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REPRODUCTIVE RIGHTS: A COMPARATIVE ANALYSIS OF ABORTION REGULATIONS AND THE CASE OF REFORM IN THE REPUBLIC OF BENIN

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Abstract Induced abortion remains controversial due to traditional, moral, political, and religious reasons. Although the common opinion about the illegality of abortion is indicated in medical conditions, its regulation varies widely according to the country. Abortion is available to women on request in many countries, while in others, there is restriction or prohibition altogether. In the contest when some countries end the nationwide right to abortion, the Republic of Benin in 2020 broadened the social grounds, allowing abortion up to 12 weeks of gestational age. This paper aims to overview abortion legislation in selected countries and to compare them to the reform in the Republic of Benin, which became one of the several African countries broadly permitting abortion within 12 weeks of amenorrhea.

Keywords
induced abortion, Case of Benin Republic, reproductive rights, comparative analysis, health reforms

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1 Introduction

The National Center for Health Statistics, the Centers for Disease Control and Prevention, and the World Health Organization (WHO) all define abortion as any pregnancy termination (spontaneous or induced) prior to 20 weeks gestation or with a fetus born weighting <500 g (Hoffman et al., 2016). Although induced abortion (IA) is a worldwide intervention and is performed daily, its liberalisation is a subject of intense controversy. Once established, it sometimes poses both a challenge and a right to health, considering the dangers of illegal abortions. While some defend access to IAs as a human right, others condemn a woman's choice of sexual and reproductive rights in the name of the embryo's right to life (Guillaume & Rossier, 2018, p. 218). According to the Center for Reproductive Rights (CRR), over the past few decades many decisions have been taken to guarantee women's access to IAs, with approximately 50 countries liberalising abortion laws (CRR, 2022). The main religious points of view are against IAs as an affront to the right to life because they imply ending the life of the fetus, i.e., killing an innocent human being (Shakhatreh et al., 2022, p. 373).

IAs laws around the world vary considerably. Some countries permit abortion on a woman's request, while others restrict it or prohibit it altogether. In the Russian Federation, for example, laws enable access to legal IAs in life-threatening medical conditions or when pregnancy results from rape (the only social indication for IA) and at a woman's request. Over the last several years the Republic of Benin has reformed its IA laws. As of December 2020, IAs are permitted up to 12 weeks of gestational age[1]. In contrast to Beninese reform, less than a year later (on June 24, 2022), the United States of America (USA) Supreme Court overturned the Roe v Wade case, ending the nationwide right to IAs.[2] This decision enabled each state to legalise or prohibit abortion. Consequently, IA laws in the USA now vary more widely than ever (Gerstein & Ward, 2022).

[1] Loi № 2021-12 du 20 décembre 2021 modifiant et complétant la loi № 2003-04 du 03 mars 2003 relative à la santé sexuelle et à la reproduction. République du Bénin, Présidence de la République.
[2] Supreme Court of the United States. (2022). Dobbs v. Jackson Women's Health Organization. Retrieved from https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf (17 November 2023).

Restricting or banning access to IAs does not reduce the rates of abortions. Whether they are legal does affect how safe they are and, subsequently, the abortion-related maternal death (MD) rate. According to WHO data, in countries that completely ban abortions or where it is permitted only to save the woman's life or to preserve her physical health, only 25% of IAs are safe, whereas in countries where abortion is legal on broader grounds, nearly 90% are performed safely (WHO, 2017). Therefore, legal or not, IAs were and are still performed and will continue to occur. Women who do not have access to a legal IA, unfortunately, pursue them illegally ("homemade" or "criminal intervention"), exposing their lives to threats and even to death. Then, every unintended pregnancy, as well as unsafe IA and abortion-related death or disability, must be prevented through many measures – supportive policies and financial commitments, providing comprehensive sex education, a wide range of contraceptive methods (including emergency contraception), accurate family planning and counselling, and access to safe and legal IAs. There is evidence that the provision of safe and legal abortion is essential for ensuring universal access to sexual and reproductive healthcare services (WHO, 2017). Given the above, we overviewed the current data about abortion laws in selected countries and analysed the reforms instituted by the Republic of Benin, expanding the socio-economic grounds for abortions.

2 Prevalence of abortion

Abortion remains a contentious issue globally, with various regions and countries grappling with its legality, accessibility, and societal implications. In many parts of the world, women seek abortions for a multitude of reasons, including but not limited to health concerns, economic instability, social stigma, and personal circumstances such as rape or incest (Supreme Court of the United States, 2022). Restrictive laws, lack of access to contraception, inadequate sexual education, and cultural taboos often contribute to the prevalence of abortion, particularly in regions where reproductive rights are limited.

The prevalence of abortion varies significantly across countries and regions, influenced by factors such as legal frameworks, healthcare infrastructure, socio-economic status, and cultural attitudes towards sexuality and reproductive health. About 73 million IAs are performed worldwide each year, with 97% occurring in developing countries (WHO, 2023). Approximately 29% of all pregnancies and 61%

of unintended pregnancies end in IAs globally (WHO, 2021). Adolescent girls aged 15-19 years constitute a significant portion of women undergoing IAs annually, with approximately 9 million pregnancies out of an estimated 21 million resulting in IAs in developing regions (Darroch et al., 2016). When performed according to WHO guidelines, the risk of severe complications or death from IAs is low. Approximately 55% of all IAs are conducted safely in medical facilities by trained health workers using modern methods appropriate to the gestational age (WHO, 2021). However, the remaining 45% are classified as unsafe, with almost 31% categorised as "less safe" and 14% as "least safe," often performed under dangerous conditions by unskilled providers (WHO, 2017). Developing countries bear the brunt of unsafe IAs, with over 97% occurring in these regions. In sub-Saharan Africa, the under-registration of abortion-related maternal deaths is a significant issue, leading to underreporting and misclassification of deaths attributed to IAs (Musarandega et al., 2021). For instance, in the Republic of Benin, where about 227,000 unintended pregnancies occur annually, approximately 84,300 end in abortions, with a rising trend in abortion rates despite efforts to reduce unintended pregnancies (Guttmacher Institute, 2022).

Unsafe IAs are a preventable cause of maternal morbidity and mortality, contributing to physical and mental health complications, social and financial burdens, and unnecessary deaths. Studies have shown that abortion-related maternal deaths may be underreported due to cultural stigmatisation, lack of access to safe and timely abortion care, and intentional misclassification of deaths (Say et al., 2014; Musarandega et al., 2021). In the Republic of Benin alone, nearly 200 women die each year from abortion complications, highlighting the urgent need for improved access to comprehensive sexual and reproductive healthcare services (Konnon et al., 2020).

In recent years, governments in certain regions have sought to stimulate natality rates by implementing policies aimed at restricting or banning abortion. These efforts are often driven by religious beliefs, cultural norms, and political agendas prioritising pro-natalist ideologies. Some policymakers argue that banning abortion will protect the sanctity of life and promote traditional family values, while others view it as a means to address the demographic decline and labour shortages (Supreme Court of the United States, 2022).

However, the prohibition or restriction of abortion can have significant implications for women's rights, public health, and social justice. These prohibitions or restrictions may lead to an increase in unsafe abortions, maternal mortality, and morbidity as individuals resort to clandestine and potentially dangerous methods to terminate unwanted pregnancies. Furthermore, they exacerbate inequalities by disproportionately affecting marginalised communities, including low-income individuals, adolescents, and those living in rural areas with limited access to healthcare services (Supreme Court of the United States, 2022).

From a religious perspective, abortion is often viewed as morally objectionable, with religious institutions and leaders advocating for the protection of fetal life from conception onwards. However, some religious traditions and interpretations recognise the complexity of ethical decision-making in cases of unintended pregnancy and prioritise compassion, autonomy, and reproductive justice (Supreme Court of the United States, 2022).

Philosophically and socioeconomically, the debate surrounding abortion intersects with broader discussions on autonomy, bodily integrity, human rights, gender equality, and social justice. It raises questions about the role of the state in regulating reproductive choices, the balance between individual freedoms and collective responsibilities, and the need for comprehensive sexual and reproductive healthcare services that respect and protect individuals' rights and dignity (Supreme Court of the United States, 2022).

Overall, abortion as a societal phenomenon is multifaceted and deeply entrenched in religious, philosophical, and socio-economic contexts. While efforts to stimulate natality rates through restrictive abortion policies persist in some regions, it is essential to consider the complex realities and diverse perspectives surrounding reproductive health and rights. Promoting access to comprehensive sexual and reproductive healthcare, including safe and legal abortion services, is crucial for advancing gender equality, safeguarding human rights, and ensuring the well-being of individuals and communities worldwide (Supreme Court of the United States, 2022).

3 Indications, methods and complications of induced abortion

3.1 Indications for induced abortion

IAs are performed at a woman's request and for many social and medical indications. At a woman's request, an IA is performed legally according to the gestational limits. Countries allowing abortion at request generally enable women and girls to decide on whether to continue or terminate a pregnancy regardless of the sexual partner or husband's approval in many cases. After the gestational age exceeds the limit for IAs on a woman's request, the procedure may be permitted only on specific grounds. Social and economic grounds for IAs include rape, incest and many situations in pregnancy when the woman's health is at risk. Abortion in many countries is legal when the pregnancy is likely to aggravate or cause a situation involving material, educational, professional or moral distress. Rape is the only social indication today for IAs in the Russian Federation.[3] Medical indications constitute substantial grounds for IAs. Accordingly, IA is legal when it is necessary to save the life of the woman, when the pregnancy risks significant injury to the woman or puts the woman's health at risk. Many fetal conditions (malformations – from non-life-threatening conditions such as Down syndrome to 100% fatal conditions like anencephaly) are also medical indications for IAs. Except for legislation, guidelines are often necessary to determine IAs' indications accurately. The Order № 736 of the Russian Federation Ministry of Health and Social Development of December 3, 2007, with an amendment on December 27, 2011, approved the list of medical indications for IAs.[4] Expanding the socio-economic grounds in the Republic of Benin, the new reform may just stipulate the legalisation of IAs on women's request since it is unclear how material, educational, professional or moral distress is diagnosed.

3.2 Methods of abortions

Several countries impose mandatory waiting periods (MWP) between when an IA is requested and when the pregnant women and girls have to definitively decide on whether to continue or terminate a pregnancy (table 1).

[3] Decree № 98 of the Government of the Russian Federation of February 06, 2012, On social indication for induced abortion.
[4] Order № 736 of the Ministry of Health and Social Development of the Russian Federation of December 3, 2007 (as amended on December 27, 2011) On approval of the list of medical indications for induced abortion.

Table 1: Mandatory waiting periods for abortion in some countries

Countries	Gestational age, weeks	MWP, days	Legal document
Russian Federation	≤7 & 11-12	2	Federal Law №323-ФЗ of November 21, 2011 (as amended on April 28, 2023) "On the Fundamentals of Protecting the Health of Citizens in the Russian Federation". Article 56 – Induced abortion.[5]
	8-10	7	
Netherlands	≥17 days of amenorrhea	5	Law on the termination of pregnancy of May 01, 1981, Section 3. However, on June 21, 2022, Dutch parliamentarians approved a law to scrap the mandatory five-day reflection period.[6]
Republic of France	up to 14	7 (2)*	Law № 2001-588 of July 4, 2001, article 6 relating to voluntary termination of pregnancy (VTP) and contraception.[7]
Republic of Benin	up to 12	as brief as possible	Ministry of Health. Medicalised abortion in Benin: guidelines and standards, 2011 (MS**, 2011, p. 16)

NB: *If the one week waiting period should cause the 12-week term of pregnancy to be exceeded, so the doctor may accept the renewed request as early as two days after the initial request; **** – ministère de la santé

MWP is required when IA is performed at the woman's request. Within the MWP, women or girls must receive counselling or advice from the health workers (midwives, obstetricians and gynaecologists, social workers, psychologists), attend the facility at the start and end of the MWP, and/or undergo mandated investigations (WHO, 2022, p. 41; Russian association of obstetricians and gynaecologists (RAOG), 2022, p. 4; MS, 2011, p. 17). Nevertheless, on June 21, 2022, Dutch parliamentarians believing that "the abolition of the WMP does justice to women's autonomy and their right to self-determination" approved a law to scrap the five-day MWP before undergoing an abortion, saying women, with a joint consultation with the doctor, should be able to determine the time before making a decision. The law was set to come into force in January 2023 (Expatica, 2022).

[5] Federal Law №323-ФЗ of November 21, 2011 (as amended on April 28, 2023) On the Fundamentals of Protecting the Health of Citizens in the Russian Federation. Article 56 – Induced abortion.
[6] Netherlands Law on the termination of pregnancy of May 01, 1981.
[7] Loi № 2001-588 du 4 juillet 2001, article 6 relative à l'interruption volontaire de grossesse et à la contraception.

Written consent by the woman or girl is required before IA is performed, and most laws/guidelines stipulate that younger pregnant girls need their parents' or her legal representative consent or that the parents must be informed of the abortion (RAOG, 2022, p. 4; International Planned Parenthood Federation (IPPF), 2019, p. 12). Turkey is the only state in Europe that requires written spousal approval for an abortion (IPPF, 2019, p. 13).

After pre-abortion consultation and investigations are done and written consent is obtained, the intervention must be performed by safe, modern methods – medical and surgical (table 2).

Table 2: Modern methods for induced abortion

Methods	Guidelines	≤11⁶ weeks	12-13⁶ weeks	14-21⁶ weeks
Medical				
Mifepristone♠ + Misoprostol♠♠	WHO, 2022, p. 68 & 71; RAOG, 2022, p. 11 & 12	approved		
Letrozole♦ + Misoprostol♦♦	WHO, 2022: 68	approved		
Misoprostol♣ only	WHO, 2022, p. 68 & 71	approved		
Surgical				
Vacuum aspiration (VA)	WHO, 2022, p. 63	approved		
	RAOG, 2022, p. 14	approved		
Dilation and evacuation (D&C)	WHO, 2022, p. 65			approved
Hysterotomy	RAOG, 2022, p. 14		approved	

NB: routes of administration – ♠oral; ♠♠oral, buccal, sublingual, vaginal; ♦oral; ♦♦ sublingual; ♣ buccal, sublingual, vaginal

Both medical and surgical VTP methods are used in the Republic of Benin. The guidelines and standards recommend that IAs for pregnancies up to 12 weeks (84 days) should be performed in facilities with gynaecological and obstetric departments while IAs in pregnancies exceeding 12 weeks should be performed in facilities with surgical departments (MS, 2011, p. 18). The VTP protocol for the gestational age up to 10 weeks recommends the combination of mifepristone (Day 1) and misoprostol (Day 3) or misoprostol only. Depending on the patient's choice, manual VA (MVA) can also be performed since this avoids the need for the woman to return for a check-up after a medical abortion. Return visits are often very burdensome for women living great distances from the medical clinic. Between 10 and 12 weeks of pregnancy both medical and surgical VTP methods may be

employed, depending on their availability and the woman or girl choice (MS, 2011, p. 22). For the MVA cervical ripening is indispensable using mifepristone (36-48 hours before the procedure) and/or misoprostol (3-4 hours before).

4 Complications of abortions and post-abortion care

When IA is done safely, its complications are rare, but they can include incomplete abortion, haemorrhage, infection, uterine perforation, anesthesia-related complications, uterine rupture and long-term complications. Long-term complications include chronic inflammatory processes of internal genital organs with the development of ovarian dysfunction, ectopic pregnancy, menstrual irregularities, infertility, isthmico-cervical insufficiency, intrauterine synechia and adenomyosis (Radzinsky, 2019, p. 819). Unfortunately, chronic inflammatory diseases, ovarian dysfunction and isthmico-cervical insufficiency may be responsible for many obstetric complications – miscarriage, preterm birth, premature rupture of fetal membranes, placenta praevia, accreta/increta/percreta, placental abruption, utero-placental insufficiency, fetal growth restriction, preeclampsia, obstetric bleeding, etc.

Since IA causes stress on the body, post-abortion care must be an integral part of the procedure. By WHO recommendations, post-abortion care should always be provided regardless of whether abortion is restricted in a particular setting (WHO, 2022, p. 79), and it must be available on a confidential basis, meaning that health workers must not disclose the facts even in situations where abortion is illegal. Post-abortion care must also be available without the threat of criminal prosecution or punitive measures. It includes any or all of the following, as needed or desired: optional follow-up check-ups, management of residual side effects or complications, and contraception services. An optional follow-up visit 7-14 days after the procedure may be offered not only to confirm the procedure was effective but also to provide contraceptive services, emotional support or management of any medical concerns. Check-ups earlier than the 14th day after Mifepristone administration is not recommended in the Russian Federation (RAOG, 2022, p. 9) in order to avoid "hyperdiagnosis" – unjustified incomplete abortion when visualising on pelvic ultrasound blood accumulation inside the uterine cavity and then providing additional procedure. Modern methods of contraception (hormonal contraceptives) should be started on the day of surgical IA or the day of Mifepristone administration,

while an intrauterine contraceptive device (IUCD) for post-abortion care using any method is advised after successful IA completion (RAOG, 2022, p. 16). Any diagnosed complication (for example, bleeding, incomplete abortion, infection) must be appropriately managed.

In the Republic of Benin, post-abortion contraception is recommended in accordance with the woman or girl's choice. Combined hormonal contraceptive (COC) from Day 3 or insertion of IUCD on check-up day (Day 15) can be used for medical IA, while in MVA COC or IUCD can be advised on the day of the procedure (MS, 2011, pp. 21, 25).

Rhesus incompatibility prevention is another crucial stage of IA care. The Beninese guidelines recommend it for all women or girls with Rhesus-negative blood. For this purpose, a single anti-D Ig dose of 200 μg in IM or IV injection is used within 72 hours after IA (MS, 2011, pp. 38, 39).

5 Induced abortion laws around the world

Many countries in the world allowing abortion have gestational limits for IAs, which may vary and globally range from 8 weeks to 24 weeks with an average of up to 12 weeks on a woman's request, up to 24 weeks for rape, incest, or socio-economic and medical grounds. Some countries do not explicitly set the gestational age for IAs. In the Republic of Benin, IA may be performed up to the gestational age of 28 weeks (MS, 2011, p. 2). since it is only from this term of pregnancy that any termination is considered as preterm birth, unlike developed countries where pregnancy termination is regarded preterm birth from 22 weeks. Although the Netherlands formally places the IAs gestational limit at 24 weeks from the last menstrual period, in practice, the limit is 22 weeks to allow for discrepancies in measurement (IPPF, 2019, p. 7). In the Russian Federation, an IA is allowed on a woman's request up to 11 weeks and 6 days of pregnancy (early IA), while on the social ground – 12-21 weeks and 6 days of pregnancy (late IA) and by medical indications – up to 21 weeks and 6 days (RAOG, 2022, p. 4). According to the same ROAG clinical guidelines, termination of pregnancy over 22 weeks of gestation is performed strictly when medically indicated.

5.1 Abortion laws around the world

Abortion laws vary widely in the world in accordance with traditional, moral, religious, ethical, medical and political reasons. The IAs laws have changed over the past few decades worldwide, with approximately 50 countries liberalising their abortion laws. Currently, as known, the laws range from abortion being freely available at a woman's request to various restrictions and or prohibitions in all circumstances (CRR, 2022).

Based on various abortion laws around the world there are 5 categories of countries from most to least restrictive (figure 1).

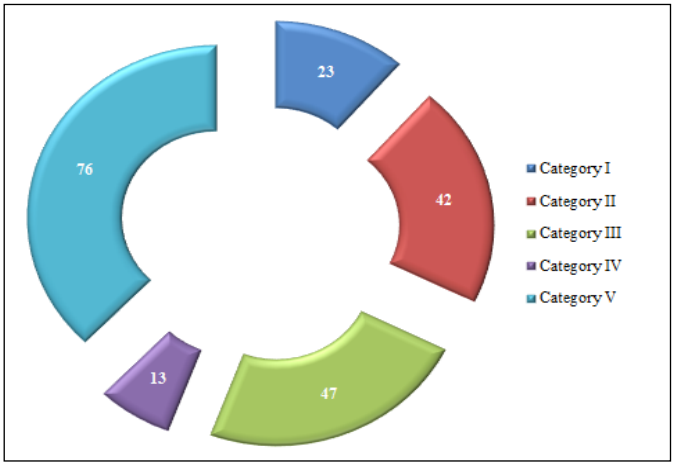

Figure 1: **number of countries by abortion laws category**
source: CRR, 2022

(**category I** – IA is prohibited altogether, **category II** – IA is allowed to save the woman's life, **category III** – IA is allowed to preserve health, **category IV** – IA is allowed on socio-economic grounds, **category V** – IA is allowed on woman request)

According to the CRR, nearly 90% of countries worldwide (178) permit IAs, at least when the woman's life is at risk, i.e. for medical indications. Most countries that allow IAs for medical indications also permit them on many other grounds, such as at women's request and in situations of pregnancies resulting from rape or incest (CRR, 2022).

The laws of the countries in the category I, not permitting IAs altogether even when the woman's life or health is at risk, affect 91 million (6%) women of reproductive age (15-49 years old). Two European countries, Andorra and Malta, fall within this category, as well as 6 African countries – the Republic of Congo, Egypt, Madagascar, Mauritania, Senegal and Sierra Leone. We do not believe that IA should be prohibited for medical indications at all and for life-threatening conditions, especially in cases involving severe pregnancy vomiting with ineffective treatment. In life-threatening conditions, the woman's life must be saved, and then pregnant women have to be informed and take the definitive decision about IA by themselves, or the decision must be taken by their husbands/relatives in case of the inability of women.

The category II impacts 358 million (22%) women of reproductive age. Since the laws allow saving the lives of women, under this category IA is legal when the pregnant woman faces life-threatening conditions.

The 48 countries permitting IAs to preserve women's health, i.e., on medical grounds, comprise 186 million (12%) of women of reproductive age. The WHO recommends to these countries allowing IAs on health grounds that they should consider "health" to mean "a state of complete physical, mental and social well-being". Since countries in each subsequent category recognise the specific grounds from the preceding category, then we believe that health or therapeutic grounds may include life-threatening conditions, so either several countries from this category or all of them have to refer to category II.

The laws of category IV are interpreted liberally to allow IAs for a broad range of circumstances and directly impact 386 million (24%) of women of reproductive age worldwide. While the most commonly accepted social grounds like rape and incest fall into this category, the countries in category IV often consider a woman's actual or more likely social or economic circumstances in considering the potential impact of pregnancy and childbearing.

Today, 576 million (36%) women of reproductive age live in countries that allow abortion on request. We emphasise, however, that in some circumstances, IA can be prohibited inside this category. For example, in Kosovo, Montenegro, China and Nepal, sex-selective abortion is not allowed at all, even though legislation permits IA at a woman's request. In 2022, only six out of 55 African countries, representing

7.9% of category V, permitted abortion at the woman's request during the first trimester of pregnancy. These countries were Benin, Cape Verde, Guinea-Bissau, Mozambique, South Africa, and Tunisia. In 1973, Tunisia became the first African country and the first Muslim country to legalise abortion on request. The gestational limits for IAs on request vary in these African countries – up to 90 days or three months in Tunisia and up to 12 weeks in Benin, Cape Verde, Mozambique and South Africa. In Guinea-Bissau, the law does not indicate a gestational limit and regulatory mechanisms vary widely.

5.2 Reform of induced abortion law in the Republic of Benin

Beninese Parliament passed a new legal amendment to the sexual health and reproduction 2003 law on Wednesday, October 20, 2021, after a lively debate. The Constitutional Court ruled the amendment conforms to the Constitution DCC21-320 on December 10, 2021, and the President promulgated the law on December 20, 2021.[8] Articles 17 and 19 of the law № 2003-04 March 03, 2003 on sexual health and reproduction in the Republic of Benin have been modified and completed. While under the previous abortion law, which was passed in 2003, a woman could only terminate the pregnancy if her life was at risk, if the pregnancy was a result of incest or rape, or if the fetus had a severe medical condition (anomaly), so excepted these grounds, according to article 17-2 of the new law, abortion is presently legal in the Republic of Benin if the pregnancy is "likely to aggravate or cause material, educational, professional or moral distress incompatible with the interests of the woman and/or the unborn child". In its article 2, the Decree № 2023-151 of April 19, 2023[9] defines a distress as feeling of abandonment, loneliness, helplessness, characterizing a difficult situation. The distress is material when the pregnant woman's situation is characterized by a lack of material means, deprivation or misery. An educational distress is that preventing the pregnant woman from continuing her studies or exposing her to an obvious risk of detrimental interruption to her education or professional training. Distress is defined as professional when it exposes the pregnant woman to an obvious risk of job's loss or rejection for access to employment. Finally, any distress, inducing a psychological imbalance in the

[8] Loi № 2021-12 du 20 décembre 2021 modifiant et complétant la loi № 2003-04 du 03 mars 2003 relative à la santé sexuelle et à la reproduction. République du Bénin, Présidence de la République.
[9] Décret № 2023-151 du 19 Avril 2023 fixant les conditions d'interruption volontaire de grossesse. République du Bénin. Présidence de la République

pregnant woman and seriously affecting her daily life, is called moral. Thus, legal IAs can be carried out up to 12 weeks after the absence of a period (Article 17-3) on broad socio-economic grounds since the Republic of Benin has joined Cape Verde, Mozambique and South Africa as one of the few African countries to legalise IAs within 12 weeks broadly. Article 17-1 of the same law prohibits the use of IA for birth control, and emergency contraception may not be considered as a method of IA (article 17-6). Contraception must be the only recommended method for birth control and, subsequently, the only way to prevent unwanted pregnancies. Although the Beninese government authorises all the modern contraceptive methods (MCM) to be available, the spouses to decide on the number of children and the inter-pregnancy interval length and the manufacturing or import of MCM, their promotion and marketing according to the legislation (law № 2003-04 of March 03, 2003), unfortunately, the MCM prevalence rate remains very low – 8.5% among young women ages 15 to 24 and 13% among those ages 25 or more (Ahissou et al., 2021, p. 3). A study from 2022 revealed a slight increase in the overall rate – 14.1% (Track20, 2022). The rate for married women was 15.1%, while for unmarried women, it was 11.5%. Over the last ten years, the MCM prevalence rate has not changed in unmarried women – 11.2% on average (10.8 – 11.5%, and 11.1% in 2012). At the same time, the rate increased almost twice in married women – from 8.1% in 2012 to 15.1% in 2022, with an increase of 0.64% on average in a year (Track20, 2022).

In accordance with article 17-2, a pregnant woman seeking IA may consult either a doctor of a licensed public/private clinic or a social worker who must refer the woman to a licensed clinic. For IA in pregnant adolescents or adult women under curatorship, the legal representative, after obtaining the girl or woman's consent and submitting the decision about IA, must see a doctor of a licensed clinic or social worker for the referral to the clinic. If there are differing opinions among individuals exercising parental authority over adolescent girls, Article 17-5 mandates that a legal, social worker can request to refer the matter to the guardianship judge, who must make a ruling within one week.

The legislation assigns the responsibility for IA services to health or social workers. Consequently, individuals are prohibited from offering such services publicly, in meetings, or through the dissemination of information. Penalties for non-

compliance are outlined in Article 519 of the Penal Code.[10] Similar penalties apply to those who promote methods, objects, or procedures related to IAs. Additionally, doctors and social workers who fail to fulfil their obligations under the new law regarding IAs may also face these penalties.

While activists claim victory for the amended law extending the socio-economic grounds for IAs in the Republic of Benin, the opponents do not approve it. Among the activists there are the government, many non-governmental organisations (NGO), health and social workers. The Beninese Minister of Health Benjamin Hounkpatin justified the law as a public health measure whose only aim is to save human lives. He explained that this measure relieves the sorrows of many women who, once facing the distress of an unwanted pregnancy, put their lives on threat by terminating pregnancies in unsafe conditions. Moreover, he mentioned that many families continue mourning the loss of a child, a wife, a mother who tragically died following a complicated abortion, and these wounds are irreparable (Faye & Houssou, 2021). The Beninese Minister of Health's opinion was supported by Ibrahim Ousmane ["Association béninoise pour la promotion de la famille" (ABPF), the NGO "Beninese association for family promotion"] and Raïmath D. Moriba, the President of "Femmes engagées pour le développement" (FED, the NGO "Women committed to development"). Ibrahim Ousmane stated that NGO ABPF, together with many other civil society organisations, campaigned for twenty years to extend access to abortion, and according to Raïmath D. Moriba the government has just restored the dignity of women in the Republic of Benin. In contrast, the Catholic Church, which has campaigned against this new law, said a "strong no to the culture of death", and Monsignor Eugène Cyrille Houdekon of the Beninese clergy insisted on "the respect for the sanctity of life, especially that of the innocent" and affirmed that "abortion destroys the life of the fetus but also that of the mother" (Faye & Houssou, 2021). Professor Francis Dossou, the President of the National Council of the Order of Physicians of the Republic of Benin, premised his opposition to the law on his Christian values and beliefs that life starts with conception and has to be saved. He promised to "make all effort to convince pregnant women to keep their pregnancies". Many patricians hold divided beliefs about IAs.

[10] Loi № 2018-16 du 04 juin 2018 portant code pénal. République du Bénin, Assemblée nationale.

Tt is evident from this discussion that the debate surrounding the new abortion law involved numerous stakeholders worldwide. These include legislative, executive, and judicial authorities, other political actors, health workers, civil society groups such as NGOs and associations, and religious institutions. However, despite the involvement of various actors, the general opinion regarding the new law remains deeply divided among the population and health workers in the Republic of Benin. Many individuals continue to oppose abortions and the new legislation due to negative perceptions of pregnancy termination and challenges in accessing abortion services.

6 Conclusion

Abortion is a reality that can occur anywhere, regardless of country, tradition, religion, or policy, and it will continue to occur globally. Even though efforts have been made to regulate or restrict abortion, the rates, especially the prevalence of unsafe abortions, are still alarmingly high in many countries. This reality is reflective of the ongoing challenges and deficiencies in preventing unwanted pregnancies and addressing contraceptive failures.

The debate surrounding abortion rights is deeply polarised, with the recognition of the right to abortion not being universal. Opponents of abortion legalisation often argue that decriminalising abortion will lead to an increase in abortion rates. However, empirical evidence suggests that restrictive abortion laws do not necessarily decrease abortion rates but rather contribute to the rise of unsafe procedures, endangering the lives and well-being of women.

Concerted efforts are needed to address these challenges. The focus should be on sexual education, reproductive health campaigns, and heightening public awareness on the benefits of contraception. In addition, it is critical that pregnant people are ensured access to medical facilities for safe abortion services in order to safeguard their health and rights. Comprehensive guidelines, grounded in evidence-based practices, are crucial to accurately diagnose material, professional, educational, or moral distress. We believe that the guidelines issued in the Republic of Benin on the specific basis for diagnosing material, professional, educational or moral distress as a socio-economic ground in the pregnant woman for induced abortion should

precise the need of multidisciplinary consultation for this purpose, then no one will personally interpret the conditions for an induced abortion.

It is necessary to address the underlying social, economic, and cultural factors that influence attitudes towards abortion, as well as legislative reforms. Promoting gender equality, empowering women and girls, and fostering open dialogues on sexual and reproductive health are integral components of comprehensive strategies to reduce the need for abortion and ensure access to safe and legal services for those who require them.

By adopting a holistic approach that combines legal reforms, education, and access to healthcare, societies can work towards reducing the incidence of unsafe abortions, protecting women's health and rights, and promoting reproductive justice for all individuals, regardless of their circumstances or geographical location.

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Legislations

Decree № 98 of the Government of the Russian Federation of February 06, 2012, On social indication for induced abortion.
Decree № 2023-151 of April 19, 2023, establishing the conditions for voluntary termination of pregnancy. Republic of Benin. Presidency of the Republic.
Federal law № 323-ФЗ of November 21, 2011 (as amended on April 28, 2023) On the Fundamentals of Protecting the Health of Citizens in the Russian Federation. Article 56 – Induced abortion.
Law № 2001-588 of July 4, 2001, article 6 relating to voluntary termination of pregnancy and contraception. Republic of France.
Law № 2003-04 of March 03, 2003 On sexual health and reproduction. Articles 17 and 19. The Republic of Benin. Presidency of the Republic.
Law № 2018-June 16 04, 2018 on penal code. Article 519. The Republic of Benin. National Assembly.
Law № 2021-12 of December 20, 2022, amending and supplementing law № 2003-March 04 03, 2003, relating to sexual health and reproduction. Articles 1. The Republic of Benin. Presidency of the Republic.
Law on the termination of pregnancy of May 01, 1981. Section 3. Netherlands.
Order № 736 of the Ministry of Health and Social Development of the Russian Federation of December 3, 2007 (as amended on December 27, 2011) On approval of the list of medical indications for induced abortion.

References

Ahissou, N.C.A. et al. (2021). Modern contraceptive use among adolescent girls and young women in Benin: a mixed-methods study. *medRxiv*, retrieved from: https://doi.org/10.1101/2021.06.07.21257758 (June 14, 2023).

CRR (Center for Reproductive Rights) (2022). *The world's abortion laws,* retrieved from: https://reproductiverights.org/maps/worlds-abortion-laws/ (June 12, 2023).

Darroch, J. E. et al. (2016). *Adding it up: costs and benefits of meeting the contraceptive needs of adolescents* (New York: Guttmacher Institute), pp. 6, 10, retrieved from: https://www.guttmacher.org/report/adding-it-meeting-contraceptive-needs-of-adolescents (June 13, 2023).

Expatica (2022). Dutch scrap mandatory abortion reflection period. *The Netherlands News*, retrieved from: https://www.expatica.com/nl/general/dutch-scrap-mandatory-abortion-reflection-period-235139/ (June 13, 2023).

Faye, A. C. & Houssou, R. (2021). Legalisation of abortion in Benin: the debate continues, 6 questions to understand / Faye Awa Cheikh & Rachida Houssou. *World today news,* retrieved from: https://www.world-today-news.com/legalization-of-abortion-in-benin-the-debate-continues-6-questions-to-understand/ (June 14, 2023).

Gerstein, J. & Ward, A. (2022). Supreme Court has voted to overturn abortion rights, draft opinion shows, *Politico*, retrieved from: https://www.politico.com/news/2022/05/02/supreme-court-abortion-draft-opinion-00029473 (June 13, 2023).

Guillaume, A. & Rossier, C. (2018). Abortion around the world. An overview of legislation, measures, trends, and consequences, *Population-E*, 72(2), 217, doi: 10.3917/pope.1802.0217.

Guttmacher Institute (2022). *Country profile: Benin – unintended pregnancy and abortion*, retrieved from: https://www.guttmacher.org/regions/africa/benin (June 13, 2023).

Hoffman, B.L., Schorge, J.O., Bradshaw, K.D., Halvorson, L.M., Schaffer, J.I. & Corton, M.M. (2016). First-trimester abortion. *In Williams Gynecology*, *3e edition by McGraw Hill Medical*, retrieved from: https://obgyn.mhmedical.com/content.aspx?bookid=1758&sectionid=118167822 (June 12, 2023).

IPPF (International Planned Parenthood Federation) (2019). Abortion Legislation and its Implementation in Europe and Central Asia. *IPPF European network Partner Survey*, pp. 7, 12, 13.

Konnon, R., Semyatov, S., Soyunov, M., Sokhova Z. & Zulumyan T. (2020). Trends on maternal mortality in the Republic of Benin and comparison with the neighboring countries. *Medicine, Law & Society*, 13(2), 209, https://doi.org/10.18690/mls.13.2.197-216.2020.

MS (Ministère de la santé) (2011). Avortement médicalisé Au Bénin: guides et standards. *République du Bénin*, pp. 2, 16, 17, 18, 21, 22, 25, 38, 39.

Musarandega, R., Nyakura, M., Machekano, R., Pattison, R. & Munjanja, S.P. (2021). Causes of maternal mortality in Sub-Saharan Africa: a systematic review of studies published from 2015 to 2020, *J. Glob Health*, 11(04048), 5, doi: 10.7189/jogh.11.04048.

Radzinsky, V.E et al. (2019). Induced abortion. *In Gynecology textbook, 2nd edition by GEOTAR-Media*, 819. ISBN 978-5-9704-4413-9.

Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.B., Daniels, J., Gülmezoglu, A.M., Temmerman, M. & Alkema, L (2014). Global causes of maternal death: a WHO systematic analysis, *Lancet Glob Health*, 2(6), e331, doi: 10.1016/S2214-109X(14)70227-X.

Shakhatreh, H.J.M., Salih, A.J., Aldrou, K.K.A.R., Alazzam, F.A.F. & Issa, M.S.B. (2022). Medico-legal aspects of abortion: updates of the literature, *Med Arch.*, 76(5), 373, doi: 10.5455/medarh.2022.76.373-376.

Supreme Court of the United States (2022). Dobbs v. Jackson Women's Health Organization. Retrieved from https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf (November 17, 2023).

Track20 (2022). *Country reporting. Benin: FP indicators*, retrieved from: https://www.track20.org/Benin (June 14, 2023).

WHO (World Health Organization) (2017). *Worldwide, an estimated 25 million unsafe abortions occur each year. News release* (Geneva). Retrieved from: https://www.who.int/news/item/28-09-2017-worldwide-an-estimated-25-million-unsafe-abortions-occur-each-year (June 13, 2023).

WHO (World Health Organization) (2019). Trends in maternal mortality: 2000 to 2017. *Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (Geneva), p. 71.

WHO (World Health Organization) (2021). *Abortion. Fact sheets***.** Retrieved from: https://www.who.int/news-room/fact-sheets/detail/abortion (June 13, 2023).

WHO (World Health Organization) (2022). Abortion care guideline. *Human Reproduction programme UNDP-UNFPA-UNICEF-WHO-World Bank* (Geneva), pp. 41, 63, 65, 68, 71, 79.

Российское общество акушеров-гинекологов (РОАГ) (2022). *Клинические рекомендации: I Искусственный аборт (медицинский аборт)* (Москва), pp. 4, 9, 11, 12, 14, 16 [Russian Association of obstetricians and gynecologists (RAOG) (2022) *Clinical recommendations: Induced abortion* (Moscow), pp. 4, 9, 11, 12, 14, 16].

Povzetek v slovenskem jeziku

Umetna prekinitev nosečnosti ostaja sporna zaradi moralnih, političnih in verskih razlogov. Čeprav je splošno mnenje o nelegalnosti splava nakazano v medicinskih pogojih zanj, se njegova regulacija močno razlikuje glede na državo. Splav je ženskam na voljo na zahtevo v mnogih državah, medtem ko je v drugih omejen ali celo prepovedan. V zgodovinskem trenutku, v katerem številne države omejujejo pravico do splava, je Republika Benin leta 2020 razširila možne podlage zanj, dovoljujoč splav do 12 tednov gestacijske starosti. Ta članek si prizadeva pregledati zakonodajo o splavu v izbranih državah in jih primerjati z reformo v Republiki Benin, ki je postala ena izmed več afriških držav, ki splav široko dovoljujejo.