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ICPD+30: Where we are on population policy in Francophone sub-Saharan Africa

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Abstract (150 words)

Thirty years have passed after a major paradigm shift in population policy at the International Conference on Population and Development (ICPD) in 1994. Around the same time in the mid-1990s, the sub-Saharan Africa, as a whole, entered the fertility transition. The measurement of the success in population policy, however, is not straightforward, given the wide variety of socioeconomic progress among the countries. This study will review the trends on population policy in sub-Saharan Africa with a focus on the last 30 years. We will use the data from the World Population Policies Database of the United Nations for the status of government positions. The changes in reproductive health laws (family code, marriage, abortion) will be also reviewed with a particular focus on Francophone countries because this cultural and linguistic group was previously more hesitant to take liberal positions in reproductive behaviors, such as birth limitation with contraceptives and induced abortion.

Introduction

Thirty years have passed after a major paradigm shift in population policy at the International Conference on Population and Development (ICPD) in 1994. Around the same time in the mid-1990s, the sub-Saharan Africa, as a whole, entered the fertility transition. The decline in fertility has been making various consequences. The measurement of the success in population policy, however, is not straightforward, given the wide variety of socioeconomic progress among the countries. This study will review the trends on population policy in its implementation in sub-Saharan Africa with a focus on the last 30 years. We will use the data from the World Population Policies Database of the United Nations Population Division for the status of government positions on population policy. The changes in reproductive health laws (family code, marriage laws, sexual and reproductive laws, abortion laws) will be also reviewed with a particular focus on Francophone sub-Saharan Africa because this cultural and linguistic group was previously more hesitant to take liberal positions in reproductive behaviors, such as birth limitation with modern contraceptives and induced abortion.

We expect to find Francophone countries to increasingly change their positions on population policy implementation for the past thirty years. Reproductive health laws would be adapted to new sociocultural norms based on human rights based approach. Accompanying behavioral changes is expected regarding the birth limitation use of modern contraceptive methods and of induced abortion if situation allows, supposing that marriage pattern changes (later marriage, less polygamous union, decline in marriage rate and increase in divorce rate) have been already taking similar direction everywhere in sub-Saharan Africa. Young generation of women in Francophone sub-Saharan Africa with educated, formally employed, and living in urban areas will be the group

to lead innovative behaviors at the beginning, but we expect this behavioral change to be diffused to other types of women of reproductive age. All of these will contribute to the decline in maternal mortality, unintended pregnancy and unsafe abortion. With increasing convergence on population policy implementation in sub-Saharan Africa, ongoing fertility transition will be accelerated towards its completion once the availability of population policy will reach the critical mass of women in need.

Data and Methodology

The World Population Policies Database of the United Nations Population Division include the data on fertility, sexual and reproductive health, family planning, maternal health, and abortion regarding their policies and laws. Historical trends based on sexual and reproductive health (SRH) related Sustainable Development Goal (SDG) indicators will be analyzed for sub-Saharan African countries. Francophone countries will be compared with Anglophone countries regarding the changes on indicators for the last thirty years. Available Demographic and Health Survey (DHS) data for the past thirty years will be also used to complement population policy trends between Francophone and Anglophone countries. Table 1 shows the summary of the DHS source for years and selected countries (18 Francophone countries and 16 Anglophone countries).

Table 1

SRH related SDGs were defined as follows:

Goal 3. Ensure healthy lives and promote well-being for all at all ages

- Indicator 3.7.1: Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
- Indicator 3.7.2: Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000

women in that age group

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

- Target 4.1: 4.1.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex
- Indicator 4.7.1: Extent to which (i) global citizenship education and (ii) education for sustainable development, including gender equality and human rights, are mainstreamed at all levels in: (a) national education policies, (b) curricula, (c) teacher education and (d) student assessment

Goal 5. Achieve gender equality and empower all women and girls

- Indicator 5.6.1: Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
- Indicator 5.6.2: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education

In this paper, the major research methods employed were secondary data analysis and the review of government reproductive health related policy and regulation documents including family planning, maternal and child health and school health education policies. The focus was given to the following indicators:

- Modern contraceptive prevalence rates for married women and unmarried sexually active women

- Unmet need for family planning (spacing and limiting) for married women and unmarried sexually active women
- Adolescent fertility rates (10-14 years, 15-19 years)
- Liberalization of abortion laws (based on abortion index)
- Comprehensive sexuality education (CSE)

A limitation of the data is related to the most recent period 2020-2024. The number of the DHS was relatively less compared to previous periods (1995-1999, 2000-2004, 2005-2009, 2010-2014, 2015-2019) to aggregate the trends in Francophone or Anglophone countries. Besides, the selection of the indicators for analysis may not have a consensus to aggregate the trends in Francophone and Anglophone countries. In spite of them, this paper will give us an idea for the holistic picture of the SDG SRH issue with available quantitative data after ICPD+30.

Results

Modern contraceptive prevalence rate

Demographic and Health Surveys have collected data on modern contraceptive prevalence rates (CPR) (currently using modern contraceptive methods) for both married women and sexually active unmarried women of 15-49 years old. The data on selected Francophone countries (18) in sub-Saharan Africa were compared with those of Anglophone countries (16) in the past 30 years. The HIV/AIDS response was a major setback for family planning policy implementation between 1995 and 2005. The funding for population policy shifted away from family planning programmes towards the HIV/AIDS related behavioral change and care during that period. The repositioning of family planning, however, emerged after those years, meaning the refocus on investment on

family planning programmes to address unwanted pregnancy and unsafe abortion which is closely related to maternal death. Figure 1 and Table 2 show the trends on the current use of modern contraceptive methods.

Figure 1

Table 2

Figure 1. Modern contraceptive prevalence rates for women of reproductive age 15-49 in Francophone sub-Saharan Africa

Table 2. Modern contraceptive prevalence rates for women of reproductive age 15-49 in Francophone sub-Saharan Africa

The average modern CPR for married women and sexually active unmarried women in Francophone countries in the period 1995-1999 was 6.1% and 27.3%, respectively. They increased to 16.5% and 37.3%, respectively, in the period 2015-2019. In the period 2020-2024, they increased to 30.7% and 37.2%, respectively, but for this period the number of the countries was only three so far, thus rather better looking at the evolution until the period 2015-2019 to evaluate the overall trend. Then, if we look at individual countries, we will see some interesting changes. Burkina Faso had already higher modern CPR of 43.8% for sexually active unmarried women in the period 1995-1999, but what seems to be significant is a rapid increase of modern CPR for married women. It increased from 4.8% in the period 1995-1999 to 31.5% in the period 2020-2024. This may reflect an evolution of the use for the modern contraceptive methods to limit the births. Cameroon increased modern CPR for sexually actively unmarried women significantly from 21.6% in the period 1995-1999 to 42.7% in the period 2015-2019. Congo equally increased modern CPR for sexually active unmarried women from 26.8% in the period 2005-2009 to 43.2%

in the period 2015-2019. Same for Cote d'Ivoire from 26.7% in the period 1995-1999 to 42.6% in the period 2020-2024. Gabon increased it from 30.5% in the period 2000-2004 to 45.0% in the period 2010-2014. Guinea increased it from 31.8% in the period 1995-1999 to 50.7% in the period 2015-2019. Madagascar is an interesting case because both married women and sexually active unmarried women increased modern CPR significantly. For married women, 9.7% in the period 1995-1999 increased to 42.7% in the period 2020-2024, whereas for sexually active unmarried women, it increased from 9.8% to 46.7% in the same period. This may reflect the population policy influence or context change that the government has undertaken in the past 30 years. For Niger, modern CPR for sexually active unmarried women remained high. It was already 44.1% in the period 1995-1999 and remained at the same level afterwards. Senegal is similar to Niger. Modern CPR for sexually active unmarried women was already high at 43.0% in the period 1995-1999 and remained at the same level afterwards. In sum, in spite of individual particular case depending on the contexts, after 30 years Francophone countries made steady progress in increasing modern CPR for sexually active unmarried women.

The average modern CPR for married women and sexually active unmarried women in Anglophone countries in the period 1995-1999 was 26.8% and 35.1%, respectively, already much higher at the time compared with those of Francophone counterparts. They increased to 38.6% and 47.7%, respectively, in the period 2015-2019. In the period 2020-2024, they increased to 38.6% and 47.0%, respectively, but for this period again the number of the countries was only three so far, thus rather better looking at the evolution until the period 2015-2019 to evaluate the overall trend. Then, if we look at individual countries, we will see some interesting changes. Eswatini reached high modern CPR of 47.7% and 62.9% for married and sexually active unmarried women,

respectively, in the period 2005-2009. Gambia's modern CPR was high at 42.0% for sexually active unmarried women in the period 2010-2014. Ghana has gradually increased the modern CPR to 45.7% for sexually active unmarried women in the period 2020-2024. Kenya had already relatively high modern CPRs of 31.5% and 36.2% for married women and sexually active unmarried women, respectively, in the period 1995-1999 and they reached 56.9% and 59.2% in the period 2020-2024. Likewise, Lesotho had high modern CPRs of 35.2% and 46.7% for married women and sexually active unmarried women, respectively, in the period 2000-2004 and they reached 59.8% and 72.1% in the period 2010-2014. Liberia followed a similar pattern as Ghana because the modern CPR for sexually active unmarried women gradually increased to 44.9% by the period 2015-2019. Malawi increased the modern CPRs to 42.2% and 46.3% for married women and sexually active unmarried women, respectively, in the period 2010-2014. They reached 58.1% and 43.2% for the following period 2015-2019. Namibia followed a similar pattern like Kenya as their modern CPRs were already high at 42.6% and 57.5% for married women and sexually active unmarried women, respectively, in the period 2000-2004 and they reached 55.3% and 77.6% by the period 2010-2014. Nigeria followed the patterns of Ghana and Liberia by attaining the modern CPR of 42.4% for sexually active unmarried women in the period 2005-2009, even though the rate dropped to 27.7% in the period 2015-2019. Rwanda shows an interesting evolution of the modern CPRs as they reached 46.3% and 37.6% for married women and sexually active unmarried women, respectively, in the period 2010-2014. The higher rate for married women compared to that for sexually active unmarried women may suggest more limiting needs for family planning in the country with reinforced population policy implementation. Both rates increased to 58.4% and 48.1% by the period 2015-2019. Sierra Leone followed the patterns of Ghana, Liberia and Nigeria by increasing the modern CPR to 56.3% for sexually active unmarried women in the period 2010-

2014 and remained at the same level for the following period. South Africa experienced earlier fertility decline thus they had high modern CPRs of 55.1% and 67.8% for married women and sexually active unmarried women, respectively, in the period 1995-1999. And the rates remained high at 54.0% and 64.2% in the period 2015-2019. Tanzania followed the patterns of Western African countries by reaching high modern CPR of 44.7% for sexually active unmarried women in the period 2010-2014 and maintained the same level of 45.8% for the following period 2015-2019. Likewise, Uganda achieved 44.0% for sexually active unmarried women in the period 2000-2004 and remained at the same level at 47.3% in the period 2015-2019. Zambia shows an interesting evolution. The modern CPR for sexually active unmarried women reached 43.5% in the period 2005-2009 and then the rates remained high but reversed for the following period 2015-2019, that is the rates were 44.8% and 37.7% for married women and sexually active unmarried women. The modern CPR of 47.5% remained higher for married women than that of sexually active unmarried women at 43.1% in the following period 2015-2019. As in the case of Rwanda, limiting needs for family planning seems to have increased during those periods possibly related to population policy implementation. Zimbawe had already high modern CPRs of 50.4% and 53.5% for married women and sexually active unmarried women, respectively, in the period 1995-1999, reflecting also their earlier fertility decline pattern. The rates became higher at 65.8% and 66.4% by the period 2015-2019. In sum, Anglophone countries as a group had higher modern CPR than that of Francophone counterparts in the period 1995-1999. Then increased the prevalence for both married women and sexually active unmarried women after 30 years. All the Anglophone countries have been benefiting from population policy implementation. Some countries such as Rwanda and Zambia even reversed the prevalence between married women and sexually active unmarried women with possibly the reinvigoration of family planning programmes to respond to

limiting needs.

In terms of the comparison between the two linguistic groups, modern CPR for married women and sexually active unmarried women have increased over the past 30 years in both Francophone and Anglophone countries. The gap between the two group seems to be narrowing in particular for sexually active unmarried women.

In the past 30 years, rapid economic and social change has been accelerated in the world. The effects of economic liberalization, migration, urbanization and globalization have been widely spread in sub-Saharan Africa. In the area of sexual and reproductive health, major shifts have been also happening in terms of the change in sexual attitudes and behaviors. With waning social pressure, premarital sex and co-habitation by young people have been gradually gaining the acceptance. It is evident that those young people will need modern contraceptives in order to prevent unwanted pregnancy. Thus, this indicator on modern CPR is useful to measure the progress on universal access to family planning services. The family planning programme will reduce unwanted pregnancy and unsafe abortion.

Unmet need for family planning

The table 3 shows the unmet need for family planning in Francophone countries in sub-Saharan Africa in the past 30 years. Comparison has been made against Anglophone countries. For Francophone countries, both spacing needs and limiting needs for married women have changed little from 19.1% and 8.0% in the period 1995-1999 to 18.6% and 8.6% in the period 2015-2019.

For sexually active unmarried women, on the other hand, spacing needs increased from 25.5% to 36.5% in the same time span, whereas liming needs have remained at the same level from 3.7% and 4.6%. This finding corresponds to the modern CPR progress for sexually active unmarried women in Francophone countries. If we look at individual countries, Benin (46.7% in 2015-2019), Chad (52.4% in 2010-2014), Mali (49.4% in 2015-2019), Niger (49.6% in 2010-2014) and Senegal (45.0% in 2015-2019) show a similar trend in terms of the increase in spacing needs for sexually active unmarried women. Mauritania and Rwanda show an interesting increase in limiting needs for sexually active unmarried women. Mauritania recorded 34.6% for limiting needs in the period 2000-2005. Rwanda recorded 25.3% in the period 2000-2004 and 31.5% in the period 2005-2009, respectively, for limiting needs. They were higher than spacing needs for sexually active unmarried women. This finding needs to be analyzed with individual country context and its population policy.

Table 3

Table 3. Unmet need for family planning in Francophone countries in sub-Saharan Africa, 1995-2024

For Anglophone countries, both spacing needs and limiting needs for married women have changed much also from 14.7% and 10.3% in the period 1995-1999 to 13.1% and 7.7% in the period 2015-2019. For sexually active unmarried women, spacing needs increased from 23.7% to 28.6% in the same time span but not as big as that of Francophone countries. Liming needs remained at the same level from 9.7% and 6.5%. For individual countries, Gambia (44.2% in 2015-2019), Liberia (43.6% in 2010-2014) and Nigeria (43.9% in 2015-2019) show a similar trend in terms of spacing needs increase for sexually active unmarried women. Lesotho shows an interesting case where limiting needs are greater than spacing needs for both married women and

sexually active unmarried women. In the period 2000-2004, 21.4% and 26.3% were unmet needs for limiting and they decreased to 9.9% and 11.15 by the period 2010-2014 but they were always greater than spacing needs. Lesotho experienced an earlier fertility decline, thus the evolution of the unmet needs may correspond to their fertility transition. This finding may merit a further analysis with individual country context and its population policy.

Adolescent birth rate

Tables 4 and 5 show the evolution of adolescent fertility rates in Francophone countries in sub-Saharan Africa in the past 30 years. Comparison has been made against Anglophone counterparts. The majority of adolescent pregnancies have declined both 10-14 and 15-19 year age groups. The legal reforms increased the minimum legal age of marriage for women to 18 years old for most of the countries. The advancement for girls' education (primary and lower secondary) has played a major role in reducing adolescent pregnancies. The adolescent fertility rates amongst 10-19 years old is further indicative of unmet need for contraception among sexuality active unmarried girls. It is evident that the fertility decline is underway in vast majority of the countries in sub-Saharan Africa, but the improvement in the ability of young women to prevent unintended pregnancy is significantly important in order to reduce unsafe abortion rates. Therefore, the liberalization of abortion laws is an important part of population policies.

Table 4

Table 5

Tables 4 and 5. Adolescent fertility rates in Francophone sub-Saharan Africa (birth numbers per 1,000 women)

Figure 2

Figure 2. Adolescent fertility rates (10-19 years old) in Francophone sub-Saharan Africa during 1995-2024 (‰)

Tables 4 and 5 as well as Figure 2 show the evolution of the age specific fertility rates for adolescents of 10-14 year and 15-19 year between Francophone and Anglophone countries. For the 10-14 year group, the number is relatively smaller for both language groups, but a significant decline is obvious for the 15-19 year group in Francophone countries from 142 in the period 1995-1999 to 104 in the period 2015-2019 with 27% reduction. On the other hand, adolescent fertility rates have rather stagnated for Anglophone countries from 116 in the same time span. Francophone countries have been narrowing the gap in adolescent fertility rates with Anglophone counterparts. And this could be an evidence of a convergence of fertility behavior in younger generation, even though this may need further analysis.

Induced abortion (abortion laws)

Abortion rate is defined and calculated as the number of induced abortions per 1,000 women between the ages 15 and 44 years. Safe abortion is a key dimension of sexual and reproductive rights. In many contexts, attention and advocacy are appropriately focused on overcoming legal, social and health systems constraints to access by women to this service. With the exception of medical reasons, abortions are generally the result of unintended pregnancies. If people have good access to effective contraceptives so that the majority of pregnancies are planned and desired, and there are very few hidden unsafe abortion, the abortion rate should be low. The abortion rate can be used as an indicator to reflect women's access to and the quality of contraceptive services, since it implies that those women seeking abortions have either not used contraceptives or experienced contraceptive failure.

In sub-Saharan African context, collecting abortion data remains difficult because of either illegal or highly restrictive legal conditions, or even legally allowed still a high proportion of abortions are carried out clandestinely by untrained providers with non-recommended methods. Efforts are being made to overcome this difficulty as well as underreporting and underestimation related with social stigma by estimating the incidence indirectly. But further progress will be required in this area. As of 2015-2019, an estimated 33 abortions occur each year per 1,000 women age 15-49 in sub-Saharan Africa (Bankole et al. 2020). Sexually active adolescents have far higher rates of abortion than all women of reproductive age. Abortion remains as high risk in sub-Saharan Africa compared with other world regions. As of 2010-20014, 77% of abortions in sub-Saharan Arica were unsafe, compared with the global average of 45%. Unsafe abortions are the sum of those that are less safe (done by either an untrained person or with a nonrecommended method) and least safe (done by an untrained person using a nonrecommended method). In most sub-Saharan countries, legal restrictions and stigma still compel women to undergo clandestine abortions, the safety of which cannot be ensured. Nearly all abortions result form unintended pregnancies. Sub-Saharan Africa has the highest unintended pregnancy rate of any world region, at 91 per 1,000 women.

DHS started collecting abortion data in the recent round (2021-2022). Table 6 shows five countries (Burkina Faso, Cote d'Ivoire, Ghana, Kenya, Tanzania) in the region for comparison. It is still early to compare between the groups between Francophone and Anglophone countries.

Table 7 shows the evolution of the abortion law legalization based on the abortion index. The index

was calculated by giving 1 if a reason for abortion is allowed legally based on seven major reasons for the justification by the law: 1) Life threatening; 2) Physical health; 3) Mental health; 4) Rape; 5) Foetal impairment; 6) economic or social reasons; and 7) On request. The evolution of the degree of legalization show tendencies and characteristics. In Africa, Maputo Plan of Action, adopted by African Union in 2003, is a legal framework for the operationalization of the continental policy on sexual and reproductive health and rights. It includes the acceleration of legal reforms for safe abortion by allowing abortion when the woman's life or physical or mental health is threatened and in base of rape, incest and grave foetal impairment. Prior to the Cairo Conference in 1994, many countries did not allow abortions for most of the cases. Eight countries (Comoros, Cote d'Ivoire, Togo, Ghana, Kenya, Lesotho, Liberia, Zambia) did not allow abortions even if a woman's life is threatened between the 1960s and 1980s. Many countries (Benin, Burkina Faso, Central African Republic, Chad, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Gabon, Madagascar, Mali, Mauritania, Niger, Senegal, Botswana, Eswatini, Kenya, Lesotho, Malawi) did not allow abortions for physical or mental health reasons until the 2000s. The implementation of the Maputo Plan of Action has contributed to the legal reforms afterwards. Thus, there are increasing number of countries with ongoing liberalization of the abortion laws. Many countries (Benin, Burkina Faso, Burundi, Central African Republic, Chad, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Guinea, Togo, Botswana, Eswatini, Ghana, Lesotho, Liberia, Namibia, Rwanda, South Africa, Tanzania, Uganda, Zimbabwe) also relaxed the laws to allow abortions for rape and foetal impairment reasons since the 2000s. In sub-Saharan Africa, countries fully liberalized abortion laws with economic and social reasons or on request from a woman are relatively few. Among Francophone and Anglophone countries, Benin, South Africa and Zambia are pioneers. Zambia's case is interesting because they allowed abortions with economic and social

reasons starting from the 1980s even if they do not allow abortions for rape reason. Further analysis with social setting will be required. For South Africa, it's fertility decline started earlier and they have liberalized abortion law with the adoption of the Choice on Termination of Pregnancy Act in 1997. Benin is the most recent country to have fully liberalized abortion law in 2021. Considering its French colonial history with strict restrictions on population policy (ban on contraception and abortion), this new movement is a highly symbolic case that colonial legacy can be severed with each country's political willingness.

Table 7

Countries in sub-Saharan Africa can be classified into six categories, according to the reasons for which abortion is legally permitted: 1) Prohibited altogether (no explicit legal exception); 2) To save life of a woman; 3) To save life of a woman/preserve physical health; 4) To save life of a woman/preserve mental health; 5) To save life of a woman/preserve physical or mental health/socioeconomic reasons; and 6) Without restriction as to reason (Table 8). In the past especially until the 1980s, Francophone countries were more conservative and reluctant to liberalize their abortion laws than Anglophone counterparts. But today it seems that both Francophone and Anglophone countries are increasingly liberalizing the abortion laws.

Table 8

Comprehensive sexuality education

Comprehensive sexuality education (CSE) is an important component of reproductive health and is also an explicit SDG target under the education goal. There is strong international evidence that CSE can reduce unwanted pregnancy and associated abortion and prepare young people to better prevent STIs (Herat et al. 2018). This indicator is therefore strongly linked to the above indicators

of contraceptive prevalence, adolescent fertility and abortion. The indicator recommended by the Guttmacher Institute is "proportion of schools that serve students in the age range of 12-17 years in which comprehensive sexuality education is available." However, CSE remains as a sensitive issue even if all stakeholders including health care provides, health department officials, education department officials and researchers are aware of the issues of premarital sex and unwanted pregnancies and associated abortion among young people and also acknowledges the importance of CSE. Officials fear being held responsible for any unwanted consequences of CSE by being criticized for encouraging sex among young people.

Table 9 shows the comparison for the provision of CSE between Francophone and Anglophone countries with the 2021 UNESCO report. Francophone countries provided 76-100% coverage in 6 out of 17 countries (35%) at primary schools, while the coverage at secondary schools was in 8 out of 17 countries (47%). As for Anglophone countries, they provided 76-100% coverage in 9 out of 16 countries (56%) at primary schools, while the coverage at secondary schools was in 10 out of 16 countries (63%). Anglophone group may be slightly in advance in expanding the CSE throughout the educational system in their countries, but Francophone group may catch up and reduce the existing gap in the near future as they are making efforts to make sexuality education increasingly comprehensive and expand coverage with the aim of reaching all learners at different stages of their education. There are set-backs in some contexts, but progress has been made in many countries in sub-Saharan Africa.

Table 9

Discussion: Implications for action

In comparison to many other health goals, SRH is very broad, covering many different but interconnected issues, and is also contentious. Despite the internationally agreed definition in indicators, SRH in different socioeconomic and cultural contexts has been understood and interpreted differently and is subject to contention, particularly with regard to sexual and reproductive rights.

Based on the existing data collection and reporting systems, majority of the sub-Saharan African countries need to improve data on abortion rate and CSE. The number of abortion tends to be underestimated. The officially reported number of the abortion may not correctly include the number of abortions carried out in private facilities whether clandestine or not. Another major source of underreporting is that official data does not include the use of medical abortion (using mifepristone and misoprostol) when drugs are bought from pharmacies. The growing use of misoprostol to induce abortion could make clandestine abortions safer, as demonstrated in Latin American context.

With increasing universal education including the expansion of girls' education in sub-Saharan Africa, further development of CSE both at primary and secondary schools are absolutely useful. Both the coverage and contents of the CSE will need to be improved so that girls can avoid unwanted pregnancies and unnecessary abortion. This should be a part of the adolescent reproductive health strategy.

Conclusion

This paper reviewed selected indicators (modern CPR, unmet need for family planning, adolescent

fertility rate, abortion laws, CSE coverage) on their progress at ICPD+30 with a focus on Francophone countries in sub-Saharan Africa. They showed major progress and narrowed the gap in population policy implementation in reference to those of Anglophone countries. Convergence on reproductive behavior in sub-Saharan Africa is a likely scenario together with ongoing fertility transition in the region.

The desire for smaller families is increasing, but in order to have smaller families, women need access to modern contraceptives to limit and space pregnancies. Otherwise, many women will have unintended pregnancies that they resolve through abortion. Many of these abortions will be clandestine, and thus likely unsafe, unless the strong stigma attached to abortion – which is reflected in the region's restrictive laws – is addressed.

Further data collection efforts in induced abortion as well as the refinement of its indirect estimates methodology will be necessary. The reduction in unwanted pregnancy for adolescents by way of strengthened family planning programme to expand modern contraceptive provision, and by legal and social reforms to ease more liberal options for abortion will require urgent policy attention. More detailed indicators on CSE that can cover comprehensive contents are also desperately needed in sub-Saharan Africa to monitor progress towards SDG sexual and reproductive health and rights targets.

Key words: Francophone sub-Saharan Africa, ICPD+30, population policy, sexual and reproductive and health and rights,

References

Abubakari, Shamsiyatu, Vincent Uwumboriyhie Gmayinaam, and Eric Osei. 2023. “Knowledge and attitude towards Ghana’s abortion law: A cross-sectional study among female undergraduate students,” *Pros Global Public Health* 3(4): 1-13.

Bankole, Akinrinola, Lisa Remez, Onikepe Owolabi, Jesse Philbin, and Patrice Williams. 2020. *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress*. Guttmacher Institute, New York.

Fang, Jing, Shenglan Tang, Xiaoping Tan, and Rachel Tolhurst. 2020. “Achieving SDG related sexual and reproductive health targets in China: What are appropriate indicators and how we interpret them?,” *Reproductive Health* 17(84): 1-11.

Herat, Joanna, Marina Plesons, Chris Castle, Jenelle Babb, and Venkatraman Chandra-Mouli. 2018. “The revised international technical guidance on sexuality education – a powerful tool at an important crossroads for sexuality education,” *Reproductive Health* 15(185): 1-4.

Sedgh Gilda, Jonathan Bearak, Susheela Singh, Akinrinola Bankole, Anna Popinchalk, Bela Ganatra, Clementine Rossier, Caitlin Gerdts, Ozge Tuncalp, Brooke Ronald Johnson Jr., Heidi Bart Johnston, and Lesotine Alkema. 2016. “Abortion incidence between 1990 and 2014: Global, regional, and subregional levels and trends,” *Lancet* 388(10041): 258-267.

UNESCO. 2021. *The Journey Towards Comprehensive Sexuality Education: Global Status Report*. Paris.

United Nations. 2021. *World Population Policies 2021: Policies Related to Fertility* (UN DESA/POP/2021/TR/NO.1). Population Division, New York.

WHO. 2011. *Unsafe abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*. Italy.