Id.*
54. *Id.* at 22-23.
55. *Id.* at 24-25.
56. *Id.* at 25.
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.* at 27.
62. *Id.* at 27-28.
63. *Id.* at 27.
64. *Id.* at 29.
65. *Id.* The Health Policy states that when certain diseases and cases require special treatment that cannot be provided in Tanzania, subject to financial constraints, some patients must be sent for treatment abroad.
66. *Id.* at 29-30.
67. *Id.* at 29. These were: Muhimbili Medical Centre (serving the eastern zone), Kilimanjaro Christian Medical Centre (serving the northern zone), Bugando Hospital (serving the western zone), and Mbeya Hospital (serving the Southern Highlands).
68. *Id.*
69. *See* 1 MILTON ROEMER, *Comprehensive Health Systems in Very Poor Countries*, NATIONAL HEALTH SYSTEMS OF THE WORLD: THE COUNTRIES 555, 561 (1991).
70. HEALTH POL., *supra* note 34, at 38.
71. *Id.* at 38-39.
72. Brian Abel-Smith & Pankaj Rawal, *Can the Poor Afford "Free" Health Services? A Case Study of Tanzania, Health Policy and Planning* 7 HEALTH POLICY & PLANNING 329 (1992).
73. *Id.*
74. HEALTH POL., *supra* note 34, at 36.
75. *Id.*
76. *Id.*
77. *Id.*
78. *Id.*
79. *Id.*
80. *Id.* at 37.
81. *Id.*
82. Medical Practitioners and Dentists Ordinance, Cap. 409, Supp. 59 (1960).
83. Nurses and Midwives Registration Ordinance, Cap. 325 (1956).
84. Pharmacy and Poisons Ordinance, Cap. 416, Supp. 59 (1960).
85. Medical Practitioners and Dentists Ordinance, Cap. 409, Supp. 59 (1960).
86. *Id.*
87. *Id.* ¶ 7.
88. One U.S. dollar is worth approximately 589 Tanzanian Shillings. *See U.N. Operational Rates of Exchange* [visited Feb. 27, 1997] <gopher://gopher.undp.org./00/uncurr/exch_rates>.
89. Medical Practitioners and Dentists Ordinance, Cap. 409, Supp. 59, ¶ 36 (1960).
90. *Id.* ¶ 37.

91. *Id.* ¶ 9.
92. Nurses and Midwives Registration Ordinance, Cap. 325, ¶ 3 (1956).
93. *Id.* ¶ 5.
94. *Id.* ¶ 7 (1). A person must (i) pass the final nursing examination conducted by the Nurses Council; or (ii) produce evidence to the satisfaction of the Nurses Council that he or she is certified or registered or is entitled to be certified or registered as a nurse in any country; or, (iii) produce evidence to the council's satisfaction that she or he is entitled to be certified or registered as a nurse in any country which is not prescribed in the regulations; or (iv) if he or she produces evidence to the satisfaction of the Nurses Council that he or she is a person of "good character" and that he or she has successfully completed a course of training as a nurse of not less than three years duration in a country in which there was, at the material time, no law for certification or registration of nurses. *Id.*
95. *Id.* ¶ 7 (2). Training in another country need only last one year.
96. *Id.* ¶ 16.
97. Pharmacy and Poisons Ordinance, Cap. 416, Supp. 59, ¶ 3 (1960).
98. *Id.* ¶¶ 5-6.
99. *Id.* ¶ 8.
100. *Id.* ¶¶ 18 (1), (2).
101. *Id.* ¶¶ 18 (4), (5).
102. *See id.* ¶ 24.
103. *See* A.A.F. Massawe, Legal Aspects of Hospital Administration 1-5, 12-15 (1992) (discussing law of torts, including issues of consent in the administration of hospitals).
104. Penal Code, Cap. 16, Supp. 66-74, § 230 [hereinafter Pen. Code].
105. Pop. Pol., *supra* note 42.
106. *Id.* at iii.
107. *Id.* at 10.
108. *Id.* at 27-30.
109. *Id.*
110. *Id.* at 34-35.
111. *Id.* at 35-36.
112. *Id.* at 31-32.
113. *Id.* at 32.
114. *Id.* at 34.
115. National Policy Guidelines and Standards for Family Planning Services Delivery and Training (Ministry of Health [Tanz.], 1994) [hereinafter Pol. Guidelines].
116. *Id.* at 2.
117. *Id.*
118. *Id.*
119. *Id.* at 3.
120. *Id.* at 7.
121. *Id.* at 10.
122. *Id.* at 11.
123. *Id.* at 12.
124. *Id.* at 13.
125. *Id.* at 15.
126. *Id.* at 16.
127. *Id.*
128. Pop. Pol., *supra* note 42, at 4-5.
129. Kathleen Beegle, The Quality and Availability of Family Planning Services and Contraceptive Use in Tanzania 6 tbl. 3 (1995).
130. Pol. Guidelines, *supra* note 115, at 3.
131. *Id.*
132. Pen. Code, Cap. 16 § 151.
133. *Id.* § 150.
134. *Id.* § 152.
135. Massawe, *supra* note 103, at 18.
136. (1939) I.K.B. 687, *cited in id.* at 18-19.
137. Massawe, *supra* note 103, at 18-19. The author of the book suggests: "In such cases it is eminently desirable that the surgeon should safeguard himself by taking a second opinion." *Id.*
138. Pharmacy and Poisons Ordinance, Cap. 416, Supp. 59 ¶ 38 (1960).
139. *Id.* ¶ 40 (4)(a).
140. Pol. Guidelines, *supra* note 115, at 19.
141. *Id.* at 2.
142. *Id.* at 12. These tests are inspection of the gums to exclude anemia; palpation of the lower abdomen for tenderness; pelvic tenderness; blood pressure; and weight. *Id.*
143. *Id.* at 13.
144. *Id.* at 17.
145. *Id.*
146. *Id.*
147. Jacqueline Smith, Visions and Discussion on Genital Mutilation of Girls: An International Survey 134 (1995).
148. Nahid Toubia, Female Genital Mutilation: A Call for Global Action 25 (Rainbǫ 1995).
149. Smith, *supra* note 147 at 134.
150. The United Republic of Tanzania Ministry of Health, National Aids Control Programme Tanzania Mainland: National Policy on HIV/AIDS/STD 1 (1995) [hereinafter AIDS Policy]. In 1994, only a total of 53,247 cases of AIDS had been reported to the MOH for both mainland Tanzania and Zanzibar. However, it is estimated that only one out of four to six AIDS cases are reported. *Id.*
151. *Id.* at 1.
152. *Id.*
153. Pen. Code, Cap. 16, § 179.
154. AIDS Policy, *supra* note 150, at 4.
155. *Id.* at 3.
156. *Id.* at 3-4.
157. *See id.* at 6-9.
158. *Id.* at 8.
159. *Id.*
160. *See id.* at 10-13.
161. *Id.* at 10.
162. *Id.*
163. *Id.* at 10-13.
164. *See id.* at 14-18.
165. *Id.* at 20.
166. *Id.*
167. *Id.* at 9.
168. *Id.*
169. *Id.*
170. *Id.* at 7.
171. *Id.* at 8.
172. *Id.*
173. *Id.* at 21.
174. *Id.*
175. *Id.*
176. Law of Marriage Act, No. 5 (1971). As with other non-union matters, the Marriage Act is not in effect in Zanzibar.
177. B.A. Rwezaura, *Tanzania*, 8 Annual Survey of Family Law 1983-1984, at 193 (M.D.A. Freeman ed., 1985).
178. Marriage Act, No. 5 ¶ 16 (1971).
179. *Id.* ¶ 13.
180. *Id.* ¶¶ 59-62.
181. *Id.* ¶ 63.
182. *Id.* ¶ 16.
183. *Id.* ¶ 13.
184. *Id.* ¶ 63(a).
185. *Id.* ¶ 63(b).
186. *Id.* ¶ 56.
187. *Id.* ¶ 58.
188. *Id.* ¶ 59.
189. *Id.* ¶ 13.
190. *Id.* ¶ 99.
191. *Id.*
192. *Id.* ¶ 100.
193. *Id.* ¶ 101. Some exceptions exist in which the parties are not required to go to the Marriage Conciliatory Board, such as when the petitioner alleges that he or she has been deserted by, and does not know the whereabouts of, his or her spouse. *Id.*
194. *Id.* ¶ 107(2).
195. *Id.* ¶ 107(3).
196. The Marriage Act defines infant child to be any child who has not attained the age of 18 years. *Id.* ¶ 2 (1).
197. *Id.* ¶ 114.
198. Kabeberi-Macharia, *supra* note 32, at 7-8 (citing Hawa Mohammed v. Ally Sefa, Civil Appeal No. 9 (1983). The Court of Appeal ruled that joint marital efforts as used in

Section 114 must be "construed as embracing the domestic efforts of husband and wife." *Id.*

199. This customary period is known as the *iddat*. Iddat is the period a woman who has been divorced has to wait before she is allowed to remarry. During the period of iddat, which usually lasts three menstrual cycles, a woman is forbidden to marry.

200. Marriage Act, No. 5 ¶ 115 (1971).

201. *Id.*

202. *Id.* ¶ 125.

203. *Id.*

204. *Id.* ¶ 125(3).

205. *Id.* ¶ 125(4).

206. TANZ. CONST., ¶ 24.

207. THE LAW REFORM COMM'N OF TANZ., REPORT OF THE COMMISSION ON THE LAW OF SUCCESSION INHERITANCE 25 (1995).

208. *Id.*

209. For a discussion of the application of these tests, *see* THE LAW REFORM COMM'N OF TANZ., DISCUSSION PAPER ON LAW OF SUCCESSION 5-9 (1992).

210. *Id.* at 5-6.

211. *Id.* at 7-8.

212. *Id.* at 14.

213. If the deceased had no lineal descendants, than one half of the property goes to the descendant's spouse and the other half goes to kindred of the deceased. If the deceased has no kindred, then the entire estate goes to the surviving spouse. *Id.* at 17-18.

214. Kabeberi-Macharia, *supra* note 32, at 12 (*citing* Population Census for 1988).

215. TANZ. CONST., ¶¶ 22, 23.

216. Employment Ordinance, Cap. 366, Supp. 56 (1957).

217. An Act to amend certain Labour Laws, Gazette of the United Republic of Tanzania, Apr. 4, 1975, Acts Supp. No. 1, Pt. II (amending The Security of Employment Act, Cap. 574 (1964)).

218. Employment Ordinance Cap. 366, Supp. 56, § 83 (1957).

219. *Id.* § 84.

220. *Id.* § 86.

221. *Id.* § 95.

222. An Act to amend certain Labour Laws, Gazette of the United Republic of Tanzania, Apr. 4, 1975, Acts Supp. No. 1, § 4 (replacing Employment Ordinance, Cap. 366 § 25B(1)(a)).

223. *Id.* (replacing Employment Ordinance, Cap. 366 § 25B(1)(b)).

224. *Id.* (replacing Employment Ordinance, Cap. 366 § 25B(2)).

225. *Id.* (replacing Employment Ordinance, Cap. 366 § 25B(a)).

226. *Id.* (replacing Employment Ordinance, Cap. 366 § 25B(b)).

227. *Id.* (replacing Employment Ordinance, Cap. 366 § 25B(c)).

228. TANZANIA WOMEN: COUNTRY REPORT TO 4TH WORLD CONFERENCE ON WOMEN, BEIJING, SEPTEMBER 1995, at 39-41 (United Republic of Tanz. 1995) [hereinafter TANZANIA WOMEN].

229. *Id.* at 41.

230. *Id.* at 21-22.

231. *Id.* at 22.

232. POP. POL., *supra* note 42, at 35-36.

233. MINISTRY OF COMMUNITY DEV., WOMEN AFFAIRS AND CHILDREN [Tanz.], POLICY ON WOMEN IN DEVELOPMENT IN TANZANIA (1992).

234. *Id.* at 4-5.

235. PEN. CODE, Cap. 16, § 130.

236. *Id.* § 132.

237. *Id.* §§ 131, 132.

238. *Id.* § 133.

239. *Id.* § 135.

240. *Id.* § 139.

241. *Id.* § 140.

242. *Id.* § 143.

243. TANZANIA WOMEN, *supra* note 228, at 15.

244. *Id.*

245. The Marriage Act does not impose any penalties for the violation of this section of the act.

246. Pen. Code, Cap. 16, § 240.

247. *Id.* § 241.

248. *Id.* § 228.

249. *Id.* § 225.

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271. *Id.* ¶ 148(1).

272. *Id.* ¶ 148(2).

273. PEN. CODE, Cap. 16, § 138(2).

274. TANZANIA WOMEN, *supra* note 228, at 23.

275. POP. POL., *supra* note 42, at 21.

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277. TANZANIA WOMEN, *supra* note 228, at 23.

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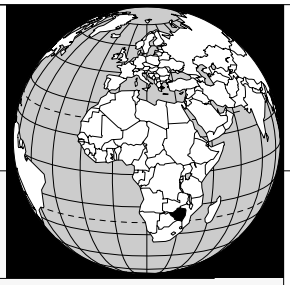
8. Zimbabwe



Statistics

GENERAL

Population

■ Zimbabwe's total population was 10.7 million as of 1993,[1] of which approximately 51% were women.[2] Annual population growth for 1980-1993 was 3.2%;[3] the median age of the population was 16.6 years in 1988.[4]

■ While 31% of Zimbabweans live in urban areas,[5] 86% of women live in rural areas.[6]

Economy

■ In 1993 the gross national product ("GNP") per capita was U.S.$520.[7] Estimated gross national income per capita in 1993 was $310 (in 1987 U.S. dollars).[8]

■ The gross domestic product ("GDP") grew 4.6% in 1993 after falling 5.3% in 1992.[9] The government spent approximately 6.2% of its GDP on health in 1990, as compared with the U.S., which spent approximately 12.7% of its GDP on health in the same year.[10]

Employment

■ Zimbabwe's labor force numbered approximately 4.3 million in 1993.[11] Women accounted for 34% of the total labor force in 1993.[12]

■ As of 1995, 1.3 million women were participating in the labor force. However, through the 1980s, average wages for women were lower than those for men in most categories of labor.[13] Women constitute approximately 76% of the economically inactive population.[14]

WOMEN'S STATUS

■ Zimbabwe's Central Statistical Office estimated life expectancy in 1992 at 62 years for women and 58 years for men.[15]

■ Polygamy is practiced within customary law marriages and unregistered customary unions. One in five married Zimbabwean women are in polygamous unions. The average union consists of 2.3 wives per man.[16]

■ In 1992, 79 women attended secondary schools for every 100 men.[17] The adult female literacy rate was 60% in 1990, while the general literacy rate was 67%.[18]

■ In 1993, there were 2,315 reported cases of rape and 274 reported cases of attempted rape in Zimbabwe.[19]

ADOLESCENTS

■ In 1993, 14% of all births were to women under the age of 20.[20]

■ In 1994, 62% of Zimbabwean women were married by the age of 20.[21] The median age for women at first marriage is 19.[22]

MATERNAL HEALTH

■ The maternal mortality rate in Zimbabwe is estimated to be 283 per 100,000 live births.[23]

■ The infant mortality rate for Zimbabwe is estimated to be 53 per 1,000 live births. The under-five mortality rate is estimated to be 77 per 1,000 live births.[24]

CONTRACEPTION AND ABORTION

■ In 1994, 35.1% of women reported use of a contraceptive method, compared with 41.4% for men.[25]

■ The most common method of contraception currently in use among women is the pill, which has a prevalence rate of 23.6%;[26] 14% of men report using condoms.[27]

■ In 1994, induced abortions were estimated to occur at an annual rate of 80,000.[28]

HIV/AIDS AND STDs

■ The first official AIDS case was reported in 1987; since then, over 48,000 cases have been reported.[29] Women account for 43% of all AIDS cases.[30]

■ There were nearly one million reported cases of STDs in Zimbabwe in 1987.[31]

ENDNOTES

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3. World Development Report 1995, *supra* note 1, at 210.
4. Governing Council of the United Nations Development Programme, United Nations Population Fund Proposed Programmes and Projects, Recommendation by the Executive Director: Assistance to the Government of Zimbabwe: Support for a Comprehensive Population Programme 2, U.N. Doc. DP/FPA/CP/59 (10 May 1989).
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6. Republic Of Zimbabwe, Framework For Economic Reform, Technical Note 7 (1991).
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9. *Id.* at 23.
10. The World Bank, World Development Report 1993: Investing in Health: World Development Indicators 210, 211 (1993).
11. World Tables, *supra* note 8, at 747.
12. World Development Report 1995, *supra* note 1, at 218.
13. Rene Lowenson, Lorna Edwars and Priscilla Ndlovu-Hove, Reproductive Health in Zimbabwe in a Framework of Reproductive Health Rights 35 (1996) [hereinafter Reproductive Health in Zimbabwe].
14. Ministry Of Health and Child Welfare, Government of Zimbabwe, Women's Health in Zimbabwe: a Path to Development 25 (1994) [hereinafter Path to Development].
15. Census 1992, *supra* note 5, at 153; *but see*, World Tables, *supra* note 8, at 747, which gives life expectancies in the low 50s for both sexes for the 1990s.
16. Central Statistical Office, Harare, Zimbabwe and Demographic and Health Surveys, Macro International, Demographic and Health Survey 72 (1994) [hereinafter Demographic and Health Survey].
17. World Development Report 1995, *supra* note 1, at 218.
18. *Id.* at 162.
19. Path to Development, *supra* note 14, at 26.
20. World Development Report 1995, *supra* note 1, at 212.
21. Demographic and Health Survey, *supra* note 16, at 77, 78.
22. *Id.* at 77-78.
23. *Id.* at 173.
24. *Id.* at 100.
25. The reported contraceptive prevalence rate for married women in Zimbabwe was 48%. Demographic and Health Survey, *supra* note 16, at 43, 45.
26. *Id.* at 43.
27. *Id.* at 45.
28. Path to Development, supra note 14, at 39.
29. Health Information Unit & National AIDS Coordination Programme, Ministry of Health and Child Welfare, *HIV, STD and AIDS Surveillance Zimbabwe*, Quarterly Report 2 (July-Sept. 1995).
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31. Reproductive Health in Zimbabwe, *supra* note 13, at 30.

In 1965, the white minority in the British colony of Rhodesia seized control of the local government and unilaterally declared independence from the United Kingdom.[1] Following a lengthy civil war between the African majority and the newly constituted Rhodesian government, and a negotiated settlement (Lancaster House Agreement) in 1979, Zimbabwe became an independent republic on April 18, 1980.[2] Elections under the new constitution were held in 1980, at which time the country received international recognition.[3] For the past 16 years, Zimbabwe has retained a representative form of government.

In 1992, Zimbabwe had a population of 10.4 million, including roughly 5.3 million women.[4] Over 60% of Zimbabweans live in communal farming areas.[5] Christian and traditional beliefs predominate; fewer than one percent of Zimbabweans are Muslim.[6] Shona is the predominant ethnic group, comprising 77% of the population; the remainder of the population is Ndebele (14%), Kalanga (5%), white (1%), or from another ethnic group (3%).[7] The official language is English, and a majority of Zimbabweans also speak Chishona or Sindebele, the languages of the dominant ethnic groups.[8]

I. Setting the Stage: The Legal and Political Framework

To understand the various laws and policies affecting women's reproductive rights in Zimbabwe, it is necessary to consider the legal and political systems of the country. Without this background, it is difficult to determine the manner in which laws and policies are enacted, interpreted, modified, and challenged. The passage and enforcement of law often involves specific formal procedures. Policy enactments, however, are not subject to such a process.

A. THE STRUCTURE OF GOVERNMENT

The Constitution of Zimbabwe (the "Constitution") establishes a tripartite division of government consisting of the executive, the legislature, and the judiciary.[9] Each of the country's nine provinces forms an electoral district and is administered by a governor appointed by the president.[10] City, municipal, town, and rural councils administer government programming and services. In addition, the Constitution recognizes the authority of tribal chiefs, whom the president appoints, with consideration given to customary principles of succession.[11]

The executive authority of the government vests in the president and may be exercised directly or through the Cabinet and designated ministers.[12] The president functions as head of state, head of the government, and commander-in-chief of the defense forces.[13] He or she may appoint ministers, deputy ministers, and up to two vice-presidents from among the members of Parliament to assist in the discharge of executive authority or to perform such administrative functions as may be assigned to them.[14] An executive cabinet, consisting of the president, the vice-presidents, the attorney-general,[15] and ministers appointed by the president, advises the president in the exercise of executive functions.[16] From independence until 1990, the executive operated with enhanced powers under a declared state of emergency.[17]

The legislature of Zimbabwe consists of the Parliament and the president. The Constitution empowers the Parliament to make laws "for the peace, order and good government of Zimbabwe."[18] The unicameral Parliament consists of 150 members, of whom 120 are directly elected.[19] The remaining 30 seats are occupied by 12 non-constituency members appointed by the president,[20] ten traditional chiefs,[21] and eight provincial governors.[22] The president and other members of the executive ministry may address the assembly; in addition, the president has veto power over legislation.[23] The Constitution also established a Parliamentary Legal Committee, which reviews the constitutionality of bills, draft legislation, and statutory instruments.[24]

Zimbabwe has a constitutionally protected, independent judiciary. The Constitution provides that members of the judiciary "shall not be subject to the direction or control of any person or authority, except to the extent that a written law may place him [or her] under the direction or control of another member of the judiciary."[25] The Supreme Court of Zimbabwe is the highest court in the country and the final court of appeal.[26] The Constitution provides that Supreme Court justices are appointed by the president.[27] Furthermore, Supreme Court justices may only be removed for infirmity or gross misconduct.[28]

Courts both create and interpret law. The judicial system can have a significant impact on legislation, including that affecting reproductive rights, because it is able to enforce the law and deal with complaints from individuals challenging the constitutionality of specific laws.

The 1990 Customary Law and Local Courts Act[29] (the "Local Courts Act") establishes a unified court system for the integrated administration of both customary and civil law.[30] Pursuant to the Local Courts Act, all levels of the judiciary, including magistrates courts, the High Court, and the Supreme Court, have jurisdiction to hear customary law cases.[31] The Local Courts Act also establishes primary and community courts of first instance ("local courts") and sets forth their jurisdiction.[32] Local courts are presided over by chiefs or

headmen, and only have jurisdiction over civil customary law disputes.[33] In addition, certain types of claims cannot be heard by the local courts, including: claims that involve the interpretation of wills; the dissolution of a registered marriage; or the determination of custody, guardianship, maintenance, or rights in land or other "immovable property."[34] Writs of the local courts carry the same level of authority as writs from the magistrates courts.[35] Furthermore, the local courts provide access to the formal legal system in rural areas.[36] The Local Courts Act mandates that proceedings in local courts "shall be conducted in as simple and informal a manner as is reasonably possible" and bars legal practitioners from appearing on behalf of parties to a dispute.[37]

The Local Courts Act limits the application of customary law to cases where the parties have agreed that customary law should apply, or where "it appears just and proper that it should apply."[38] Absent any other, controlling legislation, courts deciding whether customary law should apply to a dispute may consider, *inter alia*:

> (a) the mode of life of the parties; (b) the subject matter of the case; (c) the understanding by the parties of the provisions of customary law or the general law of Zimbabwe, as the case may be, which apply to the case; [and] (d) the relative closeness of the case and the parties to the customary law or the general law of Zimbabwe, as the case may be.[39]

Generally, customary law only applies to Africans.[40]

Similar principles govern the choice between conflicting systems of customary law.[41] African customary law in Zimbabwe is diverse, often differing from tribe to tribe, and different systems of customary law may be implicated by a single claim.[42] The Local Courts Act also establishes a general procedure to determine substantive issues in customary law.[43]

B. SOURCES OF LAW

Domestic Sources of Law

Laws that affect women's legal status — including their reproductive rights — derive from a variety of sources. The Constitution declares itself the supreme law of Zimbabwe.[44] It includes a Declaration of Rights that articulates and seeks to protect "the fundamental rights and freedoms of the individual."[45] The Supreme Court has the authority to enforce the provisions contained in the Declaration of Rights.[46] Zimbabwe has had a dual set of laws in place since the colonial period: the Constitution provides for the administration of both African customary law and general law following the Roman-Dutch common law tradition.[47] In a case of conflict between the two systems, statutory provisions govern the legal regime to be applied.[48] Most criminal law is not codified.

International Sources of Law

International laws are not included as sources of law in the Constitution; they must be enacted by Parliament in order to become domestic law.[49] Principles expressed in international treaties become law upon incorporation into national legislation. Although international treaties are not legally binding, they form a foundation for legislative change in Zimbabwe. Moreover, international covenants may be cited by advocates to challenge the unfairness of or lack of adequate protections within existing laws. Zimbabwe has ratified a number of major international and regional human rights instruments, including: the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights;[50] the African Charter on Human and Peoples' Rights;[51] the Convention on the Elimination of all Forms of Discrimination Against Women[52] ("CEDAW"); the International Convention on the Elimination of All Forms of Racial Discrimination;[53] and the Convention on the Rights of the Child.[54] International law can be an additional tool for the advancement of women's rights and reproductive rights. A number of international human rights treaties, particularly CEDAW, recognize and promote specific reproductive rights. Because international instruments are legally binding, they create an obligation on the part of the government to undertake numerous actions, including those at a national level.

II. Examining Reproductive Health and Rights

Issues of reproductive health and rights are dealt with in Zimbabwe within the context of the country's health and population policies. Thus, an understanding of reproductive rights in Zimbabwe must be based on an examination of those policies.

A. HEALTH LAWS AND POLICIES

Objectives of the Health Policy

The government of Zimbabwe has identified health as a human right and prioritized the improvement and extension of health services as "a necessary and primary condition of development."[55] Between 1985 and 1991, 80% of the rural population and 90% of the urban population had access to health care.[56] The Ministry of Health and Child Welfare ("MHCW") administers the national health policy, which establishes the framework for health services in Zimbabwe. The MHCW has identified as its overall purpose the promotion of "the health and quality of life of the people of Zimbabwe."[57] Primary health care, as defined by the World Health Organization's ("WHO") Health Care for All by the

Year 2000 mandate, is a central component of this policy.[58] The approach to primary health care in Zimbabwe embodies the basic idea "that the promotion of health depends fundamentally on improving socio-economic conditions, and on the elimination of poverty and under-development."[59]

MHCW strategies have focused on integrating the delivery of basic health, as well as informational and educational services, and increasing access to health facilities "to support health activities at the primary level, which respond to the health needs of the people."[60] Health facilities offer comprehensive services in promotive and preventive care, including: basic and essential preventive and curative care; immunization; maternal and child health services; family planning programming; health and nutrition education; and the control of communicable diseases.[61] In addition, the MHCW provides fee exemptions for families earning less than a threshold monthly income.[62]

Although the government has adopted the WHO's definition of health as "a state of complete physical, mental and social well-being," the national health policy does not address reproductive health.[63] However, maternal and child health ("MCH") programs are a major component of the health care system. Under the design and implementation of its MCH department, the MHCW has improved ante- and postnatal care, the monitoring of births, and child immunization and nutrition programs.[64] The MCH department has also instituted training for health personnel in maternity services and improved telecommunications and transportation systems in rural areas to facilitate referral and supervision in obstetric emergencies.[65] The MCH department has advocated for the improvement of employment conditions affecting the health status of women workers, lobbying for state-guaranteed maternity leave and breast-feeding time.[66] In addition, the MHCW monitors work environments and worker health in the industrial and commercial sectors.[67]

Infrastructure of Health Services

The MHCW, local government authorities, church organizations, and the private sector are the major providers of modern health care in Zimbabwe.[68] Traditional and alternative medical care is provided by traditional practitioners,[69] midwives, and "natural therapists."[70]

The MHCW is the largest provider of health care in Zimbabwe, employing 90% of all health personnel and providing financial support to other health care providers in the country.[71] The MHCW utilizes a four-tiered system of facilities, with a centralized public health administration.[72] At the primary level, urban primary care clinics and rural health centers are staffed with state-certified nurses and midwives, and rural health centers also have environmental health technicians.[73] In addition, community-based family planning personnel and "village community workers" provide basic treatment and preventive care, and conduct educational activities outside of the clinics.[74] At the secondary, tertiary, and quaternary levels, hospitals are staffed with doctors and nurses and are equipped for surgical procedures and laboratory tests.[75] An internal referral system facilitates access to specialized services and more sophisticated equipment.[76] However, internal evaluations by the MHCW have concluded that the referral system functions poorly.[77]

The secondary, district level is the planning unit for MHCW programming.[78] Each district is under the responsibility of a provincial health executive, who is responsible for the coordination and integration of services throughout the district, as well as the supervision of health services in each province.[79] Municipal health clinics, hospitals affiliated with church organizations, and services provided by the rural and district councils are supervised and coordinated by district medical officers and provincial medical directors under national health policy guidelines set by the MHCW.[80] Private health care providers, concentrated in the urban areas, are subsidized through the provision of government facilities and the extension of tax abatements for private medical costs.[81]

Major health initiatives to expand the health services infrastructure have included the Family Health Project, which focused on the integration of MCH and family planning services, the development of rural health facilities, and the training and development of MCH personnel. Currently, the Family Health Project is targeting 16 underserved districts to provide services to an additional 40% of the rural population, many of whom cannot afford health care costs under the economic and structural adjustment reform program.[82]

The MHCW has developed guidelines to aid regional managers in the allocation of personnel resources and to set personnel standards to improve the training, recruitment, and retention of health personnel, especially in rural areas.[83] In addition, the MHCW has established multidisciplinary health training schools in four cities, with the goal of establishing one training school in each province.[84] Since 1984, the MHCW has conducted training sessions for traditional birth attendants, who attend 69% of births.[85] The MHCW developed a national training model in 1993 that focused on basic antenatal maternal nutrition, referral services for major complications, referrals to institutions for postpartum care and vaccinations, education on hygiene in labor, antenatal care, and improved data collection.[86]

Cost of Health Services

In budget estimates for the 1996 fiscal year, the MHCW was allocated approximately Z$1.35 billion (U.S.$129 mil-

lion).[87] The government has proposed that reductions of public subsidies for health services would be offset by improved financial management of health services, increased provision of care by non-governmental organizations ("NGOs") and local and municipal authorities, and the establishment of health insurance programs or the expansion of existing schemes of coverage.[88] In addition, the government has implemented a cost-recovery program through the imposition of fees for health services.[89]

Currently, the MHCW provides free health care to individuals earning less than Z$400 per month (U.S.$38.10), including family planning and MCH services.[90] All immunization services for children and pregnant women are provided free of charge.[91] However, the Z$400-per-month income limit for the general health subsidy is below the poverty line in Zimbabwe.[92] Moreover, it is often difficult for individuals to prove that they qualify for the health subsidy.[93] The MHCW has implemented measures addressing fee evasion, and MHCW clinics require subsidy applicants to provide proof of their income level or their unemployed status.[94]

Regulation of Health Care Providers

Who is legally permitted to provide what types of care? Are there meaningful guarantees of quality control? Because the Zimbabwean government regulates these issues, reviewing such laws is important. All health institutions and medical practitioners, including midwives, are regulated pursuant to the Medical, Dental and Allied Professions Act (the "MDAP Act").[95] The MDAP Act establishes a Health Professions Council (the "Council"), which acts as a regulatory body, imposing a code of conduct and providing a mechanism for investigation of improper conduct and sanctions. Furthermore, professional associations and health institutions have internal regulatory bodies, which are not mandated by statute.[96] Medical practitioners may also be subject to criminal prosecution or to a civil suit for negligence.[97] In addition, hospitals and other health institutions may be liable for the negligent act of an employee performed in the course of his or her employment.[98]

All health personnel in Zimbabwe must be registered and have a current practicing certificate.[99] Certificates to practice must be renewed annually, and renewal is subject to any restrictions on employment the Council may impose that it considers "desirable in the public interest."[100] The MDAP Act provides that health practitioners not registered with the Council cannot recover fees and are subject to prosecution under the MDAP Act.[101] The Council is an autonomous body, but may receive direction from the Minister of Health and Child Welfare.[102] The Council sets standards for training and examination requirements.[103]

Statutory regulations issued pursuant to the MDAP Act provide some guidelines for medical conduct. For example, by statute, medical practitioners in non-emergency situations may not perform any procedure for which they have not received adequate training or in which they are insufficiently experienced,[104] nor may they use any apparatus or pursue a course of treatment that is inadequate for the procedure required.[105] In addition, medical practitioners are prohibited from divulging confidential information without the consent of the patient, or of the patient's guardian or next of kin, unless required by law to do so.[106]

The Council has also promulgated a code of ethics setting forth "the fundamental duties and requirements to be fulfilled by all registered health personnel" and to be supplemented by Council regulations.[107] The code of ethics provides that the welfare and safety of both the patient and the public should be the primary concern of all health personnel.[108] The code of ethics also includes a duty to protect patient confidentiality, to stay abreast of developments in medical technology and any legal developments, and to maintain medical facilities and equipment.[109] The disciplinary committee of the Council has full powers to investigate any allegation of misconduct or gross incompetence, and may examine any records or documents or compel disclosure of pertinent materials.[110] The disciplinary committee also has the authority to suspend health professionals, censure them, or order them to pay penalties.[111] In addition, the Council may direct the Registrar to publicize the results of any disciplinary hearings resulting in disbarment or suspension.[112]

Traditional practitioners and natural therapists are regulated separately in Zimbabwe, pursuant to the Traditional Medical Practitioners Act[113] and the Natural Therapists Act.[114] All traditional medical practitioners and natural therapists must be registered with the appropriate supervisory body.[115] The Natural Therapists Council and the Traditional Medical Practitioners Council have the power to regulate the practice of registered practitioners, to define and investigate improper conduct and incompetence, and to suspend registration.[116] However, there are no formal training or examination requirements for traditional medical practitioners.[117]

Patients' Rights

Laws also seek to ensure quality health services by protecting the rights of patients. All Zimbabweans have the right of access to health care, regardless of their ability to pay.[118] The right to treatment encompasses rights to confidentiality, privacy, and nondiscrimination, including on the ground of sex.[119] Furthermore, all persons over the age of 18 and "of sound mind" have a constitutional right to "security of their person,"[120] which includes the right to determine their own

medical treatment.[121] For example, medical treatment cannot be performed legally without the free and informed consent of the patient, or of another empowered by law to grant consent.[122] This requirement seeks to protect the right to bodily integrity and "upholds the vitally important values of self-determination and personal autonomy."[123] Also, all major risks of a medical procedure must be disclosed. An individual does not need spousal approval in consenting to medical treatment.[124] However, married persons may experience difficulty in obtaining a medical procedure that impacts on the reproductive functions without spousal consent.[125] Under customary law, a woman is required to obtain her husband's consent for all medical treatment, including the use of contraceptives.[126] Medical treatment for minors requires the consent of a parent or guardian by law; however, if the parent or guardian unreasonably withholds consent, a medical practitioner may appeal to a magistrate or perform the treatment if it is a medical emergency.[127] If the parents are in conflict over the medical treatment, the father's wishes are usually followed.[128]

Statutory regulations also prohibit the divulgence of confidential patient information by a medical practitioner, unless he or she is required by law to do so.[129] Breach of statutory conduct regulations, or any improper conduct, may result in sanctions by the appropriate professional regulating body. In addition, failure to meet the requirements of informed consent may result in a criminal prosecution for assault or medical negligence.[130] Aggrieved clients may also file a civil action against their health care provider for not providing full information about a treatment or procedure, but there is no reported case in Zimbabwe where damages were recovered.[131]

B. POPULATION AND FAMILY PLANNING

Zimbabwe does not have an explicit population policy. However, the government has associated population issues with development concerns and has given national priority to family planning activities since 1985. The country's First (1986-1990) Five-Year National Development Plan ("NDP") sought "to further reduce population growth to levels consistent with economic growth and the objective of raising the living standards of society."[132] The Second (1991-1996) NDP also recognized population as a development concern, targeting both the reduction of the total fertility rate from an average of 5.5 children per woman to 4.5 children per woman, and the increased use of modern methods of contraception to 50% of women of reproductive age.[133]

Since 1985, the government has focused national family planning activities on the goals of limiting family size and conforming population growth to the pace of infrastructure development.[134] In 1985, the government established a national family planning program through the Zimbabwe National Family Planning Council Act (the "Family Planning Act").[135] The Family Planning Act nationalized family planning activities through the creation of the Zimbabwe National Family Planning Council (the "ZNFPC"), a parastatal organization under the MHCW.[136] The ZNFPC is responsible for the provision of child-spacing and fertility services, and treatment and research in infertility, reproductive health, and related family health areas.[137] Its powers include authorization to establish and administer research into the areas of contraception, sterilization, reproductive health, and sexually transmitted disease.[138] The Family Planning Act also created the Zimbabwe National Board of Family Planning, composed of representatives from governmental and non-governmental agencies, to oversee general policy and to ensure the integration of family planning activity into the national development program.[139] The ZNFPC acts as an advisory body to government agencies on population and development issues.

The ZNFPC is funded through an annual direct grant from the national Parliament, as well as through fees, loans, and donations from NGOs.[140] In 1991, when the government began to pursue a policy of economic reform, the national program for structural adjustment contained pledges to continue support for population initiatives and the expansion of family planning services.[141] For the fiscal year 1995, the ZNFPC received Z$23 million (approximately U.S.$2.19 million) in appropriations.[142]

Both NDPs identified the equitable distribution of services as a primary objective of family planning programming.[143] In 1986, the Central Statistical Office ("CSO") established a Population Planning Unit to refine family planning programming and service distribution with improved demographic data.[144] The Population Planning Unit acts to advise officials on population issues and to promote studies on the impact of population growth on development. The CSO has also introduced a simplified registration system to improve population projections and development planning.[145]

From its inception, the ZNFPC has made broad access to services a primary goal. The ZNFPC maintains that "all individuals in the community have a right to information on the benefits of family planning for themselves and their families. They also have the right to know where and how to obtain more information and services for planning their families."[146] The ZNFPC's Kubatsirana Project was initiated to strengthen women's role in fertility decisions.[147] The ZNFPC established its Kubatsirana Project as a part of a general governmental initiative to support the participation of women in development. The Kubatsirana Project employs a broad focus that includes addressing disparities in literacy and income levels and the promotion of collective bargaining.[148]

Government Delivery of Family Planning Services

The ZNFPC's mandate encompasses the provision of contraceptives to public sector facilities. The ZNFPC is a major provider of contraceptives in Zimbabwe, supplying over 1,000 public hospitals and clinics that are the main source of family planning services for most modern contraceptive users.[149] The ZNFPC utilizes a community-based system for delivery. The community-based distribution system employs over 800 salaried field personnel to provide counseling and to distribute pills and condoms in rural villages.[150] The ZNFPC provides training and transportation for its field workers, who reach an estimated 29% of the rural population.[151] The Second NDP provides for the expansion of the rural delivery system by integrating family planning into the program of rural health center construction and the Family Health Project.[152]

Public heath facilities distribute pills, condoms, chemical barriers, and injectable contraceptives.[153] In addition, some facilities are equipped to perform intrauterine device ("IUD") insertion and sterilizations.[154] However, a 1991 study of family planning facilities found that although over 90% of clinics offered both combined and progestin-only pills and condoms, fewer than one quarter made available spermicides, IUDs, and injectable contraceptives, and only two percent of facilities were equipped to perform female sterilization.[155]

In 1993, the ZNFPC announced its intention to increase the range of methods available, focusing on long-term and permanent methods of contraception.[156] The ZNFPC directly operates 34 clinics, including two facilities where female and male sterilizations are available (in Harare and Bulawayo) and facilities within the three central hospitals, where NORPLANT® has been available since 1992.[157] In 1992, the government reintroduced injectables, which had been restricted in Zimbabwe since 1980,[158] and the ZNFPC has introduced sterilization training at district and provincial hospitals.[159] In addition, the ZNFPC has proposed a new training protocol that provides for staff instruction on IUDs and for integration of STD prevention education into family planning programming.[160]

ZNFPC delivery services are supplemented by the activities of its Information, Education and Communication ("IEC") Unit. The IEC unit consists of MHCW and ZNFPC provincial core groups that identify regional needs and conduct campaigns to promote family planning services.[161] Recent campaigns have specifically targeted men and youth.[162] A main objective of these campaigns has been to promote cooperative decision-making between couples regarding contraception and family size. IEC activities have included motivational talks conducted by ZNFPC and MHCW staff, a radio drama series, and two pamphlets about contraceptive methods.[163]

The ZNFPC has monitored its health and family planning programming through an Evaluation and Research Unit (the "ERU"). In 1984, the ERU conducted a national survey of reproductive health.[164] In 1991, the ZNFPC conducted an intensive evaluation of national family planning facilities through its Family Planning Service Expansion and Technical Support Project.[165] The study identified deficiencies in family planning programming, particularly in the areas of staff training and management. Study results indicated that over half of the family planning facilities in Zimbabwe did not keep accurate, long-term records on individual clients, and that 30% of staff had not been formally trained in family planning methods.[166] The ZNFPC has since initiated the development of a new service-delivery policy, with additional protocols to ensure accurate record keeping. The ZNFPC has also revised training procedures for medical personnel, nurses, and midwives.[167]

C. CONTRACEPTION

Although contraceptive prevalence rates in Zimbabwe are among the highest in sub-Saharan Africa, these rates vary by region.[168] In 1995, contraceptive prevalence was estimated to be 43%.[169] The most common method of contraception in 1996 among women was the pill, which has a prevalence rate of 23.6%.[170] The ZNFPC reports a high demand for the pill, condoms, and injectables in rural areas, while in urban areas, spermicides, the diaphragm, and other forms of contraception are more commonly requested.[171] Twenty percent of the population in rural areas does not have access to ZNFPC or other MHCW services.[172]

The national government supports more than half the cost of national family planning programming.[173] The government subsidizes up to 90% of the cost of contraceptives, and contraceptives are free of charge to low income families.[174] However, following introduction of the government cost-recovery program in 1991, fees for all health services were increased and condom distribution declined by 43%.[175]

Legal Status of Contraceptives

Modern contraceptives in Zimbabwe are regulated by the Drugs Control Council (the "DCC"), established by the 1988 Drugs Control Act.[176] The DCC advises the Minister of Health and Child Welfare on the imposition of restrictions regarding the preparation, distribution, and use of certain drugs.[177] The DCC may also prohibit the sale of "undesirable drugs."[178] There are no specific regulations governing the sale or use of traditional contraceptives.[179]

All new drugs must receive the approval of the DCC.[180] The Drugs Control Act establishes a register describing which drugs are permitted for sale in Zimbabwe.[181] Any clinical trials of new drugs require written authorization from the DCC and the approval of the Secretary for Health and Child Welfare.[182] In addition, the Drugs Control Act imposes informed consent requirements on all clinical trials, and empowers the DCC to specify the conditions under which a clinical trial must be conducted.[183] All trials are monitored by the DCC, which makes an independent assessment of the results.[184] The DCC may, in the public interest, suspend any trial.[185] Failure to comply with regulations governing the conduct of clinical trials is an offense punishable by a fine of up to Z$10,000 (approximately U.S.$952) or imprisonment for up to five years, or both.[186]

Clinical trials of the contraceptive NORPLANT®, conducted in 1992, were successful. The ZNFPC has since trained local practitioners on procedures for the administration of NORPLANT®, and is developing a system of distribution appropriate to the delivery of long-term services.[187] The Department of Obstetrics and Gynecology at the University of Zimbabwe is currently testing the "morning after" pill.[188]

Regulation of Information on Contraception

There is no legislation specifically addressing the advertisement of contraceptives.[189] The Drugs Control Act prohibits the false or misleading advertisement of any drug,[190] and the 1967 Censorship and Entertainments Control Act (the "1967 Act") governs general restrictions on advertisements.[191] The 1967 Act establishes a Board of Censors that is empowered to examine any publication or record and declare it to be "undesirable."[192]

D. ABORTION

Legal Status of Abortion

Abortion is legally permissible in limited circumstances in Zimbabwe. Pursuant to the 1977 Termination of Pregnancy Act[193] (the "1977 Act"), abortion is defined to be "the termination of a pregnancy otherwise than with the intention of delivering a live child."[194] Pregnancy is defined to be "an intra-uterine pregnancy where the foetus is alive,"[195] and the term "foetus" is defined to include the embryo.[196] Any abortion, irrespective of the duration of pregnancy, must be performed in accordance with the provisions of the 1977 Act.[197]

The 1977 Act sets forth the circumstances and conditions under which a medical practitioner may lawfully perform an abortion. An abortion may be legally performed under four circumstances: (1) when the pregnancy endangers the life of the woman; (2) when the pregnancy represents "a serious threat of permanent impairment of her physical health"; (3) when there is a severe risk that the child to be born would suffer from a permanent, serious physical or mental handicap; or (4) when the pregnancy was the probable result of "unlawful intercourse."[198] The 1977 Act defines "unlawful intercourse" to be rape,[199] incest, or intercourse with a mentally handicapped woman or girl.[200] Other sexual offenses, such as statutory rape, are not permissible grounds for an abortion under the 1977 Act.[201]

Requirements for Obtaining Legal Abortion

The 1977 Act establishes the procedure which must be followed before an abortion may be performed.[202] In general, an abortion may only be performed by a "registered medical practitioner"[203] in an institution designated by the MHCW.[204] The medical practitioner must obtain written permission from the institution's superintendent or designated administrator;[205] any refusal to grant permission may be appealed to the Secretary for Health and Child Welfare.[206] Spousal consent is not a legal requirement.[207] Abortion services are provided by the MHCW, and are free to low-income or unemployed women, as part of the fee exemption program.[208] Fees for all services involved in the provision of abortions are set by the state.[209] The 1977 Act excludes practitioners, nurses, and institutional employees from legal liability or any other obligations for refusing to participate or assist in an abortion.[210]

Additional conditions for compliance with the 1977 Act's requirements vary for each of the permitted grounds for abortion. When the ground for abortion is concern for the life or physical health of the mother, the 1977 Act requires the institution's superintendent to obtain certification of the mother's health status by two independent, registered medical practitioners before she or he may grant permission for the abortion to be performed.[211] However, when a woman's life or health is in danger and the proper facility or institutional permission cannot be obtained, a medical practitioner may perform an abortion provided she or he submits a report to the Secretary for Health and Child Welfare within 48 hours of the intervention.[212] When the ground for abortion is severe fetal impairment, certification to this effect by two independent, registered practitioners is similarly required. In addition, the practitioners must certify that the risk of defect in the fetus was properly investigated.[213] Abortion on the ground that the pregnancy resulted from "unlawful intercourse" requires precertification by a local magistrate.[214] A magistrate may issue certification only if a criminal complaint has been filed and after an investigation has established that the crime most likely occurred and that the pregnancy could have resulted

from the crime.[215] A woman asserting that her pregnancy resulted from rape or incest must submit a supporting affidavit or statement under oath.[216]

Penalties

Contravention of any of the 1977 Act's provisions carries a penalty of imprisonment up to five years and/or a Z$5,000 fine (approximately U.S.$476).[217] The terms of the statute may be violated on a number of grounds, including: performance of an abortion on grounds other than those permitted under the 1977 Act; noncompliance with any specified procedure, including charging a fee in excess of state-prescribed levels; issuing false or improper certification or permission for an abortion; attempting to self-induce the termination of a pregnancy; and making false statements in connection with any supporting affidavit or during an investigation.[218]

The 1977 Act empowers the Secretary of Health and Child Welfare to gather information on any abortion performed in a public or private facility, legal or illegal.[219] The Secretary may give this information to the office of the Attorney General for use in a criminal prosecution, or to the Registrar of the Health Professions Council for review of any incompetent or improper conduct.[220] Failure to cooperate with an investigation is also a criminal offense in violation of the provisions of the 1977 Act.[221]

E. STERILIZATION

Availability

No legislation in Zimbabwe directly addresses sterilization.[222] However, a sterilization for health purposes is legally permissible, provided that the operation is performed by a registered medical practitioner who has obtained the consent of his or her patient.[223]

Nontherapeutic sterilization, commonly for contraceptive purposes, has not been criminalized through legislation. The legality of nontherapeutic sterilization is implicit in Zimbabwe's family planning legislation. The Family Planning Act establishes that a primary function of the ZNFPC is "to provide and manage facilities for performing surgical operations for infertility and sterilization."[224] In addition, the Family Planning Act grants the ZNFPC the power to develop "research personnel or the training of persons engaged or to be engaged in the investigation and treatment of infertility and sterilization."[225] Nontherapeutic sterilizations must be performed with the free and informed consent of the patient, and ZNFPC practices include the counseling of all clients considering sterilization.[226]

Sterilization is available at private clinics and MHCW institutions. The ZNFPC operates a referral system with MHCW facilities equipped for sterilization procedures.[227] Government facilities perform female and male sterilizations for a fee of Z$32.50 (approximately U.S.$3).[228]

Requirements

Spousal consent is not a legal requirement to undergo sterilization.[229] However, medical practitioners may be reluctant to perform a sterilization operation without spousal consent because of its nature and seriousness.[230] Because infertility may be a ground for annulment of a marriage,[231] it is possible that a doctor performing a sterilization operation without spousal consent may incur third party liability for any injury resulting from the loss of reproductive ability.[232]

Minors must obtain parental consent to undergo sterilization.[233] If the sterilization is necessary for health purposes, a medical practitioner may appeal to the local magistrate if the parents of the child are unreasonably withholding consent.[234]

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

There have been no reported incidents of female genital mutilation ("FGM") — also referred to as female circumcision — in Zimbabwe.[235] FGM could be prosecuted under the common law as assault with the intent to inflict grievous bodily harm.[236]

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

Examining HIV/AIDS issues within a reproductive health framework is essential insofar as the two areas are interrelated from both a medical and public health standpoint. Hence, a full evaluation of laws and policies affecting reproductive health and rights in Zimbabwe must examine HIV/AIDS and sexually transmitted diseases ("STDs"). By September 1995, 48,882 cases of AIDS were reported in Zimbabwe.[237] However, it is estimated that two thirds of all AIDS cases remain unreported.[238] Government estimates place HIV infection at 10% of the general population and at up to 25% of sexually active adults between the ages of 15-49.[239] HIV is mainly transmitted through heterosexual contact in Zimbabwe. While male cases of AIDS slightly outnumber female cases, the MHCW has reported that incidence of HIV infection among women is rising.[240] The highest incidence rates of AIDS and AIDS-related deaths among women occurs in the 20-to-29 age group, and women between the ages of 15 and 29 have a higher incidence of HIV infection than their male counterparts.[241] Teenage girls comprise 80% of AIDS cases in their age group.[242]

The rapid increase in infection rates is linked to the prevalence of STDs. Over one million cases of STDs were reported in 1991.[243] Since then, the number of reported incidents

has declined.[244] A 1993 survey within rural and urban clinics found that 50% to 60% of patients receiving STD treatment had been infected with HIV.[245]

Laws Affecting HIV/AIDS and STDs

Pursuant to the Public Health Act, the Minister of Health and Child Welfare may declare that an infectious disease shall be "notifiable," requiring infected persons to be immediately reported to the local authorities and imposing a fine or period of imprisonment for noncompliance.[246] HIV/AIDS has not been made a notifiable disease.[247] The Public Health Act also criminalizes the transmission of certain STDs, including syphilis, gonorrhea, and venereal warts, and empowers health authorities to investigate and detain infected persons. Pursuant to the Public Health Act, it is a criminal offense for any person infected with a specified STD, and knowing of the infection, to willfully or negligently expose another to the risk of infection.[248] The Public Health Act also requires doctors and other medical officers to report untreated cases of the identified STDs, and provides for the detention of infected persons for treatment.[249] In addition, the Minister of Health and Child Welfare may order compulsory examinations of all persons in an area where a disease is believed to be prevalent.[250] The Public Health Act provides that all inquiries arising from these situations must be held *in camera*, and that any determinations, as well as the identity of infected persons, be kept secret and that records of the proceedings remain unpublished.[251] The MHCW may add to the list of STDs that are regulated pursuant to the Public Health Act.[252] HIV/AIDS has not been identified for such treatment.[253]

Policies Affecting Prevention and Treatment of HIV/AIDS

Although the first AIDS cases were reported in Zimbabwe in 1985,[254] the government of Zimbabwe did not begin to address AIDS as a critical public health problem until the early 1990s.[255] The MHCW established a National AIDS Coordination Unit and a National AIDS Advisory Committee to establish programming providing for the care of AIDS patients as well as for the prevention and control of HIV transmission. The MHCW also instituted surveillance programs monitoring infection levels and the screening of blood products in an attempt to control or reduce infection levels of HIV/AIDS.[256] In addition, education and awareness campaigns target patterns of sexuality and contraceptive use to encourage self-protective behavior. A major component of these campaigns has been the promotion of condom use. In 1993, the government of Zimbabwe received funding of U.S.$64.5 million for the prevention and control of AIDS and other STDs, U.S.$12 million of which was allocated to the purchase of condoms.[257] Condoms are distributed free at government and municipal health centers.[258] Zimbabwean traditional healers and leaders have joined in the campaign to promote safer sex practices. The Zimbabwe Traditional Healers Association has advocated modification of certain cultural practices: the encouragement of safe sex in polygamous marriages, for example, and in widow inheritance.[259]

MHCW programs have also focused on the provision of pre- and post-diagnosis counseling services and the training of health workers in the public and private sector.[260] However, the increase in health service fees introduced by the 1991 economic reform program has caused a decline in the use of hospital-based care.[261] The MHCW has implemented a national training program on the management of disease control programs, a program that targets care-givers at the provincial level, in the private sector, and in NGOs.[262]

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

Women's reproductive health and rights cannot be fully evaluated without investigating women's status within the society in which they live. Not only do laws relating to women's legal status reflect societal attitudes that will affect reproductive rights, but such laws often have a direct impact on women's ability to exercise reproductive rights. The legal context of family life, a woman's access to education, and laws and policies affecting her economic status can contribute to the promotion or the prohibition of a woman's access to reproductive health care and her ability to make voluntary, informed decisions about such care. Laws regarding age of first marriage can have a significant impact on a young woman's reproductive health. Furthermore, rape legislation and other laws prohibiting sexual assault or domestic violence present significant rights issues and can also have direct consequences for women's health.

Women's legal status in Zimbabwe depends largely upon the rights accorded to women under customary law and the enactment of remedial legislation.[263] Protection from discrimination, including discrimination on the ground of gender, is guaranteed in Section 23 of the Declaration of Rights.[264] However, Section 23 specifically exempts from its coverage laws which give effect to customary law or constitutional provisions, or which take "due account of physiological differences between persons of different gender,"[265] or which are "in the interests of defence [sic] public safety or public morality."[266]

In 1982, Parliament enacted the Legal Age of Majority Act,[267] which grants full legal capacity and majority status to

all Zimbabweans over the age of 18.[268] Zimbabwean women also obtain legal majority when they marry.[269] Upon attainment of majority status, women may: enter into contractual relations; acquire, own, and dispose of interests in property independently; and have legal standing to sue and be sued.[270] The Legal Age of Majority Act provides that the attainment of legal majority "shall apply for the purpose of any law including customary law."[271] The Local Courts Act reaffirms that questions of legal capacity are to be governed by the general law of Zimbabwe.[272]

A. RIGHTS WITHIN MARRIAGE

Marriage Law

There are two types of marriage — customary and civil — in Zimbabwe. Customary marriage is exclusively available to Africans.[273] If registered under the Customary Marriages Act,[274] a customary marriage is legally valid for all purposes. However, an unregistered customary union, the most common form of marriage in Zimbabwe, is legally recognizable with respect to spousal claims of maintenance and the status, guardianship, custody, and rights of succession of children from the union.[275]

Customary marriages may be polygamous. A man may enter into more than one registered customary marriage provided that he discloses the existence of prior marriages.[276] Under customary law, families contract marriages between their daughters and sons, giving consent to the union and making arrangements for marriage consideration or bridewealth[277] to be paid to the woman's family.[278] However, pursuant to the Customary Marriages Act, an African woman cannot be forced to enter into any form of marriage against her will.[279] The bridewealth agreement for a registered marriage is legally enforceable.[280] If the marriage has not been registered, the bridewealth arrangement is unenforceable and no action may be legally taken for payment.[281]

Civil marriages must be registered in accordance with the provisions of the Marriage Act.[282] Civil marriages in Zimbabwe are monogamous and require the consent of both the man and the woman.[283] The civil law governs spousal rights and obligations, including the obligations of fidelity and cohabitation.[284] Zimbabweans wishing to enter into a civil marriage must satisfy the conditions set forth in the Marriage Act, as well as common law requirements of "competency."[285] An individual may be "incompetent," thus allowing for an annulment of the marriage if he or she is permanently impotent or willfully refuses to consummate the marriage.[286] In addition, a woman who at the time of her marriage was pregnant with another man's child fails the "competency" requirement.[287] Any of these circumstances may be grounds for annulment of the marriage.[288]

In any civil or customary marriage, the spouses have a reciprocal duty of maintenance and the obligation to maintain their children.[289] The determination of responsibility for maintenance depends upon the financial situation of the parties, as well as their ability to work.[290] Upon failure of the responsible party to pay adequate sums for maintenance, an aggrieved spouse may apply to a magistrates court for an order directing payment or providing for direct payment from the responsible spouse's employer.[291] Adultery by the applicant may result in the court's refusal to grant a maintenance order or the revocation of a previously granted order.[292] An order for maintenance of a child is valid throughout the period of his dependency; an order for maintenance of a wife is valid until she remarries, or until the couple is divorced.[293]

For a discussion on marriage and adolescents, see section on adolescents below.

Divorce and Custody Law

The dissolution of a valid registered marriage, either civil or customary, is governed by the Matrimonial Causes Act.[294] There is no legal action available for the dissolution of an unregistered customary marriage.[295] The Matrimonial Causes Act grants judges of the High Court and magistrates courts jurisdiction to adjudicate matters pertaining to divorce, separation, and annulment, and sets forth the grounds for the determination of such orders. The magistrates courts have jurisdiction over marriages registered under the Customary Marriages Act, while the High Court has jurisdiction in cases involving the dissolution of a civil marriage.

Pursuant to the Matrimonial Causes Act, there are two possible grounds for divorce in Zimbabwe: incurable mental illness or unconsciousness of a spouse and the "irretrievable break-down of the marriage."[296] Irretrievable breakdown is defined to be a state where "there is no reasonable prospect of the restoration of a normal marriage relationship."[297] Courts may regard as relevant evidence of cruelty, including mental abuse, and the presence of alcohol or drug addiction.[298] Proof of adultery may establish an irretrievable breakdown if the adultery is regarded by the spouse petitioning for divorce as "incompatible with the continuation of a normal marriage relationship."[299] Annulment of a marriage may be obtained on the grounds of any failure of competency under common law or customary law provisions.[300]

The Matrimonial Causes Act empowers courts to determine an equitable division of assets for civil and registered customary marriages, as well as to provide for the maintenance of spouses and children.[301] However, property that has been inherited or acquired according to custom, including personally held property and property belonging to a familial line, may only be distributed for the provision of

maintenance.[302] In the allocation of marital property, courts must consider: the present and future financial situation of the parties; the duration of the marriage; and domestic and indirect financial contributions made by each party throughout the marriage.[303] Depending upon the attribution of blame for the breakdown of the marriage, the dissolution of a marriage may entitle the man and his family to a return of part of the paid bridewealth.[304] However, in dividing assets, courts generally seek to ensure that the financial position of either spouse does not substantially change with the dissolution of the marriage.[305] Child maintenance orders are valid throughout the period of the child's dependency, and an order for spousal maintenance is valid until the spouse remarries.[306]

In addition, the Matrimonial Causes Act gives courts discretion to award custody of any children to "such of the parties or such other person as the court may think best fitted to have such custody."[307] In custody determinations, the interests and protection of the child are paramount.[308] Pursuant to the Guardianship of Minors Act, courts will award custody to the mother of a child upon separation.[309] However, the father remains the natural guardian of his legitimate children.[310] Under the Children's Protection and Adoption Act, courts may remove children from an unsafe situation to protect a child from mistreatment or neglect.[311] Resisting a custody order, or failing to cooperate with the court, is a punishable offense.[312]

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

The Legal Age of Majority Act grants to all Zimbabweans over the age of 18 the legal capacity to own, transfer, and dispose of property.[313] However, women married in customary marriages may only hold "movable" property, such as livestock or cash, as permitted under customary law.[314] Although customary law recognizes married women's property rights in some acquired assets, most movable property acquired during the course of a customary marriage belongs to the husband. Under Shona and Ndebele law, the most important forms of property women may own are the *mombe yohumai* or *inkomo yohlanga* ("motherhood animal"), property given to a mother upon the marriage of her daughter, and the *mavoko* or *impahla zezandla* ("hands property"), the property a woman acquires through her work, including her wages or salary.[315]

In 1982, Parliament enacted the Immovable Property (Prevention of Discrimination) Act[316] (the "Immovable Property Act") prohibiting discrimination with respect to the acquisition and financing of "immovable property" such as land, buildings, or construction projects.[317] The Immovable Property Act prohibits gender discrimination in the sale, lease, or disposal of immovable property.[318] The penalty for contravention of these provisions may include a fine of up to Z$2,000 (approximately U.S.$190) and imprisonment for up to one year.[319] However, the Immovable Property Act provides exemptions for property specially reserved or subject to discriminatory conditions that are "justified in the interests of decency or morality," and does not limit the effect of any other legislative enactment.[320]

Access to communal land, vested in the president of Zimbabwe and held for communal use, is governed by customary laws.[321] Under customary law, women have limited rights to occupy and use communal land.[322] Mirroring this traditional discrimination against women, the government has also restricted women's rights to use "resettlement land" — land acquired by the government for the purposes of resettling individuals or families in rural areas.[323] Permits for the resettlement of married couples are always issued in the name of the husband, and only two percent of married women currently occupying resettlement land have permits to plow.[324] Grazing permits are also restrictively granted to women.[325]

Inheritance

Legislative enactments set forth the choice of law and the procedure for testate and intestate succession in Zimbabwe. Every individual in Zimbabwe over the age of 16 has the legal capacity to make a will providing for the disposition of his or her estate and the custody or guardianship of his or her children.[326] Intestate succession, when the deceased has not left a will, may be in accordance with either general or customary law. The Administration of Estates Act[327] provides that the determination of which law will govern intestate succession depends upon the type of property involved as well as the heritage and marital status of the deceased. Pursuant to the Administration of Estates Act, customary law governs the intestate succession of movable property belonging to Africans married under customary law and Africans who are "the offspring of parents married according to African law and custom."[328] In all other cases, the wishes of the deceased or the justice of the circumstances will determine the applicable system of law.[329]

Customary laws, which govern the succession of movable property, vary throughout Zimbabwe. Generally, when a woman dies, her personal belongings are distributed among her sisters, daughters, and close relatives.[330] Under Ndebele law, the property a woman has received through the marriage of her daughters (*inkomo yohlanga* property) passes to the woman's eldest daughter, and any property she has earned (*mavoko* property) passes to her eldest son.[331] According to Shona law, a woman's *umai* property is inherited by her brothers.[332] The property that a Shona woman has earned through

her own work devolves to her sons.[333] Among both the Shona and the Ndebele, the husband does not inherit property from the estate of his wife.

Under Ndebele and Shona laws, when a man dies, his movable property devolves to his eldest child.[334] Widows do not inherit from their husbands' estates.[335] However, following passage of the Legal Age of Majority Act, female heirs suffer no legal disability with respect to inheritance rights under customary law, and a daughter may inherit from her father's estate.[336] In Shona custom, the heir receives property in a representative capacity; all family obligations of the deceased remain intact and pass also to the heir, who must maintain all of the deceased's dependents.[337] In contrast, according to Ndebele custom, the heir inherits in his own personal capacity and owns absolutely any property inherited. However, the heir to a man's estate, under both Shona and Ndebele tradition, carries some obligation to maintain the dependents of the deceased.[338]

Intestate succession to all other estates is in accordance with the provisions of the Deceased Estates Succession Act[339] (the "Succession Act"). In Zimbabwe, all children, regardless of sex, may inherit under the Roman-Dutch common law.[340] Pursuant to the Succession Act, surviving spouses and children inherit in equal shares, and a spouse must receive at least a minimum share of the estate, as well as any household goods and effects.[341] Upon the application of a dependent, a court may vary the distribution of an estate to satisfy any maintenance obligations of the deceased.[342] In addition, surviving spouses and children retain the right to remain on land possessed by or allocated to the deceased and to remain in the house they had been occupying, as well as rights to the use of household goods, tools, animals, and crops reasonable for their own support, "[n]otwithstanding any law, including customary law, to the contrary."[343]

Labor Rights

The 1985 Labour Relations Act[344] (the "Labour Act") prohibits discriminatory employment practices, including those relating to women. The Labour Act sets forth the fundamental rights of employees, defining unfair labor practices and providing regulations governing conditions for employment.[345] The Labour Act also establishes a labor relations board and tribunal to handle worker grievances. By amendment, women and men are subject to the same criteria for public or civil offices.[346] In addition, the government has pursued a policy of affirmative action in hiring for civil posts, giving preference to women candidates for public service positions.[347]

The Labour Act prohibits gender discrimination in several circumstances. These include: advertisement of employment; recruitment; the creation, classification or abolition of jobs; the provision of wages, salaries, pensions, leave, or other benefits; training; advancement, transfer and promotions; and the provision of employee facilities.[348] Certain acts of discrimination are exempt, including discrimination on the ground of gender that is "in accordance with the provisions of this Act or any other law, or in the interests of decency or propriety."[349] Violation of the Labour Act's antidiscrimination provisions is an offense punishable with a fine up to Z$2,000 (approximately U.S.$190) or imprisonment for up to one year, or both.[350] The court may also choose to award the complainant with damages for his or her loss, or issue an order requiring compliance with the provisions of the Labour Act.[351]

Pursuant to the Labour Act, employers must provide their female employees with partially paid maternity leave for a minimum of three months without prejudice to their accrual of any entitlements or benefits, including those affecting seniority and advancement.[352] A woman on maternity leave is entitled to a minimum of 60% of her salary; if she chooses to forego any accumulated vacation leave, she must receive at least 75% of her salary.[353] Maternity leave as provided for in the Labour Act may only be taken once in a 24-month period and a maximum of three times with each employer.[354] Women taking maternity leave are entitled to return to their employment on the same or better terms.[355] In addition, the Labour Act requires employers to furnish nursing women, at their request, at least one hour or two half-hour periods during normal working hours to nurse their children.[356] There is no legislation that provides for leave to attend antenatal care clinics.[357] Moreover, except for a prohibition against exposure to pesticides, working conditions for pregnant women are not regulated by law.[358]

Access to Credit

The Immovable Property Act requires banks, other finance organizations, and insurance companies to grant loans and other assistance in a nondiscriminatory manner for the acquisition or maintenance of land, buildings, or construction projects.[359] Moreover, the government of Zimbabwe has initiated an informal policy of affirmative action to enhance women's access to credit.[360] However, development funds are often disbursed through commercial lenders, who require credit applicants to provide security for their loans, a condition that is difficult for many Zimbabwean women to meet.[361]

Access to Education

Pursuant to the Education Act, education is established as a fundamental right in Zimbabwe.[362] The Education Act also establishes a right of access to public and secondary schools in Zimbabwe.[363] Tertiary educational institutions, such as

universities and training colleges, have instituted affirmative action programs to benefit women.[364] In addition, the national university is prohibited from imposing tests for admission that discriminate on the basis of gender in the selection of employees, students, or officers of the university, including academic or administrative staff.[365] For further discussion regarding education, see section on adolescents below.

C. RIGHT TO PHYSICAL INTEGRITY

Rape

Rape in Zimbabwe is a common law crime.[366] Rape is defined to be "[i]ntentional, unlawful sexual intercourse by a male over 14 years of age with a woman without her consent."[367] Girls under the age of 12 are presumed incapable of consenting to sexual intercourse.[368] Evidence of violent threats or fraud, or the use of drugs or alcohol, also vitiates the element of consent.[369] Zimbabwean criminal law does not recognize marital rape as a crime.[370]

Sexual intercourse for the purposes of a rape prosecution is defined to be an act of penetration, or partial penetration.[371] Other sexual offenses may be prosecuted under the laws prohibiting assault, indecent assault, or attempted rape.[372] The crime of assault is defined to be the unlawful, intentional application of force to the person of another, or the commission of acts which inspire the belief that the application of force is imminent.[373] Indecent assault is defined as an "unlawful and intentional assault of an indecent character."[374]

Corroboration of a rape charge is not required.[375] However, evidence of the complainant's prior sexual behavior may be admitted as relevant to the issue of consent.[376] In any prosecution for an indecent act, the identity of the complainant is concealed, and the court may direct that the proceedings be held *in camera*.[377] There are no sentencing guidelines for rape convictions; typically, a rape conviction is punishable with a fine or imprisonment.[378]

For a discussion on sexual offenses against minors, see section on adolescents below.

Domestic Violence

While criminal law assigns penalties for verbal and physical assault, no law specifically addresses domestic violence in Zimbabwe.[379] There are no statistics available on the incidence of domestic violence in Zimbabwe because police records do not differentiate between incidences of domestic violence and other assaults.[380] A victim of domestic violence may apply to a court for a "binding-over" order against any person who "(a) is conducting himself violently towards or is threatening injury to the person or property of another; or (b) has used language or behaved in a manner towards another likely to provoke a breach of the peace or assault."[381] A binding-over order may require the batterer to pay a fine or post a bond not exceeding Z$200 (approximately U.S.$20).[382] If the order is violated, the perpetrator forfeits his bond and may be arrested.[383] Victims of domestic violence may also apply to a court for civil damages as compensation for any injury suffered directly or as a result of an assault.[384]

Victims of domestic violence also have recourse under customary law. In a registered customary marriage, incidents of domestic violence are grounds for separation or divorce.[385] Under customary law, the families of the married couple may mediate domestic disputes or provide refuge for the victim, and may require the perpetrator to post a "peace bond" to ensure his compliance with the families' resolution of the dispute.[386]

Sexual Harassment

Although no statistics on sexual harassment are available,[387] informal reports from the Zimbabwe Congress of Trade Unions indicate that harassment is a common complaint of women workers.[388] Public service regulations prohibit sexual harassment in the workplace of government employees.[389] No laws in Zimbabwe address sexual harassment in the private sector.[390] Criminal sanctions, however, are available under the common law prohibition against indecent assault.[391] A woman's consent is a defense to a charge of indecent assault or attempted indecent assault unless it has been obtained through the use of force.[392] However, the use of nonviolent threats against a woman, such as threats of eviction, confinement, or the loss of employment, is not illegal under the current law.[393]

Sexual harassment may also be prosecuted as *crimen injuria*, defined as the infliction of an unlawful, intentional, and serious injury to the dignity of another.[394] Acts constituting *crimen injuria* may include "[i]mproper sexual suggestions, or abusive, insulting or degrading communications."[395] However, a charge of *crimen injuria* is generally not pursued if a more specific charge is available.[396]

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

The needs of adolescents are often unrecognized or neglected. Given that approximately 45% of the Zimbabwean population is under the age of 15,[397] it is particularly important to meet the reproductive health needs of this group. The effort to address issues of adolescent rights including those related to reproductive health is important for women's right to self-determination, as well as for their health.

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

The Youth Advisory Services ("YAS") of the ZNFPC is responsible for focusing ZNFPC programming on the sexuality and reproductive health issues of adolescents.[398] YAS has defined reproductive health to be "the health implications surrounding reproductive choices and behaviour," encompassing maternal and child health, contraception, and protection from sexually transmitted disease.[399] The ZNFPC has attempted to modify its facilities to service youth populations and to work cooperatively with community youth organizations.[400] However, in practice, adolescents' access to contraceptives may be limited through informal policies of private family planning providers and government clinics.[401] Although minors require parental consent to obtain medical treatment, many health and family planning services to adolescents are not restricted under the law. For example, a minor may receive treatment for a sexually transmitted disease without parental consent or knowledge.[402] In addition, minors' access to contraceptives is not legally restricted.[403] However, parental consent for contraceptive use is often practically imposed, and in ZNFPC and government clinics, contraceptives are not dispensed to youth under the age of 16.[404]

B. MARRIAGE AND ADOLESCENTS

Under customary law, there is no minimum age for marriage.[405] Girls under the age of 16 and boys under the age of 18 may not enter into a civil marriage without the consent of their legal guardians, a judge, or written permission from the Minister of Justice, Legal and Parliamentary Affairs.[406] The Customary Marriages Act criminalizes forced marriages and the pledging of girls or women in marriage.[407] However, the laws governing marriage in Zimbabwe entrench the institution of bridewealth in all marriages of African girls under the age of 18. Pursuant to the Customary Marriages Act, the customary marriage of an African girl under the age of 18 is not legally valid without parental or guardian consent and agreement on payment of bridewealth.[408] Similarly, an African girl under the age of 18 entering into a civil marriage must obtain a certificate from the local magistrate verifying the consent of her parents or guardian and stating the amount, form, and terms of payment of the marriage consideration.[409]

C. EDUCATION AND ADOLESCENTS

Between 1979 and 1989, the number of primary schools increased by 88%,[410] and attendance by female pupils increased 195%.[411] However, the reintroduction of school fees in 1991 has had a negative impact on enrollment rates, especially of female students.[412] The Ministry of Education provides some donor-funded scholarships that are reserved for the disadvantaged children of commercial farm workers and are disbursed in favor of girls.[413] Although the government provides additional funds to aid low-income families with health and education fees, difficulties in access and in the application procedure have contributed to the low numbers of families benefiting from these funds.[414]

Although the initial enrollment of girls and boys at the primary level remains equal, the attrition rate for girls is much higher, and this disparity increases in the higher levels of education.[415] Pregnancy is a common factor disrupting the education of female students, due to the fact that pregnant students are required to leave school.[416] The student may be readmitted after she gives birth, but is usually transferred to a different school.[417] The government has actively pursued educational programming to neutralize gender biases in curricula.[418] In addition, the Ministry of Education has instituted a counseling program within each school that targets female students, providing career and educational guidance and information on sexual health, including AIDS.[419]

D. SEX EDUCATION FOR ADOLESCENTS

In cooperation with the MHCW, the Ministry of Education and Culture, and United Nations Children's Fund ("UNICEF"), the ZNFPC has introduced a compulsory Family Life Education ("FLE") program to incorporate family planning into the formal educational system.[420] The FLE program will replace life skills curricula with materials that directly address gender and reproductive issues. Educational programs have been supplemented by youth counseling and parent education programs to address adolescent sexuality.[421]

E. SEXUAL OFFENSES AGAINST MINORS

The 1901 Criminal Law Amendment Act (the "1901 Act") criminalizes the unlawful carnal knowledge of or the commission of any immoral or indecent act with a girl under the age of 16.[422] The 1901 Act provides that a "reasonable" mistake about age is a sufficient defense to a statutory rape charge; in addition, men who solicit child prostitutes cannot be prosecuted under the 1901 Act.[423] Statutory rape, attempted statutory rape, and the solicitation or enticement of a girl under the age of 16 to commit any indecent act are offenses punishable by a fine up to Z$1,000 (approximately U.S.$100) or imprisonment for up to five years.[424] A charge of indecent assault on a person under the age of 16 may be prosecuted regardless of whether the act was consensual.[425]

Sexual intercourse with a girl under the age of 12 constitutes both rape and statutory rape.[426] Although the majority of

reported rape cases involve victims under the age of 14,[427] court records indicate that police and prosecutors in Zimbabwe often treat sexual offenses against minors, including non-consensual intercourse and intercourse with girls under the age of 12, as cases of statutory rape.[428] Statutory rape carries a lower penalty than a rape conviction.[429]

ENDNOTES

1. *ZimWeb*, *Zimbabwe History* (visited Jan. 17, 1997) <http://www.mother.com/~zimweb/zim/int_hist.htm>.
2. *Id.*
3. *Id.*
4. MINISTRY OF HEALTH & CHILD WELFARE, HEALTH HUMAN RESOURCES MASTER PLAN: PART I, 1993-1997, at 2 (unpublished paper on file at The Center for Reproductive Law and Policy) [hereinafter HEALTH HUMAN RESOURCES MASTER PLAN].
5. *Zimbabwe*, WALDEN REPORTS, *available in* LEXIS, World Library, Courep file [hereinafter WALDEN REPORT].
6. U.S. Cent. Intelligence Agency, *Zimbabwe*, WORLD FACTBOOK, Sept. 7, 1995, *available in* LEXIS, World Library Profiles. There is an official separation of church and state, and Islamic law and institutions are generally not a part of the legal or political landscape. WOMEN IN LAW & DEV. IN AFRICA (WILDAF), REPRODUCTIVE HEALTH RIGHTS IN ZIMBABWE 1 (1996) (unpublished paper on file at The Center for Reproductive Law and Policy) [hereinafter WILDAF].
7. U.S. Dep't. of State, *Zimbabwe Human Rights Practices*, *1994*, 1994 HUMAN RIGHTS REPORT (1995), *available in* LEXIS, World Library.
8. WALDEN REPORT, *supra* note 5.
9. ZIMB. CONST. §§ 27-63, 79-92.
10. *Id.* § 111A; *see also Zimbabwe*, KCWD/KALEIDOSCOPE REPORT, Feb. 20, 1995, *available in* LEXIS, World Library, KCWD file.
11. ZIMB. CONST. § 111(1), (2).
12. *Id.* § 31H(1).
13. *Id.* § 27(1).
14. *Id.* §§ 31C(1), 31D(1). The power of appointment includes the power to fix and vary the conditions of service, including remuneration and terms of appointment. *Id.* § 113(5)(d).
15. The attorney-general is a non-voting member of the cabinet. *Id.* § 76(3b)(a).
16. *Id.* § 31G(1); *see also id.* § 31H(5) (stating the extent to which the president must rely on the advice of the cabinet).
17. The 1980 government retained the state of emergency instituted by the former government of Rhodesia. *See id.* §§ 25, 31J, schedule 2; *see also* John Hatchard, *The Constitution of Zimbabwe: Towards A Model for Africa?*, 35 J. OF AFRICAN L. 79, 89 (1991).
18. ZIMB. CONST. § 50.
19. *Id.* § 38(1). Members of Parliament hold their seats on condition of their retaining party membership, as in other Westminster-style systems. *Id.* § 4(e).
20. Appointed members have in the past represented minority groups.
21. The traditional chiefs appoint their own representatives. Telephone interview with Luta Shaba, Attorney and Member, WILDAF (Feb. 20, 1997).
22. ZIMB. CONST. § 38(1).
23. *Id.* §§ 46, 51.
24. *Id.* § 40B(1).
25. *Id.* § 79B.
26. *Id.* § 80(1). Constitutional amendments 11-13 were passed by the legislature either in the wake of, or in anticipation of court decisions affecting areas in which the government wished to set policy. In addition, President Mugabe has invoked the Presidential Powers Act to overturn an order of the High Court. U.S. Dep't. of State, *Zimbabwe Human Rights Practices, 1993*, 1993 HUMAN RIGHTS REPORT (1994), *available in* LEXIS, World Library.
27. ZIMB. CONST. § 84(1).
28. *Id.* § 87(1).
29. Customary Law & Local Courts Act, ch. 7:05.
30. The colonial judicial system had two court hierarchies, one for Africans and the other for non-Africans. DEVELOPMENT, INNOVATIONS AND NETWORKS (IRED), WOMEN, LAW DEVELOPMENT (1996) (unpublished paper on file at The Center for Reproductive Law and Policy) [hereinafter IRED].
31. Customary Law & Local Courts Act, ch. 7:05, §§ 24, 25; *see also* WELSHMAN NCUBE, FAMILY LAW IN ZIMBABWE 12 (1989).
32. Customary Law & Local Courts Act, ch. 7:05, §§ 10, 15.
33. *Id.* § 11, 16(1)(a). In addition, primary courts may not hear claims in excess of Z$1,500 (U.S.$143) and community courts may not hear claims in excess of Z$3,000 (U.S.$286). *Id.* § 16(1)(b). Such cases may be removed from a local court and transferred to a court of competent jurisdiction. *Id.* § 22.
One U.S. dollar is worth approximately 10.5 Zimbabwean dollars. *See U.N. Operational Rates of Exchange* (visited Feb. 27, 1997) <gopher://gopher.undp.org.100/uncurr/exch_rates>.
34. Customary Law & Local Courts Act, ch. 7:05, § 16(1)(c)-(g). "Immovable" property commonly denotes land, buildings or construction projects. For further discussion, *see infra* section on property.
35. Customary Law & Local Courts Act, ch. 7:05, § 18(1), (2) (discussing the Customary Law and Primary Courts Act, No. 6 of 1981, which preceded the Customary Law and Customs Law Act).
36. *See* CHARLES R. CUTSHALL, JUSTICE FOR THE PEOPLE: COMMUNITY COURTS AND LEGAL TRANSFORMATION IN ZIMBABWE 1-2 (1991) (discussing the recognition of customary law to make courts more accessible).
37. Customary Law & Local Courts Act, ch. 7:05, § 20(1); *see also id.* § 20(2).
38. *Id.* § 3(1). This agreement may be explicit or implicit. *see* NCUBE, *supra* note 31, at 22, 26.
39. Customary Law & Local Courts Act, ch. 7:05, § 3(2).
40. WILDAF, *supra* note 6, at 1; *but see* NCUBE, *supra* note 31, at 12, 20 (noting the recent use of customary law for non-African parties and citing Lopez v. Nxumalo, SC 115/85). The term "African" is used throughout this chapter to refer to a Zimbabwean of African descent.
41. Customary Law & Local Courts Act, ch. 7:05, § 8.
42. In the area of family law, most systems of customary law in Zimbabwe have similar provisions. NCUBE, *supra* note 31, at 26.
43. *See* Customary Law & Local Courts Act, ch. 7:05, § 9 (stating what legal materials regarding the content of customary law courts may consider).
44. ZIMB. CONST. § 3.
45. *Id.* § 11; *see generally id.* § 11-26 (Declaration of Rights).
46. *Id.* § 24.
47. *Id.* § 89; *see also id.* § 113(1) (defining "law" for the purposes of constitutional interpretation); Customary Law & Local Courts Act, ch. 7:05, § 2 (defining "the general law of Zimbabwe").
48. ZIMB. CONST. § 89.
49. *See id.* § 111B(1)(B)
50. International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, 999 U.N.T.S. 171 (*entry into force* Mar. 23, 1976) (ratified by Zimbabwe on May 13, 1991); International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, 993 U.N.T.S. 3 (*entry into force* Sept. 3, 1976) (ratified by Zimbabwe on May 13, 1991).
51. African Charter on Human and Peoples' Rights, *adopted* June 26, 1981, OAU Doc. CAB/LEG/67/3/Rev. 5 (1981), *reprinted in* 21 I.L.M. 59 (1982) (*entry into force* Oct. 21, 1986) (ratified by Zimbabwe on Sept. 11, 1990).
52. Convention on the Elimination of All Forms of Discrimination against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 14 (*entry into force* Sept. 3, 1981) (ratified by Zimbabwe on May 13, 1991).
53. International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (*entry into force* Jan. 4, 1969) (ratified by Zimbabwe on May 13, 1991).
54. Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, G.A. Res. 44/25, U.N. G.A.O.R., 44th Sess., Supp. No. 49, U.N. Doc. A/44/49, *reprinted in* 28 I.L.M. 1448 (*entry into force* Sept. 2, 1990) (ratified by Zimbabwe on Sept. 11, 1990).
55. GROWTH WITH EQUITY: AN ECONOMIC POLICY STATEMENT ¶ 85, at 12 (Republic of Zimbabwe 1981).
56. U.N. DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT, 1994, at 149 (1994).
57. HEALTH HUMAN RESOURCES MASTER PLAN, *supra* note 4, at 1.
58. U.N. DEP'T OF INT'L ECONOMIC AND SOCIAL AFFAIRS, III WORLD POPULATION POLICIES 232, U.N. Doc. ST/ESA/SER.A/102/Add.2 (1990); FIRST FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1986-1990 art. 3.8, at 36 (Republic of Zimbabwe 1986).
59. DEP'T OF HEALTH SERVICES PLANNING & MANAGEMENT, MINISTRY OF HEALTH [ZIMB.], PLANNING FOR EQUITY IN HEALTH: 1992 REVISION art. 2.1, at 3 (1992).
60. *Id.*

61. Central Statistical Office [Zimb.] & Macro International, Inc., Zimbabwe Demographic and Health Survey 1994, at 4 (1995) [hereinafter Zimbabwe Demographic and Health Survey 1994].
62. WiLDAF, *supra* note 6, at 2-3. MHCW initially introduced fees as part of a cost recovery program.
63. Ministry of Health & Child Welfare, Women's Health in Zimbabwe: A Path to Development 2 (1994); *see also* WiLDAF, *supra* note 6, at 2.
64. Dep't of Health Services Planning & Management, *supra* note 59, art. 9.11, at 17-18.
65. *Id*.
66. Zimbabwe Demographic and Health Survey, 1994, *supra* note 61, at 4.
67. First Five-year National Development Plan, 1986-1990, *supra* note 58, art. 2.10, at 21.
68. Telephone interview with Luta Shaba, *supra* note 21.
69. The practice of a traditional medical practitioner is defined to be "every act, the object of which is to treat, identify, analyse or diagnose, without the application of operative surgery, any illness of body or mind by traditional methods." Traditional Medical Practitioner Act, ch. 27:14, § 2(2).
70. Natural therapists include homeopaths, naturopaths and osteopaths. Natural Therapists Act, No. 31, § 2(1) (1981). Natural therapists are usually white Zimbabweans or foreigners. WiLDAF, *supra* note 6, at 3.
71. Dep't of Health Services Planning & Management, *supra* note 59, art. 4, at 7.
72. *Id*.
73. Zimbabwe Demographic and Health Survey 1994 *supra* note 61, at 4.
74. *See* Godfrey B. Woelk, *Primary Health Care in Zimbabwe: Can It Survive?*, 39 Soc. Sci. Med. 1027, 1030 (1994) (noting current trend to centralize village community workers).
75. Zimbabwe Demographic and Health Survey 1994 *supra* note 61, at 4.
76. Dep't of Health Services Planning & Management, *supra* note 59, art. 4, at 7.
77. *Id*.
78. *Id*. art. 4.2, at 7.
79. *Id*. art. 4.3, at 8.
80. Local authorities provide services ranging from primary and preventative care to maternity homes. Although in the past these services had received financial support from the MHCW, this funding will not be continued. *Id*. arts. 4.5.4, 4.9.2, at 9-10.
81. *Id*. art. 4.9.3, at 11; *see also* WOELK, *supra* note 74, at 1029. Private midwifery services are also available and are regulated by the MHCW'S Nursing Directorate and the Health Professions Council. WiLDAF, *supra* note 6, at 2.
82. *Technical Note: Assessing and Addressing the Social Dimensions of Adjustment, in* Zimbabwe: A Framework for Economic Reform (1991-1995) Annex III, at 21 (Republic of Zimbabwe 1991) [hereinafter *Technical Note*]. The Family Health Project is in its second phase, encompassing the years 1991-95. *Id*.
83. Health Human Resources Master Plan, *supra* note 4, at 1.
84. Second Five-year National Development Plan, 1991-1995, at 74 (1991).
85. Population Action Int'l, Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health: 1995 Report on Progress Towards World Population Stabilization (1995).
86. Maternal & Child Health Dep't, Ministry of Health, An Evaluation of the Traditional Birth Attendant Training Programme in Zimbabwe 10 (1994).
87. Republic of Zimbabwe, Budget Estimates for the Year Ending June 30, 1996, at 118 (1995).
88. Second Five-year National Development Plan, 1991-1995, *supra* note 84, at 69.
89. For the fiscal year 1989-90, fees provided MHCW revenue of Z$15 million (U.S.$1.5 million). *Technical Note*, *supra* note 82, at 14.
90. WiLDAF, *supra* note 6, at 3.
91. Patient's Charter: Zimbabwe 1996 § 4 (Ministry of Health & Child Welfare 1996) [hereinafter Patient's Charter]. In addition, there is no charge for treatment for tuberculosis or leprosy. *Id*.
92. Rene Lowenson et al., Reproductive Health Rights In Zimbabwe 40 (1996).
93. WiLDAF, *supra* note 6, at 3.
94. *Technical Note*, *supra* note 82, at 20. The Department of Social Welfare has instituted training to aid staff in identifying low-income individuals who qualify for fee exemption and has deployed personnel to major urban health facilities to issue fee exemption papers. *Id*.
95. Medical, Dental and Allied Professions Act, ch. 27:08, §§ 25, 47. A "health institution" is defined to be "any hospital, clinic, medical laboratory, consulting room or other premises used by a health practitioner for…the diagnosis, treatment, mitigation or prevention of any illness, injury or disability." *Id*. § 2(1). However, regulations providing minimum standards for all health institutions (part IIIB of the Medical, Dental and Allied Professions Act) are not yet operative. Health Professions Council, Functions and a Guide to Ethics 21 (1993).
96. WiLDAF, *supra* note 6, at 3.
97. Geoff Feltoe & Timothy Joseph Nyapadi, Law & Medicine in Zimbabwe 3 (1989). Negligence is defined as the "failure to exercise reasonable care." *Id*.
98. *Id*. at 21.
99. Medical, Dental and Allied Professions Act, ch. 27:08, §§ 25, second schedule.
100. *Id*. § 43(2), (5); *see also* Health Professions Council, *supra* note 95, at 8, 12.
101. Medical, Dental and Allied Professions Act, ch. 27:08, §§ 65(1), 68(1).
102. Health Professions Council, *supra* note 95, at 4. The Council's members include: the Secretary for Health and Child Welfare, 16 elected members and 10 MHCW appointees. Medical, Dental and Allied Professions Act, ch. 27:08, § 6(1).
103. Medical, Dental and Allied Professions Act, ch. 27:08, § 32; Health Professions Council, *supra* note 95, at 5, 7, 11.
104. Medical Practitioners (Professional Conduct) Regulations, S.I. 252, § 30 (1987).
105. *Id*. § 27.
106. *Id*. § 22.
107. Health Professions Council, *supra* note 95, at 19.
108. *Id*.
109. *Id*. at 19-20.
110. Medical, Dental and Allied Professions Act, ch. 27:08, §§ 55, 56. Members of the public, other health professionals or health institutions may make complaints of incompetence or improper conduct. *See* Medical, Dental and Allied Professions (Information) Regulations, S.I. 93, § 3 (1993) (providing for a penalty of fine and/or imprisonment for failure to comply with a request for information from the Health Professions Council registrar).
111. Medical, Dental and Allied Professions Act, ch. 27:08, § 59(2).
112. *Id*. § 61(1).
113. Traditional Medical Practitioner Act, ch. 27:14.
114. Natural Therapists Act, No. 31 (1981).
115. *Id*. § 34; Traditional Medical Practitioner Act, ch. 27:14, § 31.
116. Traditional Medical Practitioner Act, ch. 27:14, §§ 26-28, 30, 34; Natural Therapists Act, No. 31, §§ 27-29, 33, 36 (1981). The Traditional Medical Practitioners Council also promotes the practice of and sponsors research into traditional medicine. Traditional Medical Practitioner Act, ch. 27:14, § 3(2).
117. WiLDAF, *supra* note 6, at 3.
118. Patient's Charter, *supra* note 91, at § 1.
119. *Id*. §§ 1.2-1.4.
120. Zimb. Const. § 11(a).
121. WiLDAF, *supra* note 6, at 9.
122. Feltoe & Nyapadi, *supra* note 97, at 35. Consent must be given without the use of deception, coercion or undue influence, and with knowledge of the procedure and an appreciation of the possible consequences. *Id*. at 36.
123. *Id*. at 35.
124. *Id*. at 42.
125. Doctors are reluctant to perform surgical operations without a husband's consent. *Id*. at 74-75. Lawful abortions (those performed to protect the mother's life or health) do not require consent. *Id*. at 81.
126. Julie Stewart et al., *The Legal Situation of Women in Zimbabwe*, *in* II Women and Law in Southern Africa: The Legal Situation of Women in Southern Africa 165, 199 (Julie Stewart & Alice Armstrong eds., 1990).
127. Children's Protection And Adoption Act, ch. 5:06, § 76.
128. Feltoe & Nyapadi, *supra* note 97, at 42; *but see* Stewart et al., *supra* note 126, at 198-99 ("Under Roman-Dutch law, minors are capable of consent once they have…the intellectual maturity to understand the nature and consequences of that treatment").
129. Medical Practitioners (Professional Conduct) Regulations, S.I. 252, § 22, (1987). For example, any investigation or procedure initiated under the provisions of the Public Health Act dealing with infectious diseases may require disclosure of patient information. In addition, communications between medical practitioners and their patients are not privileged under Zimbabwean law and may be disclosed in legal proceedings. Feltoe & Nyapadi, *supra* note 97, at 67. The appropriate civil action for breach of patient confidentiality is a suit to recover damages from an *actio injuriarum*, an act resulting in defamation, insult, degradation, humiliation or an invasion of privacy without public benefit. There have been no reported cases of suit for an *actio injuriarum* in Zimbabwe. *Id*. at 63-64.
130. Feltoe & Nyapadi, *supra* note 97, at 53-54.

131. *Id.* at 36, 54.
132. First Five-year National Development Plan, 1986-1990, *supra* note 58, at 18.
133. Second Five-year National Development Plan, 1991-1995, *supra* note 84, at 68. The ZNFPC is ultimately targeting a "replacement rate" growth of approximately 2 children per couple. Liz Sly, *Father of 57: "It's Too Many,"* Chicago Tribune, Jan. 30, 1996, at 1.
134. Ministry of Health & Child Welfare, *supra* note 63, at 59.
135. Zimbabwe National Family Planning Council Act, ch. 15:11.
136. *Id.* § 3; *see also* Ministry of Health & Child Welfare, *supra* note 63, at 59.
137. Zimbabwe National Family Planning Council Act, ch. 15:11, §22 (1).
138. *Id.* schedule (§22(2)), ¶ 21.
139. *Id.* § 4(1), (2).
140. *Id.* § 27(1).
141. Zimbabwe: A Framework For Economic Reform (1991-1995), *supra* note 82 ¶ 59, at 16.
142. Republic of Zimbabwe, *supra* note 87, at 122.
143. First Five-year National Development Plan, 1986-1990, *supra* note 58, at 37 (citing Dep't of Health Services Planning & Management, *supra* note 59); Second Five-year National Development Plan, 1991-1995, *supra* note 84, at 68 (citing World Health Org., Health Care for All by the Year 2000).
144. U.N. Dep't of Int'l Economic & Social Affairs, *supra* note 58, at 231.
145. *Id.*; *see also* Births and Deaths Registration Act, ch. 5:03, *reproduced in part in* 13 Ann. Rev. of Population L., 1984, at 574-579 (Reed Boland & Jan Stepan eds., 1989).
146. Zimb. Nat'l Family Planning Council, Statement of Client Rights (1994), *quoted in* Lowenson et al., *supra* note 92, at 13.
147. Lowenson, et al., *supra* note 92, at 22.
148. *Id.*
149. Central Statistical Office [Zimb.] & Macro International, Inc., Zimbabwe Demographic and Health Survey 1994, summary report 11 (1995).
150. *Id.* Family planning services in Zimbabwe have utilized both community-based and clinic-based delivery systems since 1967. Thomas Dow et al., *Characteristics of New Contraceptive Acceptors In Zimbabwe*, 17 Stud. in Fam. Planning 107, 108 (1986).
151. Zimbabwe Demographic and Health Survey 1994, *supra* note 61, at 3.
152. Second Five-year National Development Plan, 1991-1995, *supra* note 84, at 67.
153. Zimbabwe Demographic and Health Survey 1994, *supra* note 61, at 3.
154. *Id.*
155. Barbara Mensch et al., *Using Situation Analysis Data to Assess the Functioning of Family Planning Clinics in Nigeria, Tanzania and Zimbabwe*, 25 Stud. in Fam. Planning 18, 22 (1994).
156. *Id.* at 20.
157. Zimbabwe Demographic and Health Survey 1994, *supra* note 61, at 3. NORPLANT® can also be obtained from private practitioners in both Harare and Bulawayo. *See also* WiLDAF, *supra* note 6, at 6. *See infra* section on contraception for further discussion of contraceptive methods.
158. Zimbabwe Demographic and Health Survey 1994, *supra* note 61, at 3.
159. Ministry of Health & Child Welfare, *supra* note 63, at 59.
160. *Id.* at 60.
161. *Id.* at 61.
162. Phyllis T. Piotrow et al., *Changing Men's Attitudes and Behavior: The Zimbabwe Male Motivation Project*, 23 Stud. in Fam. Planning 365, 366 (1992).
163. *Id.* at 365-66.
164. Zimb. Nat'l Family Planning Council & Westinghouse Pub. Applied Sys., Zimbabwe Reproductive Health Survey, 1984 (1985).
165. Zimb. Nat'l Family Planning Council, Zimbabwe: A Situation Analysis of the Family Planning Program (1992), *cited in* Mensch et al., *supra* note 155, at 21.
166. Mensch et al., *supra* note 155, at 22-23.
167. *Id.* at 20.
168. WiLDAF, *supra* note 6, at 5.
169. Population Action Int'l, *supra* note 85.
170. Zimbabwe Demographic and Health Survey 1994, *supra* note 61, at 43.
171. WiLDAF, *supra* note 6, at 5. ZNFPC workers distribute condoms and pills in rural areas and utilize a clinic referral system to facilitate access to other types of contraceptives.
172. *Id.*
173. Bill Keller, *Zimbabwe Taking a Lead in Promoting Birth Control*, N.Y. Times, Sept. 4, 1994, at 16.
174. *Id.*; WILDAF, *supra* note 6, at 6.
175. Lowenson et al., *supra* note 92, at 29.
176. Drugs and Allied Substances Control Act, ch. 320, § 3.
177. *Id.* §§ 28-29; *see also* Drugs and Allied Substances Control (Condom) Regulations, S.I. 147 (1991), *reproduced in* 43 Int'l Dig. of Health Legis. 335 (1992) (requiring condom vendors to obtain approval from the Drugs Council of the type of condom to be offered and specifying that all condoms sold in Zimbabwe must meet the standards of the World Health Organization as well as requirements regarding packaging and storage).
178. Drugs and Allied Substances Control Act, ch. 320, § 31.
179. WiLDAF, *supra* note 6, at 6.
180. Drugs and Allied Substances Control Act, ch. 320, § 23.
181. *Id.* § 19. Depo-Provera® was banned in Zimbabwe until it was registered in its country of origin. WiLDAF, *supra* note 6, at 6.
182. Drugs and Allied Substances Control Act, ch. 320, § 15A.
183. *Id.* §§ 15D-15F. The Drugs Control Act requires that any conditions imposed by the DCC be strictly followed to ensure "the safety of all persons or animals taking part in such trial." *Id.* § 15D.
184. *Id.* §§ 15H-15I.
185. *Id.* § 15G.
186. *Id.* § 15J.
187. WiLDAF, *supra* note 6, at 6. In government health centers, a NORPLANT® implant may be obtained for Z$100 (approximately U.S.$9.50). In private clinics, the cost of NORPLANT® is Z$300 (or U.S.$29). Zimb. Nat'l Family Planning Council, Revised Prices for Drugs: November, 1993 (1993) (document on file at The Center For Reproductive Law and Policy).
188. WILDAF, *supra* note 6, at 6.
189. *Id.*
190. Drugs Control and Allied Substances Act, ch. 320, § 30(1).
191. Censorship and Entertainments Control Act, ch. 8:04, § 11 (prohibiting the printing, distribution, display or sale of any undesirable publication or record).
192. *Id.* §§ 3, 11. In addition, a publication "likely to be outrageous or disgustful [sic] to persons who are likely to read, hear or see it" or which "deals in an improper or offensive manner with criminal or immoral behaviour" may be deemed offensive or harmful to public morals. *Id.* § 27(b),(c). However, this Act does not appear to restrict the advertisement of contraceptives. Condom advertisements are common in the press.
193. Termination of Pregnancy Act, ch. 15:10. There have been no changes in the law since passage of the 1977 Act. WiLDAF, *supra* note 6, at 6-7.
194. Termination of Pregnancy Act, ch. 15:10, § 2(2); *see also* Concealment of Birth Act, ch. 9:04; Infanticide Act, ch. 9:12 (creating the charge of infanticide); Criminal Procedure and Evidence Act, ch. 7:04, § 280(1) (defining live birth for the purpose of an infanticide prosecution to be a child that is "proved to have breathed, whether or not it has had an independent circulation, and it shall not be necessary to prove that such child was at the time of its death entirely separated from the body of its mother").
195. Termination of Pregnancy Act, ch. 15:10, § 2(1). The 1977 Act's definition of pregnancy excludes ectopic pregnancies.
196. *Id.* § 2(1); *See* Feltoe & Nyapadi, *supra* note 97, at 79 (suggesting that the definition of "foetus" in the Termination of Pregnancy Act embraces all stages of development after implantation in the uterine wall); S.A. Strauss, Doctor, Patient and the Law: A Selection of Practical Issues 204 (1980) (noting that the "morning after pill" and insertion of an IUD may amount to an unlawful abortion).
197. Termination of Pregnancy Act, ch. 15:10, § 3. However, a court may exercise discretion in sentencing. *See* State v. Makufa, HC-H-107-85, MT-58/95 (Mar. 27, 1985) (reducing sentence based on circumstances of case).
198. Termination of Pregnancy Act, ch. 15:10, § 4.
199. Rape is defined to be "[i]ntentional, unlawful sexual intercourse by a male over 14 years of age with a woman, without her consent." Geoff Feltoe, Guide to the Criminal Law of Zimbabwe 36 (1989), at 120.
200. Termination of Pregnancy Act, ch. 15:10, § 2(1). Intercourse with a mentally handicapped woman or girl is a criminal offense. Criminal Law Amendment Act, ch. 9:05 § 3(d).
201. *See* Ian Chikanza & Webster Chinamora, *Abortion in Zimbabwe: A Medico-legal Problem*, *in* Women and Law in Southern Africa 237, 242 (Alice Armstrong & Welshman Ncube eds., 1987).
202. Termination of Pregnancy Act, ch. 15:10, § 5. The 1977 Act empowers the Minister of Health to issue further regulations giving effect to enacted provisions. *Id.* § 13.
203. *Id.* § 5(1). "Medical practitioner" is defined to be a medical practitioner registered pursuant to the Medical, Dental and Allied Professions Act, ch. 27:08. *Id.* § 2(1).
204. *Id.* § 5(1).

205. *Id.* "Superintendent" is defined to be the medical superintendent of a State hospital or, in other institutions, any person designated by the Minister of Health. *Id.* § 2(1).
206. *Id.* § 6.
207. FELTOE & NYAPADI, *supra* note 97, at 42, 81; STRAUSS, *supra* note 197, at 199-200 (stating that a doctor may be liable under the Roman-Dutch common law for an infringement of the husband's right to procreate).
208. Telephone interview with Luta Shaba & Everjoice Win, WILDAF (Aug. 6, 1996).
209. Termination of Pregnancy Act, ch. 15:10, § 11.
210. *Id.* § 10.
211. *Id.* § 5(2). The Ministry of Health has not issued an official statement regarding the legality of abortions performed on HIV-infected women. Telephone interview with Luta Shaba & Everjoice Win, *supra* note 208; Susan Njanji, *Zimbabweans Call for Review of Abortion Laws*, AGENCE FRANCE PRESSE, Feb. 15, 1994, *available in* LEXIS, World Library (reporting that at a Zimbabwe Medical Association conference, local gynecologists stated that they had been performing abortions on HIV-infected women with government approval).
212. Termination of Pregnancy Act, ch. 15:10, § 7.
213. *Id.* § 5(2).
214. *Id.* § 5(3), (4).
215. *Id.* §5(4)(a)(i), (ii). An investigation may include a review of documentation and direct questioning of the woman seeking to have the abortion performed. *Id.* § 5(4)(a)(ii). In the case of incest, the magistrate must also establish that the woman was within the prohibited degree of relation with the perpetrator. *Id.* § 5(4)(a)(iii).
216. *Id.* § 5(4)(b).
217. *Id.* § 12.
218. *Id.* § 12(a)-(d).
219. *Id.* § 8(2).
220. *Id.* § 9.
221. *Id.* § 12(a).
222. FELTOE & NYAPADI, *supra* note 97, at 73.
223. *See id.*; WILDAF, *supra* note 6, at 8.
224. Zimbabwe National Family Planning Council Act, ch. 15:11, § 22(1)(g).
225. *Id.* schedule (§22(2)) ¶ 21(a).
226. WILDAF, *supra* note 6, at 8.
227. *Id.*
228. ZIMB. NAT'L FAMILY PLANNING COUNCIL, *supra* note 187. Government health services are heavily subsidized. In addition, families with incomes less than Z$400 (U.S.$38.10) per month receive all health services for free. *See supra* note 90-91 and accompanying text.
229. WILDAF, *supra* note 6, at 8.
230. FELTOE & NYAPADI, *supra* note 97, at 73.
231. Permanent impotence may render an individual incompetent for marriage. NCUBE, *supra* note 31, at 147.
232. The mutual right of married couples to procreation is well-established under the Roman-Dutch common law. STRAUSS, *supra* note 196, at 142. The right to procreation may implicate the distribution of contraceptives or any therapeutic treatment affecting the reproductive functions. However, as of 1989, there had been no case in Zimbabwe on the failure to obtain spousal consent before performance of a sterilization operation on a married woman. FELTOE & NYAPADI, *supra* note 97, at 75.
233. FELTOE & NYAPADI, *supra* note 97, at 72, 74. Sterilization of a minor imbecile may only be performed upon parental request to protect the child from the consequences of possible sexual abuse. WILDAF, *supra* note 6, at 8.
234. Children's Protection and Adoption Act, ch. 5:06, § 76(1) (1974).
235. WILDAF, *supra* note 6, at 13. *But see* U.S. Dep't. of State, *supra* note 26 (reporting that the Remba, a small ethnic group in Zimbabwe, engage in initiation rites that include infibulation).
236. WILDAF, *supra* note 6, at 13.
237. HEALTH INFO. UNIT & NAT'L AIDS COORDINATION PROGRAMME, MINISTRY OF HEALTH & CHILD WELFARE, HIV, STI AND AIDS SURVEILLANCE ZIMBABWE: QUARTERLY REPORT JULY TO SEPTEMBER 1995, at 1 (1995).
238. *Zimbabwe High HIV Infection Reported*, AFRICA NEWS, Dec. 23, 1995, *available in* LEXIS, World Library.
239. *Id.*
240. HEALTH INFO. UNIT & NAT'L AIDS COORDINATION PROGRAMME, *supra* note 237, at 1.
241. *Id.* at 5-6, 11; MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 63, at 42. AIDS and AIDS related deaths among men are the highest in the 30-39 age group. HEALTH INFO. UNIT & NAT'L AIDS COORDINATION PROGRAMME, *supra* note 237, at 5-6, 11.
242. IMPLEMENTING ICPD AND BEIJING: WOMEN'S HEALTH IN ZIMBABWE 12 (Commonwealth Medical Association & Zimbabwe Medical Association 1996).
243. HEALTH INFO. UNIT & NAT'L AIDS COORDINATION PROGRAMME, *supra* note 237, at 4.
244. *Id.*
245. Sunanda Ray et al., *Acceptability of the Female Condom in Zimbabwe: Positive but Male Centred Responses*, 5 REPRODUCTIVE HEALTH MATTERS 68, 69 (1995).
246. Public Health Act, ch. 15:09, §§ 17-21.
247. WILDAF, *supra* note 6, at 7.
248. Public Health Act, ch. 15:09, § 50. There is no record of a person tried under the offenses stipulated in the Public Health Act. WILDAF, *supra* note 6, at 7.
249. *Id.* § 49(1), (3)(d). There is no record of a person detained in accordance with the provisions of the Public Health Act. WILDAF, *supra* note 6, at 7.
250. Public Health Act, ch. 15:09, § 52.
251. *Id.* § 55.
252. *Id.* § 47.
253. WILDAF, *supra* note 6, at 7. The government has proposed legislation specifically criminalizing infection of another person with HIV. *Id.*
254. SECOND FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1991-1995, *supra* note 84, at 67.
255. ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY 1994, *supra* note 61, at 141. In 1991, the President of Zimbabwe declared a "war on AIDS." SECOND FIVE-YEAR NATIONAL DEVELOPMENT PLAN, 1991-1995, *supra* note 84, foreword.
256. LOWENSON ET AL., *supra* note 92, at 30.
257. *Zimbabwe AIDS Fight Gets $64 Million Loan*, CHI. TRIB., June 22, 1993, at 10. This was the largest amount the World Bank had given to any African country for the prevention of sexually transmitted disease. *Id.*
258. Ray et al., *supra* note 245, at 77-78.
259. *Healers Call to Modify Zimbabwean Traditional Practices*, AFRICA NEWS, July 1995, *available in* LEXIS, World Library.
260. LOWENSON ET AL., *supra* note 92, at 30.
261. In addition, home-based care has been the "prescribed treatment protocol" for AIDS in Zimbabwe. Paul Taylor, *AIDS Overwhelming Zimbabwe's Advanced Defenses*, WASH. POST, April 12, 1995, at A1.
262. *Zimbabwe Lacking Political Will to Curb AIDS*, AFRICA NEWS, June 1995, *available in* LEXIS, World Library.
263. *See* Stewart et al., *supra* note 126, at 169.
264. Amendment No. 14 to the Constitution established gender as an impermissible ground for discrimination. However, Amendment No. 14 also reversed recent gains concerning the citizenship rights of married women, and removed substantive rights guarantees that had been implicit in the constitutional text. ZIMB. CONST. AMENDMENT, No. 14 (1996) (unpublished departmental draft, on file with The Center for Reproductive Law and Policy); telephone interview with Luta Shaba, *supra* note 21.
265. ZIMB. CONST. § 23(5)(b), *as amended by* ZIMB. CONST. AMENDMENT, NO. 14, § 9 (1)(d) (1996).
266. *Id.* § 23(5)(c), *as amended by* ZIMB. CONST. AMENDMENT, NO. 14 § 9(1)(d) (1996).
267. Legal Age of Majority Act, ch. 8:07.
268. *Id.* § 3. In Katekwe v. Muchabaiwa, 1984 ZLR 112, 128 (1984), the court stated that the purpose of the Legal Age of Majority act was "the liberation of African women from the legal disadvantages of perpetual minority."
269. NCUBE, *supra* note 31, at 156; Stewart et al., *supra* note 126, at 170.
270. KNOW YOUR RIGHTS: THE LEGAL AGE OF MAJORITY 4 (undated pamphlet produced by Legal Resources Foundation, on file with The Center for Reproductive Law and Policy).
271. Legal Age of Majority Act, ch. 8:07, § 3(3).
272. Customary Law & Local Courts Act, ch. 7:05, § 4.
273. *See* Customary Marriages Act, ch. 5:07, § 2 (defining customary marriage to be "a marriage between Africans").
274. *Id.* § 1(b).
275. *Id.* § 3(5).
276. *See* NCUBE, *supra* note 31, at 138.
277. Traditionally, payment of a bridewealth (*roora* or *lobolo*) signified a transfer of rights in the woman and her children, including the man's sexual right to the "labour value" of the woman. Fareda Banda, *The Provision of Maintenance for Women and Children in Zimbabwe*, 2 CARDOZO WOMEN'S L.J. 71, 72 (1995); JOAN MAY, ZIMBABWEAN WOMEN IN CUSTOMARY AND COLONIAL LAW 48 (1983).
278. Banda, *supra* note 277, at 72.

279. Customary Law & Local Courts Act, ch. 5:07, §§ 7(1)(b), 15.
280. JOAN MAY, CHANGING PEOPLE, CHANGING LAWS 56 (1987).
281. NCUBE, *supra* note 31, at 135; *cf.* CUTSHALL, *supra* note 36, at 57.
282. Marriage Act, ch. 5:11.
283. NCUBE, *supra* note 31, at 138, 145-46. Parties who are mentally incompetent or under duress are incapable of consenting. *Id.* at 145.
284. *Id.* at 153.
285. *See* NCUBE, *supra* note 31, at 137. Although the Customary Marriages Act requires that customary law govern the formation of civil marriages between Africans, section 12 (1) (mandating guardian consent and payment of a bridewealth) of the Customary Marriages Act was repealed by implication for women over the age of eighteen by the Legal Age of Majority Act. *Id.* at 143; *see also* KNOW YOUR RIGHTS: THE LEGAL AGE OF MAJORITY, *supra* note 270, at 13.
286. NCUBE, *supra* note 31, at 147.
287. *Id.*
288. *Id.*
289. Maintenance Act, ch. 5:09, § 6(3)(a)-(b); *See* NCUBE, *supra* note 31, at 156. An order for maintenance has the same effect as a civil judgment. WOMEN AND LAW IN SOUTHERN AFRICA RESEARCH PROJECT, MAINTENANCE IN ZIMBABWE 33 (1991).
290. Maintenance Act, ch. 5:09, § 6(2)(b), (4). However, courts will not consider any unwillingness to work, unemployment because of repeated misconduct, or the presence of unreasonable debts in the assessment of maintenance responsibility. *Id.* § 23(4).
291. *Id.* §§ 4, 6; *see also* Children's Protection and Adoption Act, ch. 5:06, § 50 (authorizing contribution orders for maintenance of a child who is part of a juvenile court proceeding); Guardianship of Minors Act, ch. 5:08, § 5(5); Maintenance Orders (Facilities for Enforcement) Act, ch. 5:10. Failure to comply with a maintenance order is a punishable offense for omitted payments does not preclude later prosecution. Maintenance Act, ch. 5:09, §§ 23-24.
292. Maintenance Act, ch. 5:09, § 10.
293. *Id.* § 11(1), (3).
294. Matrimonial Causes Act, ch. 5:13, § 2(1).
295. *See* NCUBE, *supra* note 31, at 135 (citing Tinga v. Shekeda, 1970 AAC30). However, pursuant to the Maintenance Act, courts may make orders for spousal and child maintenance at the dissolution of an unregistered marriage. *See* Maintenance Act, ch. 5:09, § 6(3)(a), (b).
296. Matrimonial Causes Act, ch. 5:13, § 4. The statute provides several examples of "irretrievable break-down." *Id.* § 5(2)(d). However, it is unclear if these examples are merely guidelines or if the statute requires courts to grant a divorce in such situations. NCUBE, *supra* note 31, at 214.
297. Matrimonial Causes Act, ch. 5:13, § 5(1). "Irretrievable break-down" also refers to the marital rights and duties under the common law, including the duties of companionship, fidelity, and love. For example, a long-term separation, including the long-term imprisonment or "habitual" criminality and imprisonment of a spouse, may be relevant to show that the marriage has broken down. *Id.* § 5(2)(a),(c); NCUBE, *supra* note 31, at 212 n.59.
298. Matrimonial Causes Act, ch. 5:13, § 5(2)(d). The common law concept of cruelty encompasses "grave conduct which has caused or is likely to cause danger to the life, limb or health, physical or mental, of the other party." NCUBE, *supra* note 31, at 220.
299. Matrimonial Causes Act, ch. 5:03, § 5(2)(b); *See* NCUBE, *supra* note 31, at 218.
300. Matrimonial Causes Act, ch. 5:03, § 13(1).
301. *Id.* § 7. This provision also grants the court power over the property of a spouse that is held by a third party. *Id.* § 7(2)(a).
302. *Id.* § 7(3). Communal lands would presumably belong to the male kin group.
303. Matrimonial Causes Act, ch. 5:03, § 7(4)(a)-(b), (e)-(g). Other considerations include the particular history of marital relations. *See* NCUBE, *supra* note 31, at 176-180 (discussing direct contributions to the family).
304. NCUBE, *supra* note 31, at 210.
305. Matrimonial Causes Act, ch. 5:03, § 7(4).
306. *Id.* § 8.
307. *Id.* § 10(2).
308. Guardianship of Minors Act, Ch. 5:08, § 4; Customary Law & Local Courts Act, ch. 7:05, § 5.
309. The high court of Zimbabwe may make a custody decision upon the petition of either of the parents; the act affirms the legal capacity of women to make such an application without assistance. *Id.* § 4(7). After awarding custody, a juvenile court may make any additional orders regarding maintenance and access to the child as required under the settlement agreement. *Id.* § 5(3)(d).
310. *See* MAY, *supra* note 280, at 75 (noting that women cannot be guardians).
311. Children's Protection and Adoption Act, ch. 5:06, §§ 14, 16.
312. Guardianship of Minors Act, ch. 5:08, §§ 6(7), (8), 7(3), 8(1). Orders transferring custody may be enforced by the police; furthermore, the Guardianship Act authorizes the use of reasonable force to effect any court provisions. *Id.* § 7(2).
313. Legal Age of Majority Act, ch. 8:07; *see also* Stewart et al., *supra* note 126, at 170.
314. However, in unregistered customary marriages, a husband's claims in his wife's property are not legally enforceable. NCUBE, *supra* note 31, at 167.
315. *See* NCUBE, *supra* note 31, at 171. Rural women rarely acquire *mavoko* property. Furthermore, it is often difficult for a woman to prove that property is part of her *mavoko*. *Id.* at 171-72.
316. Immovable Property (Prevention of Discrimination) Act, ch. 8:12.
317. Customary law does not govern disputes over rights to own immovable property. *See* NCUBE, *supra* note 31, at 166; WHITE PAPER ON MARRIAGE AND INHERITANCE IN ZIMBABWE 3 (Republic of Zimbabwe 1993).
318. Immovable Property (Prevention of Discrimination) Act, ch. 8:12, § 3(1)(a), (b). In addition, a 1991 amendment to the Deeds Registries Act repealed a provision requiring married women to disclose their marital status and to provide their husband's name on all registered deeds and documents. Deeds Registries Act, No. 2 (1991), *summarized in* 18 ANN. REV. OF POPULATION L., 1991, at 112 (Reed Boland & Jan Stepan eds., 1993).
319. Immovable Property (Prevention of Discrimination) Act, ch. 8:12, § 6(1).
320. *Id.* § 5(1)(a), (d).
321. COMMUNAL LAND ACT, NO. 20, § 8(2) (1982).
322. *See* Janet M. Sawaya, *Rights Education as a Means of Economic Empowerment for Women in Subsaharan Africa*, 2 GEO. J. ON FIGHTING POVERTY 329, 342 (1995), *available in* WESTLAW. Communal land is allocated by the government for individual use through the issuance of permits. Over 50% of the population in Zimbabwe live on communal land; 82% of inhabitants are women and children under the age of 14. *Id.*
323. Resettlement permits may be issued to male or female heads of households. *See* Rural Land and District Councils Act, ch. 29:13. However, only a small percentage of permits are issued to women. WOMEN & LAND RIGHTS IN RESETTLEMENT AREAS IN ZIMBABWE 3, 10 (undated pamphlet produced by Women and Law in Southern Africa Research Trust-Zimbabwe (WLSA), on file at The Center for Reproductive Law and Policy); Sawaya, *supra* note 322, at 343. Government policy on disposition of resettlement land is determined by the Minister of Local Government, Rural and Urban Development. WOMEN & LAND RIGHTS IN RESETTLEMENT AREAS IN ZIMBABWE, *supra* note 323, at 10.
324. WOMEN & LAND RIGHTS IN RESETTLEMENT AREAS IN ZIMBABWE, *supra* note 323, at 3. Women also experience discrimination in the allocation of credit assistance in connection with resettlement expenses. LOWENSON et al., *supra* note 92, at 36.
325. WOMEN & LAND RIGHTS IN RESETTLEMENT AREAS IN ZIMBABWE, *supra* note 323, at 5. Under most customary law regimes, women may own livestock and have the right to use grazing land for their animals. In addition, a husband traditionally allocated a field to his wife for her own use and control. *Id.* at 4-5.
326. Wills Act, ch. 6:06, § 4(1).
327. Administration of Estates Act, ch. 6:01.
328. *Id.* § 69(1), *quoted in* NCUBE, *supra* note 31, at 191. The general law governs intestate rights in immovable property. *See* NCUBE, *supra* note 31, at 193-94.
329. Customary Law & Local Courts Act, ch. 7:05, §3; *see also* Julie Stewart & Welshman Ncube, *Legal and Cultural Framework of Succession in Zimbabwe*, *in* WORKING PAPERS ON INHERITANCE LAW IN SOUTHERN AFRICA 100, 117 (1992). Consent for the choice of law may be express or implied from the individual's manner of living, including entry into a civil marriage. *See* Mujawo v. Chogugudza, 1992 (2) ZLR 321, 328.
330. Stewart & Ncube, *supra* note 329, at 119. The personal belongings of a woman generally consist of her clothes and blankets. *Id.*
331. *Id.* at 119.
332. *Id.*; WHITE PAPER ON MARRIAGE AND INHERITANCE IN ZIMBABWE, *supra* note 317, at 2.
333. Stewart & Ncube, *supra* note 329, at 119.
334. *Id.*
335. LOWENSON ET AL., *supra* note 92, at 35.
336. Chihowa v. Mangwende, S.C. 84/1987, *summarized in* 15 ANN. REV. OF POPULATION L., 1988, at 174 (Reed Boland & Jan Stepan eds., 1991); *see also* NCUBE, *supra* note 31, at 195-96; Stewart & Ncube, *supra* note 329, at 118. Traditionally, the eldest son was the preferred heir. Vareta v. Vareta, S.C. 126/90, Civ. App. No. 452/89, at 8 (unpublished case July 31 & Sept. 13, 1990) (dicta citing Muhango v. France 1940 SRN 100).
337. Stewart & Ncube, *supra* note 329, at 120-21.
338. *Id.* at 121; Telephone interview with Luta Shaba, *supra* note 21.
339. Deceased Estates Succession Act, ch. 6:02.
340. NCUBE, *supra* note 31, at 190.
341. Deceased Estates Succession Act, ch. 6:02, § 3. For marriages in community of prop-

erty, intestate succession follows the dissolution of the joint estate; as in other forms of civil marriage, the surviving spouse is the primary beneficiary. WHITE PAPER ON MARRIAGE AND INHERITANCE IN ZIMBABWE, *supra* note 317, at 1.

342. Deceased Persons Family Maintenance Act, ch. 6:03, § 3. Dependents entitled to receive maintenance from an estate include the surviving spouse, a divorced spouse receiving maintenance by court order, dependent parents and children. *See also* Stewart & Ncube, *supra* note 329, at 122 (noting that it would be consistent with case law to allow maintenance claims by the surviving spouses of unregistered customary unions).

343. Deceased Persons Family Maintenance Act, ch. 6:03, § 10(1). The penalty for interference with the exercise of these rights is a fine up to Z$2,000 (approximately U.S.$190) or imprisonment for up to two years, or both. *Id.* § 10(2). In addition, a surviving spouse may apply for a spoliation order to regain possession of property or to assert an occupancy right. Julie Stewart, *The Widows Lot — A Remedy?: The Application of Spoliation Orders in Customary Succession*, 1 & 2 ZIMB. L. REV. 72, 73 (1983-84).

344. Labour Relations Act, ch. 28:01 § 5.

345. *Id.*, preamble. Most Zimbabwean women are employed in unskilled, non-union positions; consequently, statutory regulations are the primary determinants of working conditions for the majority of women in Zimbabwe. WILDAF, *supra* note 6, at 11. Customary law does not affect workers rights. *Id.* at 12.

346. General Law Amendment Act, ch. 8:07, § 12.

347. WILDAF, *supra* note 6, at 11.

348. Labour Relations Act, ch. 28:01, § 5(1).

349. *Id.* § 5(7)(a)(ii).

350. *Id.* § 5(3).

351. *Id.* § 5(4).

352. *Id.* § 18(3). A woman requesting maternity leave must furnish to her employer a certificate signed by a registered medical practitioner or state registered nurse certifying that she is likely to give birth within 45 days. *Id.* § 18(1). With proper certification, a woman may extend her leave indefinitely without pay. *Id.* § 18(2)(ii).

Regulations providing maternity leave for female public servants are slightly different. *See* Public Services (Conditions of Services for Employees) (Amendment) Regulations, No. 26, §§ 7, 52A(2),(3),(4),(6), 52B (1989), *reproduced in* 16 ANN. REV. OF POPULATION L., 1989, at 483 (Reed Boland & Jan Stepan eds., 1992); District Councils (Conditions of Service) (Amendment) Regulations, S.I. 246 (1984), *cited in* 12 ANN. REV. OF POPULATION L., 1985, at 106 (Reed Boland & Jan Stepan eds., 1988) (providing maternity leave for women employed by the district councils).

353. Labour Relations Act, ch. 28:01, § 18 (1)(a), (b).

354. *Id.* § 18(1)(b)(ii).

355. *Id.* § 18(3).

356. *Id.* § 18(4). A woman may combine this period with any of her other breaks; however, an employer may also require that these periods do not disrupt normal business. In addition, most employers do not provide child care facilities, making it difficult for women to exercise this right. *See* Stewart et al., *supra* note 126, at 204.

357. LOWENSON ET AL., *supra* note 92, at 29.

358. *Id.*; *see also* Hazardous Substances Act, ch. 15:05 § 47(2)(a)(vii). Although the MHCW is empowered to regulate working conditions for pregnant women pursuant to the Factories and Works Act, no regulations have been issued.

359. Immovable Property (Prevention of Discrimination) Act, ch. 8:12, § 4; *see also id.* § 2 (defining "financial organizations" to be any organization registered under the Banking Act, ch. 188, the Building Societies Act, ch. 189, and the Insurance Act, No. 27 (1987)).

360. WILDAF, *supra* note 6, at 14.

361. *Id.* at 14-15.

362. Education Act, No. 5 § 4 (1987). This section also regulates school admissions policies, but does not include gender as an impermissible ground for discrimination. *Id.* § 4(2).

The provisions of the education act do not apply to the University of Zimbabwe or such other schools as may be exempted by the Minister of Education. *Id.* § 3.

363. *Id.* § 10; *see also* Stewart et al., *supra* note 126, at 200.

364. WILDAF, *supra* note 6, at 13.

365. University of Zimbabwe Act, ch. 25:16, § 5(1).

366. Customary law does not govern criminal offenses. Stewart et al., *supra* note 126, at 209.

367. FELTOE, *supra* note 199, at 120. Males under the age of 14 are presumed incapable of sexual intercourse, but may be prosecuted for the crimes of assault or indecent assault. *Id.* at 121.

368. *Id.* at 122.

369. *Id.*; *see* Stewart et al., *supra* note 126, at 210.

370. Intercourse between a married couple, lacking a judicial order for separation or divorce, is presumed to be consensual. FELTOE, *supra* note 199, at 120; *see also* NCUBE, *supra* note 31, at 147 (stating that refusal to consummate a marriage may be a ground for annulment).

371. FELTOE, *supra* note 199, at 121.

372. See Criminal Procedure and Evidence Act, ch. 7:04, § 199 (providing for a conviction of assault with the intent to inflict grievous bodily harm following a charge of rape or assault with the intent to commit rape if facts are proven).

373. FELTOE, *supra* note 199, at 55, 59.

374. *Id.* at 59.

375. *Id.* at 124. A woman may introduce any "immediate complaint" she may have made as evidence of her lack of consent. However, the Zimbabwean courts have often interpreted this rule to require that an immediate complaint support a rape charge. Stewart et al., *supra* note 126, at 213.

376. FELTOE, *supra* note 199, at 124. Evidence as to the character of the accused is also sometimes admissible. Criminal Procedure and Evidence Act, ch. 7:04, § 245 (stating that such evidence is permitted only if it is considered admissible "in any similar case depending in the Supreme Court of Judicature in England").

377. Criminal Procedure and Evidence Act, ch. 7:04, §§ 186A(1), 360(1), (2).

378. LOWENSON ET AL., *supra* note 92, at 14-15; *see also* Stewart et al., *supra* note 126, at 213-14.

379. *See* LOWENSON ET AL., *supra* note 92, at 19 (discussing how general law is usually not enforced in domestic violence cases).

380. Ministry of Health & Child Welfare, *supra* note 63, at 26; telephone interview with Luta Shaba, *supra* note 21.

381. Criminal Procedure and Evidence Act, ch. 7:04, § 361(1).

382. *Id.* § 361(3)(a).

383. *Id.* § 361(5), (7), (9).

384. Mary Maboreke, *Violence against Wives: A Crime sui generis*, 4 ZIMB. L. REV. 88, 95 (1986). Women may receive compensation for medical expenses. KNOW YOUR RIGHTS: DOMESTIC VIOLENCE 17 (undated pamphlet produced by Legal Resources Foundation, on file at The Center for Reproductive Law and Policy); *see also* ALICE ARMSTRONG, VIOLENCE AGAINST WOMEN IS AGAINST THE LAW 14 (1989) (noting that it is often difficult to obtain such awards without visible injuries or evidence of medical expenditures).

385. Matrimonial Causes Act, ch. 5:12, § 5(2)(d) (providing for judicial separation or divorce on the ground of mental or physical cruelty); *see also* NCUBE, *supra* note 31, at 220.

386. Maboreke, *supra* note 384, at 90. However, this method of social dispute resolution has not been effective within the modern social organization of Zimbabwean families. ARMSTRONG, *supra* note 384, at 7.

387. MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 63, at 26.

388. *Id.* at 28.

389. LOWENSON ET AL., *supra* note 92, at 16 (citing Zimbabwe Public Service Regulations of 1988). Although sexual harassment constitutes an act of misconduct for public service employees, these regulations are not well-enforced. *Id.*

390. IRED, *supra* note 30.

391. FELTOE, *supra* note 199, at 59. For further discussion of the crime of indecent assault, *see infra* section on rape.

392. FELTOE, *supra* note 199, at 59.

393. Stewart et al., *supra* note 126, at 210.

394. FELTOE, *supra* note 199, at 71. The crime encompasses any insulting, degrading, offensive or humiliating treatment that infringes upon the right to "self-respect, mental tranquillity and privacy." *Id.*

395. *Id.* at 72. If the charge of *criminal injuria* involves an accusation of sexual impropriety, the act committed must be corroborated.

396. *Id.*

397. ZIMBABWE DEMOGRAPHIC & HEALTH SURVEY 1994, *supra* note 61, at 2 (citing 1992 census).

398. LAZARUS ZANAMWE, YOUTH SEXUALITY AND REPRODUCTIVE HEALTH: A REVIEW OF LITERATURE AND YOUTH PROGRAMMES IN ZIMBABWE vi (1995).

399. *Id.* at vii.

400. MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 63, at 60.

401. ZANAMWE, *supra* note 398, at 94.

402. FELTOE & NYAPADI, *supra* note 97, 43-45, 68-69.

403. *Id.* at 70-72. There has been no case in Zimbabwe for a prosecution for the dispensation of contraceptives to minors without parental consent.

404. ZANAMWE, *supra* note 398, at 107; Stewart et al., *supra* note 126, at 198. However, the ZNFPC dispenses contraceptives to teenage girls under the age of 16 who have already had a child. IMPLEMENTING ICPD AND BEIJING: WOMEN'S HEALTH IN ZIMBABWE, *supra* note 242 at 4.

405. NCUBE, *supra* note 31, at 137 n.12.

406. Marriage Act, ch. 5:11, §§ 20(2), 22(1); *see* NCUBE, *supra* note 31, at 149. This provision does not apply to girls under the age of 18 who have previously contracted a valid marriage. Marriage Act, ch. 5:11, § 20(4).
407. Customary Marriages Act, ch. 5:07, § 11(1). An earlier version of this act (the African Marriages Act, ch. 238 (1951)) expressly prohibited the pledging of girls under the age of 12.
408. Customary Marriages Act, ch. 5:07, §§ 4(2), (3), 7(1). The Customary Marriages Act does not specify who must pay or who is to receive the marriage consideration. This provision does not apply to women over the age of 18 and women who have previously married. NCUBE, *supra* note 31, at 136, 145 (citing Katekwe v. Muchabaiwa SC 87/84).
409. Customary Marriages Act, ch. 5:07, § 12.
410. WILDAF, *supra* note 6, at 14; LOWENSON ET AL., *supra* note 92, at 39.
411. LOWENSON ET AL., *supra* note 92, at 39. Since 1991, the Ministry of Education has received advice on policy and programming from a National Education Advisory Board and regional advisory boards, composed of representatives from local authorities, church organizations and business and industry. Education Amendment Act, No. 26, § 8 (1991) (to be inserted in Education Amendment Act, No. 5, at § 28B, 28H) (1989)
412. WILDAF,, *supra* note 6, at 14.
413. *Id*. at 13. For every ten scholarships disbursed per province, the Ministry of Education awards seven to female candidates. *Id*.
414. LOWENSON ET AL., *supra* note 92, at 39-40; *see also* HOW TO USE THE SOCIAL DEVELOPMENT FUND FOR EDUCATION (undated pamphlet produced by the Zimbabwe Women's Resource Centre and Network on file at The Center for Reproductive Law and Policy).
415. Stewart et al., *supra* note 126, at 201.
416. The Education Act empowers the Minister of Education to make regulations providing for, *inter alia*, "the temporary exclusion from any school or college of any teacher, pupil or student, and any other measures necessary or desirable to preserve the well-being of teachers, pupils or students." Education Act, No. 5, § 62(2)(l) (1987).
417. WILDAF, *supra* note 6, at 13. Returning students are transferred to different schools in order to facilitate their return to student life.
418. *Id*.
419. *Id*.
420. LOWENSON ET AL., *supra* note 92, at 14; ZANAMWE, *supra* note 398, at 2; MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 63, at 61. The new curricula has been used with children as young as eight years old. LOWENSON ET AL., *supra* note 92, at 14.
421. ZANAMWE, *supra* note 398, at 2; MINISTRY OF HEALTH & CHILD WELFARE, *supra* note 63, at 61.
422. Criminal Law Amendment Act, ch. 9:50, § 3(a)-(b) (1986). To be convicted under the Criminal Law Amendment Act, the accused must be over the age of 16. *See Id*. § 3(i)(b).
423. *Id*. § 3(i)(a).
424. *Id*. § 3. In assessing a sentence for the crime of statutory rape, a court may consider, *inter alia*, the victim's loss of educational prospects. S v. Chuma, 1983 ZLR 372, 375 (1983).
425. Criminal Law Amendment Act, ch. 9:50, § 12.
426. FELTOE, *supra* note 199, at 122. Girls under the age of 12 are presumed incapable of consenting to sexual intercourse. *Id*.
427. U.S. Dep't. of State, *supra* note 26.
428. Stewart et al., *supra* note 126, at 214; *see* State v. Mwale, HC-H-11-87, CRB 12371/85 (unreported case Jan. 14, 1987).
429. Stewart et al., *supra* note 126, at 214.

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9. Regional Trends in Reproductive Rights

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

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

I. Setting the Stage: The Legal and Political Framework

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

A. THE STRUCTURE OF THE GOVERNMENT

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

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

B. SOURCES OF LAW

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

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

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

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

Domestic Sources of Law

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

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

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

International Sources of Law

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

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

Regional Legal Models

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

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

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

II. Examining Reproductive Health and Rights

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

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

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

A. HEALTH LAWS AND POLICIES

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

Objectives of the Health Policy

The major objective of national health policy in all seven

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

Infrastructure of Health Services

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

Despite the high degree of government involvement, all seven countries suffer from an inadequate health service infrastructure. This is particularly true in Ethiopia and Nigeria. In Ethiopia, there are only 72 hospitals (with approximately 9,500 beds), 153 health centers, and 2,094 health stations to serve a population of approximately 55 million people. Nigeria, a nation of about 112 million people, has only approximately 1,071 health facilities, 119 district hospitals, and 780 general hospitals. In addition, in recent years the Nigerian health system has deteriorated as a result of rising costs and the continuing shortages of drugs, personnel, and equipment and has not been able to eliminate sharp disparities in the availability of medical services. Not only are health care systems in most countries biased toward the provision of services in urban areas, but their ability to provide a consistent level of services throughout a particular country is limited. For example, the government of Ghana acknowledges that health care delivery in rural areas remains woefully inadequate.

Cost of Health Services

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

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

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

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

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

Regulation of Health Care Providers

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

Modern Medical Providers

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

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

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

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

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

Traditional Medical Practitioners

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

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

Regional Legal and Policy Models

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

Patients' Rights

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

Rights Based on Criminal Law

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

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

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

Rights Based on Tort Law

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

B. POPULATION AND FAMILY PLANNING

A review of population and family planning policy reveals that almost all Anglophone African nations seek to reduce the rate of population growth. The region also reflects very little movement towards the broader reproductive health perspective endorsed at recent international conferences. Ghana has recently promulgated a reproductive health services policy, while South Africa and Kenya are in the process of reformulating their policies. Yet family planning services continue to be the primary, often the exclusive, public reproductive health services made accessible to citizens in the region.

Population and Family Planning Policy

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

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

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

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

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

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

Implementing Strategies

To implement their population policies, countries have established several different strategies. In Ethiopia, implementation includes expanding contraceptive distribution, promoting breast-feeding as a means of birth-spacing, and integrating women into the "modern" sector of the economy. In addition, Ethiopia's strategy involves amending all laws "impeding, in any way, the access of women to all social, economic and cultural resources" and amending relevant laws to remove unnecessary restrictions on the "advertisement, propagation and popularization of diverse contraception control methods." Ghana's implementation strategies appear to be broader. In 1996, the Ministry of Health issued the Reproductive Health Service Policy, which sets out rules and regulations for the provision of reproductive health care. As a result, implementation strategies for the nation's population policies focus not only on the provision of affordable family planning services, but they also include a host of other measures, such as: developing programs aimed at the empowerment of women; educating the general public about HIV/AIDS and other sexually transmitted diseases; and ensuring that law-making bodies are well sensitized to population issues. Nigeria's population policy also identifies several means for meeting its objectives. One strategy is to embark on an aggressive information and communication campaign to educate individuals about the importance of maintaining a reasonable family size. The policy also proposes to encourage the use of family planning methods by raising the status of women, to promulgate legislation to eliminate discrimination against women in education and employment, and to increase the age of first marriage to 18 years.

Executing Agency

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

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

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

Recent Changes in Population Policy

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

Two Anglophone African countries, Kenya and South Africa, are in the process of reformulating their population policies. In 1995, Kenya prepared a draft National Population Policy for Sustainable Development that was to replace its current Population Policy Guidelines. The document addresses a wide variety of issues, such as the environment, gender, poverty, disability, youth, and HIV/AIDS. It also outlines demographic, health services, and social services goals, which are to guide the implementation of population programs until the year 2015. A notable inclusion in this draft is its emphasis on the empowerment of women, as well as the improvement of women's social status and role in development, and the elimination of all forms of discrimination against women and girls. But the draft has yet to be adopted by the Kenyan government. In South Africa, the Ministry for Welfare and Population Development also recently released a discussion document inviting public comment on the possible content of a population policy for the nation. This "Green Paper on Population Policy" was intended to stimulate debate on the relationship between population issues and development. It acknowledges that a policy concerning development and population should deal not only with population trends, but also with the environment, resources, production, and patterns of consumption. The Green Paper raises a variety of issues, including, for example, whether or not South Africa should set specific goals in relation to the average number of children a woman or man should have, and what mechanisms, if any, should be available for coordinating activities aimed at women's empowerment.

Government Delivery of Family Planning Services

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

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

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

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

Cost of Family Planning Services

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

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

C. CONTRACEPTION

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

Legal Status of Contraceptives

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

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

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

Regulation of Information on Contraception

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

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

Regional Legal Models

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

D. ABORTION

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

Legal Status of Abortion

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

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

Requirements for Obtaining Legal Abortion

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

Penalties

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

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

Regulation on Abortion Information

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

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

Regional Legal Models

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

E. STERILIZATION

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

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

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

Regional Legal Models

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

F. FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

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

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

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

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

Regional Legal Models

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

G. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

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

Laws Affecting HIV/AIDS and STDs

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

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

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

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

Policies Affecting HIV/AIDS and STDs

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

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

Regional Legal Models

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

H. REPRODUCTIVE TECHNOLOGIES

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

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

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

A. RIGHTS WITHIN MARRIAGE

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

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

Marriage Laws

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

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

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

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

Divorce and Custody Law

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

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

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

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

Regional Legal Models

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

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

B. ECONOMIC AND SOCIAL RIGHTS

Property Rights

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

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

Regional Legal Models

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

Labor Rights

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

Regional Legal Models

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

Rules Governing Credit/ Access to Credit

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

Access to Education

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

Women's Bureaus

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

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

C. RIGHT TO PHYSICAL INTEGRITY

Rape

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

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

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

Regional Legal Models

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

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

Domestic Violence

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

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

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

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

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

Regional Legal Models

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

Sexual Harassment

Most countries in Anglophone Africa have not adapted specific laws prohibiting sexual harassment. Only Kenya specifically criminalizes both physical and verbal sexual harassment. Pursuant to Section 144 of Kenya's Penal Code, an act of physical sexual harassment constitutes a felony, whereas verbal sexual harassment is punishable as a misdemeanor offense.

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

Regional Legal Models

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

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

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

A. REPRODUCTIVE HEALTH AND ADOLESCENTS

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

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

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

B. FEMALE GENITAL MUTILATION AND ADOLESCENTS

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

C. MARRIAGE AND ADOLESCENTS

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

D. EDUCATION AND ADOLESCENTS

See section on Access to Education above.

E. SEX EDUCATION FOR ADOLESCENTS

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

F. SEXUAL OFFENSES AGAINST MINORS

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

V. Conclusion

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

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

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

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

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

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

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