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Trends of abortion in Francophone sub-Saharan Africa

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Abstract (150 words)

Francophone countries in sub-Saharan Africa had been more resistant to induced abortion. Their cultural heritage from France had been influential in strengthening their pronatalist position regarding contraception and abortion. Most of them inherited the judicial system and cultural value from France, which have been transmitted to Francophone countries. However, cultural and behavioral changes in reproductive health have begun in Francophone sub-Saharan Africa since the mid-1990s after the paradigm shift on population policy with the International Conference on Population and Development (ICPD) in 1994. Some women have started to use contraception for birth limitation. Induced abortion to prevent unintended pregnancy has been increasingly liberalized in some settings. In this study, the changing contexts for induced abortion in Francophone countries will be reviewed. Recent step undertaken by Benin to legalize abortion in most circumstances shows that Francophone countries may be overcoming their cultural barriers and adapting universal human rights based reproductive behaviors.

Introduction

Francophone countries in sub-Saharan Africa had been more resistant to induced abortion. Their cultural heritage from France had been influential in strengthening their pronatalist position regarding contraception and abortion. The treatment of abortion by a society is undoubtedly linked with attitudes toward family planning and therefore closely tied to policies on contraception. Most of the Francophone countries inherited the judicial system and cultural value from France, which have been transmitted to Francophone countries, including abortion law (Knoppers et al. 1990). However, cultural and behavioral changes in reproductive health have begun in Francophone sub-Saharan Africa since the mid-1990s after the paradigm shift on population policy with the International Conference on Population and Development (ICPD) in 1994. Some women have started to use contraception for birth limitation. Induced abortion to prevent unintended pregnancy has been increasingly liberalized in some settings. In this study, the changing contexts for induced abortion in Francophone countries will be reviewed. Recent step undertaken by Benin to legalize abortion in most circumstances shows that Francophone countries may be overcoming their cultural barriers and adapting universal human rights based reproductive behaviors.

Benin joined the list of African countries that allow women to have abortions legally and safely. Tunisia, South Africa, Cape Verde, and Mozambique have similar liberal legislation like Benin. Anglophone countries in sub-Saharan Africa had been relatively more open and liberal in accepting induced abortion as a choice for the control of reproduction. We expect that increasing number of Francophone countries are taking steps to liberalize induced abortion in the last thirty years so that they can catch up the status of Anglophone countries. This change would be led by younger generation of women with educated, formally employed, and living in urban areas at the beginning,

but increasing liberalization of abortion laws will allow other types of women of reproductive age to follow the new practice. Thus, breaking the cultural barrier on reproductive behaviors for Francophone countries will eventually lead to a convergence of fertility outcomes in sub-Saharan Africa and the completion of its fertility transition.

Historical context

Cabo Verde, Mozambique and Sao Tome and Principe have more liberal abortion laws in sub-Saharan Africa. Women are allowed to resort to induced abortion upon their request if the pregnancy is within the limit of 12 weeks. They are former colonies of Portugal, even though Angola, another former colony of Portugal, has not adopted the liberal policy on abortion. Otherwise, South Africa and recently Benin have adopted the liberal position on induced abortion. Considering more traditional stance with historical resistance of artificial intervention on reproductive behavior of former French colonies, notably the use of modern contraception and induced abortion for the birth limitation, the development and adoption of the liberal abortion laws in Benin can indicate a changing trend in the recourse to induced abortion in sub-Saharan Africa.

This study considers the variation in abortion laws by colonial origin. Many countries that gained independence in the 1960s maintained the laws of Britain or France at that time. Since the time of independence, British and French laws have liberalized significantly, but former colonies have more often than not maintained the laws of the 1960s, or liberalized to a lesser extent. Thus the starting point matters significantly for what countries experience today. Of note, those countries that have British colonial origin have more liberal laws than those under French influence. The

abortion law for example is on average 46% of the maximum possible degree of liberalization in countries with British colonial origin, whereas it is only 27% of the maximum possible degree of liberalization in countries with French colonial origin

Data and Methodology

The World Population Policies Database of the United Nations Population Division as well as the Global Abortion Policies Database of the World Health Organization will be used to assess historical trends and the analysis of country's positions, laws, and policies on induced abortion. Data for the abortion law is generated for information summarized by the United Nations Population Division (2001, 2002, 2014, 2017). United Nations Population Division has been releasing a series of reports on abortion policies in the world concerning induced abortion and the context within which abortion took place since the 1960s. The report based its source on the Population Policy Data Bank maintained by the Population Division. The country profiles catalogues abortion policies on seven grounds on which abortion was permitted. These included: "To save the life of the woman", "To preserve physical health", "To preserve mental health", "Rape or incest", "Fetal impairment", "Economic or social reasons", and "Available on request". It noted additional requirements such as report of psychological and social problems by the woman, counseling before abortion is performed, and whether abortion must be performed by a physician in a public or private health institution.

Results

Abortion rate is defined and calculated as the number of induced abortions per 1,000 women between the ages 15 and 44 (or 49) 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. The difficulty stems from the lack of health systems data and the typically high levels of underreporting in surveys that ask women directly about their abortion experience. Abortion remains one of the most sensitive sexual and reproductive behaviors because of social stigma, privacy concern, and fear of legal sanctions (Singh et al. 2019). 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. The proportion of pregnancies in Africa ending in abortion each year, estimated at 15% in 2010-2014, has changed little since 1990-1994. Africa has the highest number of abortion-related deaths. In 2014, at least 9% of maternal deaths (or 16,000 deaths) in Africa was from unsafe abortion. An estimated 21.6 million unintended pregnancies occur each year in Africa; of these, nearly four in

10 (38%) end in abortion. 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 from 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 1 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 1

Table 2 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. At ICPD, a paradigm shift took place in sexual and reproductive health and rights as well as gender equality promotion and it has become a leading cause for further liberalization of abortion rights afterwards. 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 2

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 3). 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 3

Figure 1 shows the evolution of the abortion laws liberalization index based on the table 1 data. It is clear that both Francophone and Anglophone groups have been liberalizing abortion laws over the decades. We particularly notice that improvements are significant at first during the 1970s and later in the 2010s. We need further verification but these changes could be attributed to the woman's rights movement in the 1970s, including the adoption of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and to the implementation of the Maputo Plan of Action in the 2010s. Akinrinola et al. (2020: 12) reported that 21 out of 48 sub-Saharan African countries reformed their penal codes or passed laws to expand the legal grounds for abortion since 2000. They consider that the inclusion of abortion in African Union's women's rights protocol, the Maputo Protocol adopted in 2003, helped the acceleration of the legal reform on abortion in sub-Saharan Africa.

Figure 1

Country case studies

Senegal

As for population policy, Senegal is the pioneer in Francophone sub-Saharan Africa. They adopted its national population policy in 1988 and started the national family planning programme in 1991.

Their position on the use of family planning was that of spacing; however, thus the decline in fertility has been slow in its pace. Senegal's position on induced abortion has been one of the most traditional and restrictive in the world. Conservative social norms, religion, and the value placed on large families have resulted in broad public support for strict legal restrictions on abortion, many of which date back to laws imposed by France in the nineteenth and twentieth centuries. The 1920 French colonial law was repealed in 1980, but replaced by a new law asserting similar restrictions. In principle, abortion is illegal in all cases except for a life threatening case to save a woman's life. Those who attempt an abortion for themselves, and those who provide abortions for others, are penalized with up to five years in prison and fined. Groups in Senegal have long advocated for the legalization of abortion in cases of rape or incest, to prevent people from making the impossible choice between family and an unacceptable pregnancy. However, conservative religious clerics strongly oppose law amendments. Parents, primarily women, may view infanticide as their only option because legal pregnancy termination is not available (Moseson et al. 2019).

Benin

Benin has a colonial past that had shaped restrictions on access to safe abortion. For many years, the "French Law of 1920" prohibited access to both abortion and contraception. This law was repealed in 2003 in Benin as part of legislation on sexual and reproductive health. Abortion became legal in Benin in cases of risk to the woman's life, rape, or incest, and incases of foetal impairment. However, in practice, access to safe abortion has been more theoretical than actual. In fact, Benin took two steps to liberalize abortion. In 2013, new law allowed abortion when the pregnancy put the life or health of the mother at risk, as well as in case of rape, incest, or foetal impairment. Then, in October 2021, Benin's Parliament passed a new legal amendment to the 2003 Law on Sexual

and Reproductive Health legalizing elective abortion. With the amendment, Benin rather completely liberalized the abortion with social and economic reasons, or on request (Omondi et al. 2023).

Kenya

Kenya is famous for its early acceptance on neo-Malthusian and liberal position on the use of modern contraceptive methods to curb rapid population growth. However, Kenya's position on abortion had been rather far from liberal. While the national population policy was declared in 1967, the first country in Anglophone sub-Saharan Arica, and its national family planning programme was adopted in 1968, induced abortion was not at all allowed until the 1980s. Kenya had maintained its traditional position against abortion. The 2010 Kenyan constitutional referendum that introduced article 26 broadened access to abortion by allowing it for maternal health reasons. Prior to the 2010 referendum, criminalization for abortion was common, especially that of abortion providers. The 2010 Constitution permits safe abortion in a wide array of circumstances and is complemented by county laws that are increasingly emerging to allow for safe abortion. But there are still conflicts in Kenya between the Constitution and the penal code, which criminalizes abortion as a felony punishable by seven to fourteen years' imprisonment for the client and the provider. These contradictions discourage women from seeking care and shape service providers' perceptions of abortion (Omondi et al. 2023).

South Africa

Abortion was first legalized in South Africa under the Abortion and Sterilization Act, 1975. This law stated that women could access pregnancy terminations if; continuing the pregnancy could be life-threatening or cause serious health issues, continuing the pregnancy could be of severe risk to

the woman's mental health, the child is likely to be born with significant irreparable physical or mental defects, or, the foetus was conceived by means of rape or incest. This was later overridden by the Choice on Termination of Pregnancy Act of 1996 which allows all women to access abortions in their first trimester, and on the above-mentioned terms after week 13 of the pregnancy. In South Africa, a woman of any age can get an abortion on request with no reasons given if she is less than 12 weeks pregnant. The Act serves as a global as well as regional model of reform with a rights-based framework in the area of abortion laws, even though its implementation remains inadequate as women still face serious barriers in access to lawful services with social and legal challenges (Pizzarosa and Durojaye 2018).

Amid the struggle for democratization prior to 1994, feminist arguments for abortion services tended to focus on public health needs rather than a choice- or rights-based framework. During this time, many of those opposing apartheid believed that gender equality needed to take a backseat to racial equality. Eventually, advocates' public health rhetoric addressed the racial inequity in South Africa's maternal mortality rate, tying these issues of equality together. In 1994, South Africa's maternal mortality ratio was 69 deaths per 100 000 live births, compared with a regional maternal mortality ratio of 944 deaths. However, a study conducted the same year found that over 90% of the estimated 45 000 women admitted to hospital for incomplete abortion were black by apartheid-era classification, and all 425 women who died from illegal abortion were black (Favier et al. 2018). The push towards women's rights and gender equality for the adoption of the Programme of Action at the International Conference on Population and Development in 1994 may have contributed to South Africa's reform on abortion laws.

Zambia

Zambia is one of the few countries in Africa to allow termination of pregnancy on a wide range of legal grounds in particular with broad socio-economic grounds since the 1980s; however, unsafe abortion is high as multiple barriers to care remain. In addition, in spite its relatively liberal stance by allowing economic and social reasons to justify induced abortion, curiously Zambia had not allowed abortion for rape cases in terms of humanitarian and moral/ethical reasons until the criminal code was amended in 2005. The Zambian case is not easily placed into standard categories of liberal or restrictive abortion laws as restrictive elements were in focus when the Zambia Termination of Pregnancy Act was passed in 1972 which was drafted on the basis of the United Kingdom Abortion Act of 1967 (Haaland et al. 2019).

The Termination of Pregnancy Act of 1972 states that an abortion may take place if the continuation of the pregnancy involves a risk to the pregnancy woman's life, physical or mental health; a risk to the health of any existing children; or if there is a substantial risk of birth abnormalities.

Conclusion

We demonstrated associations and trends observed across countries and across time using the aggregate liberalization scores for abortion laws, which would have been difficult to compare without the standardized, systematic collation of the laws from each country and year. The abortion index allowed us to summarize trends between Francophone and Anglophone countries at ICPD+30. Most of the countries seem to have taken steps to advance the liberalization of abortion with time. The acceleration has been expected with further operationalization of the Maputo Plan of Action. Francophone countries are no exception and catching up towards the liberalization of abortion in spite of their colonial and cultural heritage.

Reducing unsafe abortion will directly reduce maternal deaths. Ethiopia legalized its abortion in 2005. Within a decade of liberalizing the penal code, the proportion of maternal deaths attributable to unsafe abortion dropped from 32% to less than 10% (Feyssa and Gebru 2020). Ghana and South Africa are also other examples that followed same paths. The use of misoprostol for abortion is not the norm in Francophone countries, but at least some educated and well-off women are already using it as an alternative option to avoid unintended pregnancy as it happened in Latin American countries some decades earlier. Many countries started including misoprostol on the essential medicine list, even though the approval is not for induced abortion purpose but for other reproductive health indications. The demand for medical abortion is growing in Anglophone countries in sub-Saharan Africa as the pharmaceutical system is more liberal than that of Francophone countries, with greater readiness to integrate new medicines, which are more easily distributed through multiple wholesalers, pharmacies, and drugstores in the private sector. Anglophone countries have been influencing some behaviors of Francophone countries in sub-Saharan Africa as part of the globalization process, this may include reproductive behavior and abortion rights.

Key words: abortion law, Francophone sub-Saharan Africa, induced abortion

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