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Collège National des
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du Bénin

Benin Country Report

NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

FOR THE NATIONAL SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS IN BENIN (CNGOB)

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)
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Abbreviations

ABMS	<i>Association Béninoise pour le Markéting Social</i> (Benin Association for Social Marketing)
ABPF	<i>Association Béninoise pour la Promotion de la Famille</i> (Benin Association for the Promotion of the Family)
AFJB	<i>Association des Femmes Juristes du Bénin</i> (Association of Women Lawyers of Benin)
ASFB	<i>Association des Sages-femmes du Bénin</i> (Association of Midwives of Benin)
CNGOB	<i>Collège National des Gynécologues Obstétricien du Bénin</i> (National Society of Gynaecologists and Obstetricians of Benin)
DNS	<i>Direction Nationale de la Santé</i> (National Direction for Health)
DNSP	<i>Direction Nationale de la Santé Publique</i> (National Direction for Public Health)
DPPD	<i>Document de Programmation Pluriannuelle des Dépenses</i> (Multiannual Programming Document for Expenditures)
EMICoV	<i>Enquête Mondiale Intégrée sur les Conditions de Vie des ménages</i> (Global Integrated Household Living Conditions Survey)
FAQ	Frequently Asked Questions
FIGO	International Federation of Gynaecology and Obstetrics
FJB	<i>Les femmes Juristes du Benin</i> (Women Lawyers in Benin)
FP	Family Planning
GDP	Gross Domestic Product
IPPF	International Planned Parenthood Federation
KIT	Royal Tropical Institute
MAJ	<i>Mouvement d'Action des Jeunes</i> (Youth Action Movement)
MOH	Ministry of Health
MVA	Manual Vacuum Aspiration
RH	Reproductive Health
SNM/SRAJ	<i>Stratégie Nationale Multi Sectoriel de Santé de la Reproduction des Adolescents et jeunes</i> (National Multi Sector Strategy for Reproductive Health of Youth and Teenagers)

Executive Summary

This needs assessment set out to provide better and more in depth understanding of the capacity of CNGOB and in particular to identify the main abortion advocacy needs that a forthcoming multi country project can address. It also explored how FIGO can effectively strengthen the capacities of the society. The assessment involved conducting a literature review, a survey of members of the society, key informant interviews with stakeholders at various levels with the majority being associated with CNGOB as well as a stakeholder workshop for CNGOB members and partners.

The literature review, the key informant interviews and the workshop confirmed that unsafe abortion and its complications is a major problem in Benin, endangering the lives of many teenagers, girls and women. The practice of unsafe abortion is so rampant that the need for safe abortion to reduce this problem is urgent. Although the legal framework (Law 2003-04 of March 03, 2003 on sexual health and reproduction in Article 17) provides for circumstances of access to abortion, its restriction puts service providers in a dilemma and a real confusion: provide abortion against law (leads to safe but illegal abortion) or be respectful to the abortion law (leads to a high probability of unsafe abortion). Thus abortion, even secure, is provided clandestinely. In addition, advocacy for safe abortion faces many challenges in a context where social norms and religious beliefs are rooted against safe abortion. So, to strengthen advocacy for safe abortion, the society in partnership with the various stakeholders must initiate a frank dialogue to convince the ins and outs of its social norms and religious beliefs. The CNGOB's strong presence as a leader in abortion technical knowledge and experience is an opportunity to influence and network with like-minded organizations for defending and delivering safe abortion services to women who express the need.

Building its base as a safe abortion advocate, the association will require addressing the various and potential challenges as were identified during the key informant interviews and the two-day's workshop. This includes the following:

- Strengthening the management and organization of CNGOB as a formidable agency for safe abortion advocacy;
- Establishing a coordinated and vibrant network of associations that are supportive of safe abortion.
- Transforming the social and gender norms at all levels regarding safe abortion but within the context of the Benin law.
- Ensure that the legal framework is consistent while raising awareness of the legal framework to stakeholders at all levels for a harmonious interpretation.
- Ensuring a process for data generation and use for monitoring and planning for services.

These different challenges, identified in collaboration with CNGOB, were taken forward and translated into a preliminary action plan with tangible activities and outcomes. The action plan will be further developed in collaboration with the CNGOB and FIGO and serve as a source of inspiration for the development of a future program for the promotion of safe abortion in Benin.

1. Introduction

This country report is the result of a need assessment conducted by KIT Royal Tropical Institute with the National Society of Gynaecologists Obstetricians of Benin (CNGOB) regarding Safe Abortion Advocacy. Benin is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country Federation of Gynaecologists and Obstetricians (FIGO)-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and should provide a better and more in depth understanding of the capacities and needs of CNGOB, to then identify the main needs in relation to safe abortion advocacy that the following multi country project could address. Also, it should provide more clarity on how FIGO can strengthen more effectively the capacities of national societies, in this case CNGOB. This includes the provision of recommendations on the content of the capacity building program by developing country action plans with budget, as well as a comprehensive program proposal for the whole ten countries.

Needs Assessment Objectives

The specific objectives are that by the end of the needs assessment in ten countries, FIGO should have:

1. Insights on the situation of abortion in each country
2. Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on abortion advocacy
3. Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
4. Recommendations on FIGOs role to strengthen the capacity of the ten National Societies as abortion advocates, translated into a comprehensive proposal

2. Methodology

This Needs Assessment was formative and the approach used was highly participatory. This means constant mechanisms of communication and feedback with CNGOB took place in order to create mutual understanding and joint objectives. The following methods were used in order to meet the objectives of the assessment:

1. Desk study review

A desk study review was committed between February and April 2018 through a desk review tool. Academic/scientific databases and grey literature were searched for the relevant themes as addressed in the assessment framework (inception report). The CNGOB was asked to improve and validate the documentation during the workshop.

2. Online survey

An online survey, using Survey Monkey software, was sent out to all 91 registered members of CNGOB to ask them about their membership of CNGOB, the position of the society towards safe abortion and their own professional and personal position towards safe abortion. KIT sent the Web link to society members on March 28, 2018. Before starting the workshop the paper versions of the survey were completed by a few respondents who had not yet completed the online survey. After several reminders to get more answers, 40 responses returned, of which 36 were complete (90% completion rate). The survey remained open for 5 weeks and was closed on May 7, 2018. The analysis was conducted using the Survey Monkey software.

3. Key Informant Interviews

A total of 10 key informants were interviewed on April 2, 3 and 4, 2018. They included representatives from the CNGOB, the Youth Action Movement, IPPF/ABPF, PSI/ABMS, ASFB, the Women Lawyers of Benin and the Ministry of Health. The interviews were conducted within representatives' offices (clinic as office). With permission, the interviews were recorded as well as taking of notes. These notes were extended using the tape recordings. The notes were reinforced and organized along thematic areas as outlined in the findings section. The findings were analysed taking into account the various perceptions regarding safe abortion.

4. Stakeholder workshop

A two day workshop took place in Cotonou on April 5-6. The purpose of the workshop was to identify the needs of CNGOB for abortion advocacy and develop a plan of action for the next safe abortion advocacy proposal that will be developed for the National Societies of Obstetrics and Gynaecology in ten countries involved in the needs assessment.

The objectives were that, by the end of the workshops participants have:

1. Discussed and identified opportunities and barriers for providing safe abortion in the country based on the desk review presentation and own experience.
2. Explored their personal and professional values related to abortion and identified activities for improving access to safe abortion and post abortion care based on professional ethics.
3. Explored the implications of the national abortion law and policies for access to safe abortion.
4. The ability to explain the concept and levels of advocacy and identify challenges and barriers of abortion advocacy.
5. Identified the strengths and weaknesses of the national society in abortion advocacy.
6. Formulated action points for an abortion advocacy program.

The workshop brought together 30 participants from the various institutions mentioned above. A full program of the workshop and list of participants can be found in Annex 1.

Challenges

One of the challenges of the literature is that Benin has limited information available on abortion. As a result, much of the information we were looking for was not available and we only had a few reports and articles. In addition, the difficulties encountered during the interviews were largely related to the time limit to cover all relevant key informants. Some interviews were cancelled because the interviewee was not available on scheduled days or was late. If there had been more participants, there would have been more insight into the answers. However, the interviewers felt that they reached a certain level of saturation.

The participants who took part in the workshop and the interviews mainly came from urban areas: Cotonou and Porto-Novo. This gave a good overview of what is happening in urban areas; however, there has been less information available on rural areas that could also show other realities.

Concerning the survey, the response rate was 44%. We tried to take into account the voice of most members. However, due to the lack of e-mail addresses in the list of members, it was not possible to send the survey to everyone. In addition, it is possible that only those members who are interested in the subject have completed the questionnaire, which could slightly influence the findings.

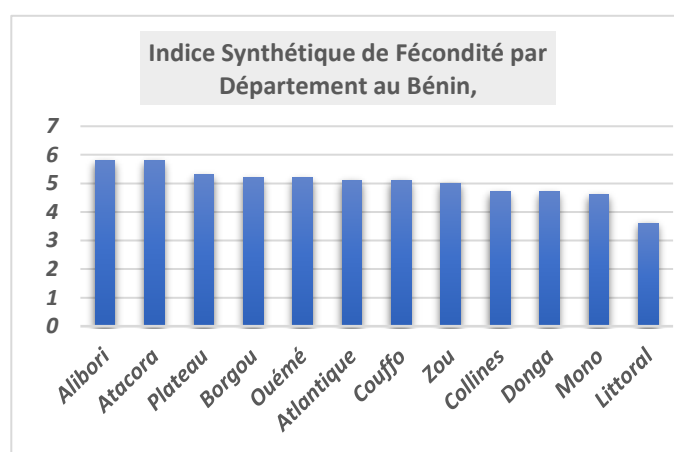
3. Findings

3.1 Literature review

Demographic and socio-economic information

In 2013, the fourth General Census of Population and Housing (RGPH4) made it possible to count 10,008,749 inhabitants, 51.2% of whom were women in Benin (INSAE, RGHP4: Que retenir des effectifs de population en 2013, 2015). In 2018, this number has increased to an estimated 11,496,140 inhabitants. 44.6% of Benin's population lives in urban areas and 55.4% live in rural areas (INSAE, 2013). The country has a fairly young population; 45% are under 15 years old and 15-54 years old make up 50% of the population (Turner, Senerowics, & Marlow, 2016). Life expectancy at birth is 63.84 years for both sexes, of which 64.74 in urban area and 61.88 in rural areas (INSAE, 2013).

In 2012, a Beninese woman has an average of 4.9 children at the end of her fertile life; the average number of children per woman varies from 4.3 in urban areas to 5.4 in rural areas (INSAE, 2013). The graph opposite shows disparities at the departmental level ranging from 3.6% in the Littoral to 5.8 in the Alibori of Benin. In addition there is a large fertility disparity based on different levels of education and wealth (Turner, Senerowics, & Marlow, 2016). In 2014, the growth rate of Gross Domestic Product (GDP) was 6.5%. GDP was USD 8.583 billion (2016) and GDP per capita was USD 789 (2016) (Population data, 2018).



In 2011, 36.2% of the population lived below the poverty line (Index Mundi, 2018). From 2011 to 2015, the overall poverty line worsened by about 16.5%. It rose from 120,839 FCFA per capita in 2011 to 140,808 FCFA in 2015 (EMICOV, 2015).

Indicators on Sexual and Reproductive Health Rights in Benin

In Benin, the maternal mortality rate is high: 336 deaths per 100,000 live births, with 289 per 100,000 in urban areas and 367 per 100,000 in rural areas (INSAE, 2013). Other sources even show a higher figure: 347 maternal deaths per 100,000 live births (MICS, 2014-2015). The Guttmacher institute reports that between 2007 and 2012, 19% of births were unplanned (Guttmacher Insitute, 2015). According to EDSB IV, this rate was 17.6% among 15-24 years old, with 11% in urban areas and 21% in rural areas (INSAE, 2013).

The proportion of unmarried women with unmet need for family planning is estimated at 33%, of which 21% for birth spacing. Among sexually active teenage girls aged (15-19 years), unmet need was respectively 35% for those in a relationship and 51% for those that are single (INSAE, 2013). The birth rate among teenage girls (aged 15-19 years) was 94 per 1000 live births (INSAE, 2015). As a consequence, each year, 274,222 pregnancies occur among teenage and young girls, with 14,664 reaching their term but with a stillborn; and one in five maternal deaths occurring in mother-daughters under 18. According to the EDSB4, in 2013, 14% of adolescent girls in Benin were married before the age of 15, and 36% under 18 (INSAE, 2013). Table 1 shows data on reproductive health among adolescents and young people in Benin.

Table 1: Reproductive health data of adolescents and youth in Benin²

²SNM/SRAJ (2018-2022)

Indicators	% of women aged 20-49 married before the age of		Fertility rate among adolescents (births per 1,000 women aged 15-19 and 20-24) 2014		% of women using a modern contraceptive method 2005/2011	
Data	15 years	18 years	15-19 years	20-24 years	15-19 years	20-24 years
	10%	32%	94	259	4%	6%

Indicators and evidence on abortion

There is not enough recent information and data on abortion, probably because of the sensitivity of the subject. However, the Ministry of Health estimates that unsafe abortions still exist and account for up to 15% of maternal deaths (hospital data) (Ministry of Health, 2011). A study conducted in 2016 on the theme reveals that 73,321 induced abortions and 68,922 spontaneous abortions take place at the national level. A 5-year study conducted in Benin in 3 hospitals showed that 3,139 women had been hospitalized for incomplete abortions (from an induced abortion), out of which 630 had not required care, 1,277 had been treated by Manual Vacuum Aspiration (MVA) and 537 by misoprostol administration (Turner, Senerowics, & Marlow, 2016). In 2016, the number of hospital-registered abortions is 11,423³. Table 2 shows data on unsafe or secure abortions in Benin (ABPF, 2015).

Table II: Data on unsafe and secure abortions in Benin (SGI/DPP)

Years (2010-2016)	2010	2011	2012	2013	2014	2015	2016
Percentage of pregnancies ending with safe/unsafe abortion (Number of abortion ratio and number of CPN1)	0.86%	0.94%	0.66%	0.93%	0.88%	0.89%	0.84%
Number of registered hospital abortions nationally per year.	8 991	10 152	10 974	10 832	9 813	10 849	11 423

A study done by Ezin (2016) among adolescents and young people (12-25 years) in the community of Tchaourou describes that the abortion rate among girls surveyed is 9%, of whom 5% was voluntary abortions and 4% spontaneous abortions. This could be an underestimate since often abortion is not included in the registry.

National laws and policies on abortion

The last 15 years, the laws on abortions in Benin have been liberalized. But before these changes, abortions were only allowed to save a woman's life. (Turner, Senerowics, & Marlow, 2016). In 2003, a new law on reproductive health (law 2003-04 of 03 March 2003) was adopted whose article 17 defines the conditions under which abortion will be carried out (Republique du Benin, 2003). This law authorizes the abortion services under three conditions in Benin:

- « When the continuation of pregnancy endangers the life and health of the pregnant woman.
- At the request of the woman when the pregnancy is the consequence of rape or an incestuous relationship.
- When the unborn child has a congenital malformation »(Republic of Benin, 2003, p17).

³ SGI/DPP/Ministère de la Santé - (SNM/SRAJ 2018-2022)

Article 17 also provides that a decree is needed to establish the procedure and legal conditions for voluntary termination of pregnancy (Republique du Benin, 2003). However, since 2002, this decree has not yet been implemented and the conditions for access to abortion services remain compromised (Turner et al., 2016). For example, it has not been defined who is authorized to perform the abortions or what procedures should be followed by the providers.

However, in 2011 the document "guidelines and standards on safe abortion in Benin" was developed by the Ministry of Health with the collaboration of IPAS and CNGOB. This guideline provides for terminating pregnancies up to 12 weeks in all facilities that have a gynaecology department with sufficient technical capacity to manage complications. In addition, the importance of safe abortion has been emphasized and progressive language is being used on women's rights and abortions (Turner, Senerowics, & Marlow, 2016).

Indeed the abortion laws in Benin allow, in the light of the foregoing, abortion in case of risk to health, rape, incest or congenital malformation and in case of danger for the life of the pregnant woman. But the fact remains that these legislative provisions are not known by providers, beneficiaries and other stakeholders (lawyers, civil society organization, police, etc.) and this creates difficulties (Turner, Senerowics, & Marlow, 2016). The law and the guide developed for medical abortion have not been disseminated and are not known by key actors.

Penal Code & Children's Code

In 2003 the law 2003-04 was adopted and promulgated authorizing abortion under certain conditions. However, the Penal Code of Benin, which criminalizes abortion, should be brought into conformity with the so-called 2003 law. Thus, there are prison sentences and fines (also for persons known to be accomplices or guilty of abortion practices) provided for in this penal code in case of abortion. However, the 2015 Child's Code Act in the Republic of Benin has criminal provisions in its articles 324, 325, 326, and 330 which are harmonized with SR 2003-04. In the child's code, it is described that the woman who voluntarily aborts, the abortionist and the accomplice will be punished. Penalties vary from fines to imprisonment and suspension.

Code of the child (law 2015-08 bearing code of the child in the Republic of Benin):

Article 324: *Anyone who aborts a woman with food, drink, medicine, violence or any other means is liable to a term of imprisonment of five (5) to twenty (20) years and a fine of two hundred thousand (200,000) to five hundred thousand (500,000) CFA francs.*

If the death of the woman results, the offender is sentenced to life imprisonment.

Article 325: *A woman who voluntarily aborts or has an abortion is punished by five (5) years to twenty (20) years of imprisonment and a fine of two hundred thousand (200,000) to five hundred thousand (500,000) CFA francs.*

Article 326: *The perpetrator of an abortion attempt shall be punished by the penalties provided for in article 325 of this law. The accomplice is punished with the same penalties.*

Article 330: *The doctor or midwife who is the author of an unauthorized abortion, loses the benefit of the full amount of the act which is debited for the benefit of the Treasury. The material used is seized and donated to a public health facility. If he is an official of the state, he is demoted by one step in his highest rank and is suspended from promotion for two (02) years. He is also punished with the same penalties as in accordance with the provisions of the preceding article.*

Characteristics of women seeking abortion

Little information is available on the characteristics of women seeking abortion. In Turner's study (2016), participants shared that the richest women receive higher quality of care (abortion) and that poor women are forced to move to centres with less skilled providers or even people without formal

training (Turner, Senerowics, & Marlow, 2016). In addition, in this study it is noted that knowledge about misoprostol is quite low, especially among less educated women, older women or women outside of the city who are considered far less likely to know and use misoprostol. Young, urban, educated women are the biggest users of the drug (Turner, Senerowics, & Marlow, 2016)

Barriers to safe abortion

A study on the use of misoprostol in Benin and Burkina Faso describes several barriers to women's access to abortion services (Baxerres, Boko, Konkobo, Ouattara, & Guillaume, 2018). These obstacles include:

- The ignorance of the law by women;
- The ignorance of the law by the health professionals;
- The position of health professionals against abortions;
- Medical clearance is required for abortion where there is a risk to the life of the woman and fetal malformation;
- Legal authorization is required in case of rape and incest;
- Stigma, as abortion does not conform to social and religious norms.

Stigmatisation of abortion

In Benin, a major barrier to accessing abortion is strong social stigma (Turner, Senerowics, & Marlow, 2016). A qualitative study on abortion done by ABPF (2015) shows that abortions are often perceived as a crime or sin according to religious and cultural values. In addition, in the community the difference between spontaneous abortion and induced abortion is often not done. The complications and consequences of abortions are perceived by most as a « spiritually » deserved suffering or as a punishment whose alleviation is beyond human understanding (ABPF, 2015). Another study of attitudes, beliefs and stigmatizing action on abortion was done by ABPF (ABPF, 2016). During this study, 200 interviews were conducted with men and women in the community and this study shows that:

- 60% of respondents have negative perceptions about abortion.
- 21% of respondents support the exclusion and discrimination of women who have used abortion.
- 45% of respondents have negative prejudices and agree to the exclusion of girls who use abortions.

On the basis of the interviews, emerges the finding that if complications arise as a result of unsafe abortion, clandestinity decreases. So the clandestinity only decreases when the condition of the woman is in danger (IPPF 2015).

Service delivery environment

In Benin, the decentralization process began in 1995. In the wake of this decentralization, Benin now has 77 health communes organized in 34 health zones (Turner, Senerowics, & Marlow, 2016). At primary health level, services are provided by village health Units, health centres (district and commune) with the first level of reference, the zone hospital. For patients, these are normally the entry points to the health system. Limited specialized services such as paediatrics and gynaecology are provided at the peripheral level (the zone hospital) and at the intermediate level (the departmental hospital centres). At the highest level of care there are « university hospital centres» in urban areas (Turner, Senerowics, & Marlow, 2016). Table 3 shows some general characteristics of Benin's health system.

The directory of maternal and child health is in charge of reproductive health. However, the Ministry of Health has developed several strategies on reproductive health to reduce maternal mortality, including post abortion care (Turner, Senerowics, & Marlow, 2016).

Table III: General features⁴

Infrastructure coverage	93,1%
Attendance rates	50,4 (2014)
Health endowments	86 991 851 000 FCFA
Health expenditures of GDP	4,59% (2014)
Pocket expenses	52% of health expenditures (2006) (Index Mundi, 2018)
Human resources	7,8 qualified health personnel for 10.000 inhabitants
Percentage of births attended by a qualified health professional	77.2% (2014) (HRP, 2017)

Availability and accessibility of safe abortion

In general, reproductive health services are not well accessible. The most important reasons for this inaccessibility are: « the lack of trained providers and the poor functioning of infrastructure and equipment due to poor maintenance» (Turner, Senerowics, & Marlow, 2016, p. 19). For the time being, it is not yet determined to what extent women have access to comprehensive abortion care (Turner, Senerowics, & Marlow, 2016).

However, the guide to *Medical Abortion in Benin* describes what types of services should be established at which level of the health system. District health centres must be able to practice the MVA. At the zone hospital level and accredited private health centres, MVA services, medical abortions and the management of abortion complications must be available. In the university hospitals, second trimester abortions and the management of complications of abortion must be available.

Through qualitative data, ABPF has done an analysis that shows that « the safest structures are those that are less accessible and available, so the least safe and riskiest services are the most available and the most accessible for the population» (ABPF, 2015). The qualitative study of Tuner (2016) shows that the majority of respondents say that abortions are mostly done in private clinics or NGO clinics. The quality of abortions performed in private clinics is not always known. Also the study of Baxerres (2018) shows that private clinics play a big role in abortions, especially small private health centres. In these centres, prices vary between 15,000 CFA and 55,000 CFA.

In Benin, only misoprostol is registered on the list of essential medicines as a generic medicine. In 2007, the Ministry of Health ruled that misoprostol can only be administered on prescription. It seems that the prescribing rules for misoprostol are well respected. However, it is easily accessible in the Cotonou markets. The official status of mifepristone is not clear enough. Officially, mifepristone is not registered on the list of essential drugs. However, mifepristone who has a marketing authorization is described in the guidelines and standards on safe abortion in Benin, so approved by the Minister of Health (Turner, Senerowics, & Marlow, 2016). It is not described if mifepristone is really unavailable or not.

⁴DPPD Health sector (2016-218)

Unsafe abortion: actors and methods

The ABPF study (2015) describes that several methods are used for unsafe abortions. During the interviews, the following methods emerged: drug methods (traditional products or combinations containing at least 1 medical product), instrumental methods (various metal/non-metallic tools) and mixtures of non-specific substances as gasoline mixed with alcohol or Guinness with potash. The study by Turner (2016) describes that stems and herbal teas are often used as a method of unsafe abortion. The actors who provide unsafe abortion services are people with widely varying qualifications. They are practiced by health workers, matrons, traditional healers, street medicine vendors or the woman herself (ABPF, 2015).

Perception of women and experience of abortion

Little information is available on women's perceptions. The Turner study, Senerowics, Marlow (2016, p.20) confirms this: « There are no published studies currently on the attitudes of providers and women towards abortion and abortion behaviour of women in Benin ». Only one study was found: Ezin (2016) did a study among adolescents and young people (12-25 years) in the community of Tchaourou which shows that 9 out of 10 think that « the fact of having contracted a non-desired pregnancy is not a valid reason to abort ». More than 90% of adolescents and young people think that because of the belief or mother's health, abortions should not be done. More than 50% think abortion is a sin. « 46% believe that abortion can lead to the death of women ». The main reasons given by adolescents and youth who believed abortion to be justified in cases of unwanted pregnancy were: education, family pressure, lack of financial resources for pregnancy monitoring and spouse (Ezin, 2016).

Advocacy activities and actors

Looking at what is happening in Benin with regard to advocacy for abortion, we can see that the number of NGOs in Benin is lower than in many other countries in West Africa. The situational analysis of Turner (2016) describes that only a few international NGOs are working on abortions or reproductive health: ABPF and PSI. The number of local organizations working in RH is also very limited (Turner, Senerowics, & Marlow, 2016). However, there are several professional associations working on the issue of abortion, such as the Association of Midwives of Benin (Turner, Senerowics, & Marlow, 2016).

Advocacy activities were conducted at the level of the National Assembly of the Republic of Benin but did not result in any changes to the law on abortion. The opposition is strong and comes mainly from the Catholic Church, Muslim leaders or others who have religious or moral objections. They played a big role in blocking the liberalization of abortion policies. There is no agreement according to the participants of the ABPF study (2016) on how these activities are structured.

Professional attitudes towards abortion

Limited information is available on the attitudes of professionals regarding abortion. In an IPAS project on misoprostol, mysterious client visits were made to 10 pharmacies in Cotonou. During these visits, the client tried to buy misoprostol without prescription but did not receive it. It has been found that in pharmacies the language of judgment and stigmatization has been used towards women (Turner, Senerowics, & Marlow, 2016).

The interview-based ABPF study (2015) describes that « some providers define abortion as a way of « saving life », - that of the mother - by avoiding risking death, ruin, more poverty and suffering ». Another survey conducted by ABPF (2016) in Benin shows that in a clinic where service providers were trained on Values Clarification and Attitude Transformation (VCAT), 84% clients did not feel judged by staff about their choices to have an abortion in 2016 (ABPF, 2016).

3.2 Online survey

This survey was sent to members of the CNGOB. A total of 40 people answered the various online questions addressed in the survey (response rate 44%). The purpose of this online survey was to gain a better understanding of the level of involvement and engagement of members in the activities of the CNGOB, how members communicate with each other, and the actions of society in relation to abortion in Benin. An overview of the survey findings is attached to this document.

Characteristic of society members

65% of the respondents are gynaecologists/obstetricians with over 15 years of experience and having integrated the society during the last five years. 70% of surveyed members also belong to another organization outside the CNGOB.

Commitment and level of involvement of the society

In general, the majority (82.5%) of members interviewed state that they were moderately up to very involved in society activities. Most of them participate in trainings (62.5%), conferences (80%) and special thematic meetings (60%).

Communication within the society

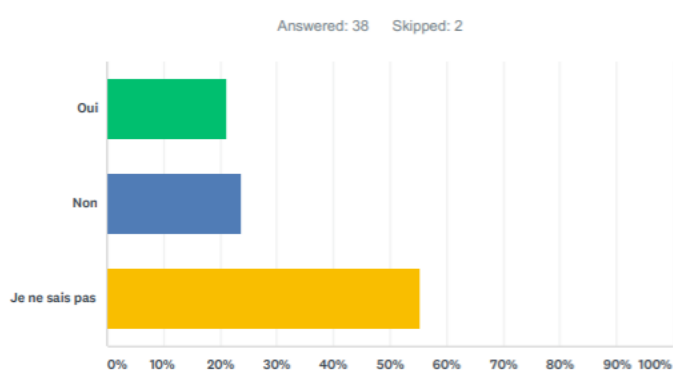
The largest communication channel used within the CNGOB is WhatsApp: 100% of surveyed CNGOB members say that WhatsApp is the most used communication channel between the society and its members. Other communication channels such as emails and the website are used between the members and the society. However, a large majority of respondents (86.9%) agree that there is a need to strengthen communication between members and the CNGOB.

ANSWER CHOICES	RESPONSES	
La communication est déjà bonne	13.16%	5
La communication est acceptable mais peut être renforcée	76.32%	29
La communication est mauvaise et doit être améliorée	10.53%	4
Je ne lis pas les communications du CNGOB	0.00%	0
TOTAL		38

Society position on abortion

Most responded that they do not know if the CNGOB has a clear position on safe abortion (55%) or said the CNGOB doesn't have any position (23.7%). For the eight respondents who are aware of the society's position on abortion, 75% feel strongly in agreement with the CNGOB's position on safe abortion and 75% of this number says they have been informed of the position of the society during training.

Q12 Est-ce que le CNGOB a une position claire envers l'avortement sécurisé ?



A 68.4% majority stated that the CNGOB does not inform its members about new evidence of abortion, laws, policies, and abortion practices. Almost all of the members surveyed (97.4%) wish to receive more knowledge on topics related to safe abortion. Members emphasized that they especially wish to receive more information on safe abortion laws, policies and protocols.

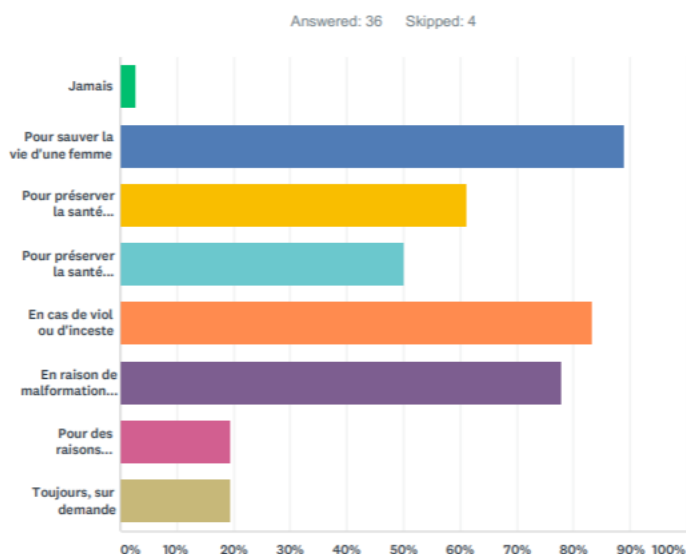
Position of society members on abortion

In general, respondents feel they are not sufficiently informed about national laws, international guidelines and policies on safe abortion (score of 2 to 3 on a scale of 5). For guidelines, policies and information on post-abortion care, respondents feel well informed (score 3 to 4 on a scale of 5).

	PAS INFORMÉ	UN PEU INFORMÉ	MODÉRÉMENT INFORMÉ	INFORMÉ	TRÈS INFORMÉ	TOTAL	WEIGHTED AVERAGE
Lois nationales sur l'avortement	18.42% 7	34.21% 13	15.79% 6	21.05% 8	10.53% 4	38	2.71
Directives internationales sur l'avortement sécurisé	26.32% 10	31.58% 12	21.05% 8	18.42% 7	2.63% 1	38	2.39
Politiques nationales sur l'avortement sécurisé	39.47% 15	28.95% 11	18.42% 7	7.89% 3	5.26% 2	38	2.11
Informations pratiques relatives à la pratique de l'avortement médicalisé (lignes directrices, recommandations)	13.16% 5	18.42% 7	28.95% 11	34.21% 13	5.26% 2	38	3.00
Directives internationales sur les soins post-avortement	2.63% 1	7.89% 3	10.53% 4	71.05% 27	7.89% 3	38	3.74
Politiques nationales sur les soins post-avortement	5.26% 2	10.53% 4	5.26% 2	63.16% 24	15.79% 6	38	3.74
Informations pratiques relatives aux soins post-avortement (lignes directrices, recommandations)	2.63% 1	7.89% 3	15.79% 6	60.53% 23	13.16% 5	38	3.74

The majority of members believe that safe abortion should be allowed or legalized when it comes to saving life (88.9%) or maintaining the physical (61.1%) and mental (50%) health of the woman, rape or incest (83.3%), foetal malformation (77.8%). A minority believe that abortion should be legal for economic or social reasons (19.4%) or always on demand (19.4%). One respondent thinks that abortion should never be allowed.

Q22 Dans quelles circonstances pensez-vous que l'avortement sécurisé devrait être autorisé / légalisé? (plusieurs réponses possibles)



The majority of surveyed CNGOB members agree:

- That safe abortion becomes part of health care and should not be separated from the rest of medicine (38.9% strongly agree, 33.3% agree).
- That health providers should have the right to decide whether or not to perform safe abortions based on their personal values and position towards abortion (52.8% strongly agree, 27.8% agree).
- That health workers who oppose safe abortions should be required to refer women to other health workers who practice safe abortion (41.7% strongly agree, 38.9% agree).
- That health workers have a role to play as advocates for safe abortion (41.7% strongly agree, 38.9% agree).
- That post-abortion care is part of health care and should not be separated from the rest of medicine (55.6% strongly agree, 38.9% agree).
- That health workers should be required to provide post-abortion care to all women regardless of whether the abortion was legal or not (72.2% strongly agree, 16.7% agree).
- That health workers should report to the respective authorities, cases showing signs of illegal abortions (33.3% strongly agree, 25% agree and 22.2% neutral).

But rather disagree for:

- That safe abortions should be performed only in private clinics and not in the public health system (61.1% disagree, 33.3% strongly disagree).

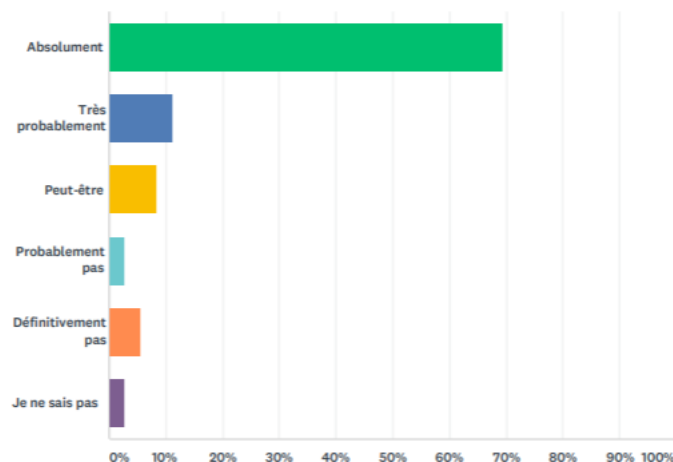
On the following statement there was a variety of opinions and a significant majority for the agreement or disagreement was not found:

- That specialized health workers (gynaecologists and obstetricians) should be required to perform safe abortions where permitted by law (27.8% strongly agree, 13.9% agree, 11.1% neutral, 27.8% disagree, 19.4% strongly disagree).

A large majority of members say they are absolutely or very likely to support CNGOB in advocating for safe abortion.

Q24 Souhaitez-vous soutenir le CNGOB dans le plaidoyer pour l'avortement sécurisé?

Answered: 36 Skipped: 4



Summary

The survey shows that communication between members can be strengthened and that the most common means of communication is WhatsApp. Among CNGOB members, the societies' position on safe abortion is not well known. Almost all of them want more information on safe abortion and shared that they do not feel well informed about safe abortion policies, standards and procedures. But they feel well informed about post-abortion care.

The majority agree that abortion must be legalized to save life, preserve the physical and mental health of the woman, in case of rape or incest or foetal malformation. The majority of respondents agree that health workers who oppose safe abortions should be required to refer women to other health workers who will practice secure abortion. In addition, most of the participants wish to support the CNGOB in advocacy for safe abortion.

As a result, communication could be improved by further using email, website and WhatsApp to share CNGOB's position on secure abortion. There is a need to clarify the position of society and that of its individual members on safe abortion in order to increase the commitment to advocate for safe abortion.

3.3 Interviews with key stakeholders

A total of 10 interviews were conducted for the needs assessment. Interviews were held with representatives of the CNGOB, the youth action movement, IPPF/ABPF, PSI/ABMS, a midwife, Benin women lawyers and the Ministry of Health (Table No. 4).

Table N°4 Interviews participants

No.	Association/ Society/Organisation	No of Respondents
1	Members of CNGOB	3
2	Youth action movement (YAM)	2
3	ABPF/IPPF	1
4	PSI/ABMS	1
5	Benin women lawyers	1
6	Ministry of Health	1
7	Midwife	1
	TOTAL	10

Safe abortion environment

Legal framework

The Sexual and Reproduction Health Law of 2003 states: « The voluntary termination of pregnancy is permitted only in the following cases and on the prescription of a physician: When the continuation of the pregnancy endangers the life and the health of the pregnant woman; at the request of the woman, when the pregnancy is the consequence of rape or an incestuous relationship; when the unborn child has a condition of particular gravity at the time of diagnosis ».

Almost all respondents shared that the law on abortion of Benin is a big barrier to access safe abortion. Participants described that because of the law, abortions are frequently done illegally because trained providers are afraid to offer services. Not, only the law is seen as a barrier, but its poor knowledge is described as an obstacle by several respondents. It has been reported that often doctors/gynaecologists, magistrates and police are not aware of the 2003 law.

The various interviews confirm that several participants are not aware of this law but always refer to the one before the 2003 law. Several reasons were given for the poor knowledge of this law. The MOH said they have not yet had time to disseminate the law. Other participants said that the MOH did not want to disseminate this law with certain people or that doctors/gynaecologists are not interested in knowing and understanding the law on safe abortion. A disinterest in women's issues was also highlighted by one respondent.

« It is the penal code which is used by the men of justice, the law of 2003 is not even known by them. As part of a decree draft workshop, police and magistrates, pastors, etc. were invited. During the workshop the magistrates were not aware of the law they said that they look at the penal code only » (IPPF)

During the interviews, it was discussed that the 2003 law does not describe sanctions/penalties for abortion and that because of this the penal code dating from the 1700s is still in force. This penal code does not take into account the three legal conditions of abortion described in the 2003 law. It was noted that for this reason it is very important to harmonize the different laws and codes.

During the workshop, it appeared that the 2015 law on the child's code in the Republic of Benin, provided for criminal provisions and it is this code that is in force and not the penal code. During the interviews, no one spoke about the Child's Code which could still show a weak understanding of the legal framework concerning abortion.

Application decree

It has been found that the lack of an implementing decree causes difficulties as the way in which the law is to be interpreted is unclear: who is allowed to offer abortion services, what process should be follow-up in case of incest or rape, in which health structures abortions can be done and how to interpret « health » in the sentence « endangers the life and health of the pregnant woman ». At the time of the interviews (April 2018), the implementing decree was developed under the initiative of the Ministry of Justice but had not yet been signed. The reasons justifying the non-signing of this decree are not clearly understood or known.

Request

Several participants shared that they think the demand for abortion exist and that it is the law and other socio-cultural factors that justify why abortions are done illegally.

« The demand for abortion is very high in Benin, I think I have at least 5 girls/women per week who ask me to do the abortion » (society member)

One participant shared that the demand situation for abortion is different from that for family planning (FP). For FP the demand must always be created but for abortions the demand is already there: if a woman decides to do an abortion, she will do everything to succeed.

Positions on safe abortion according to different institutions

Ministry of Health (MOH): The MOH is fighting to reduce the ratio of maternal deaths (347 per 100,000). They found that among the causes of maternal deaths, there is unsafe abortion. The MOH has not yet developed a specific strategy on safe abortion but there is a strategy for post-abortion care. Together with IPAS, they developed a guide and standards on medical abortions. IPAS wants to do a study on abortion in Benin to better understand the situation. The MOH said they will tailor their actions based on these IPAS figures. During the interview, it was discussed several times about how FP can be a strategy for reducing maternal deaths.

During the interviews, some participants showed that they have the feeling that the ministry is neutral when it comes to abortion. One participant said that she thinks being neutral means being opposed because you do not give support. She witness that the ministry normally participates in the abortion workshops but after the workshops they do nothing: the promises they make are not followed by action. Another participant said that the MOH is open to abortion discussions, that they are aware of the problem of abortion and that they can help other organizations working on safe abortions.

Society (CNGOB): The society does not have a clear position on safe abortion. One participant said that this clear position does not exist because abortion is prohibited by law. During the interviews the majority of the society members shared to be ready to support the society for advocacy for safe abortion. In addition, the participants showed that if the law should be liberalized, it would be very important that the process for receiving abortion services be structured: the guidelines are needed to know the different steps to follow during an abortion and to know who can offer safe abortion services (which provider and in which centres).

ABPF: This Benin association member of IPPF describes that in their clinics all the services are available for RH. They think that abortion is a fundamental choice and we must not impose what a woman must do. Several gynaecologists shared that they refer girls/women for abortion under the conditions provided by law to ABPF clinics.

PSI/ABMS: Due to the Mexico City Policy (presented by Trump), PSI and ABMS have become two separate organizations. ABMS is no longer working on abortion. The goal of PSI is to advance on safe abortion. They say that presently they are complying with the law but they want it changed so that a woman voluntarily seeking for abortion obtains satisfaction.

MAJ (Youth Action Movement): This structure shares that they are for safe abortion and that they are in a process of advocating for the changes of the law and the signing of the implementing decree. A MAJ participant says, « I see abortion as services against malaria or HIV, everyone has this right ».

The Association of Women Lawyers of Benin (AFJB): The position of the AFJB is that it does not agree with the law and that they want it to be changed. They explained that when abortion is not allowed by law, abortions will always be done illegally and that if abortions are not done illegally there will be fewer complications, infections and infertility.

Professional attitudes

The opinions of gynaecologists differ on abortion: some support it and others not. Most gynaecologists have said that they generally do not practice abortions, except in rare cases (incest for example). Two important reasons were given for not performing abortions. The first is that because of the law, gynaecologists do not wish to take risks or have problems as they think that abortion is completely forbidden. A gynaecologist said that if the law allowed abortion, he would do it. He illustrated with an example that only because of the fear for the sanctions that he does not do the abortions:

« Once I did the abortion as it was a magistrate who had come. He said that his wife has a contract of employment and that she has to wait two years before getting pregnant. I did the abortion because I knew that the magistrate was not going to complain » (Member of the society)

The second reason for not supporting abortions or not performing them is religion and/or conscience.

« I have no comments and no opposition on voluntary termination of pregnancy or post-abortion care. Everyone decides his life and especially women. A woman who decides to terminate the pregnancy, if you listen to the reasons it's powerful. But I do not do abortions myself because women cannot pay my conscience so we have to make sure with FP» (Society member)

« Spiritually it's dangerous to kill someone; and for God to forgive you, you have to save lives. When I'm going to die, I hope it's going to be fine for me and that I'll be forgiven for my first twenty years, when I did the abortions. Now I've had 10 years of transition without abortions and I hope I still have 45 years to save lives ». (Society Member)

Referral

Some gynaecologists said that they do not refer when a woman asks for an abortion but they do not practice it either. They said that the referral is not made because they do not know where to refer. Other gynaecologists said that they make reference when a woman asks:

« If you make the reference you are not author but you are accomplice, in my life I saw horrible things. Before, I said no to voluntary pregnancy termination but afterwards I saw girls who went elsewhere to do it. But you are in the custody and these same girls come back with blood everywhere or poop everywhere and we will have to put an artificial anus that's why now I am accomplice, I refer »(Member of the society)

Post-abortion care

Regarding post-abortion care, participants were much more open. Everyone says they offer these services because it is not illegal. In addition, many participants said that the majority of care providers have had post-abortion care training and that guidelines exist and are known.

A PSI participant shares that in Benin, personal opinion strongly influences the decision to perform abortions or not. For example, the policy and guide on abortion exists, yet its application during the offering of services depends on the opinion of the provider.

Relationships between different professional societies

During the interviews, it became clear that there are several organizations working on abortion. However, a good collaboration lacks between these different organizations and even when the collaboration exists, it is not structural. Some organizations were surprised to hear that the society is working on advocacy for safe abortion. In addition, many gynaecologists do not know where to refer women/girls for safe abortion. This may explain the difficulties at the level of collaborations. Respondents shared that it would be important to strengthen collaborations between different organizations and partners:

«It's important to work together with the other parties, so we have more strength if we work together. For example, young people should be involved in advocacy actions to ensure synergy of action» (MAJ).

Level of influence

During the interviews, it was clearly noted that the religious lobby against abortion is strong; especially Catholics who are very influential. It seems that on the other side (pro-choice), the different actors are less powerful. The MOH said that in order to better address the religious lobby, it is very important to have the data/figures on abortion so that a change can be made. Several participants from different organizations said they want to work with the society to advocate for safe abortion in order to have more influence.

Opportunities to strengthen networking on safe abortion

As noted above, several respondents said the society is well positioned to advocate for safe abortion. As this is their area of expertise and they know the reality well. It will be an opportunity.

« I wish collaboration with gynaecologists as gynaecologists are better placed. If we have their support, it will be very easy to have legalization. We can do an advocacy project for abortion together. We want to hear them and tell them what we do! » (MAJ)

« Technicians are always people who are known and have authority; it's them who can talk about problems. If they advocate for revising the law or if they will be more active it will have more impact » (PSI)

Some participants said that while the law is restrictive, it is an opportunity as it is not completely forbidden. In addition, in the law it is described that abortion is allowed when the continuation of the pregnancy endangers the life and the health of the pregnant woman; it's "health" that is not defined or operationalized. At the MOH level, the respondent said that normally health means the whole state of well-being and that it also includes the mental aspect. He describes it as an open door for advocacy actions. However, at the same time he realizes that the absence of this definition can pose difficulties.

In addition, respondents said that to advocate for safe abortion, it is important to work together with the population and religious leaders. The participants described that there is some hypocrisy at the population level: if the others want to do the abortions, they hide behind the religion and say that it's like killing the children but when it happens on them they will even ask for abortion.

« We must continue with advocacy, we must always inform the public and inform the representative of the people to remove hypocrisy » (Member of the society)

The participants noted that at the moment the media play a limited role in abortion but to work with the population, it is important that they are involved too. One participant said that the society itself must carry out actions/activities to inform the population.

« I think that the society must carry out awareness campaigns: once a month we have to leave Cotonou, go to the localities to do sessions on FP, STIs, HIV and AIDS and talk about the complications of unsafe abortion. It is necessary to plan the pregnancies but also to avoid the complications of the pregnancies. We need to talk about it! Talking is not forbidden » (Society member)

Current role of some actors in advocacy for safe abortion

In the country, several advocacy activities for safe abortion have been done at various levels and by different organizations/structures. One of the results of the advocacy activities is the development of the guide and standards on medical abortions. In addition, advocacy activities have been done for the registration of misoprostol on the generic list (Current Role in defending Safe Abortion). Now PSI wants to advocate for the registration of a Combi-pack of misoprostol and mifepristone.

PSI agrees that the guide and standards on safe abortions is an entry point for advocacy activities as it refers to the use of mifepristone in this document. Also PSI shares that it is advocating for the training of providers on safe abortion. PSI mentioned that they worked together with the society on introducing « harm reduction » into the care provider curriculum. Since December, this curriculum is developed and implemented.

In addition, the MAJ and ABPF developed an advocacy action plan for the signing of the implementing decree for the 2003 Abortion Law. For the moment, the activities are not yet implemented but the idea in the action plan is not only focused on the change of mentality at the community level (working with religious and traditional leaders).

3.4 Stakeholder Workshop

During the various sessions of the workshop, five broad themes emerged: improving the legal dimensions; transforming social norms at all levels; improving partnership and networking; ensuring a process of generating and using evidence for action and then building the society's capacity for safe abortions. Participants identified different activities during the workshop to increase access to safe abortion through advocacy, as described below. The final action plan (Annex 5) for the CNGOB is strongly based on these identified activities.

1. Improve legal dimensions

- Speed up the process of signing the RH law implementation decrees
 - o Lobby for the quick submission of the communication to the council of ministers
 - o Follow up (MOH)
- Disseminate the law and its decrees of application on safe abortion
 - o Popularize the law and its decrees of applications: posters, spots, plates etc.
 - o Have Ministry of Health produce application orders/memos
 - List the health facilities that can offer the services
 - Clarify the profile of service providers
- Revise the law on RH
 - o Advocate for the revision of the law (MOH -> Deputies)
 - o Review the law (health professionals)

2. Transform social norms at all levels

- Improve the perception on abortion of at least 50% of the population within 3 years
 - o Organize 15 training sessions for 450 professionals and media on safe abortion in 3 years
 - o Organize 36 value clarification sessions for authorities at various levels of government (government and institutions)
 - o Design communication tools and supports on abortion during sensitization and carnivals (500)
 - o Organize bi-weekly awareness sessions for the population
 - o Popularize the laws governing the opening of private clinics and the provision of abortion services
- Ban unsafe abortions

3. Improve partnership and networking

- Identify the partners
 - o List existing partners
 - o Find new partners
- Define a collaborative strategy
 - o Organize meetings with partners
 - o Establish partnership agreements according to deconcentrated subject areas
 - o Submit an advocacy project
- Networking the different stakeholders
 - o Naming focal points (secure abortion)
 - o Coordinate the interventions of the partners
 - o Develop reference and counter-reference procedures
 - o Organize periodic meetings (platform)

4. Ensure a process of production and use of evidence for action

- **Produce evidence on abortion needs**
 - Make a census of previous studies
 - Initiate new studies
 - Collect data in post-abortion care registers
 - Collect testimonials (victims, parents and caregivers)
 - Make a voxpopuli on the theme
 - Make the documentary of cases of unsafe abortion admitted in the Health Centers
 - Sensitize health professionals for the collection of video images and probes from abortion cases.
 - Develop communication materials (on the law and decree): brochures, awareness guide
- **Use evidence and support in an innovative way**
 - Use mass media and social networks: broadcasts, debates, radio, TV, documentaries and posters diffusion
 - Development of « frequently asked questions » (FAQ)
 - Development of a Green Number
 - Popularize the laws and decrees
 - Quizzes
 - Distribution/displays
 - Organize illustrated interviews. Targets: opinion leaders, various authorities, grassroots community organizations (networking).
 - Organize periodic universal reviews and trainings. Targets: health professionals

5. Strengthening society's capacity for safe abortions (to make it visible and accessible)

- Identify resource persons
 - Name focal points
 - Train the identified focal points (on the clarification of values and transformation of attitudes)
 - Develop the society's vision on safe abortions
- Energize the activities of the society
 - Achieve Post University Teaching (UPE) quarterly
 - Organize the biannual days
 - Revitalize the CNGOB website
- Master the law on safe abortion
 - Organize the vulgarization workshops of the law on abortions
- Equip the society with material (didactic, logistics)
 - Advocate towards institutions
 - Acquire teaching/logistics material
 - Build headquarters for society

Networking

During the group work, networking for safe abortion was done. Appendix 3 provides a summary of allies and networks where potential allies could be found. This should be seen as a dynamic table. New allies can be identified and potential allies can move.

Strengths, Weaknesses, Opportunities, and Threats

During the workshop, participants have identified during group work: the strengths, weaknesses, opportunities and threats of the CNGOB in advocacy for safe abortion. Their theoretical and practical knowledge of reproductive health and their experiences with abortions are among other things seen as strengths. However, the weaknesses noted are: their ignorance of the law and the limited financial resources. The identified opportunities are the fact that they can train health personnel through the introduction of a curriculum in abortion care training and that they can raise awareness at the community level. The threats identified are related to lobbying activities by religious leaders and the socio-cultural context. The main findings of the SWOT analysis are given in Annex 4.

Action plan

As a final exercise, the groups began to define the objectives and activities of an advocacy plan for safe abortion. The overall goal of the Action Plan is to improve the capacity of CNGOB in advocacy for abortion to increase access to safe abortion and reduce morbidity and mortality from unsafe abortion. Activities should be used to achieve the objectives and include the different levels of advocacy and social networks discussed during the workshop. Following the stakeholder workshop, the team of consultants continued to develop the action plan, including the deliverables. The action plan will continue to be developed in consultation with the CNGOB and FIGO. A preliminary action plan can be found in Appendix 5.

4. Conclusion

The different components of the needs assessment have confirmed that unsafe abortion and its complications are a major problem in Benin. Unsafe abortions endanger the lives of many women. The practice of unsafe abortion is so widespread that there is a call for safe abortion to reduce this problem. However, advocacy for safe abortion will face many difficulties where norms, (religious) beliefs and personal values do not support safe abortion.

This study shows some of the challenges that the society may face during advocacy for safe abortion:

- **Lack of data on safe abortion:** For healthcare providers who perform a safe abortion, for fear of being arrested, they do not collect the data as such. Comprehensive abortion care is sometimes recorded as post-abortion care. There is therefore a lack of sufficient and reliable data that can be used to promote safe abortion
- **Legal framework:** multiple documents exist on abortion including the 2003 law, the penal code, and the code of the child which define the conditions of access to abortion services. These documents are not harmonized in terms of information; also the 2003 law lacks a decree of application perplexing the service providers on its application.
- **Ignorance of the law and guidelines:** In general, there is not a good knowledge of the texts and or documents that govern abortion in Benin. Service providers and actors working in the field do not have adequate control of national policies and the law on abortion.
- **Social environment:** The stigma attached to abortion is observed at different levels. It exists at the individual, community, organizational or political level. For fear of stigma, women and girls are forced to go to high-risk services, putting their lives at risk. Religious beliefs and the social perception of abortion reinforce stigma and constitute a strong barrier to access to secure services.
- **Different views in the society:** Within the CNGOB, members do not all have the same perceptions of secure abortion services. The views on safe abortion are divergent among members depending on whether religion or personal perception makes it possible to offer services or not. However, the majority seems to be ready to play a role in advocating for safe abortion. For this, the definition of a clear CNGOB position on safe abortion will be important.
- **Providing services in clandestinity:** There is a great demand for abortion services but because of the law and the social environment, abortions are frequently done in clandestinity. Because of this, healthcare providers who practice abortion do not speak openly about the services they provide. For example, many providers offer comprehensive abortion care but register it as post-abortion care.

To strengthen advocacy for safe abortion, the various stakeholders must commit to take action at all levels to convince decision-makers. The strong presence of the CNGOB is an asset as a leader in technical knowledge and experiences that can influence decision-makers on safe abortion. The society is an ideal setting to network with like-minded associations and organizations to ensure safe abortion services for girls and women who express the need.

5. Recommendations for the future program

By building its base as a safe abortion advocate, the association will have to address the various potential challenges identified during key informant interviews and the two-day workshop. This could include the following:

1. Strengthen the management and organization of the CNGOB as a valuable advocate for safe abortion
2. Establish a coordinated and dynamic network of associations that support safe abortion
3. Transforming social and gender norms at all levels regarding safe abortion but in the context of Beninese law
4. Ensure that the legal framework is consistent while raising awareness among stakeholders and at all levels for a harmonious interpretation of legislation.
5. Ensure a process of generalization and use of data for monitoring and planning services

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- Turner, K., Senerowics, L., & Marlow, H. (2016). *Comprehensive abortion care needs and opportunities in Francophone West Africa: Situational Assessment Results.* Récupéré sur <http://www.ipas.org/en/Resources/lpas%20Publications/Comprehensive-Abortion-Care-Needs-and-Opportunities-in-Francophone-West-Africa.aspx>

Annex 1 Program and participants of stakeholder workshop

Due to time constraints the program was adapted during the days. Starting time was later and some workshop components were skipped. (Marked in italics)

Time	Content
Day 1: 5 April	
8.30– 9.10	Introduction: Welcome and prayers President society Getting to know each other, expectations, purpose, objectives, agenda, facilitator's participant roles, group norms, evaluation process, housekeeping
9.10-10.20	Presentation preliminary country results; validation of analysis; dialogue about reasons for abortion and what needs to improve to meet women's need for safe and legal abortion
10.20-10.35	Break
10.35 -11.00	Presentation and discussion results of group work dialogues
11.00-11.30	Implications of national abortion laws on access to safe abortion.
11.30-12.30	Share positions and personal beliefs and discuss professional responsibilities
12.30-13.30	Lunch
13.30-14.00	What is advocacy: concept, levels and challenges
14.00 -14.30	<i>Advocacy perspective, risks and benefits in advocacy (shortened)</i>
14.30-15.00	Roles in advocacy
15.00-15.15	Break
15.15 -16.00	Roles in advocacy continued
16.00-16.25	<i>Power dimensions in advocacy</i>
16.25-17.15	Advocate for safe abortion care
17.15-17.30	Evaluation of the day
Day 2: 6 April	
8.30-9.00	Welcome and prayers Recap of day 1 by 2 volunteer participants identified day before
9.00-10.00	Social networks and reaching different audiences
10.00-10.30	Break
10.30-11.00	Address parked issues (none parked)
11.00-12.30	Presentation of achievements weaknesses barriers and opportunities of abortion project. Then: strengths, weaknesses, opportunities and threats of the national association for abortion advocacy.
12.30-13.00	Lunch
13.00-15.00	Develop an action plan for abortion advocacy in small groups
15.00-15.15	Break
15.15 -16.00	Continue develop action plan
16.30-17.00	Presentation and discussion action plans in plenary
17.00-17.30	Evaluation and goodbye

Elaboration on Content of the workshop

The workshop contained eight components:

1. **Introduction:** a session where the background and objectives of the needs assessment and the stakeholder workshop were explained, logistics of the facilitations process, roles and group norms were discussed. Professor Benjamin Hounkpatin opened the day.
2. **Presentation of draft country results and identification of women's needs for safe and legal abortion:** a session where the preliminary results of the desk review on country background, legal and political context, abortion stigma, service delivery environment and advocacy activities in the country were presented and validated with the participants. In a second part of the session case studies about women having obtained unsafe abortion were discussed and analysed in groups. Needs from the perspective of the woman were identified with respect to availability, access to and quality of safe abortion services, environmental and legal dimensions.
3. **Share positions and personal beliefs; discuss professional responsibilities:** a session where personal barriers and motivations to provide safe abortion were explored, with the emphasis that everybody has a right to personal beliefs, which are not questioned. Personal beliefs were benchmarked against professional responsibilities and FIGO's resolution on conscientious objection was discussed in the light of remaining barriers (such as limited professionals available in the country).
4. **What is advocacy and why providers as advocates:** a session to define advocacy and emphasize health providers' unique strength for advocacy, based on: first-hand experience, trustworthiness, extensive network, intermediary client-provider, prestige and status.
5. **Three roles of an advocate:** a session to explore one's advocacy role as an educator, witness or persuader within different advocacy scenarios: provider-client, provider-provider, provider-professional network, provider-media, provider-policymaker.
6. **Social networks and reaching different audiences:** a session to explore social networks for advocacy on safe abortion, identify current and potential allies and ways to reach them.
7. **Strengths, weaknesses, opportunities and threats (SWOT) analysis:** to the abortion advocacy capacity of CNGOB.
8. **Development of an action plan:** a session to, based on the outcomes of the previous session components, identify objectives and activities for the next proposal on safe abortion advocacy.

The following sources were used for development of the workshop activities:

- Ipas | Providers as advocates for safe abortion care: A training manual. 2009
[http://www.ipas.org/en/Resources/Ipas Publications/Providers-as-advocates-for-safe-abortion-care-A-training-manual.aspx](http://www.ipas.org/en/Resources/Ipas%20Publications/Providers-as-advocates-for-safe-abortion-care-A-training-manual.aspx)
- Ipas | Abortion attitude transformation: A values clarification toolkit for global audiences. 2011
<http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation-A-values-clarification-toolkit-for-global-audiences.aspx>

Participants of the workshop

	Name	From where?	CNGOB ?
1	PERRIN RENE XAVIER	CHU MEL	CNGOB
2	HOUNKPATIN BENJAMIN	CHU MEL	CNGOB
3	BAGNAN TONATO ANGELINE	CHU MEL	CNGOB
4	ABOUBAKAR MOUFALIOU	CHU MEL	CNGOB
5	FIOGBE ARNETTE	CHU MEL	CNGOB
6	DENAKPO JUSTIN	CUGO	CNGOB
7	TSHABU AGUEMON CHRISTIANE	CUGO	CNGOB
8	HOUNDEFFO TIBURCE	CUGO	CNGOB
9	TAIROU ADAMA	CUGO	CNGOB
10	KLIKPEZO ROGER	HIA	CNGOB
11	MOUSTAPHA RAZACK	PRIVE	CNGOB
12	EWAGNIGNON EMMANUEL	PRIVE	CNGOB
13	DAOUDA SIKIROU	PRIVE	CNGOB
14	ATTADE WILLIAM	PRIVE	CNGOB
15	ADJAO RAZAKI MOUSTAPHA	PRIVE	CNGOB
16	DETONGNON COHOVI	CHUD-OP PORTO NOVO	CNGOB
17	DR SYMPHOROSE LOKOSSOU	CHUD-OP PORTO NOVO	CNGOB
18	PATRICE DANGBEMEY	CHU MEL	CNGOB
19	SOLANGE ABLAWAVI KANMADOZO ADECHOKAN	PADRE PIO CDU COTONOU	CNGOB
20	MATHIEU OGOU DJOBI	CHUD-OP PORTO NOVO	CNGOB
21	SOSTHÈNE ADISSO	UNIVERSITE D'ABOMEY-CALAVI	CNGOB
22	BÉRENGER AMADJI	PRIVE	CNGOB
23	ESTHER DADJO	HZ OUIDAH	CNGOB
24	ZANNOU ROBERT FRANCK	DSME (MINISTERE DE LA SANTE)	
25	TOSSOU BOCO THIERRY	DSME (MINISTERE DE LA SANTE)	
26	AYIVI PRUDENCIA	ABMS/PSI	
27	KITIHOON SERGE	ABPF	
28	ELVIS SERIKI	MAJ/ABPF	
29	WILDAF BÉNIN	WILDAF	
30	BLANDINE SINTONDJI	ASSOCIATION DES FEMMES JURISTES	
31	LAURENCE MONTEIRO	L'ASSOCIATION DES SAGE- FEMMES	
32	EGOUNLETY PASCALINE		
33	YARINE MOUTAÏROU		

Annex 2 Overview of outcome online survey

The summary of responses to the online survey comes in an additional file, in PowerPoint format.

Annex 3 Social Networks

Level	Actors	How to achieve
Global actors	FIGO	
Professional networking	<ul style="list-style-type: none"> • Association Béninoise pour le Markéting Social (ABMS) “Benin Association for Social Marketing” • Association des Cliniques Privées du Bénin (ACPB) « Benin private clinics’ Association » • Association des Gynécologues Obstétriciens Privés du Bénin (AGOPB) “Association of Private Gynaecologists Obstetricians of Benin” • Association des Etudiants en Médecine “Association of Medical Students” • Gynaecologists & obstetricians (individuals) • ONMB • Professional Associations 	<ul style="list-style-type: none"> • Formal meetings (support: procedural manuals) & formal meeting of persuasion (bringing in ethics and deontology). • Days of reflection • Symposium • Training • Congress • Exchange meeting • Seminars/workshops • Training on Value Clarification on Safe Abortion • Training on the use of misoprostol
National policy level	<ul style="list-style-type: none"> • Ministry of the Family • Ministry of Health: DNS, DNSP • Ministry of Justice • Ministry of Education • Parliament 	<ul style="list-style-type: none"> • Formal and informal meetings • Individual interviews • Sensitization • Testimonial case presentation
Local policy level	<ul style="list-style-type: none"> • Association Nationale des Municipalités du Bénin National Association of Benin Townships (ANCB) 	
ONGs& bi and multilateral	<ul style="list-style-type: none"> • BASM • ABPF • CARE BI 	<ul style="list-style-type: none"> • Formal meetings • Information seminar and training on abortion methods, follow-up, draft action plan • Days of reflection • Symposium • Training • Congress • Exchange meeting • Seminars / Workshops
Legal network	<ul style="list-style-type: none"> • Wildaf Network 	<ul style="list-style-type: none"> • Days of reflection • Symposium • Training

		<ul style="list-style-type: none"> • Congress • Exchange meeting • Seminars/Workshops
Religious network	<ul style="list-style-type: none"> • Religious leaders • Traditional leaders • Local elected officials 	<ul style="list-style-type: none"> • Support the coalition of traditional/religious leaders • Formal meetings (preaching, video, statistics, testimony) • Exchange meetings • Individual interviews • Training on value clarification on safe abortion with use of images
Community	<ul style="list-style-type: none"> • Youth Associations: MAJ/OCJ/PJB, JA /SR/PF • Association pour la Formation en Milieu Rural (AFMR) “Association for Training in Rural Areas” • Civil society organizations (CSOs): Rifonga Benin • Women’s organizations • Coalition Organisations de la société civile pour la PF (OSCPF) “Coalition of Civil Society Organisations for FP” • L'association générale des producteurs de blé et autres céréales (AGPB) “The General Association of Wheat and Other Cereal Producers” 	Inform, clarify values, train, draft action plans
Media	Journalists	

Annex 4 SWOT analysis

SWOT analysis of the capacity of the national society to advocate for safe abortion	
<p>STRENGTHS</p> <ol style="list-style-type: none"> What do you think doing well? <ul style="list-style-type: none"> Awareness conference (information on abortions and their complications: statistics) Interventions in the media (radio, TV, print media) Periodic meeting What are your sole strengths? <ul style="list-style-type: none"> Skills as health professionals What specialized knowledge do you have? <ul style="list-style-type: none"> Theoretical and practical knowledge on reproductive health. On what knowledge can you draw from? <ul style="list-style-type: none"> Professional experiences, daily experience Do better : <ul style="list-style-type: none"> Lobbying based on theoretical knowledge, practices and experiences 	<p>WEAKNESSES</p> <ul style="list-style-type: none"> Lack of knowledge of the law Insufficient qualified human resources (AS) Insufficient financial resources Lack of material (videos, cars and others) Some health professionals who want / cannot do abortions Religious leaders + traditional leaders <p>Needs :</p> <ul style="list-style-type: none"> Communication Knowledge of the law Capacity building
<p>OPPORTUNITIES</p> <ol style="list-style-type: none"> What more to do: <ul style="list-style-type: none"> Train health staff Introduce in the training curriculum, the management of abortions Train community relays on abortion issues Sensitization of the population to the base How to accomplish: <ul style="list-style-type: none"> Extend actions towards state institutions Train the members of the government, parliament and institutions, Sustaining achievements (monitoring, evaluation) Use of various testimonies Public to reach: <ul style="list-style-type: none"> Health workers Medical students Community relays 	<p>THREATS</p> <ol style="list-style-type: none"> Barriers <ul style="list-style-type: none"> Religious lobby Administrative heaviness Socio-cultural context: social providers, sexual taboos, stigmatization) Reluctance of some providers Strength of your opponents <ul style="list-style-type: none"> Strong influence of religious leaders Essential in making decisions Strength of tradition What do they do that you do not do? <ul style="list-style-type: none"> The religious leaders are in permanent contact with the population Disciplinary organization

<ul style="list-style-type: none">- National decision makers- Leaders and religious leaders- The crowned heads- Traditional chiefs- The journalists <p>4. The new channels:</p> <ul style="list-style-type: none">- Social networks- The press- Social radios, the stars of Beninese music	
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Annex 5 Country action plan

A preliminary country action plan will come in a separate file in excel format.