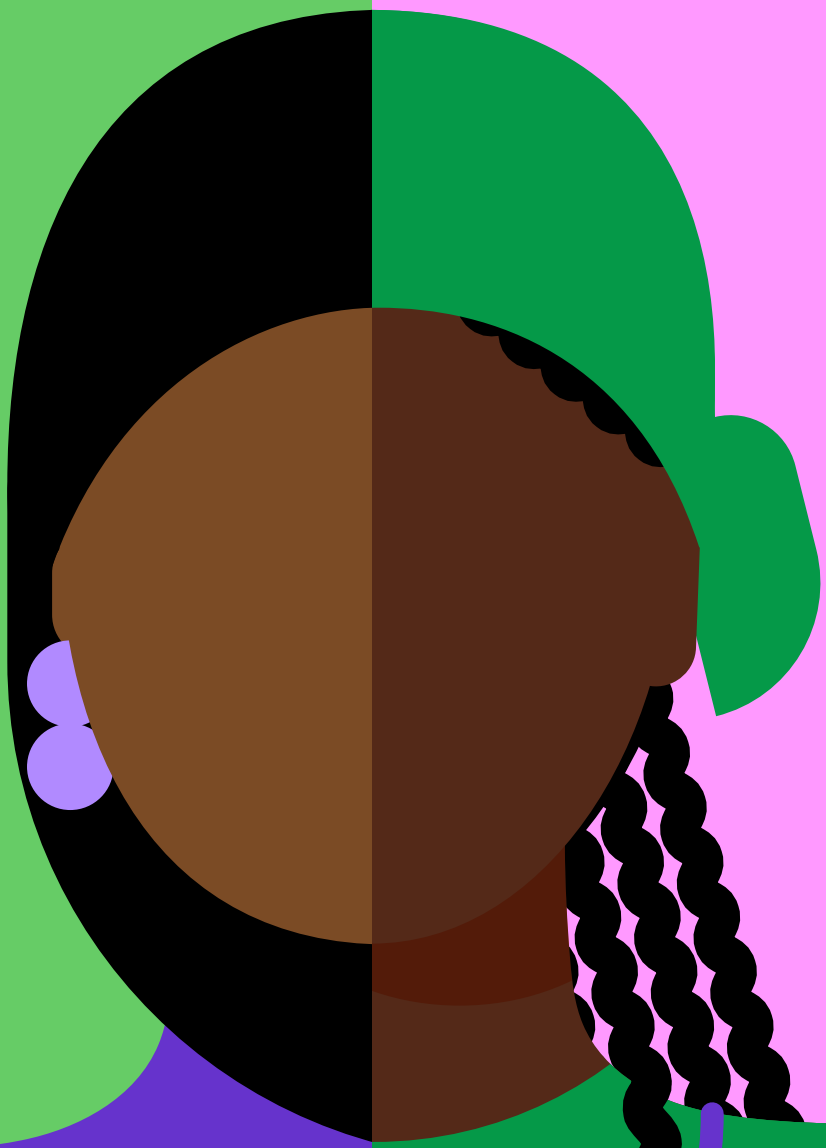


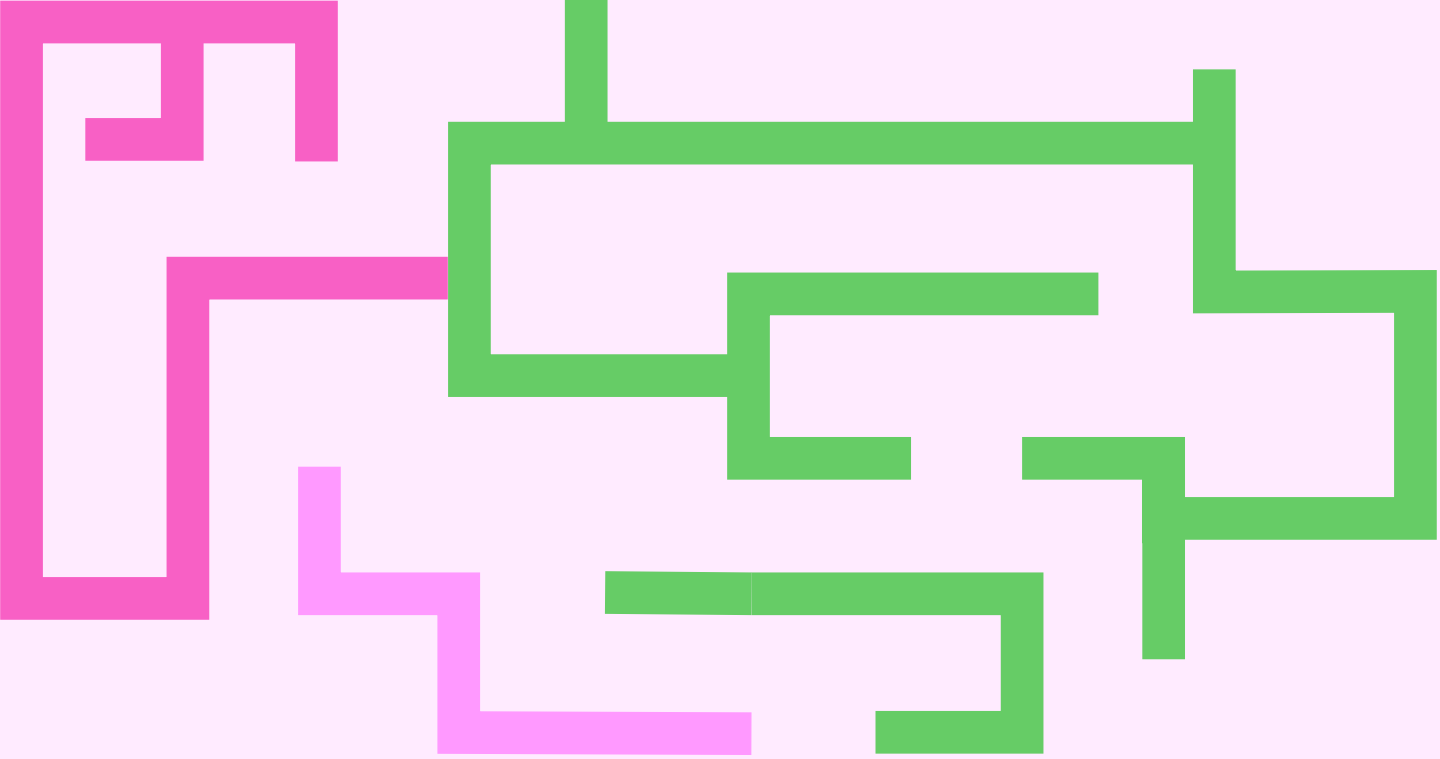
OUT OF THE MAZE:
EXPANDING ACCESS TO SAFE ABORTION IN BENIN

A qualitative study from the Borgou and Atlantique departments

Rutgers

APHRC
African Population and Health Research Center

ABPF Association Béninoise Pour la Promotion de la Famille



Authors

Ramatou Ouedraogo – Principal Investigator (APHRC)

Jonna Both – Co-Principal Investigator (Rutgers)

Camille Houetohossou – Co-Principal Investigator (ABPF)

Audrey Semevo Eunice Amoussou – Coordinator (APHRC)

Déo-Gracias Vanessa Dossi Sekpon – Coordinator (APHRC)

Pervenche Dorcas Ashley Metohoue – Research Assistant (APHRC)

Esther Cadja Dodo – Research Assistant (APHRC)

Françoise Kouinmayoa – Research Assistant (APHRC)

Iradhatou Bio – Research Assistant (APHRC)

Yélian Ingrid Tottin – Research Assistant (APHRC)

Leonce Masso Tikandé Ganigui – Research Assistant (APHRC)

Alina Meyer – Consultant (Freelance)

Suggested citation: APHRC, ABPF & Rutgers (2026), *Out of the Maze: Expanding Access to Safe Abortion in Benin*, Utrecht: Rutgers.

Acknowledgements

The research team would like to express its deep gratitude to the Benin Ministry of Health for supporting this research project. We would also like to thank the health authorities and all healthcare professionals in the Atlantique and Borgou departments for their support during the research phase and the validation of the results.

We are deeply grateful to the participants in this research – in particular the adolescent girls and women, their partners and their relatives – who shared with us their stories, journeys and experiences regarding access to abortion. Their testimonies have demonstrated the necessity and importance of this research.

Our thanks also go to all the key informants and stakeholders who generously agreed to be interviewed or supported the research team in their data collection activities, in particular our colleagues at the Beninese Association for the Promotion of the Family and the Benin Youth Action Movement, as well as the youth advisory committee set up for this research.

This report is based on data collected by six dedicated young researchers and two coordinators over a period of seven months. Without their commitment and perseverance, this research would not have been possible.

This research was made possible with the financial support of the Postcode Loterij (Postcode Lottery Netherlands), via Rutgers.

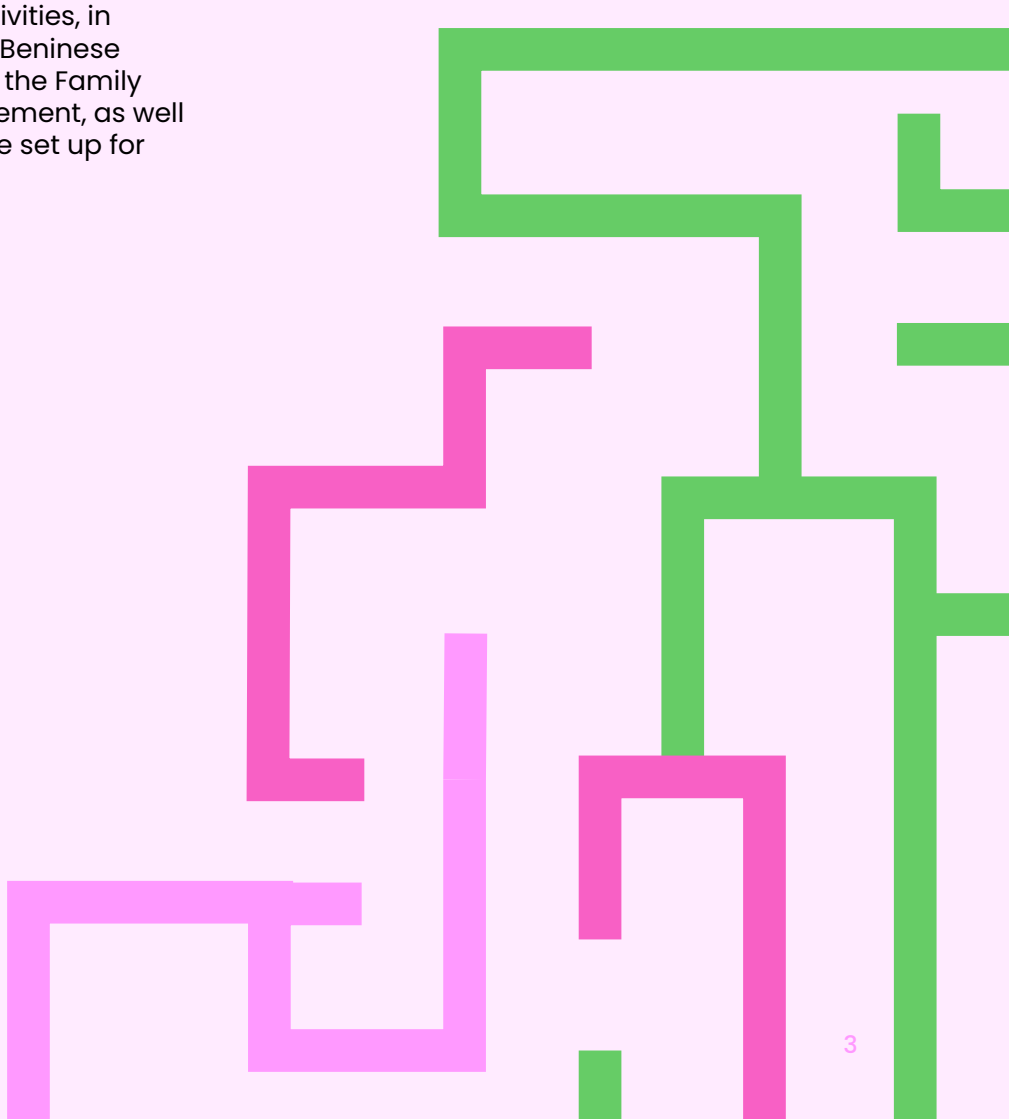


Table of contents

Executive Summary

Introduction

'Out of the Maze: Expanding Access to Safe Abortion in Benin' presents findings from research on abortion experiences in Benin. The ethnographic study examines access to abortion care for adolescent girls and women in Benin following the 2021 adoption of the amended law on Sexual Health and Reproduction. The findings point to improvements in access to safe abortion care in Benin, while also underscoring the persistence of significant obstacles. Many adolescent girls and women continue to face a complex set of barriers that limit effective access to safe care. Building on this analysis, the report offers concrete recommendations to improve equitable access for all those who need it.

Before 2021, most adolescent girls and women in Benin facing an unintended pregnancy that they could not or did not wish to continue had access to legal abortion only under limited circumstances. These included situations in which the pregnancy caused a risk to the woman's life or health, in cases of rape, incest or serious fetal abnormalities. Outside these conditions, adolescent girls and women were forced to resort to clandestine methods, exposing themselves to serious health risks and potential legal prosecution.

In 2021, a legislative reform aimed at reducing maternal mortality[1], introduced a legal framework unprecedented in the West Africa region. The amended law permits voluntary termination of pregnancy within the first 12 weeks in cases of material, educational, professional or moral distress. It came into effect following the publication of the implementing decree in May 2023.

This study examines how the amended law has shaped access to safe abortion for adolescent girls and women in Benin, and the obstacles that persist. Evidence from other countries shows that while legal reform is essential, it is not sufficient on its own to remove all barriers. In-depth research such as this helps identify the additional measures needed to ensure equitable access to care.

Legal reform has expanded access to safe abortion but significant barriers remain

1 Government of Benin, 2021

How the experiences of adolescents and women were documented

This study was conducted in the Atlantique and Borgou departments, selected for their sexual and reproductive health indicators, particularly on abortion and teenage pregnancy.[2] Furthermore, Atlantique was chosen due to a prior study by the team before the amendment of the law, which allowed for data comparison. The study used an ethnographic approach.

Data was collected by a team of six young women researchers. They conducted participant observations in 15 health facilities and surrounding communities and held in-depth interviews with 73 adolescent girls and women who had had an abortion. Additional interviews were conducted with health professionals, relatives and other key informants.

The research was carried out by APHRC, Rutgers and APBF, as part of the She Makes Her Safe Choice programme, aimed at reducing maternal mortality and morbidity linked to unsafe abortions in West and Central Africa.[3]

Benin

2 Health Statistics Yearbooks 2022

3 For further information: She Makes Her Safe Choice - Rutgers International. The programme is funded by Postcode Loterij (Postcode Lottery Netherlands)

Key findings

1. A diversity of abortion pathways persists

The findings reveal multiple pathways to abortion. Just over half of the adolescents and women interviewed (39 out of 73[4]) accessed formal and safe abortion care, either directly or after an initial unsuccessful attempt using unsafe methods. The remaining participants (34 out of 73) relied on unsafe methods, including herbal teas, medicines obtained from pharmacies or the informal markets, or went to informal providers before seeking formal post-abortion care for their complications.

These clandestine pathways remain common and are often associated with serious medical health complications, including two deaths recorded during this study.

Women aware of the reform are more likely to seek safe abortion care

2. Factors facilitating access to safe care

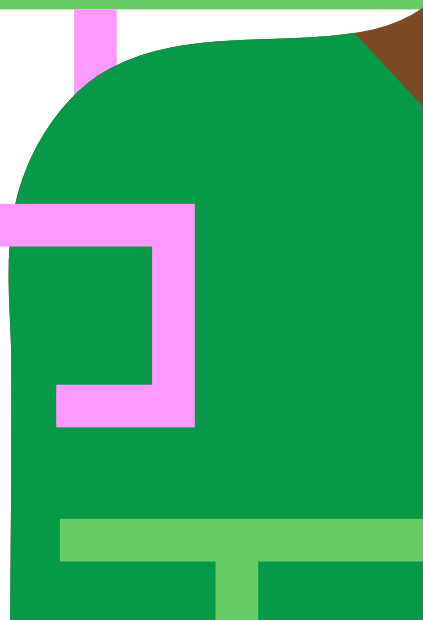
Several factors were found to facilitate access to safe abortion care among adolescent girls and women.

Knowledge of the law

Even partial knowledge of the law – among adolescent girls and women or those around them – helps normalise seeking care and reduces fear of legal prosecution, it is the main reason that prompts them to seek care at a health facility.

Referral pathways

Referrals are an important mechanism for overcoming barriers such as conscientious objection and structural constraints within health facilities. Some providers actively refer adolescent girls and women to alternative facilities or providers willing to provide safe abortion care.



4 Given the relatively small sample size (n = 73), the figures mentioned in this paragraph are not intended to be representative or generalisable. Rather, they are presented to illustrate the patterns and trends observed in terms of abortion experience within the data.

Civil society organisations

Civil society organisations play a pivotal role in facilitating access, including through helplines and social media. They connect adolescent girls and women to supportive providers, help ensure confidentiality and act as intermediaries, particularly where financial barriers are present.

Women's financial resources

Financial autonomy significantly influences women's access to care. Where women lack independent financial resources, support from partners, family or civil society organisations, particularly through referral vouchers, helps to overcome financial barriers.

3. Persistent barriers to accessing safe abortion care

Despite the reform, multiple barriers continue to hinder effective and safe access to abortion care.

Lack of awareness of the law

About four out of five adolescent girls and women who resorted to unsafe abortion methods were unaware of the legal reform. Limited dissemination of information, particularly in rural areas, fuels misinformation and uncertainty about legal rights, the reasons behind the reform and the conditions for access, undermining the legitimacy of the reform and access to care, especially for rural women and girls.

Conscientious objection by healthcare providers

Conscientious objection remains widespread, particularly in public facilities. It is sometimes collective, or institutionally imposed, and does not always comply with the provisions set out in the 2023 implementing decree. As a result, of the nine public health facilities studied, only one provided safe abortion care.

Often the consequences of conscientious objection were compounded by the failure to refer adolescent girls and women to health facilities that provide safe abortion care.

Refusal to provide care or refer patients restricts access to safe care

High cost of abortion care

Where services are available, mainly in private and non-profit facilities, cost remains a major barrier. Tariffs vary between 12,000 FCFA (18 euros) and 100,000 FCFA (152 euros) due to further tests such as ultrasound scans and blood tests. These tariffs are unaffordable for many adolescent girls and women, particularly those in vulnerable economic situations.

Lack of family or partner support

The persistent stigma surrounding premarital pregnancy and abortion often forces adolescent girls and young women to seek abortions in secret. This deprives them of the financial support from their family or partner, even though this is essential for them to access safe healthcare.

Requirement for parental consent for minors

The legal requirement for parental consent for abortion poses a major obstacle for adolescent girls. Fearing their parents' reaction, many avoid formal healthcare services and instead resort to unsafe methods.

Legal limits and delays

Delays in decision-making, repeated attempts using unsafe methods and limited information often results in adolescent girls and women presenting beyond the 12-week legal limit, leading to refusal of care. The exceeding of time limits is sometimes due to the attitudes and practices of healthcare professionals. The interviews indicated that some use medical and administrative procedures as a covert form of conscientious objection.

Availability of informal care

Informal abortion services remain widely available, including through social networks and in the community, and compete directly with formal abortion care. Their accessibility and flexibility make them an interesting alternative for many adolescent girls and women, particularly those facing financial or institutional barriers.

Conclusion

This study shows that the 2021 legislative reform represents a clear step forward in improving access to safe abortion care in Benin. This is particularly evident when compared to the situation prior to the reform, when very few adolescent girls and women had access to safe abortion care.

However, as seen in other countries, legal reform alone remains insufficient to ensure equitable access. Structural, economic, informational and socio-cultural barriers persist, disproportionately affecting the most vulnerable, including minors, women living in rural areas, and those in precarious economic situations. As a result, many continue to rely on informal and unsafe abortion care, with significant health risks.

Recommendations

Drawing on these findings and the perspectives of young people, healthcare professionals, civil society organisations and other stakeholders, the researchers developed the following recommendations to improve access to safe abortion care in Benin. The recommendations are guided by the principle that adolescent girls and women should be meaningfully involved in the development, implementation and oversight of abortion laws and policies.

For the Ministry of Health with the support of other ministries:

1. Improve the dissemination and understanding of the amended law amongst health care providers and the public.
2. Address and regulate conscientious objection in public healthcare centres and insist on the obligation to refer.
3. Reduce the financial barrier to accessing abortion care in public and private healthcare facilities.
4. Strengthen the human and technical capacity of healthcare facilities to provide high-quality abortion care.
5. Establish a monitoring and accountability mechanism that ensures the continuity and accessibility of safe abortion care.

For civil society organisations:

1. Strengthen and diversify outreach strategies relating to the amended law.
2. Improve access to helplines, referral services, financial and psychosocial support.
3. Support the government in improving the quality of abortion care.

For global donors:

1. Sustain and increase dedicated funding for safe abortion care in Benin.
2. Support the implementation of the Sexual and Reproductive Health Law to ensure that legal provisions translate into accessible, high-quality care in practice.

Introduction

In December 2021, the Beninese government amended its law on Sexual Health and Reproduction (SRH) as a way to address the high number of women who were dying or experiencing severe complications from unsafe abortions. Five years on from this legal change, this report examines the current experiences of adolescent girls and women in Benin regarding abortion.[i]

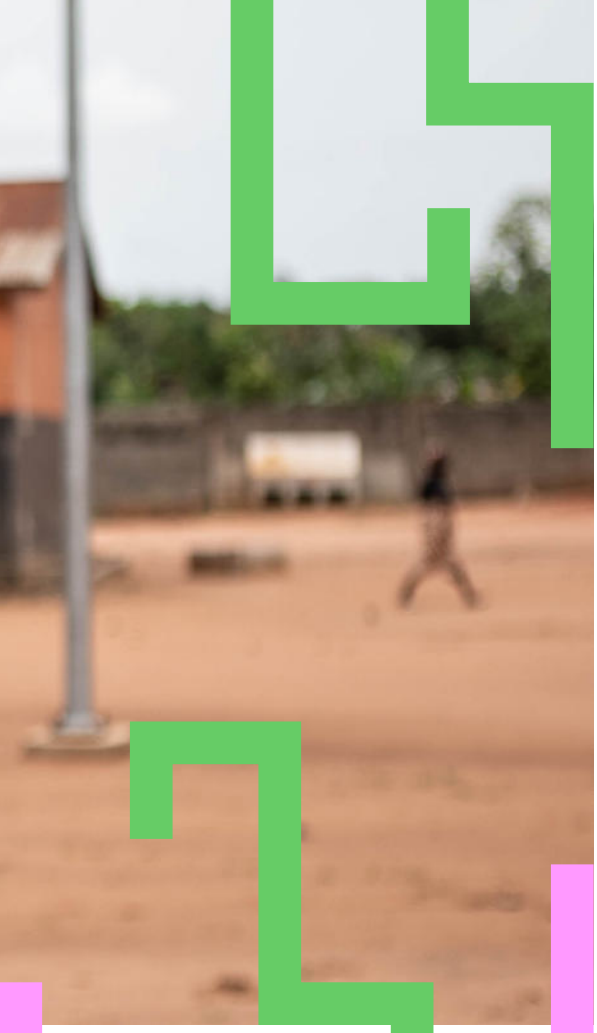
This research is the first of its kind in the region. It is based on an ethnographic approach and draws on personal accounts that highlight both the progress made and the persistent barriers faced by adolescent girls and women when seeking safe abortion care.

Before the 2021 legal change, access to safe and legal abortion was strictly limited to the following conditions:

1. where continuing the pregnancy endangered the life and health of the pregnant woman
2. at the woman's request, where the pregnancy was the result of rape or incest[ii]
3. if the foetus had a congenital abnormality.

i Throughout the report, we use the term 'adolescent girls and women', or in some cases simply 'women', to refer collectively to the 73 females (aged 15+) who had experienced an unintended pregnancy who participated in this research. Young women (ages 18-24) were the largest age group within this sample. The report also notes when findings relate specifically to adolescent girls and young women (ages 15-24).

ii In practice, there are numerous socio-cultural and administrative barriers preventing women in the second category from accessing safe abortion; see APHRC, Rutgers, ABPF, (2022), Experiences of abortion in Benin: Social determinants and care pathways in the Atlantique department, Nairobi: APHRC; Rutgers and CERRHUD, (2025) The maze women face: Stuck between rights and reality, Utrecht: Rutgers.



The limited nature of these provisions meant that most women in Benin who needed an abortion were forced to resort to unsafe methods. Not only did they face moral condemnation for their actions, they also risked legal prosecution.[1]

The legal change means Benin now also permits abortion before 12 weeks' gestation if carrying a pregnancy to term would exacerbate or cause a woman financial, educational, professional or moral distress. The amended law came into effect through an implementing decree in May 2023.

But how much has really changed? While legislative reform is an essential part of what is needed to combat the devastating, sometimes fatal, consequences of unsafe abortion, evidence from other countries.[2, 3, 4] suggests it is not sufficient on its own to ensure all women who need access safe abortion care can receive it.

This study analyses the impact of the amended law on access to safe abortion care for adolescent girls and women in Benin, as well as the persistent barriers they face to accessing this care. It examines in detail the views and experiences of adolescent girls and women, their partners, families and friends, as well as those of healthcare professionals. In-depth research such as this helps to identify the additional measures needed to ensure adolescent girls and women can access safe abortion care according to the legal framework without constraint.

Following a meeting to validate the research findings, which took place in Benin in September 2025, the researchers, in collaboration with key stakeholders – including young people, healthcare professionals and members of civil society – drew up a set of recommendations. Presented at the end of the report, these recommendations suggest ways to strengthen equitable access to safe abortion care in Benin and will also provide guidance for other countries engaged in similar legal reform processes.

Background

Unintended pregnancy[iii] is the main reason women seek abortions. One of the key factors that leads to unintended pregnancies is the low uptake of modern contraceptive methods in Benin. Data suggests only 16.9% of women of reproductive age (15 to 49 years) in a relationship in Benin use modern contraception.[5] The unmet need for contraception[iv] remains high, at 29.9%[6] among the same group.

Among adolescent girls, modern contraceptive use remains low at 9.2%,[7] mirroring the trend observed among adult women. There is a large unmet need for contraception among adolescent girls and young women, standing at 31.4% among 15- to 19-year-olds and 38% among 20- to 24-year-olds. The low level of modern contraceptive use is a driving factor in the high rate of unintended pregnancy among adolescent girls and young women in Benin.[8]

Among adolescent girls, modern contraceptive use remains low at 9.2%, mirroring the trend observed among adult women

In the Atlantique department, in southern Benin, socio-cultural norms were identified as key barriers dissuading people from using modern contraception. These norms include the belief that premarital sex is wrong and therefore shameful, which can make it hard for young or unmarried people to admit they are sexually active. A high value is also placed on young women's fertility, which is reflected by male partners often refusing to consent to the use of modern contraceptives. The need to conceal sexual activity, as well as fears of the side effects of 'modern' methods, lead adolescent girls and young women to

iii An unintended pregnancy is a pregnancy that occurs without a woman wanting to become pregnant at that time. For example, it may result from a lack of contraception, contraceptive failure or as a result of sexual violence. In this report, we use the term 'unintended pregnancies' to refer to pregnancies that were not anticipated, and we refer to them as 'unwanted pregnancies' once the decision to have an abortion was made.

iv Unmet need for contraception refers to women who are of reproductive age (whether married or sexually active), who do not wish to become pregnant, but who do not use a modern method of contraception. For a more detailed definition, see National Institute of Statistics and Demography (2023), 'Multiple Indicator Cluster Survey, Benin, 2021–2022, Report on the survey results', p.71, Cotonou: INStaD.

use traditional contraceptive methods in an attempt to avoid pregnancy.[9, 10, 11]

Certain aspects of Benin's healthcare system also limit access to modern contraception, such as the poor availability of contraceptive products and financial barriers to accessing contraceptive services. These factors combine to explain why modern contraceptive methods are underused in Benin, particularly – as the World Health Organization (WHO) describes – among 'the poorest, youngest, rural and least educated women, who are most at risk of unwanted pregnancies, clandestine abortions and obstetric complications'.[12]

Over the last ten years, the Beninese government and civil society have sought to address this lack of access to modern contraceptives. The Ministry of Health has adopted national family planning plans and strategies, specifically targeting adolescents and young people,[13, 14] strengthened the integration of contraceptive services into public health facilities and gradually increased the budget that it allocates to the procurement of contraceptive products. The country has committed to the Family Planning 2030 initiative[15] to improve access to reproductive health services for women and young people. At the same time, organisations such as the United Nations Population Fund, alongside national and international non-governmental organisations (NGOs), have supported community awareness campaigns, relationship and sexuality education programmes, youth-friendly services and the distribution of contraceptives, including in rural areas.

Despite these efforts, unintended pregnancies remain high in Benin, particularly among adolescents and young people. For example, a national study conducted in 2019 among 337 sexually active adolescent girls (aged 15 to 19) found 80.1% had already experienced an unintended pregnancy.[16] These pregnancies often occur outside marriage among adolescent girls who lack financial resources or are out of school.[17, 18] These factors, combined with a fear of social stigma, result in a large proportion of these pregnancies ending in abortion, most often carried out using unsafe methods.[19, 20, 21, 22]

Sexual violence, such as rape and incest, is another significant factor that contributes to unintended pregnancy. Incidents of sexual violence are high in Benin. A 2022 national study[23] found 30.9% of women aged 15 and over had experienced sexual violence.[v] Another national study, conducted in 2017, found that one in ten women (i.e., 10%) had experienced sexual violence at some point in their lives.[24,vi] This high rate of sexual violence leads some women to resort to unsafe abortion, despite being legally entitled to safe abortion care.[25,26]

Although there are no official or recent statistics on the scale of unsafe abortions happening in Benin, the few studies carried out in the country indicate that seeking treatment for abortion-related complications is common in healthcare facilities.[27]

The existing national data comes from Benin's health statistics yearbook, which records the number of abortion services hospitals provide. According to the yearbook, healthcare facilities in Benin recorded 13,681 abortions in 2020,[28] 14,703 in 2021[29] and 17,799 in 2022.[30] While these figures indicate an increase in the number of abortions recorded in healthcare facilities, they do not distinguish between miscarriage and abortion, nor do they separate the proportion of comprehensive, abortion care from post-abortion care.[vii] Other available data comes from the Guttmacher Institute, which estimates that there were around 589,000 pregnancies in Benin each year between 2015 and 2019. Of these, 227,000 were estimated to be unintended pregnancies, out of which an

v In the 2022 report, the definition of sexual violence adopted covers nine types of acts: indecent touching, forced sexual intercourse (including rape and attempted rape), coerced sexual intercourse, the imposition of pornographic images, indecent exposure, harassment, punishment for refusing sexual advances, unwanted sexual advances and intrusive sexualised stares.

vi The term 'sexual violence' covers acts that may or may not result in pregnancy. It includes, in particular, being physically coerced into having sexual intercourse, being forced to perform sexual acts, or being subjected to unwanted sexual acts under the influence of fear or coercion by a partner. See Ministry of Planning and Development National Institute of Statistics and Economic Analysis, (2019), Benin 2017–2018 Demographic and Health Survey, Cotonou: INSAE.

vii The research assistants also noted that, in practice, records are not always kept up to date and that abortion care is not always recorded.

estimated 84,300 (37%) pregnancies resulted in abortion, often using unsafe methods.[viii]

Although there is no reliable data on the exact number of abortions performed in Benin, what has been established is that, until the SRH law was amended in 2021 and the amended law was implemented, the majority of abortions that took place were unsafe. In 2018, unsafe abortions were estimated to be the third leading cause of maternal deaths in Benin, accounting for 15% of women dying due to pregnancy or childbirth.[31]

This situation was likely to change following the amendment to the law in 2021. However, as the literature from other countries shows, expanding the legal provisions for abortion does not automatically remove all the barriers to safe abortion care. The manner in which a law is implemented, the level of health system preparedness, as well as social and economic factors (e.g., social norms, healthcare providers' values, knowledge of the law, women's financial resources or proximity to a clinic), can still stop women accessing safe abortion care, even when it is legally permitted.[32, 33, 34, 35]

In Benin, a recent study on healthcare providers' compliance with the amended SRH law found that more than half of the providers interviewed (57.3%) did not comply with it.[36] Fewer than one in six said they were willing to provide abortion care, and 21.7% said they were categorically opposed to doing so, mainly on religious grounds.[37]

The 2023 decree implementing the amended law permits conscientious objection, a right healthcare providers can invoke to refuse to provide safe abortion care. However,

viii These figures and rates of unintended pregnancies and abortions, as well as the proportion of these pregnancies that end in abortion, are derived by the Guttmacher Institute using a statistical model. This model incorporates and draws on all available data concerning pregnancy intentions and abortions among women of reproductive age, collected nationwide, and these figures are considered estimates. Further information is available here: Guttmacher Institute, (2022), Unintended Pregnancy and Abortion Worldwide: Country-Level Estimates Explained] [factsheet], New York: Guttmacher Institute.

healthcare providers are nevertheless required to refer women to a health professional who is willing to provide safe abortion care.[38] Until this current study, no research has been available to document how healthcare professionals in Benin understand and apply this provision.

A study conducted in five public healthcare facilities in Cotonou, which focused on the availability, knowledge, attitudes and practices regarding safe abortion care, found that just under half (42.9%) of the healthcare providers interviewed felt antipathy towards women who had undergone an abortion.[39] The study also highlighted limited knowledge among healthcare providers of the concept of comprehensive safe abortion care and emphasised the need to strengthen healthcare provider training on safe abortion care as well as conducting values clarification work.[40]

Objectives of this study

With the expansion of the legal conditions that allow for access to safe and legal abortion care in Benin, it is important to examine the effects of this reform based on the personal experiences of adolescent girls, women and healthcare providers.

The main objective of this research is therefore to document the barriers and facilitators relating to the provision of and access to safe abortion care within the framework of the new legal provisions in Benin.

Discussions with stakeholders in Benin enabled us to identify the following specific objectives:

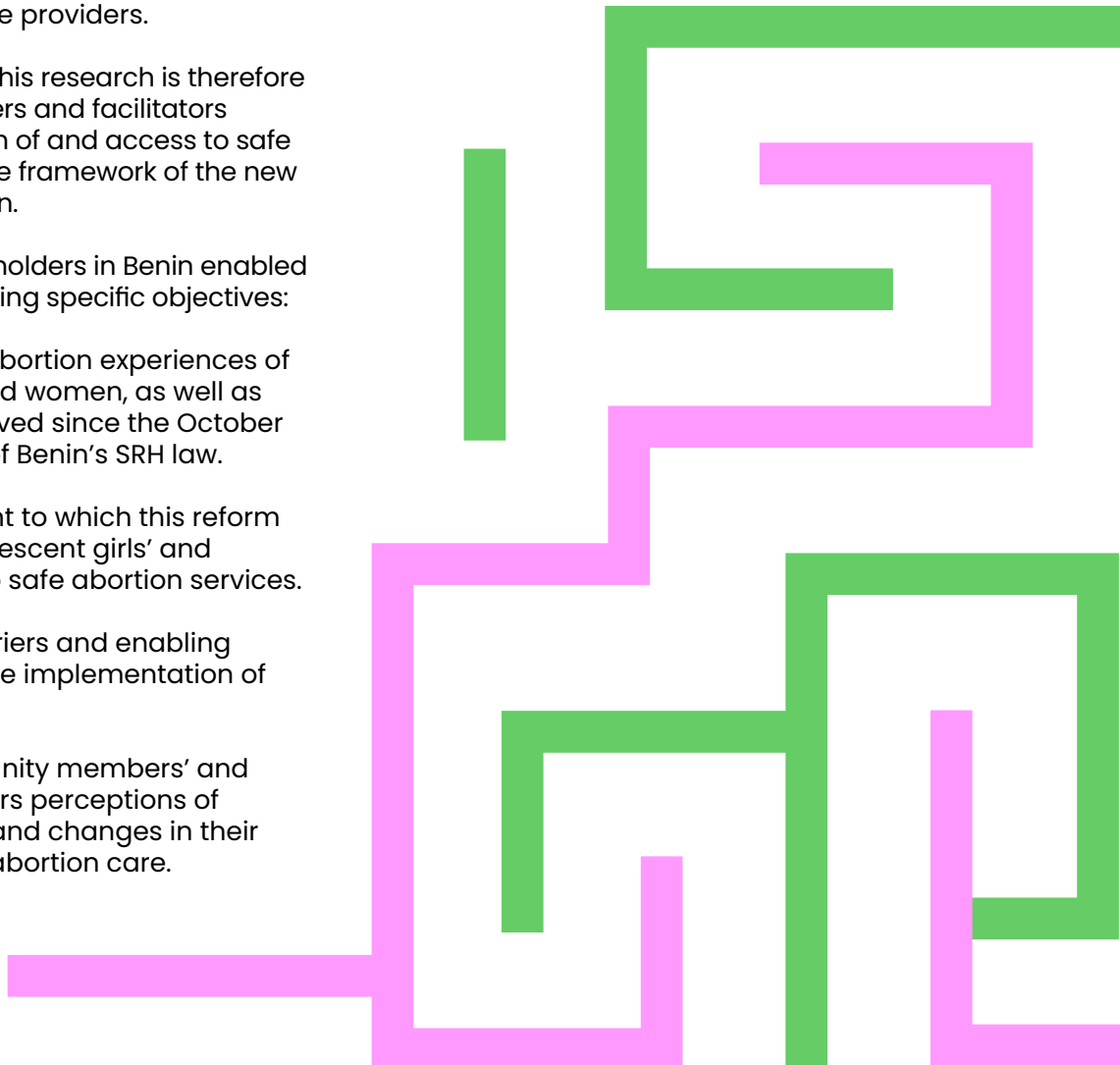
a. To document the abortion experiences of adolescent girls and women, as well as the changes observed since the October 2021 amendment of Benin's SRH law.

b. To assess the extent to which this reform has improved adolescent girls' and women's access to safe abortion services.

c. To analyse the barriers and enabling factors affecting the implementation of the amended law.

d. To analyse community members' and healthcare providers perceptions of the amended law and changes in their attitudes towards abortion care.

With the expansion of the legal conditions for accessing abortion, it is important to examine the effects of this reform



This study included 73 adolescent girls and women and documented two cases of women who died due to unsafe abortion

Methodological approach

This qualitative study is based on an ethnographic approach. It drew on participant observation in 15 health facilities and neighboring communities in the Atlantique and Borgou departments, as well as in-depth and repeated interviews with 73 adolescent girls and women (35 adolescent girls and young women aged 15–24 and 38 women aged 25 and over) who had undergone an abortion. The case studies of these 73 women were supplemented by documentation of two deaths linked to unsafe abortion. Interviews were also conducted with other individuals involved in the process of seeking abortion care, namely family members and partners (23 interviews), healthcare providers (50 interviews) and key informants (52 interviews), as well as 24 focus group discussions with young people and adults, both men and women.

The study was carried out by the African Population and Health Research Center (APHRC), Rutgers and the Beninese Association for the Promotion of the Family (ABPF). It formed part of the Sa Santé, Ses Choix programme, which was implemented in West and Central Africa to reduce maternal mortality and morbidity linked to unsafe abortion.[ix]

The study was carried out in the Atlantique and Borgou departments, located in the south and north of Benin, respectively. These departments were selected based on SRH indicators, particularly with regard to abortion and early pregnancy. The choice of the Atlantique department was also influenced by the fact that the research team had carried out an initial ethnographic study there in 2021, prior to the amendment of the law. Conducting this new research in the same department made it possible to produce comparative data on the demand for,

ix Funded by the Postcode Loterij (Postcode Lottery Netherlands). See Rutgers, 'She Makes Her Safe Choice' [web page, accessed July 2026], Utrecht: Rutgers.

provision of, and access to safe abortion care.

A team of six young female researchers and two country coordinators, all with a background in anthropology or sociology, was recruited and trained in the methodology of ethnographic research. Particular attention was paid to research ethics regarding sensitive topics, such as abortion and sexual violence. Ethical approval for this study was obtained from the Ethics and Research Committee of the Institute of Applied Biomedical Sciences (ISBA), supplemented by authorisations from the Benin Ministry of Health at national and departmetal level.

Data collection took place over a seven-month period, from September 2024 to April 2025, with regular consultations and ongoing support from senior researchers within the research team. The data collection obstacles encountered, and the initial findings were discussed during weekly debriefing sessions, which informed the research's progress and direction.

All interviews and discussions were recorded, transcribed, translated and anonymised. The data was analysed thematically. The whole team contributed to the drafting of the report. A detailed description of the methodology is provided as an appendix.

Research findings

Donna's story[x]

Donna, a 22-year-old woman, mother of a three-year-old child, lives in circumstances characterised by economic insecurity. Raised by her paternal grandmother in a polygamous family, she grew up in an environment where discussions about sexuality, contraception and abortion were mainly absent. At 15, after having sex with her first partner, Donna became pregnant. Unprepared for parenthood, the couple attempted to end the pregnancy using unsafe methods, but the attempts failed and the pregnancy continued to term.

After their child was born, Donna briefly used the contraceptive pill. But she stopped because she found it difficult to take every day. She and her partner instead relied on Donna drinking salt water after sex; an ineffective method that is widely believed in their community to prevent pregnancy.

A few years later, Donna moved to a neighbouring town for work, leaving her child in her mother's care. She entered a new relationship with a man she became emotionally and financially dependent on, but she continued to see her child's father, encouraged by her parents. Still relying on ineffective contraceptive methods, she became unintentionally pregnant.

Determined not to continue the pregnancy, Donna searched for information online. She used a combination of internet searches, informal advice and products obtained from a market vendor and her mother to attempt to end the pregnancy. None of these methods worked. Unaware that abortion law in Benin had been amended, Donna instead began navigating both private and informal health services. A private clinic agreed to provide an abortion but the cost – more than 46,000 FCFA (70 euros) – was beyond her means. *"I said, 'All right, if I can find the money, I'll come back…'"*, Donna recalls.

During this visit, Donna did learn that safe abortion care was now legally available at public health centres, where costs were lower. She went to one such facility, where a midwife listened to her but explained that she could not perform abortions for personal reasons and referred her elsewhere. Expecting further rejection, Donna turned to clandestine sellers of abortion products active on social media. She then paid 6,000 FCFA (9 euros) for an injection to be administered at home, but the provider never showed up.

After another private clinic again quoted costs beyond her means, Donna followed up on the referral from the midwife and was put in contact with a youth organisation supporting access to safe and non-judgemental sexual and reproductive healthcare. Through their financial support, she was finally able to access safe abortion care at a private clinic.

x All names used are pseudonyms to protect the study participants' anonymity

Experiences of accessing abortion in Benin: a variety of journeys

Key findings

- The data reveals a variety of pathways to abortion still exists in Benin.
- Just over half of the adolescent girls and women interviewed (39 out of 73)[xi] were able to access legal and safe abortion care, either directly or after an initial unsuccessful attempt using unsafe methods.
- The remaining participants (34 out of 73) resorted to unsafe methods.
- The use of unsafe methods remains common and often leads to serious medical complications, including two deaths recorded during this study.

xi Given the relatively small sample size (n = 73), the figures mentioned in this report are not intended to be representative or generalisable. Rather, they are presented to illustrate the patterns and trends observed in terms of lived experiences of abortion in the data.

Despite abortion now being legal in more circumstances, persistent barriers mean some women still resort to unsafe methods

Donna's story illustrates the complex dynamics involved in seeking and accessing safe abortion care in Benin. It highlights the strategies employed by women and their families to access such care. It also explains how access to information on the amended legislation, healthcare providers' values, referral to facilities offering safe abortion care, and a woman's financial resources either facilitate or hinder access to safe abortion care within the country's healthcare facilities. Donna's journey demonstrates that, despite abortion now being legal in more circumstances, persistent barriers mean some women still resort to unsafe methods.

This section outlines findings on abortion pathways (both safe and unsafe), the profiles of women who sought these two types of care, and the facilitators and barriers to accessing care in the two departments included in this study.

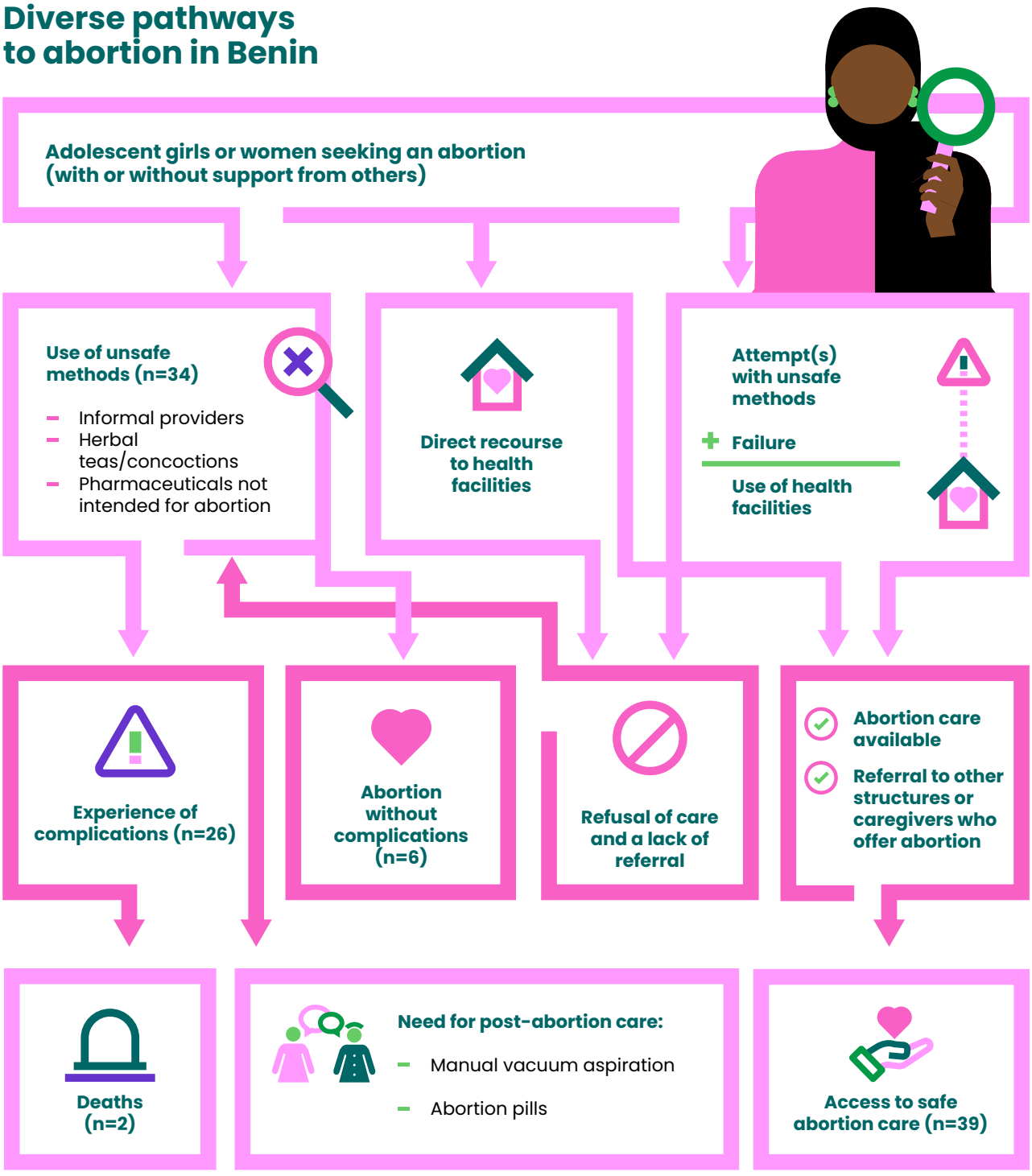
The data highlights a variety of pathways to abortion within the context of the amended law. Some women in the study, including Donna, initially resorted to unsafe and ineffective methods before turning to a healthcare facility, while others opted for formal healthcare provision from the outset.

A significant proportion of the pathways that women in the study took relied on unsafe, clandestine methods and providers. While some women used unsafe methods without encountering immediate difficulties, others suffered major complications, which were sometimes fatal.

These diverse pathways are summarised in Figure 1.

Figure 1

Diverse pathways to abortion in Benin



The data shows that just over half of the adolescent girls and women interviewed (39 out of 73) were able to access facility-based, legal and safe abortion care; some from the outset, others after unsafe methods had failed. The other participants (34 out of 73) initially resorted to unsafe methods, including herbal teas, informal providers and medicines (often not intended for abortion) obtained from pharmacies or on the informal market before turning to the formal health system to obtain post-abortion care. Clandestine practices remain common and are often associated with serious medical complications, including two deaths recorded during this study.

Seeking information and the people involved

The abortion pathways of adolescent girls and women begin with a search for information on ways to terminate an unwanted pregnancy. The adolescent girls and women in this study reported that, as soon as they realise they are pregnant and decide to terminate the pregnancy, they embark on this process.

Participants reported relying mainly on their social circle and local networks for information, notably their partner, parents (their mother or sometimes both parents), and close relatives such as a sister, cousin or aunt, or a friend. Of the 39 cases of safe abortions in the study, partners were predominantly involved in providing information (in 22 out of the 39 cases), and this was particularly the case among women aged 20 and over who were in a more serious relationship. The involvement of parents, grandparents or guardians was observed mainly among adolescent girls and young, unmarried women who were not financially independent.

Some parents intervene after suspecting their daughter is pregnant

The importance of trust and shared experience

Who adolescent girls and women choose to ask for information and support was based on specific criteria, foremost among which was trust and the guarantee of confidentiality.

For example, Nas, a 20-year-old student, who was single and living in the Borgou department, turned to her older sister, her 'confidante'. Nas's personal history sheds light on this close bond and her choice. Having lost their father before Nas was born, their mother entrusted her two daughters to their maternal grandparents where they forged a close bond, united by secrets kept from their elders. This solidarity first came to the fore when Nas' older sister, at the age of 20, faced an unintended pregnancy, which the two sisters attempted to terminate clandestinely. Later, Nas began a relationship with a young man she was infatuated with, drawn in by his financial generosity. When she, in turn, also became pregnant at the age of 20, it was only natural that she should share the news with her only

sister and confidante. Nas' sister, having gone through a similar experience, became her sole source of support.

Beyond trust, personal experience acts as a powerful factor in choosing a confidante, as demonstrated by Nas's choice. This shared experience offers adolescent girls and women a twofold assurance: the guarantee of a non-judgemental reception and tangible 'proof' of the safety of the method being suggested. The fact that the confidante has been through an abortion herself and is still alive is seen to validate the advice and the methods she suggests.

Financial resources

Similarly, financial capacity was a decisive factor in some participants' decision about who to confide in or involve in relation to abortion. This is often the case with partners who, beyond shared responsibility, may have the necessary resources to fund access to healthcare. The involvement of parents follows a similar logic, although it their involvement is sometimes not directly asked for but is more of a matter of chance or is imposed. Indeed, some parents intervene after suspecting their daughter is showing signs of pregnancy or following a partner's withdrawal. This was the case for Marline, aged 17, whose stepfather first summoned Marline's male partner and was then referred by a social worker to a private clinic where a safe abortion was carried out with his financial support.

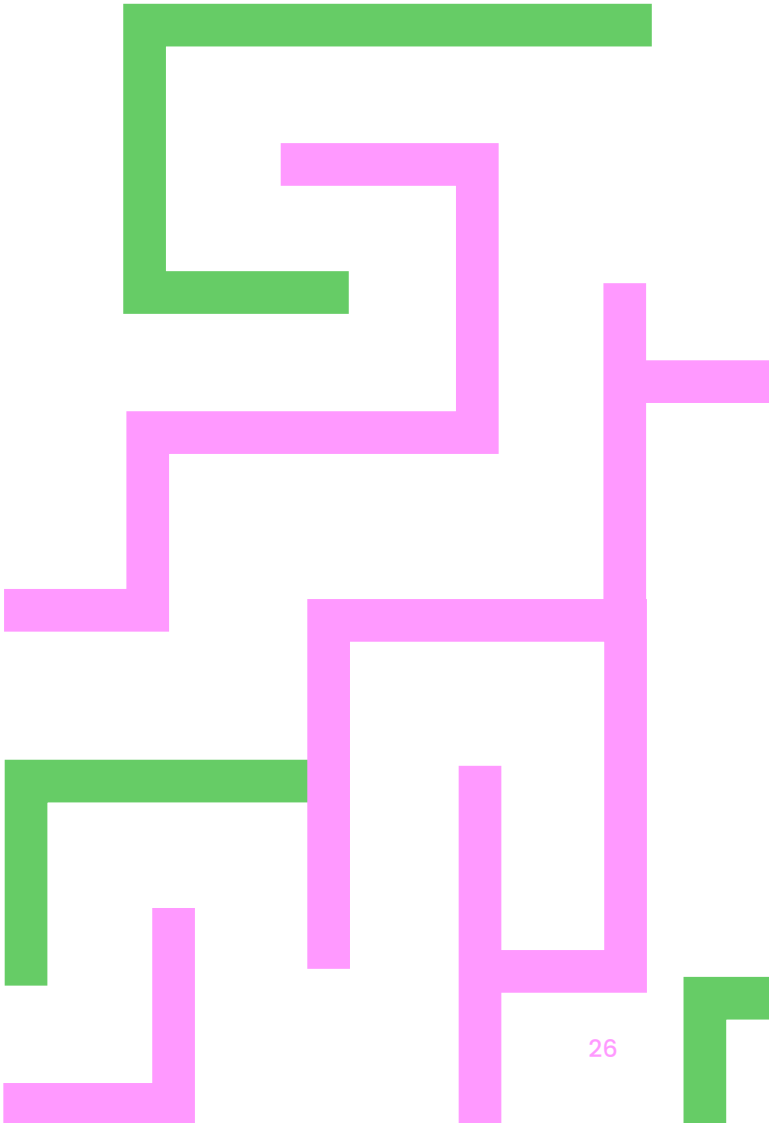
Doing it alone and the use of digital tools

In some cases, women in our study chose not to turn to anyone in their social circle for information on ways to terminate a pregnancy. Instead, they used other channels to seek help or information, including the internet and social media. Indeed, given the lack of abortion information available in Benin, digital tools are becoming key resources. Online searches on Google, TikTok or Facebook enable women to find information on various types of methods, both safe and unsafe.

This was the case for Fatima, a 21-year-old student living in the Borgou department, who discovered an online counselling platform while searching on social media. This digital channel served as a gateway to a health facility where she received care (see the section on facilitators of access to safe abortion care for further details).

Like Fatima, several other women in this study sought information online. For example, Marie, a 19-year-old from the Atlantique department, found a Facebook page called 'safe abortion', where she discovered that she could use misoprostol to terminate her pregnancy then took a photo of the leaflet shown on the page to buy misoprostol at a market: *"No, actually, I saw that on Facebook. Yes, it said 'safe and risk-free abortion'. I did the search myself and came across it."*

By using digital platforms, women in the study gained access to a wide range of information and advice pointing them towards a variety of abortion methods, both safe and unsafe. Sometimes the same social media accounts promote unsafe methods (such as herbal teas) alongside recommended methods like misoprostol.



Irène's story

Irène, 24, lives with her partner and their one-year-old daughter in the Borgou department. She works at a factory and earns between 50,000 and 60,000 FCFA (between 76 and 91 euros) per month, while also pursuing a university degree to become a communications specialist or teacher. Although her relationship is not formally legalised through marriage, she describes it as stable despite financial difficulties; their income is not enough to put sufficient food on the table, let alone pay for medical treatment. Recently Irène's father passed away, and the funeral expenses placed an additional strain on the household.

During this situation Irène became unintentionally pregnant, which she attributed to her irregular menstrual cycle and the failure of the withdrawal method they had been using. Having heard about the amended abortion law through radio and television, she and her partner jointly decided to seek safe abortion care. She was clear that she did not want to rely on traditional, unsafe methods. She wanted to protect her health and her job. She recalls:

> *"It had to be a safe abortion; we agreed on that."*

Accompanied by her partner, Irène first went to a faith-based health centre near their home. She explained her situation to a midwife, including her financial responsibilities, her young child and her wish to avoid unsafe methods that could affect her health and work. However, she was told that the facility was not authorised to provide abortion services.

The midwife referred her to a peer educator who helped her to locate one of the few public facilities where such care was available. When Irène arrived, she was informed that the facility had run out of abortion medication. Touched by Irène's situation, a midwife at the facility chose to act immediately and went out to purchase the medication from a pharmacy using her own money for transport.

Thanks to this intervention, Irène was able to receive safe abortion care in appropriate conditions.

Profiles and experiences of adolescent girls and women who have accessed safe abortion care

Key findings

Several factors were identified as having facilitated access to safe abortion care for the adolescent girls and women who were able to receive it:

- Knowledge of the law on the part of the woman or her family and friends.
- Encountering healthcare professionals who have undergone training in values clarification and were more likely to offer safe abortion care or refer the woman without turning her away or attempting to influence her decision.
- Receiving support from civil society organisations (CSOs) and local volunteers who tend to be key players in the referral mechanism.
- A woman's financial independence, as the costs remain high.
- In the absence of financial independence, financial support from family and friends or from CSOs working on sexual and reproductive health and rights (SRHR) is essential.

Irène is one of 39 women who managed to obtain a safe abortion out of the 73 who were followed in this study. Some of these women initially tried an unsafe method. Others went directly to a health facility to access safe abortion care. Like Irène, some women were initially refused abortion care before finding a facility that agreed to treat them.

The data indicates that most women who obtained safe abortion care at a formal healthcare facility were young, single women with secondary education (as shown in Table 1). They were either school pupils or students or engaged in income-generating activities in the formal or informal sector. They mainly lived in urban or peri-urban areas, which facilitated their access to information on the law and to facilities offering safe abortion services. For those living in rural areas, referral by informed relatives, particularly to community-based or private organisations, plays a decisive role in accessing safe abortion care.

Table 1 : Socio-demographic profile of women who accessed safe abortion care

Characteristics		Frequency (39)
Age	15-17	3
	18-25	26
	26-40	10
Marital status	Single	27
	Married/in a relationship	12
Level of education	None	4
	Primary	4
	Secondary	21
	Higher education	10
Occupation	Unemployed/housewife	6
	Pupil/student / in vocational training	12
	Employee/worker in the informal sector	12
	Worker in the formal sector	8
Area of residence	Rural	16
	Urban/suburban	23

With the exception of five women, including Irène, who received safe abortion care at a public facility (the only one in the research sample offering these services), all the other participants (34 in total) received safe abortion care at private, NGO or community health facilities.

Factors influencing the use of safe abortion care

An analysis of the experiences of women who received safe abortion care shows that their journeys consist of a sequence of events influenced by a variety of factors. These factors influence both the decision to seek a safe abortion and the course of care. For most women, choosing a safe procedure is guided by a keen awareness of the risks associated with unsafe methods and by a desire to protect their physical well-being. This fear of clandestine methods, often associated with social isolation, severe consequences and death, appears to be a key driver in the search for legal and safe care, as Moudjibatou, a 21-year-old student from the Atlantic region, points out: *"He told me to go to the chemist's to buy 'whatever' there, and I said I'm not the sort of person who's going to die alone in a room. For me, if it's in hospital, I'll go along with it … But dying alone in a room – that's not me."*

Clinical safety was thus prioritised by some, even when financial resources are lacking, as Irène, 24, casual worker from Borgou shared: *"It's true we don't have any money, but we wanted to do this safely."*

The need for medical safety also guides the thinking of partners and relatives involved in the process. For example, two male partners interviewed explained they had directed their partners straight to a qualified health centre: *"Well, I put her at ease. I told her that she herself knows we really can't carry the pregnancy to term and all that, and she agreed that it's normal. So that's why I'm making arrangements with the hospital at the same time, to ensure she receives proper care."* Slim, 22, nurse, Borgou

The decision to opt for a safe abortion is thus driven by two considerations: to prevent clinical complications, which, as well as being life-threatening, could risk exposing the abortion to others. By avoiding visible medical complications, those involved seek to preserve their social standing. In short, the safety offered by formal healthcare serves as a means of protecting both the physical well-being of the woman and the confidentiality surrounding the situation for her and those close to her.

However, while some women and their relatives turn to safe abortion care from the outset, others only access it after an unsafe method, such as drinking herbal teas or taking unapproved medicines, have failed. For these women, turning to the formal healthcare system is a last resort following an unsuccessful and risky attempt or attempts to terminate the pregnancy.

This was the case for Fama, a 27-year-old street vendor living in the Borgou department, who tried two unsafe methods that failed before deciding to go to hospital: "I'd say [I made] two attempts: the herbal tea I drank with my drink, and the tablet [Sédaspir] that the lady told me to keep taking. As for the herbal tea, my older sister showed me how to do it; you don't have to prepare it – it's a piece of bark – you just put it in a drink and drink it." It was these repeated failures that led Fama, on the advice of a friend who was a care assistant, to seek safe abortion care at a health centre. Fama and her partner knew that abortion was legal in Benin under certain conditions. She described how she had simply read online, sometime before her abortion, that 'abortion was legalised in Benin' but had no information about the conditions or where to access safe abortion care. Despite the uncertainty regarding actual access to safe abortion care, her partner supported this decision. Their decision was driven by a deep conviction that the hospital would guarantee success and safety, unlike the other methods which have proved unsafe and unsuccessful. She explained:

Actually, it's not her [her friend] I trust, but I trust the hospital; and as I know she works there – and you don't just decide to go and work in a hospital on a whim – no, someone who works in a hospital has definitely undergone training."

Fama, 27, street vendor, Borgou

Fama's decision was based on a recognition of the professional competence and legitimacy of the healthcare facility, perceived as the only setting capable of guaranteeing a favourable and safe outcome following the failure of informal and unsafe channels.

Factors facilitating access to safe abortion care

An analysis of the experiences of women who received safe abortion care highlights a range of factors that facilitated this access, which are explored in the following section.

Despite the legal reform, not all women in the study had access to safe abortion care. An analysis of the experiences of the 39 women who were able to access safe abortion care highlights several factors that facilitated this; notably, knowledge of the law, the existence of effective referral mechanisms to specialist services, and personal resources and/or support from a partner and/or family member. These factors, taken individually or in combination, help women to access safe abortion care.

Knowledge of the law

The case of Ariane, a 32-year-old student and recent widow, illustrates the importance of legal knowledge in accessing safe abortion care in Benin. After becoming widowed Ariane had a relationship with a former university classmate who had supported her during the death of her husband. She became pregnant but the former classmate did not want to take responsibility for a child and demanded that she terminate the pregnancy. Ariane agreed.

Ariane recalled reading online that a new law authorised access to safe abortion services in Benin. On this basis, Ariane went to the non-profit health facility where she had received contraceptive services when she was younger. After the gestational age was confirmed by ultrasound as being under 12 weeks, she received safe abortion care there, free from stigma. It was Ariane's knowledge of the law (combined with her financial means, as we shall see later) that enabled her to access safe abortion care.

Of the 39 women in this study who received safe abortion care, 16 were aware of the law's provisions, as evidenced by the comments of these two participants:

It was thanks to this information that I went to hospital for my problem. Otherwise, we wouldn't have dared to go to hospital for that; it used to be done in secret. As it's talked about everywhere now, we can freely go to hospitals to discuss this issue.

Edwige, 41, hairdresser, Atlantique

When my period stopped, I took a pregnancy test. And it was positive. I didn't know what to do. I looked it up online, where I learnt that up to six weeks[xii], you can have a voluntary termination of pregnancy. I decided to go to the CPN [antenatal clinic]. That's where I was referred from.

Lucresse, 24, civil servant, Atlantique

xii This statement is incorrect; Benin's amended SRH law allows abortion up to 12 weeks' gestation.

Even when women only have limited knowledge of the law, it can be enough to motivate them to seek safe abortion care in health centre

As illustrated by the accounts above, even when women only have limited knowledge of the law, it can be enough to motivate them to seek safe abortion care in a health facility. Awareness of the law therefore appears to be a decisive factor which encourages women to express their need for safe abortion care. The perception of a strict ban on abortion in Benin is shifting towards a form of normalisation of safe abortion care linked to its legalisation, making it more acceptable to seek care at health facilities, both public and private. This shift helps to alleviate fears of being denied safe abortion care, of breaking the law or of being reported to the authorities as evidenced by a 29-year-old community health volunteer from Borgou: *"Well, in the meantime I've learnt that abortion is no longer a criminal offence when you go to the clinics. I mean, abortion is permitted, and that makes it easier to go and ask for the service in hospitals to have an abortion; it wouldn't be a crime like it used to be."*

As this quote illustrates, the fear of an abortion being disclosed and of potential prosecution used to deter many women and their partners or families from seeking care from health facilities. Changes to the legal framework have eliminated this risk, and these facilities are now seen as an option when seeking safe abortion care in Benin.

The research examined the main sources of information that adolescent girls and women use to learn about the amended law. Some participants, such as Ariane, found out about the legal change online or on social media. Others learnt of it through traditional media, notably radio and television. For others, the information came from those around them: a partner, friend, neighbour or sister. Several NGOs and healthcare providers describe how information spreads within communities, with news circulating through personal contacts:

> *Yes, yes, I think the community is aware because you already hear people talking about it during discussions under the palaver trees or in the local tea shops. People say that abortion is now allowed. It's no longer a taboo subject. Lots of people are talking about it. Even when*

> *they come to the hospital and you tell them, 'No, we don't do that [abortion care] here', one patient once said to me: 'But we've been told it's already allowed, so why don't you do it here?' I had to explain to her that it's the principles governing this hospital that mean we don't do it. So everyone's aware of it, aren't they? Even the young girls round here know it's allowed.*
>
> **Midwife, health centre, Borgou**

In some cases, women were unaware of the law, and it was those around them who directed them towards safe abortion care. This was what happened in the case of Edwige, aged 41, a hairdresser from the Atlantique department, who was informed of the existence of this law by her husband, who then accompanied her through the process of seeking safe abortion care: *"In fact, it was he himself who went to the hospital to find out more. It was a weekend, so they told him to tell his wife to go the following Monday to the place where pregnant women go. He explained it to me, and I went there the following Monday."*

Although awareness of the law remains low within many communities, when women's support networks (parents, relatives, partners or religious leaders) are aware of it appears to be a factor facilitating access to safe abortion care in health facilities. In several cases, information a relative or partner had led to them getting involved in supporting the woman to seek safe abortion care. Thus, knowledge of the law – whether direct or relayed by those closest to the woman – is a key factor in women's decisions to seek these services.

Clarification of values and referral: drivers of access to safe abortion care

For various reasons detailed in the second part of these findings (see the section on women who have sought unsafe care), healthcare providers at the facilities observed do not systematically offer abortion care to the women who request it. The findings suggest training in abortion value clarification for action and transformation (VCAT) and adherence to the referral guidelines[xiii] are essential to ensure access to safe abortion care.

Values clarification training, delivered by NGOs in collaboration with the Ministry of Health, has helped to improve healthcare providers' knowledge of the legal framework governing abortion, as well as the conditions under which it is to be provided (including the obligation to refer patients in cases of conscientious objection). Beyond the legal framework, the VCAT sessions provided healthcare professionals with a framework for critical reflection on abortion and, in some cases, helped to foster their support for the provision of safe abortion care. According to several healthcare professionals interviewed, these activities influenced their perceptions, transformed their attitudes towards abortion and improved the quality of their interactions with people seeking these services, as one midwife explained:

> *At first, I wasn't in favour of abortions, but it was whilst attending the training that I realised, given everything that's just been said and all the examples he gave, I think the best thing to do is to help these young women. And with all the experience I've already had in the field. these are the things that convinced me.*
>
> **Midwife, private health centre, Atlantique**

xiii Referral refers to the process by which healthcare professionals, or other stakeholders, direct patients to a more suitable healthcare centre or registered practitioner who is willing to provide safe abortion care. This practice is, moreover, governed by Article 5 of the 2023 implementing decree of the law on conscientious objection, which stipulates that 'in the event of conscientious objection to an abortion procedure, the doctor, midwife or duly authorised nurse shall refer the patient to another qualified healthcare professional from the very first consultation'.

In some cases, this shift in perceptions has encouraged healthcare professionals to provide safe abortion care, while in others it has encouraged them to support the provision of safe abortion services or to refer women seeking such care to these services. For example, of the 32 healthcare professionals trained in VCAT who were interviewed, 13 stated that they had started providing safe abortion care, while 17 indicated that they were not yet ready to provide it but were now referring patients to centres or providers willing to do so. Although such referrals are not systematic in public health facilities, this research highlights practices whereby women seeking safe abortion care are referred to other suitable health facilities or practitioners:

> *No, I tell the client that we don't do that here, but I can refer you. As a healthcare worker, I can try to find out why you want to do that, try to persuade her. But if I see that she might go and do something strange, I can refer her. If I know of centres that offer this care, I can say, "Go to such-and-such a place..." I've already referred at least three or five people.*
>
> **Doctor, referral health centre, Borgou**

> *At first, I used to refuse and say, "We don't do that here", but over time, we started referring them.*
>
> **Midwife, peripheral health centre, Atlantique**

As illustrated in these quotes, many public healthcare workers in initially refused to provide safe abortion care. However, over time, and under the influence of CVTA training, they became aware of the need to refer women to prevent them from turning to clandestine, unsafe methods.

Civil society organisations and community health volunteers: key players in the referral mechanism

This study highlights the pivotal role of helplines and CSOs in referring women to safe abortion care. Remote referral systems, accessible via social media or freephone numbers, are a major driver of access to safe abortion care.

The experience of Fatima, a 21-year-old student from Borgou, clearly illustrates this dynamic. After being turned away at a health centre in her neighbourhood, she searched

for abortion medication on social media and discovered an interactive online platform. This platform, which provides advice on reproductive health and rights, referred her to an accredited health facility, enabling her to receive safe abortion care and avoid resorting to dangerous traditional methods. Accompanied by her partner, Fatima went to this facility where she was able to have a safe abortion: "That very day, on that platform, I explained the problem in the chat – that I was pregnant, that I was going to have an abortion. So she sent me to a health centre; that's where they told me where to go."

Many platforms set up by CSOs provide information and advice to women on contraceptive methods as well as on access to safe abortion services. These digital tools act as a catalyst by facilitating access to reliable information and ensuring that women and girls are referred to healthcare facilities that provide the necessary care. A CSO representative explained this service:

> *What is particularly innovative about our approach is that, for nearly two years now, we have been running a helpline. When we visit communities, we leave the helpline details so that anyone in a similar situation can call us. We receive calls at all hours from girls who wish to access the service. Depending on how the person wishes to access the service, we try to refer them to partner clinics and [youth] friendly service providers with whom we work.*
>
> **NGO manager, 28, based in Littoral, working in Atlantique**

This online support embodies a community-based, partnership-driven approach which meets the practical needs of adolescent girls and women, particularly in relation to the need for discrete and compassionate healthcare providers. Even though not all women have a mobile phone, these helplines make a real difference to many of them.

Even though not all adolescent girls and women have a mobile phone, helplines make a real difference to many of them

Alongside helplines or online information and referral channels, other stakeholders are working directly within communities to raise awareness of the legal framework and guide adolescent girls and women who are unintentionally pregnant to seek safe abortion services. These include community health workers, as illustrated in the comments below:

> *As a community health volunteer, I'm mainly involved in activities within the community. I talk to young girls who are in vocational training. We discuss the issue with the students, and if they express a need for such services, we refer them to the clinic so that they can access them.*
>
> **NGO representative, 28, Atlantique**

The interviews revealed that CSOs take a strategic community-based approach to improve women's access to high-quality abortion services. CSOs undertake awareness-raising activities and build trust with partner health facilities to ensure the availability of referral pathways. They also mobilise a range of community actors, including traditional healers, to encourage women to use safe and legal services. Consequently, some people selling herbal teas or informal products, having recognised the limitations of their unsafe methods, have chosen to refer women to accredited healthcare facilities.

Madeleine, a 24-year-old hairdresser in the Atlantique department, was referred to a healthcare facility by a seller of informal products after a failed attempt to terminate her pregnancy using medicines purchased from her: "*After she'd sold me the herbs, I went back to tell her that they hadn't worked. That's when she told me about the community health centre. As the herbal tea hadn't worked, she told me to go to the community centre and not to keep trying the herbal teas.*"

Aware that the herbal tea sold to her client had been ineffective, the seller referred her to a health centre to prevent any complications. This action demonstrates a reconfiguration of trust-based relationships: better informed about the services available, informal actors become links to the formal health system, facilitating access to safe abortion care. Some CSO staff described how their role in refferral also allows them to monitor healthcare providers performances, information which they use to continuously improve abortion care.

The pathways of women who have received safe abortion care demonstrate the importance of referral mechanisms facilitated by healthcare providers, CSOs and helplines in the two departments covered by the study. This system helps to overcome major barriers: conscientious objection by certain healthcare providers, technical or material limitations in some facilities, and a lack of information among women and their support networks regarding routes to safe abortion care.

Once referral had taken place, a woman's financial independence proved to be a key factor in ensuring effective access to a safe abortion.

Women's financial autonomy

Participants' financial circumstances played a decisive role in their access to safe abortion care. In the communities where this research was conducted, economic insecurity is a shared reality: of the 35 women who received comprehensive safe abortion care, 20 were working in the informal sector with varying, but generally low incomes. The data showed that those with access to a reasonable income or savings had more freedom to independently choose the care best suited to their health. Financial independence is thus a key factor in accessing safe abortion care.

During this study, nine women were able to cover the full cost of terminating their pregnancies. Ariane, a 32-year-old widow and student from Borgou, managed to juggle several income-generating activities to ensure her financial independence: "I worked as an invigilator during university exams and even helped with marking and administrative work for the A-levels. Although he [her former partner] did everything for me, I was earning my own money there too. He asked me to open a shop and run it. I agreed."

> *"I worked as an invigilator during university exams and even helped with marking and administrative work for the A-levels. Although he [her former partner] did everything for me, I was earning my own money there too. He asked me to open a shop and run it. I agreed."*
>
> **Ariane, 32, student, Borgou**

Thanks to her various sources of income, Ariane was able not only to meet her day-to-day needs but also to build up some savings. This financial independence proved crucial in Ariane's case, as she found herself pregnant by a former university classmate while in a state of emotional vulnerability, shortly after her husband's death. Faced with her partner's request not to continue with the pregnancy, Ariane was able to pay for a safe abortion herself:

> *His decision [her partner's] was that we should have it removed, but he didn't take any steps towards that and told me to sort it out myself. That's what he did, and I say he's not human … he didn't even want to listen, he didn't even want to help me; he just told me to sort it out myself. I even had to haggle over the price [of the treatment] because I knew the 30,000 I'd saved wouldn't be enough; there'd be nothing left. When I told him how much it would cost, he said, "What? It's just the blood that's there … no, never" . That's why he never rang me again or asked how it went – nothing.*
>
> **Ariane, 32, student, Borgou**

Shocked and left to deal with the unintended pregnancy on her own – as was the case for several other participants, some of whom were forced to resort to unsafe abortion methods – Ariane had to rely on her own resources.

Most women sought safe abortion care at community organisations or private clinics, where fees are higher than in the public sector. Ariane, for example, paid around 30,000 FCFA (45 euros) for her treatment at a non-profit organisation. In private clinics, costs averaged 60,000 FCFA (90 euros) or even more – a significant sum for most of the adolescent girls and women in this study. Women who could not afford this relied on support from their families, particularly their mothers or partners, or on CSOs to raise the necessary funds.

Support from family members and civil society organisations

Support from partners and family members also appears to be an important factor in accessing safe abortion care. The research findings highlight three forms of support: emotional support, help in finding information, and financial support.

For some family members and partners, this support involved sharing their knowledge of the legal framework and methods of safe abortion. For those who did not have this information, support took the form of actively seeking out safe medical options for their partner or loved one:

> *Others told me about the quacks. You see, we went to school, as I always say, and we've also been given health education. I know that if you do that [visit a clandestine provider], it can lead to a lot of things, not just infections. So, I thought to myself, why not go and see specialists? No matter what it costs, it's a person's life, not an animal's.*
>
> **Kev, 27, male partner, farmer, Borgou**

Kev set about looking for 'specialists' and guiding his partner in choosing a safe abortion method.

The support provided by loved ones and partners also took the form of direct financial assistance. Indeed, the cost of abortion services is often an insurmountable barrier for many adolescent girls and women. This study found some partners and family members covered all or part of the costs of the procedure. For example, Donan is a young woman who was able to access safe abortion care thanks to the combined support of her mother and her partner, who covered costs totalling over 24,000 FCFA (36 euros):

Financial support from others is a key factor in accessing safe abortion

> *I can say that my mum's contribution was significant; my own money was the 3,000 francs I used to buy medicines and the 5,000 I sent. My mum gave 4,000, and I added 1,000. Everything else was my mum's money. The 8,000 was sent by my child's father, and the 2,000 francs I borrowed from my sister-in-law to take a Zem [motorcycle taxi] because my mum was going to the village that day, and she told me she didn't have any money. So I had to borrow the 2,000, which I haven't paid back yet.*
>
> **Donan, 22, unemployed, Atlantique**

Financial support from family members or a partner appears to be a key factor in accessing safe abortion care. However, this presupposes that a woman can confide in their family or partner about her intention to have an abortion, and that they support this decision and have the necessary resources to assist with the process. This was not the case for all the participants in this study.

In the absence of support from family members or a partner, some women were able to rely on the support of CSOs involved in providing SRH services in both departments. Indeed, in addition to referring women, these organisations could sometimes help to overcome financial barriers by acting as intermediaries and providing direct financial support, sometimes through the provision of referral vouchers. A community worker recounts the care provided to a young girl in distress as follows:

> *We said, "All right, if that's the case, I'll commit to helping your daughter, because it's our duty to help girls who need our service. And it's so that she can continue her studies, isn't it?" She said yes. So, I referred her, went to the clinic and gave her a referral voucher*
>
> **NGO representative, 28, Atlantique**

Thanks to the referral vouchers they provide, as well as mediating with clinic management, these practitioners help to remove the financial barrier to accessing safe abortion care. This support forms part of a holistic approach aimed at social reintegration, particularly for rape survivors, where psychological support is intrinsically linked to the process of referring women to specialist services to restore their self-esteem. One NGO manager emphasised that clinical care does not constitute a complete recovery:

> *Once the service has been provided, the real challenge is social reintegration, because the service itself does not yet constitute a complete recovery. but when we try to facilitate social reintegration, or simply call them to say: "I've called you today just to check in on you – how are you?", she says to herself: 'Ah, so someone actually cares about me.'*
>
> **NGO manager, 28, Atlantique**

By combining online support, financial assistance and community-based follow-up, CSOs ensure a high-quality, swift and safe care pathway, grounded in empathy and human dignity.

Conclusion on access to safe abortion care

This research reveals that the adolescent girls and women who access safe abortion care in Benin are predominantly young, students or workers in the informal sector, and live in urban or peri-urban areas. What they have in common is a desire to avoid the complications that can arise from unsafe abortion which could threaten their health, even their life, and their social standing.

Nevertheless, the journey for women to access safe abortion care remains non-linear and depends on a combination of crucial enabling factors. Knowledge of the law acts as an initial catalyst by 'normalising' the possibility of requesting safe abortion care and alleviating fears of legal action.

Where there is a lack of public services – whether due to healthcare workers' conscientious objection or a shortage of supplies – referral mechanisms step in. These networks – whether established by dedicated healthcare professionals, CSOs accessible via free helplines, or community outreach workers – play a crucial role in transforming situations where access is blocked into effective pathways to safe abortion care.

Financial independence, or financial support from partners, family members or CSOs, proves to be the final lever for access.

Although some of the adolescent girls and women followed were able to access a safe abortion during this study, others had no choice but to resort to unsafe methods. The next section examines their experiences and the barriers that stopped them accessing safe abortion care.

Djomion's story

Djomion, a 26-year-old widow and mother of three children, experienced complications following an unsafe abortion. She works as a community mobiliser at an NGO but has no stable income, mainly relying on small travel allowances. To supplement her income, she opened a small restaurant with her mother. However, financial pressures often meant that she had to reduce prices or accept unpaid bills to keep customers. Ultimately, they had to close.

"Customers come, eat and don't pay," she says.

As widowhood had left her in a precarious social position, she entered a new relationship with a married man. Djomion hoped this relationship would protect her from community stigma and provide her children with a paternal figure:

"It's because of the neighbourhood gossip; if people don't see a man behind a woman, they say she's a prostitute," she says.

Djomion became unintentionally pregnant after the removal of an implant, which she had stopped using due to side effects. Based on her precarious economic situation and her lack of interest in pursuing a serious relationship with her partner, she decided to end the pregnancy without informing him.

Her attempt at having an abortion began with trying medicinal plants recommended by a friend (a health care assistant), which had no effect. She was later referred to a clinic but did not go due to cost constraints. She then visited a referral-level health facility after being encouraged by friends. Here, she was first advised to continue the pregnancy and then told the facility did not provide abortion services before being referred to a community health centre more than 50 km away. She ruled out this option due to transport and treatment costs.

Faced with limited alternatives, Djomion eventually turned to a nursing assistant who provided a clandestine home-abortion. She explains:

> "I thought about it and told myself that if I had to go to Cotonou or Allada to get the service, it would involve the very same costs I was trying to avoid. So, I rang 'that brother' and told him I didn't want a curettage. He came to my house and we had a chat … He asked me for 7,000 francs [11 euros] and I haggled until I gave him 5,000 francs [8 euros] and got the medication."

She received an injection and tablets of unknown origin. While she initially felt relieved to have accessed an abortion locally and without judgement, she later developed a uterine infection and severe abdominal pain, which required her to get treatment at a health facility.

Profiles and experiences of adolescent girls and women who have sought unsafe abortions

Key findings

Despite legislative reform, numerous barriers continue to hinder women's access to safe abortion care, including:

- low awareness of the law
- conscientious objection from healthcare workers
- financial and geographical constraints
- lack of support from family or partner
- the requirement for parental consent for minors
- pregnancy beyond 12 weeks.

Djomion's case illustrates some of the circumstances and factors that force women to continue using unsafe abortion methods, despite the recent relaxation of the law in Benin.

The research data revealed a variety of profiles of adolescent girls and women who had undergone an unsafe abortion, which are summarised in Table 2. The predominant group was adolescent girls and young women aged between 15 and 25. Around half of those who had an unsafe abortion were married or in a relationship, while the other half were single. Most worked in the informal sector and had completed secondary education.

Table 2 : Socio-demographic profiles of adolescent girls and women who have used unsafe abortion methods

Characteristics		Frequencies (34)
Age	15-17 years	3
	18 -25 years	16
	26 - 40 years	11
	41-57 years	4
Marital status	Single	17
	Married/in a relationship	16
	Widowed	1
Level of education	None	8
	Primary	7
	Secondary	18
	Upper secondary	1
Profession/occupation	Unemployed/housewife	4
	Pupil/student	2
	Employee/worker in the informal sector*	19
	In vocational training	7
	Worker in the formal sector	2
Area of residence	Rural	10
	Peri-urban	10
	Urban	14

The data shows that women follow a variety of pathways and resort to various unsafe methods to terminate their pregnancies. Some, like Djomion, initially used an unsafe method then after it failed sought post-abortion care at a healthcare facility. Others turned to clandestine facilities after being refused treatment or in the absence of a referral to a public healthcare facility.

Methods used: combinations and repeated attempts

Women resorted to a variety of unsafe 'traditional methods'[xiv] to have an abortion. In rural and peri-urban areas in particular, these practices typically involved drinking herbal teas made from medicinal plants or trees, such as kodô (a type of mahogany), or inserting plant stalks, such as those from cassava. Others use 'neo-traditional' practices, they take pharmaceutical medicines not recommended for abortion, such as the painkillers or the contraceptive pill, sometimes combined with the consumption of stimulants or alcoholic drinks. In urban areas, in addition to these neo-traditional practices, it is common to seek out clandestine abortion providers who carry out injections, suction procedures or curettage or who prescribe medicines to be administered orally or vaginally.

The findings also highlight a pattern of repeated attempts and a combination of methods used by some participants to induce abortion. Of the 34 women included in this study who had unsafe abortions, the majority (28) succeeded in inducing an abortion on the first attempt, but others had to repeat their attempts, sometimes up to four times.

These ineffective or highly dangerous methods, combined with the fact that some women need to make repeated attempts to end a pregnancy, led to medical complications in almost all cases. Of the 34 documented cases of unsafe abortion, only 6 did not report any complications. The other women faced complications, some of which were very serious; two women died during the course of data collection for this research. For the women who survived, the outcome of these unsafe procedures required them to seek emergency post-abortion care at a healthcare facility.

The reasoning behind the choice of an unsafe abortion method

Analysis of the data shows that the use of unsafe abortion methods is influenced by a range of determining factors, including the influence of the woman's immediate social circle. Advice from friends, mothers, grandmothers or partners carries significant weight. Participants also cited recommendations from the sellers and service providers of unsafe methods. In many cases, women used their own initiative to choose an unsafe method, fuelled by experiences shared among women or by conducting research on digital platforms such as Facebook and Google.

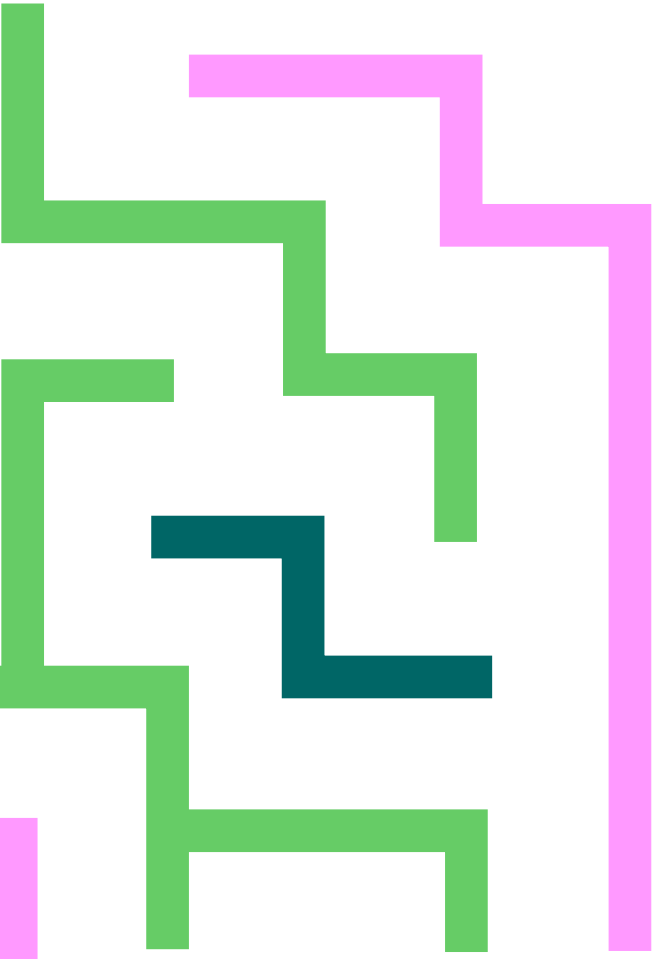
Beyond social influence, the data shows that which unsafe method women choose is guided by considerations of accessibility, both physical and financial. In Djomion's case, for example, geographical barriers and the high cost of accessing safe abortion care motivated her decision not to visit the health facility that had been recommended to her. The relative ease of accessing unsafe methods, which tend to be locally available, was confirmed by several participants:

> *Well, often the way you find them easily is that, if there are older women nearby, you might hear that so-and-so's mum did such-and-such for her daughter. So, if someone else needs it, and you've already been told who to go to, you'll refer the person in question to the person you were shown. So that's how we find out about it – word of mouth is quicker than even the radio. Because the other person will hear about it. And the other person will even show you the way.*
>
> **Mya, 30, street vendor, Borgou**

This account illustrates the power of word of mouth and intergenerational relations among women. These factors help adolescent girls and other women who are often lacking information about abortion methods, to find nearby sources of help, even if this leads them to an unsafe abortion.

xiv The term 'traditional methods' refers here to herbal teas or other natural remedies.

Unsafe methods tend to be more locally available than safe abortion care



Women who had an unsafe abortions had faced multiple barriers to accessing safe abortion care

Barriers to accessing safe abortion care

An analysis of the experiences of adolescent girls and women who resorted to unsafe abortion methods highlights a multitude of barriers to safe abortion care. These barriers, which are often cumulative, include a lack of knowledge of the legal framework alongside socio-economic factors, such as a lack of financial resources, a lack of family or partner support, and the geographical distance to health facilities that provide safe abortion care. In addition to these socio-economic barriers, there are institutional and systemic obstacles, such as healthcare workers' conscientious objection to providing safe abortion care, and when a pregnancy has exceeded 12 weeks' gestation. Further obstacles include socio-cultural norms, and the requirement for parental consent for minors. Taken individually or collectively, these factors drive adolescent girls and women towards clandestine and risky abortions.

Limited awareness of the amended law

Lack of knowledge or partial knowledge of the law

The research findings reveal a profound lack of awareness of the SRH legal reform within the communities surveyed. Of the 35 women who had undergone an unsafe abortion, 27 were unaware of the new provisions of the law which have broadened the circumstances under which abortion is legal.

This was the case for Okpe, a 26-year-old mother of two children. Having suffered physical and psychological abuse from her partner because she opposed his plan to take a second wife, Okpe felt forced to terminate her pregnancy as soon as she found out she was pregnant. Convinced that abortion remained strictly prohibited in Benin and unaware of any safe medical options, she turned to her peers. On their advice, she inserted a kpati dehoun stem (a type of plant) into her cervix, which is said to have triggered heavy bleeding a few days later. After losing consciousness, she was rushed to a healthcare facility.

During the research interview, Okpe explained that she had resorted to an unsafe abortion method because she was unaware of the law:

No, I didn't know [about the law], I was told that at the hospital. They told me that if I didn't want to carry the pregnancy to term, we'd sort it out between ourselves, and for a small sum, they'd take care of it for me. They asked me why I'd taken things to try and kill myself.

Okpe, 26, street vendor, Atlantique

During the interview, Okpe emphasised the need to inform women about this law and to ensure that safe abortion care is routinely provided in healthcare facilities to avoid complications similar to those she experienced: *"Now I tell everyone to go to hospital to have an abortion. I tell women that if I'd gone to hospital, I wouldn't have ended up with the complication."*

For some women, visiting the healthcare facility for post-abortion care becomes an opportunity to learn about the existence of the amended SRH law, its content and how it is applied.

However, the findings show that, among those who were aware of the law's existence, their understanding of its content was patchy or incorrect. Sometimes, this prevented women from using the law to have a safe abortion, as illustrated by the two examples below:

I found out about it through social media. Even though I knew a law had been passed, I couldn't quite remember the details, but I knew that abortion was no longer forbidden; it was accepted, authorised – it was authorised – but to be honest, I had no idea how it worked

Partner of Oser, 26, Borgou

I don't really know the details. I learnt about it in the village; I can't remember where I'd gone, but they were talking about it. It was a mum who said that it's the pregnancies where the scan [ultrasound] has revealed that the foetus has malformations – it's those pregnancies that the state has allowed us to terminate.

Aliciou, 22, Atlantique

Key informants and service providers confirmed that there was a lack of understanding of the law or gaps in knowledge within communities:

People just know there's a law that actually allows this [abortion], but in detail, they don't know what it actually entails. So I don't think the community is really informed, no.

Gynaecologist, 51, Atlantique

[Awareness is] very, very low. If you like, below very low, let's say. Yes, because people simply don't know about it today

NGO manager, 40, Borgou

This situation was observed in both the northern and southern regions, in rural as well as urban areas, among people who were completely unaware of the law's existence and among those who had heard of the law but did not understand its contents.

Findings reveal that knowledge of the law and its content is often based on informal conversations within the community or on information relayed by the media. What this information has in common is that it is vague, or even incorrect, and is frequently fuelled by rumours that arose after the amended law was passed in 2021.

Lack of information and the spread of rumours

Despite considerable efforts, by the government and NGOs to disseminate information about the SRH law change, both jointly and separately, not all communities have been reached. The result is an information gap that has encouraged the spread of negative interpretations and rumours of the law within communities. This includes the false claim that the reform is a mechanism put in place by the state to regulate or limit births in the country, as a key informant explained:

These days, there are people who say that this law is designed to make us have fewer children. We shouldn't stop them from having children. It's a decision from the West that's been imposed on Benin so that Benin can get foreign grants, things to do with the law … But that's not the right information.

NGO representative, 26, Atlantique

As captured in this statement above, for some community members and leaders, the legal reform is seen as the result of Western pressure aimed at controlling birth rates and securing external funding for Benin. Others interpret the amendment to the law as a means of facilitating access to abortion and encouraging sexual practices deemed deviant, particularly sex work, as one participant explained:

Misinterpretations … Well, there's one that makes me laugh: "The president is building roads, particularly the road to sin; it's to encourage prostitution. And when there are pregnancies, it'll be easy to manage and all that." Well, those are some of the interpretations, some of the feedback we're getting.

NGO representative, 45, Atlantique

The interviews and discussions show that there are also misinterpretations and rumours concerning the conditions for accessing safe abortion care which do not reflect the actual conditions the amended law sets out. This is fuelling a climate of uncertainty among adolescent girls and women. For example, some participants have heard that abortion is only permitted in cases of foetal abnormality, incest or rape or when the pregnant woman or her partner has a mental health condition

> *I simply learnt that abortion is permitted. But the way I understood it, abortion is permitted in certain cases. For example, when the unborn child has birth defects,. when the person responsible for the pregnancy is mentally ill, or when it is the child's own father who got her pregnant, abortion is permitted. But when the woman is in good health, as is the man who fathered the child, and she comes to see you saying she wants an abortion and you offer her the service, you could go to prison.*
>
> **Pharmacist, 40, Atlantique**

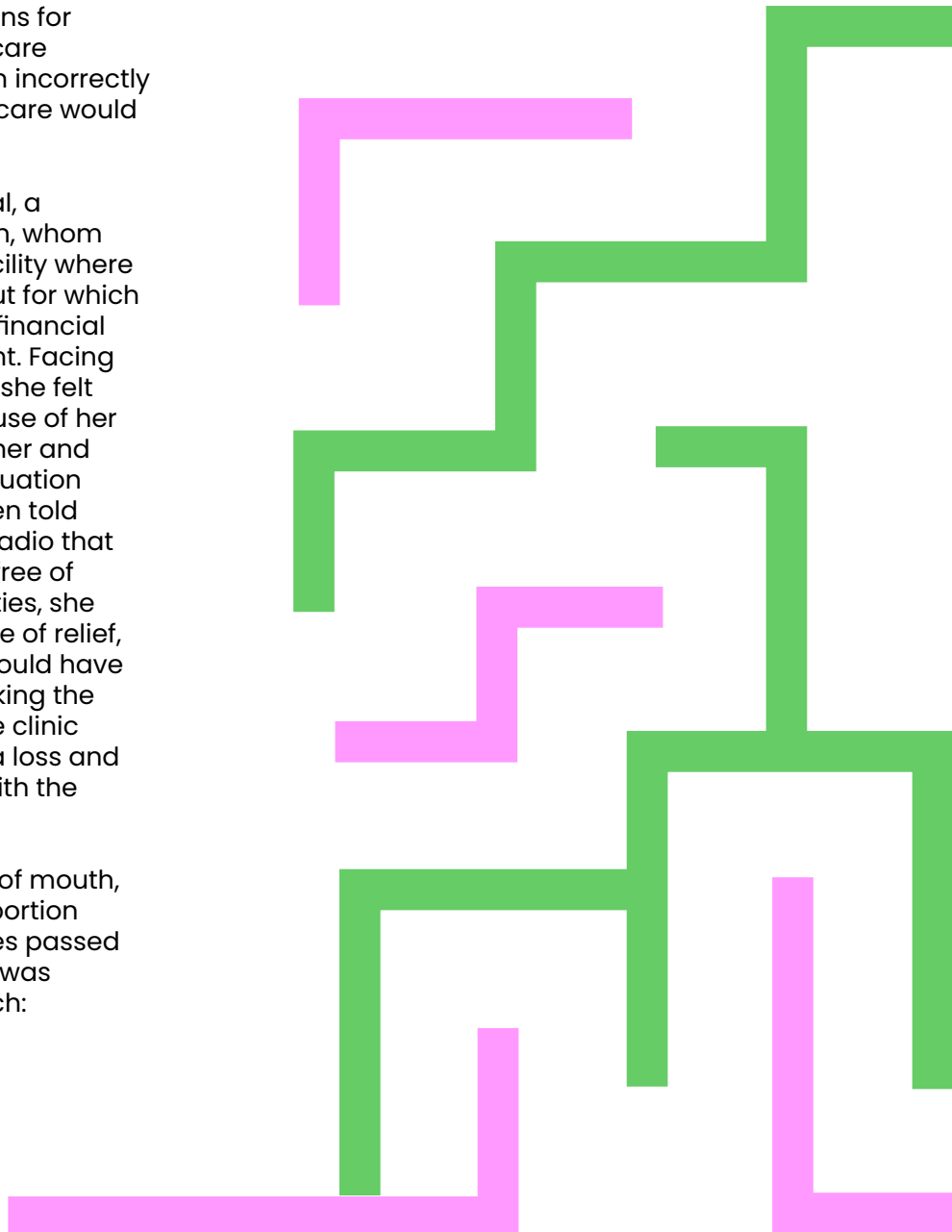
These comments highlight certain conditions set out in the old law, while omitting the grounds of hardship (financial, educational, professional or emotional) introduced in its amended version following the reform.

Rumours and misinformation are also circulating regarding the conditions for accessing abortion within healthcare facilities. Some women have been incorrectly told that access to safe abortion care would be free of charge.

This was notably the case for Innal, a 48-year-old mother of six children, whom we met at a public healthcare facility where abortion services are available but for which a fee is charged. Due to a lack of financial means, she was refused treatment. Facing an unintended pregnancy, which she felt she could not carry to term because of her age and her status as a stepmother and grandmother, Innal viewed the situation as a source of shame. Having been told by a relative and hearing on the radio that abortion services were available free of charge in public healthcare facilities, she went to a public clinic with a sense of relief, only to learn on arrival that she would have to pay for safe abortion care. Lacking the necessary resources, Innal left the clinic feeling deeply distressed and at a loss and subsequently broke off contact with the research assistant.

In addition to the radio and word of mouth, incorrect information that safe abortion services are free is also sometimes passed on by NGO workers, one of whom was interviewed as part of this research:

Some women believed safe abortion care would be free of charge at a public health facility, only to learn that they would have to pay an amount they could not afford



It is free for everyone. In fact, according to the provision – that is what the law says – it is free in all public health centres. In short, it costs not a single franc. The state has made the necessary arrangements, which is why it [the state] has said that it is free. It has said that it is free, and so it is free in all public health centres in Benin.

NGO representative, 26, Atlantique

Although this information is incorrect, it is actively promoted and disseminated through some NGO awareness-raising activities carried out within communities. While this encourages some women to seek safe abortion care, in some cases, it also leads to misunderstandings and tensions between women and healthcare providers. These negative experiences are then shared within local social networks, which can discourage women to use healthcare services in the future.

Some interpretations of the law resulted in the misunderstanding that partner consent is required as a prerequisite for accessing safe abortion services. For example, one focus group participant stated:

... They said that this is done at the hospital, but before doing so, the husband – the person responsible for the pregnancy – must give his consent for the abortion. If he refuses, you cannot have an abortion.

Apprentice, 19, focus group, Atlantique

This misconception is a significant barrier to accessing safe abortion care. Indeed, some women decide to have an abortion without informing their partner because they are neither willing nor able to seek his consent. Resorting to an unsafe abortion appears to be an alternative to what these women might perceive as a barrier to their decision-making autonomy.

In short, these comments reflect a lack of information within communities regarding the motivations and objectives of the legal reform, which are rarely, if ever, communicated through official channels. While a lack of information about the law is a reality in both departments, the data shows

that it is particularly pronounced in rural and peri-urban areas. In these areas, access to information appears limited and women rely mainly on the radio and word of mouth (friends, relatives, parents) to understand the legal situation relating to abortion. This situation contrasts with urban areas, where women have access to a wider range of information channels, such as the internet, social media, health facilities and NGOs.

Uneven dissemination of information regarding the law

Generally speaking, despite considerable efforts by the government and NGOs, uneven dissemination of information about the legal reform appears to be linked to several factors, particularly insufficient public funding to run awareness campaigns in rural areas. The centralisation of funding and the scarcity of resources limit the capacity of grassroots organisations to reach all communities equitably. The result is a concentration of initiatives in urban areas and among school-going young people, to the detriment of rural areas. An NGO coordinator explained:

> *For some time now, awareness raising and activities have focused on urban areas. For those in town, awareness-raising campaigns are constantly targeting them, especially the educated; we tend to go to them. But today, our strategy is to reach out to those in rural areas, to tell them, "Yes, you too have a right to information".*
>
> **NGO representative, 29, Atlantique**

As well as financial barriers that prohibit information campaigns to reach everyone evenly, the data shows that the limited number of information channels available in rural areas is a key factor in disparities in accessing information. A focus group participant illustrated this point with the following comment:

> *For example, me, where I am, I don't get a regular radio signal to listen to the news, so we count on what other people say. They [government] talk about things, they talk about decentralisation, they say power has come down to the grassroots – we hear about these things, but no one comes down to the grassroots to explain them to us, and things just stay up there at the top. What we're saying now is that they should have gone round to the hamlets and explained that such-and-such a measure has been introduced; that's how it should be done.*
>
> **Apprentice tailor, 20, focus group, Atlantique**

This account highlights not only the limited reach of certain media, such as radio, within rural areas, but also the lack of effective local communication mechanisms that would enable information to be effectively shared within rural communities. It also underlines the disconnect between the rhetoric on decentralisation and the reality on the ground, where information remains concentrated at the central, urban level.

"People will say you're spreading propaganda, and that could get you in trouble"

An effective communication mechanism requires training for those responsible for sharing information about the legal reform (e.g., community health volunteers, health workers). However, such interviewees acknowledged there is a lack of training on the amended law and its content, which leads them to avoid the subject or to gloss over it during their awareness-raising activities.

The lack of communication regarding the amended SRH law appears to be exacerbated by the 'promotion of abortion' ban set out in the law. Research participants observed that this provision in the law creates confusion and a fear of sanctions among those working on SRHR, as this key informant explained:

> *I also mentioned the clause on communication, which states that we must not communicate, that we must not engage in propaganda [of abortion]. If we cannot communicate, it makes the task difficult for civil society organisations because we will not be able to do so freely. What we're going to do now is highlight SRHR so we can talk about it, but you can't just go on any social media platform now and start – at least, if you run an NGO working in Benin – you can't just go on social media and start talking about safe abortion. They [government] will say you're spreading propaganda, and that could get you into trouble.*
>
> **Feminist activist, 32, Atlantique**

This quote shows that the ban on 'promotion' severely restricts communication about Benin's abortion law. CSOs feel compelled to self-censor, for fear of being accused of breaking the law when they explicitly address safe abortion care, particularly on social media. This situation reduces their ability to freely inform the public and contributes to a sparing and cautious dissemination of information regarding the amended SRH law.

In short, the incomplete communication about the amended SRH law limits not only awareness but also understanding of existing policies, healthcare provision and abortion rights. This lack of effective institutional communication creates a gap, which is filled by rumours and misinterpretations. This

highlights a disconnect between the official intention of Benin's public health initiative to broaden access to safe abortion care and the meanings attributed to it within communities.

Although some adolescent girls and women in the study managed to overcome the barrier of being unfamiliar with the legal framework to seek safe abortion care within health facilities, they then faced another major obstacle: healthcare workers' conscientious objection.

Conscientious objection as a barrier to accessing safe abortion care

Article 5 of the implementing decree regarding the amended SRH law recognises healthcare providers' right to conscientious objection. This allows healthcare workers to refuse to provide safe abortion services on the grounds of religious or personal belief. The decree specifies that, to exercise of this right, a healthcare worker must provide a written declaration addressed to the person in charge upon taking up their post and is also obliged to refer any patient requesting safe abortion care to a qualified practitioner from the very first consultation.

Observations and interviews conducted with adolescent girls, women and healthcare providers reveal that this right is widely exercised, particularly by staff in public healthcare facilities. Of the 46 healthcare providers interviewed, 30 stated that they invoked conscientious objection, 22 of whom worked in public healthcare facilities. This widespread invocation and the way it is implemented significantly affects access to safe abortion care, particularly in the public sector. Out of the nine public facilities where data was collected, only one offered safe abortion care, while none of the three faith-based facilities observed offered these services. Conscientious objection appears to be a key reason for the lack of abortion care in these facilities, as illustrated by the following research observation:

> *The midwife on duty received a young schoolgirl today who had come for an abortion. The girl explained the reasons behind her request for this service. She explained that she had lost her father and that her mother was in prison; keen to complete her education, she could not continue with the pregnancy. The midwife, despite the educational and emotional distress this young girl was experiencing, refused to provide the service. The girl eventually accepted the decision and asked which healthcare facility she could go to for the service. However, although the midwife was aware of private clinics offering the service in the area, she refused to refer the schoolgirl. The girl therefore left without any information that could help her access a safe abortion service.*
>
> **Observation notes, 21 March 2025, Atlantique**

Of the nine public facilities studied, only one offered safe abortion care

Senior staff's conscientious objection can paralyse a facility's provision of safe abortion care

This type of scenario was common in public and faith-based healthcare facilities. It highlights the dynamics surrounding conscientious objection and how it contributes to limiting women's access to safe abortion care.

Conscientious objection is sometimes practised collectively in certain facilities, as one key informant explained:

> *We've already had cases like this during awareness-raising sessions, where women told us they'd gone to clinics to request the service [safe abortion care], and the midwives there said they wouldn't provide it and that they'd tell the other midwives in the clinic not to provide it to them, or if the woman went elsewhere, not to provide it to her there either.*
>
> **Feminist activist, 32, Atlantique**

It appears that some healthcare providers who invoke their right to conscientious objection are seeking to persuade their colleagues not to offer safe abortion care either. This serves to create collective blocs opposed to the provision of such care. The data also shows that some providers are willing to offer safe abortion care but are prevented from doing so by their superiors' conscientious objection or their organisation's policy:

> *I had a case here, which I referred to the doctor. But his religious beliefs – for him personally, that's a problem – and he said he would be one of those who would opt out of providing this service [safe abortion care]. He didn't even speak to the patient. He just asked if I could refer her, to do so. If I wanted to advise her, I could; if I wanted to refer her, I could, but he, he doesn't fit in this system of providing abortions and such.*
>
> **Healthcare worker, 30, pheripheral health centre, Atlantique**

This account demonstrates that conscientious objection exercised by more senior medical staff has a paralysing effect on the overall provision of safe abortion care within health facilities. A doctor's refusal, based on their religious convictions, is not always limited to their own withdrawal of care. It can also create an institutional vacuum that instils fear (of stigmatisation and reprisals in the event of complications) which stops other staff from providing safe abortion care. For example, the involvement of midwives in providing safe abortion care depends on doctors or gynaecologists formally delegating this task to them. This delegation has to be documented by use of a special form, which when issued is perceived by those being delegated the task as an institutional protection. When a clinic's medical hierarchy opposes the provision of abortion safe care, this protection is absent.

This backdrop of widespread refusal to provide safe abortion services affects healthcare providers who do not practise conscientious objection. Some end up ceasing to offer safe abortion care due to the professional pressures and stigmatisation they face.

This dynamic was illustrated by midwife Djidjoho. She provided safe abortion care until the end of 2024, when she was forced to stop. When asked why, she explained that she had been questioned and criticised by her managers and colleagues during a meeting about the number of abortion cases she was handling: *"A senior manager was even there with us and was chatting with them [other colleagues], because they were presenting the centres that provide this service – there was the hospital and my health centre, and everyone recognised me [as being the one providing the care]."* Djidjoho described feeling exposed and stigmatised. She recalled how her colleagues were not interested in her reasons for providing these services, but instead simply mocked her and referred all abortion requests to her: *"Everyone recognises me; I don't even want to talk about it … My colleagues ring me because they don't perform abortions and say they're going to send someone my way. [In their eyes] I've become an abortionist."* Having stopped providing safe abortion care, Djidjoho now refers the cases she receives to private clinics. Conscientious objection thus appears to be a practice that is both chosen and imposed, shaped by the need to conform to professional and social expectations and by the desire to avoid stigmatisation within healthcare teams and organisations.

As well as conscientious objection being widely practised, the findings show that conscientious objectors do not always comply with the provisions set out in the implementing decree. For example, very few health care providers have signed the official declaration of conscientious objection required by law. Some perceive this formality as a form of institutional pressure designed to force them to provide safe abortion care, or to force healthcare professionals into a visible stance against abortion which could have repercussions for their career progression:

> *Asking people to sign a form – that's exerting influence; it's forcing people to do what they don't want to do. Nobody's had the courage to sign because that, too, is scary. Almost 90% of us rely on funding from the hospital. So, if you want to make a public stand and say you're not going to do it … Won't that… well, it's true that they [the managers] will say it won't affect you. If, on the other hand, another midwife says she wants to do it, and you say you don't want to… it's her, the one who wants to do it that they'll choose. You'll lose your job. So, for fear of losing their jobs … nobody signed.*
>
> **Midwife, 48, referral centre, Atlantique**

This comment shows that fear of the professional consequences associated with formally signing a declaration of conscientious objection acts as a barrier to its effective exercise. Although conscientious objection is legally recognised, having to 'come out' by signing is perceived as a coercive and risky measure in a context of job insecurity and financial dependence. The fear of being blacklisted or replaced by a colleague willing to provide abortion care, deters healthcare providers from officially declaring themselves as conscientious objectors.

As well as refusing to sign the official form declaring conscientious objection, healthcare providers who are conscientious objectors did not systematically comply with the obligation to refer women seeking abortion services to another provider. Instead, they endeavour to dissuade women seeking abortion care from receiving it. Notably, this is done by involving other people, including religious figures, by adding extra steps to the process or by using arguments centred on the future of the 'unborn child', as these two participants explained:

> *I told them that this had happened to me, but that I didn't want to keep the baby, and asked them to help me. They said that if there was a lot of bleeding and it hurt, they would help me. But in this case, they wouldn't do that; they said they would call the doctor. And that's when the doctor told me, "Your baby is healthy, isn't he? He's big and he's beautiful – keep him."*
>
> **Ahisé, 22, Borgou**

> *I was a bit sad. She said that she [the midwife] was going to call someone else; if she had to give me any advice, it would be to keep the baby. But I knew that if she went into more detail, she might change my mind. I said no.*
>
> **Lucrèce, 24, Atlantique**

This situation reveals a breach of the obligation to refer patients to other healthcare providers who could offer safe abortion care, even though this is provided for under the new legal framework. Although healthcare providers were aware of the existence of private facilities offering safe abortion care nearby, they refused to refer women to these facilities, believing that such a step would constitute an indirect form of participation in abortion.

Conscientious objection manifests as a refusal to provide safe abortion care and as a refusal to refer. This leaves women without any information about alternative legal and safe abortion care providers. During the

research, several women who were denied access to safe abortion care resorted to unsafe methods before returning to seek treatment for abortion complications, often at the same healthcare facilities and from the same healthcare providers who had initially refused to treat them.

Financial and geographical constraints

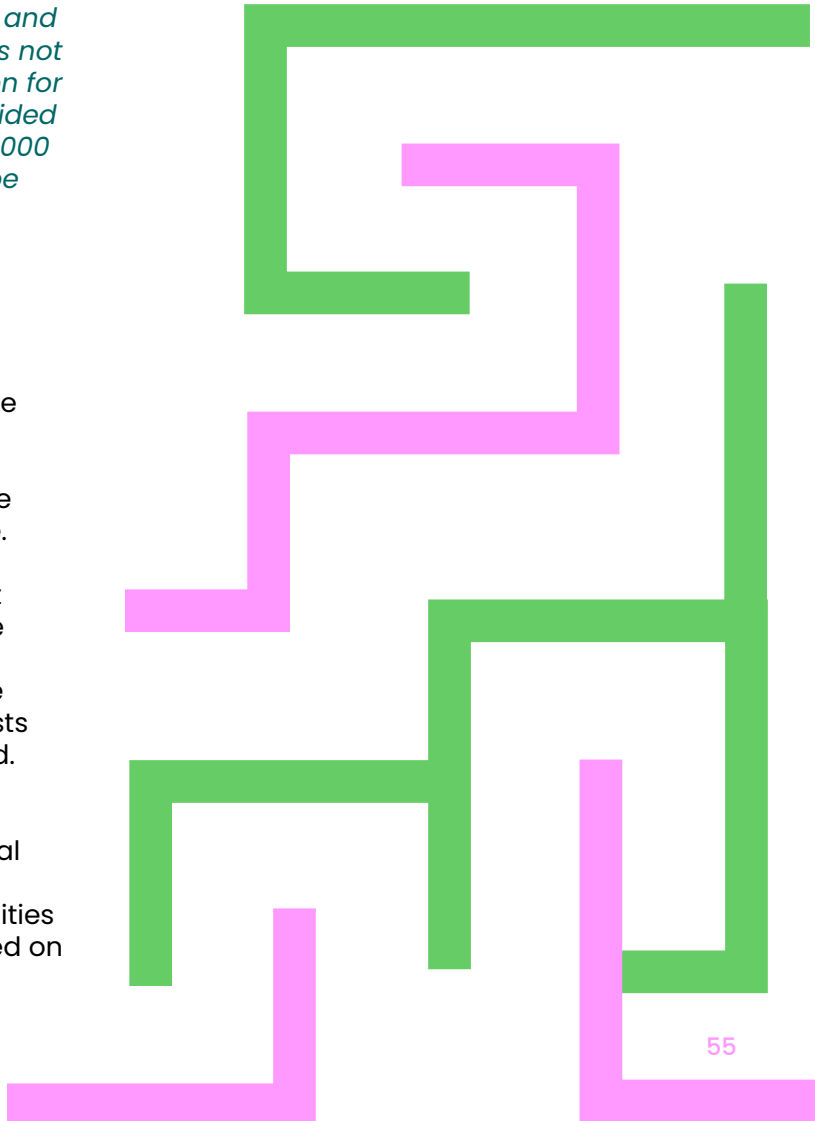
Data from observations and interviews with healthcare providers and women shows that the cost of safe abortion care varies considerably depending on several factors, as one provider explained:

> *These costs aren't fixed, they depend on each woman, because when a woman comes in and expresses a wish to terminate her pregnancy, we have to carry out a preliminary assessment. First, an ultrasound scan to determine whether the pregnancy is intrauterine or ectopic, and to establish how far along she is. We carry out blood tests to determine the woman's blood group and her haemoglobin level to check she is not anaemic. At the same time, we screen for HIV and hepatitis B. In any case, provided the woman has at least 30,000 to 40,000 francs [45 to 60 euros], that should be sufficient*
>
> **Doctor, private practice, Borgou**

In addition to consultation fees and the cost of uterine evacuation, the cost of safe abortion care in the private sector takes into account a range of additional tests as well as the provision of a contraceptive product following the abortion procedure. In the private sector, the time of the consultation also influences the final cost of care. Rates are higher at night – a time slot often preferred by women because of the discretion it offers. Women who are Rhesus-negative also face additional costs associated with the specific care required.

The cost of each component of the safe abortion care package influences the total cost and helps to explain the variations observed, not only between different facilities but also between individual women. Based on

Conscientious objection manifests as a refusal to provide safe abortion care and as a refusal to refer



the data obtained, the cost of safe abortion care ranges from 45,000 to 107,000 FCFA (~68 to 163 euros) in private facilities, and from 12,000 to 39,000 FCFA (~18 to 59 euros) in not-for profit health facilities.

As indicated in the previous section, the majority of abortion cases are managed in private or non-profit healthcare facilities, due to the frequent invocation of conscientious objection by service providers working in public facilities. However, the costs of services in these facilities are relatively higher than in the public sector. On average, the cost of safe abortion care in the public sector is estimated to be between 5,000 and 10,000 CFA francs (~8 and 15 euros), depending on the method used.

These high costs constitute a major barrier for many women and result in many resorting to unsafe abortions. Some women were referred to private facilities by public-sector service providers or by relatives but decided not to go due to concerns about the cost, as in the case of Djomion. Lacking the financial means, women are forced to abandon the safe abortion care option and turn to less expensive and readily available alternatives (see the section on availability and accessibility of informal care in the community). A midwife in charge of a delivery room in a hospital explained:

> *… they need to have a check-up; they need to have an ultrasound scan to be sure of how far along they are in their pregnancy … So when these women come here too, and you explain all this to them, they prefer to go home. The requirement for tests influences their decisions and they don't come back. You need to set aside at least 20,000 [FCFA] [~ 30 euros], if not more. Because we'll treat you like an admitted patient …"*
>
> **Midwife, referral centre, Atlantique**

Some women initially had financial resources at the start of their abortion journey, but the complexity and proliferation of care pathways gradually depleted their resources. Some first went to public health facilities, where they had to incur several expenses (consultation fees, ultrasound scans, required additional tests) before being refused the safe abortion care they sought and finally being referred to private facilities.

This was the case for Félicité, a 30-year-old religious leader and mother of four children. Keen to continue a vocational training course she had recently started, she went to a health centre in her neighbourhood to seek help in terminating the unwanted pregnancy. There, she was referred to her local referral hospital, where she had to pay for a gynaecological consultation (3,100 FCFA / ~5 euros), a medical record fee (100 FCFA / ~ 0.15euros) and the cost of setting up an obstetric file (500 FCFA / ~ 0.80euros), amounting to a total of 3,700 FCFA (~6 euros) before she had even seen the healthcare provider. However, after meeting the gynaecologist, he explained that he did not offer this service and referred her to a private clinic. Many women, like Félicité, incur significant costs without actually gaining access to an abortion. Some, particularly those in economically vulnerable situations, end up abandoning the formal care pathway altogether.

This financial barrier to accessing safe abortion care is even more pronounced among women living in rural areas. Indeed, some rural women in this study were referred to private clinics or referral centres located in urban areas or in a different municipality. In such situations, the travel distance and the additional transport costs were major obstacles which discouraged these women from accessing facilities that could offer safe abortion care.

The case of 17-year-old Bignon, who was living with her aunt as a domestic helper, illustrates this reality. Bignon became unintentionally pregnant by a labourer working on a building site in her neighbourhood who disappeared as soon as she announced her pregnancy. The family and Bignon decided, by mutual agreement, to terminate the pregnancy to prevent the teenager from being left with a child without a father. In their search for safe abortion care, Bignon and her aunt went to a primary healthcare centre in Allada where they were referred to a community-run centre in Cotonou. However, Bignon's aunt felt it would be impossible for them to make this journey without financial assistance from a CSO, due to the distance and associated costs.

and precarious employment situations. These included young women in apprenticeships, housewives without a stable income-generating activity and women working in the informal sector. These circumstances severely limited these women's financial independence and their ability to access a safe abortion at the current costs charged within the Beninese healthcare system.

While financial support by family members and partners can sometimes remove this barrier to accessing a safe abortion, the data from this research shows that the women who underwent unsafe abortions often lacked this support.

Lack of support from family members or partners

Several factors explain the lack of support from family members or partners. Some adolescent girls and women decided to have an abortion without their family's knowledge, for fear of stigmatisation. The findings indicate that premarital pregnancies and abortions are both strongly disapproved of in the communities where the data was collected. Faced with these social norms, adolescent girls and young unmarried women fear the reactions of their families and the community:

> *They [parents] don't like it. They always say, "If you get pregnant, you'll have the baby.. Nobody in this family is going to have an abortion." When I think back to what they said, I get really scared. I tell myself, "If they find out, I'll have to give birth."*
>
> **Chantou, 18, trainee seamstress, Atlantique**

Such comments highlight the lack of parental support that can occur in response to an unintended pregnancy, revealing a family environment strongly shaped by repressive social and moral norms. Chantou's parents' assertion that "no one in this family is going to have an abortion" not only reflects a categorical rejection of abortion, but it also creates a climate of social control and silence in which any possibility of dialogue or support is ruled out. This situation serves

Fear of her parents' reaction led Chantou to conceal her pregnancy and intention to have an abortion

to reinforce the fear of family and social punishment, and leaves adolescent girls isolated and vulnerable. In such a context, stigma acts as a barrier, driving adolescent girls and young women to conceal their pregnancies. These young women find themselves isolated and forced to manage their abortion alone, including the costs. However, in contexts where young women rarely have their own or sufficient financial resources, failing to inform parents or relatives significantly limits their access to financial support to cover the high cost of care. In Chantou's case, fear of her parents' reaction led her to conceal her pregnancy and her intention to have an abortion. Lacking sufficient financial resources, she was forced to resort to traditional herbal methods. This led to complications which required her to be admitted to hospital for post-abortion care.

In addition to parents, the findings show that a lack of partner support also reinforces the financial barrier to accessing safe abortion care. Just as with family members, women are sometimes forced to make the decision to have an abortion without their partner's knowledge. Although the law grants women this decision-making autonomy, financial insecurity often limits their ability to exercise it, like Ariana, a 32-year-old student from Borgou shared: "Take for example the case of a woman living with a man who decides she wants an abortion, but the man – her husband – does not agree; that can prevent it."

Some women in this study found themselves without financial support from their partner, particularly when their partner denied the pregnancy, was unreachable or refused to contribute to the cost of the abortion. The account below illustrates how male partners can disengage and shift decision-making and financial responsibility onto women:

> *I know a woman whose daughter got pregnant. She said it was Jacques, and Jacques said it wasn't him. She said it was Pierre, and Pierre said it wasn't him. And the mother said that, as that's the case, she's going to have her daughter have an abortion*
>
> **Hairdresser, 48, focus group, Atlantique**

Parental consent: a major barrier to minors' access to safe abortion care

The findings also highlight the existence of other structural obstacles, most notably the requirement for parental consent in the case of minors.

The findings show that healthcare providers systematically insist on parental authorisation in the case of minors seeking an abortion, following Articles 28 and 29 of the decree implementing the amended SRH law. This requirement constitutes a major barrier to accessing safe abortion for underage girls, particularly when parents are unaware of both the pregnancy and the decision to have an abortion. Against a backdrop of strong social stigma surrounding premarital pregnancies, the requirement for parental consent presents underage girls with a difficult dilemma between complying with the legal obligation to obtain parental consent and protecting themselves from the social risks associated with revealing the pregnancy and their intention to have an abortion.

For underage girls, informing their parents is not merely an administrative formality but a step fraught with potential consequences: moral condemnation, verbal or physical abuse, social sanctions, family rejection or the withdrawal of material and emotional support. The requirement for parental consent forces underage girls to choose between exposure to potentially threatening parental reactions and foregoing safe abortion care in favour of unsafe methods. According to the healthcare providers interviewed, underage girls tend to choose the second option, putting their health, and even their life, at risk: *"They'll do it because the girl doesn't want her parents to know, and if they come to hospital, you'll tell her to go and fetch a parent … They won't come back. So, they'll do it clandestinely."* Midwife, referral centre, Atlantique.

This quote highlights how the mandatory involvement of parents deters underage girls from accessing safe abortion care. While healthcare providers recognise the restrictive effects of parental consent, they also perceive it as a legal obligation intended to protect them professionally. In line with this self-protection mindset, many healthcare providers refuse to treat minors in the absence of their parents. A midwife working in a peripheral centre described how this requirement shapes her professional practice:

> *Even though there have been underage girls, I haven't done [provided an abortion] … because you need the approval of one of their parents … When it comes to underage girls, you need approval first, a signature … It's exhausting, that sort of thing. If you're not careful, you'll want to do them a favour and you'll fall into their trap.*
>
> **Midwife, peripheral health centre, Atlantique**

This shows the influence of healthcare providers' legal fears on their practices and, by extension, on the provision of safe abortion care for adolescent girls. While these providers may wish to help minors in accordance with their professional ethics, the fear of potential legal consequences forces them to refuse to provide safe abortion care without parental consent. While the requirement for parental consent is intended as a guarantee of legal protection for service providers, it simultaneously increases the vulnerability of minors by limiting their access to safe care.

Exceeding the legal gestation limit

Another major barrier to accessing safe abortion care highlighted by this research is exceeding the legal gestation limit for terminating a pregnancy. Under the amended law of 2021, abortion is permitted up to 12 weeks' gestation. Beyond this point, abortion care cannot be legally provided, unless other, very limited, criteria are met. In the context of this study, several women interviewed at healthcare facilities were thus denied access to safe abortion care.

This was the case for Débo, a 26-year-old housewife, who came to a public healthcare facility seeking safe abortion care. She was seen by midwives and underwent an ultrasound scan which revealed a pregnancy of 12 weeks and 6 days. As this exceeded the legal time limit, the medical team refused to continue her care, citing both medical safety considerations and compliance with the law. Following this initial refusal, Débo went to a charity-run facility, where, after reviewing her ultrasound results, the team confirmed that they could not provide safe abortion care because she had exceeded the legal time limit. Débo was forced to return to her village to seek an unsafe alternative.

Several factors explain why women may be beyond 12 weeks' gestation when they seek a safe abortion, including late care seeking at healthcare facilities due to a lack of understanding of the law (particularly the conditions for requesting an abortion), financial constraints and delays in decision-making.

The case of Amina, aged 16, illustrates this delay in seeking help. A month after her period was late, Amina realised she was pregnant. Fearing her mother's reaction, she first tried to terminate the pregnancy in secret, using unsafe methods. When these attempts failed, she was forced to tell her mother, who reacted strongly to the news, fearing shame and insults by her co-wives. She began by hitting her daughter, then mobilised the extended family and demanded a financial contribution from Amina's boyfriend's family in order to

have the abortion carried out at a private clinic. When Amina first attended the clinic, the ultrasound scan revealed a pregnancy of 16 weeks' gestation, which was beyond the legal time limit. The healthcare team was therefore unable to provide safe abortion care. The family then decided to approach another private clinic for the teenager's care. This clinic agreed to provide safe abortion care, but at a very high cost.

Amina's case illustrates how the fear of stigma, family arrangements surrounding premarital pregnancies and the search for financial resources contribute to delays in seeking safe abortion care and can result in certain women being denied access to an abortion.

Amina's mother reacted violently when she found out her daughter was pregnant, as she feared insults and shaming by her co-wives

The data also shows that, even when women attend a healthcare facility within the legal gestation time, the attitudes and practices of some healthcare providers can contribute to the authorised time limit being exceeded. As discussed in the section on conscientious objection, this constitutes an indirect form of refusal – not through explicit rejection, but through a series of procedures that delay access to care until it is too late. These practices include prescribing ultrasound scans – which are often expensive and force women to return home temporarily to raise the necessary funds – and imposing repeated appointments:

> *The way I was received was a bit odd, in my view, given that the test was positive. They examined me and asked for an ultrasound scan. After the scan, they said they'd found something without an embryo, and I was asked to have another scan and come back two weeks later. I made it very clear that the test was positive and that I didn't want to keep it, but they're forcing me to have scans and attend appointments. It's as if they don't want me to have an abortion.*
>
> **Louise, 41, hairdresser, Atlantique**

While Louise did not wait before seeking an alternative (notably an unsafe method which led to complications), other women, after repeated attempts at accessing a safe abortion, were told that they were no longer eligible.

The experiences of adolescent girls and women in this study, as well as their interactions with health care providers and other key stakeholders, show that exceeding the legal time limit for accessing safe abortion care results from a complex interplay of factors: managing tensions and conflicts surrounding pregnancy, hesitation or delays in decision-making, attempts at abortion carried out outside the formal healthcare system, and a lack of information on the legal conditions for accessing safe abortion care. The data also shows that exceeding the legal time limit may not be solely due to the women seeking care too late, but may also stem from relational normative dynamics within healthcare settings, which can hinder women from accessing safe abortion. In these circumstances, women are forced to resort to unsafe procedures, the availability and accessibility of which are not subject to these constraints.

Availability and accessibility of unsafe abortions methods

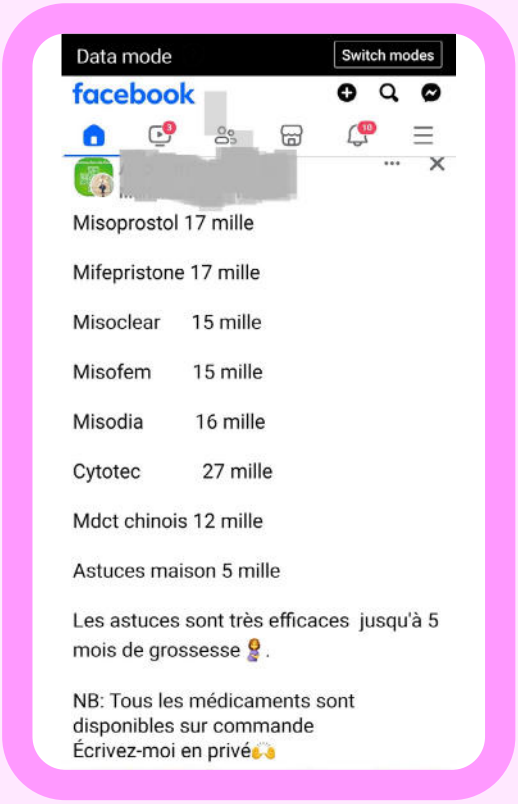
The analysis reveals the existence of a wide range of informal abortion services, which compete directly with formal healthcare. These risky practices combined use of various types of medicines that were not intended for abortion, surgical procedures (such as manual vacuum aspiration or dilation and curettage), injections, as well as traditional and neo-traditional approaches, such as mixing certain beverages or taking herbal teas, or inserting sticks into the cervix. Unlike the safe abortion methods available in healthcare facilities, access to which is officially regulated by law and limited by financial resources, these informal, clandestine and often unsafe services are provided within communities. They are often immediately available at home, in markets, in certain pharmacies, from informal providers in neighbourhoods or on social media, and allow considerable scope for negotiation. This flexibility makes them better suited to the specific constraints and needs of adolescent girls and women, particularly the most vulnerable, despite the risks they pose.

In particular, the data highlights the rise of an informal offer of abortion methods on social media platforms, which emerged following the 2021 reform. This has been fuelled by a misinterpretation of the law that led people to believe that these practices are authorised. Driven by financial considerations, against a backdrop of job insecurity and economic hardship, these informal providers offer intermediate rates: higher than those charged by pharmacies, but lower than those that healthcare facilities charge for safe abortion care. Although costs vary depending on the methods used and the client's profile, these relatively low costs (on average 5,000 FCFA / ~8 euros) facilitate access to abortion for adolescent girls and women with limited resources but expose them to high-risk practices.

In formal healthcare facilities, access to safe abortion care is subject to medical requirements (e.g., ultrasound scans, tests, parental consent) which carry financial costs and sometimes delays. Conversely, informal abortion providers adapt their practices to the social and financial circumstances of those seeking the service. This informal care offers flexibility, speed and negotiability, making it more accessible than formal care, despite the health risks involved.

Beyond issues of cost and geographical accessibility, these informal services also bypass any considerations relating to the stage of pregnancy. They go so far as to offer late-term abortions, sometimes beyond the eighth month mark, thereby exposing women to considerably increased health risks, as illustrated in the advert below.

The informal offer of abortion methods on social media platforms increased following the 2021 reform



The appeal of these informal services lies in the simplicity and discretion of their access procedures, which are perceived as being less complicated than formal channels. However, this apparent accessibility comes with increased exposure to medical complications, the risk of death, and violations of fundamental rights. Ultimately, the data shows that having an unsafe abortion is less a matter of choice than a strategy of last resort because formal healthcare systems are perceived as costly, inflexible and ill-suited to the socio-economic realities of adolescent girls and women.

Discussion

This research sheds light on the dynamics of abortion pathways for adolescent girls and women in Benin following the amended SRH law. It shows that this new legal framework and its implementation have helped to improve access to safe abortion care and highlights both the factors that facilitate access and the persistent barriers that still prevent adolescent girls and women from seeking or accessing care. The findings also provide insight into the influence of this amended law on attitudes and practices regarding the provision of safe abortion care.

Women who were aware of the amended law, and the facilities offering safe abortion, were more likely to seek such care

A variety of abortion pathways

While the amended law aims to reduce, or even eliminate, the use of unsafe abortion methods, the experiences of the adolescent girls and women who participated in this research reveal a variety of pathways, combining both safe and unsafe methods. Some women sought safe abortion care from the outset, while others initially attempted unsafe methods, which failed, before going to healthcare facilities. Some used unsafe methods as their first choice, while others resorted to unsafe methods after encountering barriers or setbacks in accessing safe abortion care within health facilities. This overlap between safe and unsafe pathways is not unique to Benin. Studies conducted in countries with comparable, or even more liberal, legislative frameworks report similar experiences.[41, 42] This research provides further evidence of the coexistence of safe and unsafe methods by highlighting the key factors that influence whether women are directed towards one or the other of these pathways.

Factors facilitating access to safe abortion care

The data collected has made it possible to identify and document several factors – at the individual, community and institutional levels – which promote effective access to safe abortion care for adolescent girls and women. One of these relates to awareness of the amended SRH law, which encourages decision-making in favour of a safe abortion to avoid complications following an unintended pregnancy. In this study, adolescent girls and women who were aware of the legal conditions for abortion in Benin, and of the facilities offering safe abortion care, were much more likely to seek such care. Awareness of the new legal framework was significantly more widespread among those living in urban areas and with at least a secondary school education; a trend also observed in other contexts.[43] In some cases, it was the partner's or relatives' knowledge of the law that facilitated access to safe abortion care.

Other studies have also highlighted the close link between knowledge of the legal framework, knowledge of the facilities providing safe abortion care, and effective access to these services.[44] Adolescent girls and women, as well as their relatives, are informed through various channels, including community awareness-raising sessions led by community health workers, as well as through family members or neighbours. The media (radio, television, the internet, social media and health apps) also appear to be an important source of information on the amended law and on options for accessing safe abortion care, as is also the case in other contexts.[45] For example, a study conducted in Nepal highlights the positive impact of awareness-raising sessions on the legal framework combined with community healthcare provision structures that enable access safe abortion care, particularly when these are driven by partnerships between the government and CSOs.[46]

In Benin, although the knowledge obtained from these various information sources is not always accurate or complete, it nevertheless plays a catalytic role in directing adolescent girls and women towards health facilities for safe abortion care.

Providers who had values clarification training showed a better understanding of the SRH law and its implications

VCAT training sessions have also contributed to improving access to safe abortion care. Providers who took part in values clarification sessions demonstrated a better understanding of the amended SRH law and its implications as well as a marked shift in attitudes supporting the provision of safe abortion care. For healthcare providers who were initially opposed to abortion, engaging in critical reflection on their personal values enabled them to overcome their reservations and make decisions more in line with their professional, ethical and public health responsibilities.

These findings are consistent with other studies which show that training in the provision of safe abortion care is a key factor in gaining the support of healthcare providers for these services,[47] although the present study places greater emphasis on the decisive role of VCAT in changing attitudes. Before-and-after studies conducted in several countries show that these approaches enhance knowledge, transform negative perceptions and reduce stigma, including among providers working in faith-based organisations.[48] In Rwanda and Ethiopia these approaches have led to supportive attitudes towards safe abortion becoming almost universal or to a significant increase in the provision of such services, even when providers do not directly deliver them.[49, 50]

A robust body of evidence demonstrates the potential of VCAT sessions to create a health system environment that better supports access to safe abortion care. It would be beneficial to fully harness the potential of VCAT sessions for healthcare providers as part of the implementation of the amended law. This would help Benin's health system fully assume its role as a provider of accessible, ethical and high-quality healthcare for the population, including safe abortion care

Referral mechanisms also appear to be a key driver in ensuring that adolescent girls and women have access to safe abortion care. Referrals enable conscientious objectors, CSOs active in SRHR and community members to refer women seeking safe abortion care to facilities or providers willing to offer these services, including in rural areas. Helplines, digital apps and community health workers or focal points play a central role in this regard.[51]

Financial capacity plays a decisive role in accessing safe abortion care, whether this stems from a woman's financial autonomy, support from family and friends or funding from NGOs. The study findings show that women with financial resources have easier access to safe abortion care, the costs of which often remain high. As illustrated in this research and by other studies conducted in similar socio-cultural contexts, financial support – particularly from a partner – often facilitates access to safe abortion care.[52]

At the same time, interventions that remove the financial barrier to accessing safe abortion care – by covering all or part of the direct costs of care – can enable women in precarious circumstances to access the services they need. Schemes offering free services, subsidies or coverage through health insurance mechanisms have proven effective elsewhere in improving access to safe abortion care, particularly among adolescent girls, poor women and those living in rural areas.[53] These initiatives, including those implemented in Benin by CSOs, are in line with the World Health Organization recommendation to remove the financial barriers to safe abortion, notably through the establishment of universal health coverage.[54] This emphasises the urgent need for the Beninese government to implement this nationally.

The geographical accessibility of healthcare facilities played an important role in ensuring safe care pathways for some women. Living close to healthcare facilities or private clinics, particularly in urban areas, facilitated access to safe abortion care. While some participants perceived this proximity as a risk due to fears that their abortion might be disclosed, for others it represented a real opportunity, as previous research has also shown. For example, a Nepalese study found that a journey time of no more than 30 minutes is a determining factor in accessing safe abortion care.[55]

The WHO recommends the financial barriers to safe abortion are removed, notably through universal health coverage

In summary, the amended law enables adolescent girls and women to access safe abortion care when one or more of the following conditions are met:

- knowledge of the law and its provisions
- referral to facilities offering safe abortion care
- financial independence, or financial support from partners, family members or CSOs
- close proximity to a health facility that provides safe abortion care.

However, these enabling factors coexist with significant barriers which continue to restrict access to safe abortion care for adolescent girls and women in Benin.

Barriers to accessing safe abortion care

The data revealed multiple factors acting as barriers to accessing safe abortion care, relating to the individual woman's circumstances, the health system and structural constraints.

Low awareness of the amended SRH law is one such barrier. This research found that many adolescent girls and women, and their relatives, have limited or even inaccurate information about the legal provisions and the conditions for accessing safe abortion care. This situation is primarily due to insufficient dissemination of information about the reform and the procedures for its implementation, despite the efforts of the government and civil society. This has encouraged the spread of rumours, misinterpretations and misconceptions about the motivations behind the reform and the procedures for accessing safe abortion care. [56]

This lack of awareness highlights significant inequalities in accessing information, which directly influence a woman's ability to make an informed decision regarding safe abortion care. Indeed, the choice of abortion method depends largely on the quality of the information available, the accessibility of services and perceptions of their safety.[57] A lack of knowledge of the law among family members can act as a barrier to accessing

safe abortion care, as they tend to play a decisive role in the decision-making process and in referring adolescent girls and women to legal providers. These dynamics highlight the importance of considering the immediate social environment of those seeking care as a key lever in strategies to improve access to safe abortion.

At the health system level, the study shows that a restrictive interpretation of the current legal framework, combined with providers' values that do not support engaging in abortion care, limits the effective provision of safe abortion care.[58] The fear of legal sanctions, combined with the weight of religious and social norms, had produced a common reluctance among providers to provide abortion safe care. This manifests itself in widespread recourse to conscientious objection, particularly in public health facilities.

While Beninese law and international standards recognise providers' right to conscientious objection, they specify that this must not impede women's prompt access to the safe abortion care authorised by law, and must therefore be accompanied by referral mechanisms.[59, 60] In this study, the frequent, and at times collective and hierarchical, use of conscientious objection and the failure to refer patients elsewhere – particularly within public and faith-based institutions – effectively amounted to an institutional denial of care.

Similar situations have been observed in other African countries, despite their having more liberal legal frameworks. In South Africa, for example, conscientious objection is frequently invoked in breach of legal obligations and limits the effective provision of public services.[61] These dynamics highlight the need to strengthen the enforcement of referral obligations, institutional accountability and provide values clarification training.

Financial constraints are another major barrier to accessing safe abortion care. The high cost of abortion care – linked to the concentration of services in private, urban facilities and to indirect costs (e.g., tests, ultrasound scans, transport, loss of income) – far exceeds the means of many adolescent girls and women in economically vulnerable situations. This exacerbates inequalities in accessing safe abortion care. Several studies

Collective conscientious objection and the failure to refer women sometimes resulted in an institutional denial of care

confirm that, in a context of significant socio-economic inequalities, these costs drive many women to resort to unsafe methods, with serious consequences for their health.[62, 63] Geographical distance and transport costs – particularly for rural women – as well as service opening hours, further exacerbate this constraint and increase the risk that women will resort to unsafe abortions.

While support from family members or a partner can help to overcome these barriers, some adolescent girls and women are deprived of such support and are forced to seek clandestine abortions to avoid social sanctions, abandonment by their partner or simply to preserve their decision-making autonomy. This lack of support significantly reduces women's ability to access safe abortion care and increases their vulnerability to unsafe abortion.[64, 65]

The requirement for parental consent set out in the implementing decree of the 2021 SRH law constitutes a major structural barrier to accessing safe abortion care for minors. Against a backdrop of significant social stigma, the obligation to involve parents or guardians deters many minors from seeking help from formal services for fear of family or social reprisals. The fear of legal and disciplinary sanctions, fuelled by a lack of

understanding of the legal provisions, also leads many healthcare providers to strictly adhere to the legal requirements, sometimes to the detriment of clinical and ethical considerations, and the minors seeking care. This requirement transforms service providers into agents enforcing regulatory controls, limits their professional discretion and indirectly contributes to the exclusion of underage girls from safe abortion services. The literature shows that health systems that require parental involvement are associated with delays in adolescents accessing safe abortion care, an increase in the use of unsafe abortion methods and a reduction in adolescents' decision-making autonomy, particularly in contexts characterised by restrictive social norms.[66, 67]

Faced with a multitude of barriers to accessing safe abortion care, unsafe abortion still appears to be a common fallback option. Informal alternatives remain more accessible, both financially and geographically, particularly in rural areas, despite the high risk of complications.[68] The findings highlight the existance of an informal provision ecosystem, consisting of online, community-based and sometimes home-based services provided by healthcare practitioners. The flexible, non-institutionalised nature of these informal services, which are low-cost and relatively free from perceived stigma, fosters a climate of trust and the sense that these approaches can better respond to women's pressing needs. Although highly risky, this informal provision has establishing itself as an alternative solution in the face of continuing constraints in Benin's formal health system. However, it is also exacerbating inequalities in accessing safe abortion care, to the detriment of the most vulnerable women, particularly minors, women living in rural areas and women with the fewest resources.


ACCEUIL
MATERNITE
CENTRE AMI
DES ADOS
(CAAD)
ACCEUIL
DISPENSAIRE
LABORATOIRE
CABINET DENTAIRE

Conclusion

This research shows that the 2021 amendment to Benin's SRH law represents a major step forward in combatting unsafe abortion and preventing maternal deaths. When a number of conditions are met – namely, awareness of the amended law, the existence of effective referral mechanisms, the financial autonomy of the woman seeking care or financial support from family and friends or from CSO – the reform is helping to improve access to safe abortion care. Training for service providers, in particular values clarification sessions, is also emerging as a key driver for improving service provision and reducing the refusal of care.

However, these levers coexist with persistent and structural barriers which continue to limit effective access to safe abortion care for a significant proportion of Benin's population. A lack of awareness of the law and its contents among a large part of the population, the widespread use of conscientious objection by healthcare providers without effective referral mechanisms, the high cost of care and the geographical remoteness of facilities, as well as the requirement for parental consent for minors, remain major obstacles.

This study shows that adolescent girls and women remain torn between seeking medical safety on the one hand and ensuring their social safety on the other. Those who prioritise medical safety brave the stigma and turn to formal healthcare facilities. But many of them are still denied treatment – often without referral – or face exorbitant costs which then force them to risk an unsafe method. Those keen to keep their abortion secret still tend to opt for informal, and predominantly unsafe, care, which is perceived as more discreet, accessible and less expensive. While such care meets women's immediate need for confidentiality, affordability, convenience and speed, it exposes them to the risk of serious complications, even death.

The findings highlight the complexity of the relationship between legal reform and the need for normative and social transformation. While broadening the legal conditions for access to safe abortion care is essential, it is undermined by the persistence of highly stigmatising social, religious and cultural norms against safe abortion care. This tension between legislative progress and social acceptance creates a disconnect between the law and its actual application by healthcare providers and communities, limiting equitable access to safe abortion care for the many adolescent girls and women who need it.

Women are constantly torn between seeking medical safety and ensuring their social safety

Recommendations

Based on the research findings, the researchers worked with stakeholders—including young people, healthcare professionals and members of civil society—to develop a set of recommendations. These recommendations outline the steps needed to realise the law's full potential to prevent unsafe abortions and their harmful consequences, including maternal death.

At national level:

Ministry of Health, with the support of other ministries, in particular the Ministry of Social Affairs and Microfinance, policy-makers and other key stakeholders

At local level:

Departmental Health Directorate (DDS), Health Zone Coordination (ZS)

Healthcare professionals

1 Strengthen the dissemination and understanding of the law on voluntary termination of pregnancy (VTP) amongst healthcare providers, the community and other stakeholders involved in managing requests

- Support efforts to disseminate and clarify the law and the legal conditions for access to abortion care within the community by adopting a communication strategy tailored to different local contexts, and by engaging community health workers.
- Strengthen healthcare professionals' understanding of the law, its implementing decree and the legal conditions governing the provision of abortion care.
- Establish a national helpline and referral service for women seeking abortion care and for healthcare professionals, enabling information to be provided to women and addressing providers' conscientious objections, in order to ensure more equitable access to abortion care for adolescent girls and women.

Identify the real issues underlying conscientious objection to come to evidence-based solutions to address this practice in public health centres

2

- Understand the challenges faced by healthcare professionals regarding conscientious objection and the conscientious objection form, in order to grasp the real reasons behind the widespread and informal use of conscientious objection (beyond beliefs and values), and to begin addressing these challenges
- Ensure the roll-out and regular delivery of abortion values clarification for action and transformation (VCAT) sessions for all healthcare providers, including those who exercise conscientious objection.
- Establish an internal monitoring mechanism to ensure that adolescent girls and women are effectively referred by healthcare professionals who are conscientious objectors.
- Provide a clear framework for the exercise of conscientious objection through institutional awareness-raising and reminder measures (including during staff meetings) intended to clarify the conditions, the limits and the obligations associated with this practice, iIncluding clear communication on the obligation to refer patients and to sign the conscientious objection form for those who do not wish to provide care.
- Issue a document specifying that failure to sign the objection form constitutes tacit acceptance of the obligation to provide care. Any refusal to provide care without a prior objection form must be regarded as professional misconduct.
- Create a confidential database enabling the Ministry to identify, centre by centre, who is available to provide care in order to guarantee full geographical coverage.
- Impose a service quorum, meaning that at least a certain percentage of healthcare staff per department (or per area) must be non-objectors to ensure effective access to care.
- Introduce a psychosocial support scheme for abortion service professionals exposed to stigmatisation, in order to minimise the risk of them withdrawing from the service.

3 Reduce the financial barrier to accessing abortion care in public and private healthcare facilities

- Define and harmonise abortion procedures and develop a national fee schedule for abortion services in public and private facilities to ensure equitable access to care and to limit regional and socio-economic disparities.
- Strengthen the central supply of abortion medicines to prevent stock-outs and ensure their availability in public health centres and pharmacies at all levels (municipal, local, etc.).
- Support the financial assistance schemes implemented by CSOs for adolescent girls and women in vulnerable situations who need abortion care.
- Raise awareness among healthcare professionals of the national guidelines that clarify that tests such as ultrasound scans and blood typing are not mandatory for providing abortion care before 12 weeks of gestation. This will help to avoid additional costs.

4 Strengthen the human and technical capacity of healthcare facilities to provide high-quality abortion care

- Provide health facilities with qualified staff and the necessary technical equipment, particularly at the peripheral level, to ensure equitable, safe and high-quality care.
- Update the guide and standard for medical abortion in Benin in line with the new WHO guidelines (2022).
- Disseminate Benin's guidelines and standards for medical abortion (2018) amongst healthcare professionals to promote standardised practices that guarantee the quality of care.
- Strengthen the technical and ethical skills of healthcare professionals through training, workshops on values clarification and institutional support, to ensure safe, high-quality care that respects the dignity of adolescent girls and women.

5 Ensure access to safe abortion care for minors

- Produce and disseminate an explanatory note on the amended SRH law. This guide must explicitly specify the cases in which parental consent is optional and codify the exact procedure for the care of an unaccompanied minor. This procedure must be based on the concept of an emancipated or mature minor in order to ensure that the minor's best interests are respected.
- Carry out an audit of healthcare professional's needs and establish a system of institutional protection (legal support) to enable the offer of safe abortion care without fear of legal harassment.

Recommendations for:

Ministry of Social Affairs and Microfinance

Improve social workers' understanding of the SRH law the articles governing the handling of requests for abortion care requests by minors by minors, to ensure consistent application that respects the rights of adolescent girls

- Organise legal and practical training sessions on the provisions of the law for social workers.
- Establish forums for discussion between legal professionals, healthcare professionals and social workers.

Recommendations for:

Representatives of civil society organisations

1 Strengthen and diversify communication initiatives relating to the amended SRH law

- Expand and diversify inclusive awareness-raising initiatives and participatory dialogues on the law, in accordance with the regulatory frameworks, in order to increase knowledge amongst different audiences (rural and urban, adults and young people).
- Implement inclusive and ongoing community dialogues (with the support of community and religious leaders) to reduce the stigma surrounding abortion, promote open and informed communication about abortion, and foster a gradual acceptance of the law within communities.

2 Improve counselling, referral services, psychosocial and financial support to facilitate access to abortion care for adolescent girls and women

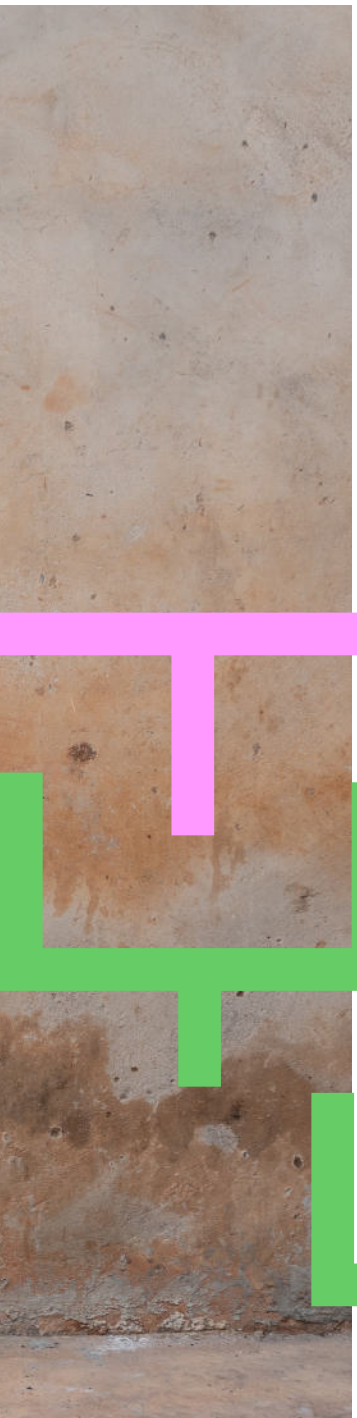
- Continue to provide counselling, referral and support services tailored to adolescent girls and women to ensure high-quality medical and psychosocial care.
- Provide specific support measures for women in precarious financial circumstances and minors.
- Establish, within local CSOs, a suitable referral system for survivors of gender-based violence, in collaboration with the One-Stop Social Protection Centres (GUPS) and the National Institute for Women (INF).

Support the government in improving the quality of abortion care

- Organise regular value clarification for action and transformation (VCAT) workshops for healthcare professionals and social workers involved in handling requests for abortion, in order to foster a better understanding of reproductive rights, mitigate the impact of conscientious objection and promote respectful and equitable professional practice.

Recommendations for:

For technical and financial partners



1 Maintain and increase funding and technical support for safe abortion care and broader sexual and reproductive health and rights (SRHR) in Benin

- Prioritise and invest in sexual and reproductive health and rights in global strategies, ensuring access to the full range of services related to sexual and reproductive health and rights.
- Maintain funding for safe abortion care in Benin to enable key stakeholders to improve access to safe abortion care, including for the most marginalised people and those living in the most remote areas.
- Invest in the long-term capacity-building of local healthcare professionals, civil society organisations and government institutions in Benin, so that they can work together to establish, oversee and promote high-quality safe abortion care and contribute significantly to the prevention of unintended pregnancies.

Annexes

Annex 1

Acronyms

ABPF	Beninese Association for the Promotion of the Family
APHRC	African Population and Health Research Center
FCFA	African Financial Community Franc
FP2030	Family Planning 2030
ISBA	Institute of Applied Biomedical Sciences
NGO	Non-governmental organisation
MVA	Manual vacuum aspiration
SRHR	Sexual and reproductive health and rights

Annex 2

Methodology

Study sites

This research was conducted in the departments of Atlantique and Borgou, located in the south and north of Benin, respectively. These departments were selected on the basis of indicators relating to sexual and reproductive health (SRH), particularly regarding abortion and early pregnancy. According to the health statistics yearbook (2022), these two departments are among the departments with the highest annual number of abortions (2,672 cases in Atlantique and 3,125 in Borgou).[xv] The choice of the Atlantique department is also based on the fact that the team conducted an initial ethnographic study there in 2021, prior to the amendment of the law, focusing on the demand for and provision of safe abortion care.

Ethical and administrative approvals

The research team obtained ethical approval from the Ethics and Research Committee of the ISBA, as well as authorisation from the Ministry of Health. At the local level, the team obtained authorisations from the heads of health districts and healthcare facilities, as well as from the local authorities.

Data collection approach

Data was collected between September 2024 and April 2025 using an ethnographic approach combining immersion, including participant observation, in fifteen health facilities and their surrounding communities, as well as in-depth interviews and interviews with key informants. Facilities were selected based on the number of abortion care cases, including post-abortion care provided in the twelve months preceding the research (2023–2024) and their location (rural or urban). Peripheral and referral facilities with a high number of post-abortion care cases were selected in each department.

The data collection team consisted of six research assistants, all of whom had a solid background in anthropology and sociology and experience in qualitative data collection, including research ethics. The start of data collection was preceded by a six-day in-person training session, which focused on the study's objectives, the basics of ethnography and research ethics relating to 'sensitive' subjects. This training also provided an opportunity to finalise and test the various research tools.

The training was followed by a seven-month field placement, during which the research assistants observed the provision of comprehensive safe abortion care and post-abortion care daily in primary and referral healthcare facilities, both private and public. This observation made it possible to track the pathways of women seeking safe abortion care and post-abortion care, as well as the interactions between the adolescent girls and women seeking such care and healthcare providers. It facilitated the identification of service users, the obtaining of their consent to participate in the research, and their follow-up within their communities. This follow-up provided opportunities to observe community dynamics and interactions among young people in public spaces and within families. It also led to participation in community engagement activities on SRH in schools and vocational training centres, as well as sessions to raise awareness of the amended SRH law. This immersion in the community made it possible to identify other adolescent girls and women who had experienced abortion, whether or not they had used the health system, as well as key informants and other stakeholders involved in abortion pathways, such as the women's relatives and partners.

After obtaining informed consent from the adolescent girls and women, in-depth interviews – repeated where necessary – were conducted with them throughout the team's time in the field. Once a relationship of trust had been established through repeated meetings, the first interview was carried out and then transcribed to develop a guide for the second interview. Interviews were also carried out with close relatives of the women

xv As a reminder, this figure includes hospital admissions related to complications resulting from induced abortions and those related to miscarriages and may include CAA. Abortions are also often under-reported. These figures nevertheless represent the best available estimates

(e.g., mothers, aunts, sisters, fathers) and partners of women who had undergone an abortion.

The interviews were conducted mainly in local languages (notably Fon, Aïzo and Bariba), and in a few cases in French and in one case in English. The interviews were recorded with the participants' consent.

Interviews were also conducted with key stakeholders, such as representatives of CSOs, community health workers, social workers, medicine sellers and pharmacists and traditional healers.

For the focus groups, participants were identified with the support of community health workers. In total, 24 focus group discussions were held in the Fon and Aïzo languages in the Atlantique department, and in Bariba and French in the Borgou department. These focus group discussions targeted four categories of participants: young people (girls and boys), women and men.

Participant profiles

As part of this research, 73 adolescent girls and women who had undergone an abortion and three partners were interviewed. Of these adolescent girls and women who were followed up and interviewed, 39 had received safe abortion care and 34 had received post-abortion care.

Table 1: Socio-demographic characteristics of the adolescent girls and women followed in the study

Characteristics		Frequency (n=73)
Age	15-17	6
	18-24	39
	25-30	13
	31-40	11
	41 and over	4
Marital status	Single	44
	Married/in a relationship	27
	Widowed	2
Level of education	None	10
	Primary	5
	Secondary	39
	Higher education	11

Characteristics		Frequency (n=73)
Occupation/ Profession	Unemployed/housewife	10
	Pupil/student	14
	Employee/worker in the informal sector[xvi]	31
	In vocational training	8
	Working in the formal sector	10
Area of residence	Suburban	13
	Rural	26
	Urban	34

In addition to the women, various relatives, partners and key informants were identified and interviewed. Their profiles are summarised in the table below.

Table 2 : Characteristics of relatives and key informants

Characteristics		Frequencies
GENDER	F	58
	M	67
Roles/profiles	Female relatives (mother/guardian, aunt, stepmother, sister-in-law) and partners	23
	CSO actors (e.g., heads of associations or NGOs, facilitators)	17
	Community health workers/ peer educators/facilitators	18
	Health workers (private/public sector)	46
	Informal care providers	2
	Social workers	5

xvi Seamstresses, hairdressers, retailers and apprentices in hairdressing and dressmaking

Characteristics		Frequencies
	Traditional and religious authorities	14
	Local councillors	5
	Teachers	4
	Pharmacists/ informal medicine sellers	7
Roles/profiles	Traditional healers	3

Data analysis

All audio files were transcribed verbatim and then translated into French. The development of the coding scheme and the data analysis were both based on theoretical foundations (drawn from the research protocol) and on an inductive approach. The research team first drew up a coding manual based on the interview guide protocol and the themes that were emerging from a sample of interviews and observation notes. Coding was carried out using Dedoose software, after ensuring consistency of approach among team members through double coding. Throughout the coding process, the team met online each week to discuss new codes, identify any duplicates and discuss passages requiring clarification or collective validation.

The findings presented in this report are illustrated by verbatim extracts from observation notes, interviews and informal discussions with participants. All names used are pseudonyms to preserve the participants' anonymity.

The research team and its positionality

This research project was designed and carried out by researchers from APHRC, Rutgers and ABPF, and subsequently validated by a youth advisory committee from Benin. The organisations and individuals involved in this research represent institutions committed to SRH, rights and justice. The study adopted an approach focused on amplifying marginalised voices, critically analysing power relations and advocating for justice and systemic reform.

The research was conducted by six researchers, most of whom were young people, and two national coordinators from Benin, who were directly involved in data collection. The project also benefited from the support of four senior researchers based in Kenya, the Netherlands and Benin. The majority of the researchers have a background in anthropology or related social science disciplines. One of the senior researchers, originally from Benin, is a doctor specialising in public health. During the data-collection period, all team members took part in weekly two-hour online debriefing sessions to discuss the practical difficulties encountered and the ethical dilemmas raised in the field. The senior researchers thus remained available to provide support throughout the data collection period.

This report was drafted collaboratively by the entire team, with the support of an external consultant. An initial set of findings was presented at a validation workshop in Cotonou on 29 and 30 September 2025. This workshop brought together the research team, research partners, health professionals, religious and community leaders, CSO representatives and the study's youth advisory committee. Workshop participants jointly formulated the recommendations presented in this report and developed the strategy for disseminating and ensuring ownership of the findings.

Limitations

More than seven months were spent conducting fieldwork in fifteen selected health facilities and communities in the Atlantique and Borgou departments to gain an in-depth understanding of access to safe abortion care and post-abortion care in these settings. However, the findings presented cannot automatically be generalised to other departments in Benin, due to the cultural, religious and socio-economic diversity specific to each region in the country.

The social tension surrounding the issue of abortion in Benin also posed an obstacle to data collection. Researchers had an extended presence at the study sites aimed at building trust. However, fears of stigmatisation and moral judgement and the reluctance to relive emotional pain sometimes affected the researchers' ability to recruit people to take part in the research. At times, it was difficult to contact certain adolescent girls and women for follow-up interviews, as they feared the secret of their abortion might be revealed. In other cases, women wished to move on from their experience of abortion and not relive it. Participants' decisions to withdraw from the study were always fully respected, in accordance with the consent protocol.

The results presented in this report have been shaped by the analyses and interpretations of the research team, whose members were themselves influenced by their worldviews, positionality and religious or cultural beliefs. These factors may have influenced the way in which the data was interpreted and presented. To enhance reflexivity and minimise potential biases, this research report was developed and co-authored by a multidisciplinary and multinational research team, ensuring a diversity of perspectives and analyses. The findings were also validated by a wide range of Beninese stakeholders, ensuring that they accurately reflect the realities in Benin.

Despite these limitations, this study offers valuable new insights and evidence that is often lacking in public debates and policy-making about abortion. The evidence produced is essential for informing future research, public policies and programmes in Benin (and beyond).

References

1. APHRC, Rutgers, ABPF, (2022), *Experiences of abortion in Benin: Social determinants and care pathways in the Atlantique department,* Nairobi: APHRC

2. Favier, M., Greenberg, J.M.S, Stevens, M., (2018), 'Safe abortion in South Africa: "We have wonderful laws but we don't have people to implement those laws."', *Int J Gynaecol Obstet,* 143, 38–44.

3. Hera R., et al., (2025), 'Abortion in South Africa: Does liberal legislation really impact safe access and use?', *Ann Med Psychol (Paris)*, 183 (2), 185–194.

4. Tchèkpé, D.D., et al., (2026), 'Implementation of safe abortion care policy in Africa: a scoping review of readiness and outcomes', *BMC Public Health.*

5. National Institute of Statistics and Demography (2023), 'Multiple Indicator Cluster Survey, Benin, 2021–2022, Report on the survey results', Cotonou: INStaD.

6. Ibid

7. Ibid

8. Ibid.

9. Ahissou, N.C.A., et al., (2022), 'Modern contraceptive use among adolescent girls and young women in Benin: a mixed-methods study', *BMJ Open*, 12: e054188.

10. APHRC, Rutgers, ABPF, (2022), *Experiences of abortion in Benin: Social determinants and care pathways in the Atlantique department*, Nairobi: APHRC.

11. Acotchéou PE, Affo MA, Dansou J, Delvaux T, Saizonou ZJ. Modern contraceptive use among adolescents in Benin: trends, determinants and prospects. Sex Reprod Health Matters. 2023;31(5):2267200.

12. World Health Organization, (2025), *Report on the state of the health sector in Benin 2023*. Brazzaville: WHO Regional Office for Africa.

13. Benin Ministry of Health, (2010), *National multisectoral strategy on sexual and reproductive health of adolescents and youth in Benin 2010-2020*, Cotonou: MoH.

14. Benin Ministry of Health, (2017), *National Multisectoral Strategy on Sexual and Reproductive Health for Adolescents and Young-People 2018-2022*, Cotonou: MoH.

15. FP2030 website, see www.fp2030.org [accessed July 2026].

16. Mintogbe M.M.M., et al., (2023), *Prevalence and determinants of unplanned pregnancies among adolescents in Benin,* Lyon, France: HAL Open Science.

17. Dansou, J., Adekunle, A.O., Arowojolu, A.O., (2017), 'Factors Behind the Preference in Contraceptive Use Among Non-pregnant and Sexually Active Women in the Republic of Benin', *Cent Afr J Public Health,* 3 (5), 80–89.

18. APHRC, Rutgers, ABPF, (2022), *Experiences of abortion in Benin: Social determinants and care pathways in the Atlantique department,* Nairobi: APHRC.

19. Ibid

20. Omondi G.A., et al., (2023), '"I wasn't sure it would work. I was just trying": an ethnographic study on the choice of abortion methods among young women in Kilifi County, Kenya, and Atlantique Department, Benin', *Reprod Health*, 20 (1), 181.

21. Afrobarometer, (2025), *The majority of Beninese people consider abortion justified under certain conditions and support access to contraceptives for all,* Report No. 1083, Accra: Afrobarometer.

22. Fourn, N. et al., (2014), 'Knowledge, attitudes and practices regarding emergency contraception among female students at the University of Parakou (Benin)', *Public Health*, 26 (4), 541–546.

23. Ministry of Social Affairs and Microfinance, (2022) *Study on gender-based violence in Benin: final report*, Cotonou: Ministry of Social Affairs and Microfinance.

24. Ministry of Planning and Development

National Institute of Statistics and Economic Analysis, (2019), *Benin 2017–2018 Demographic and Health Survey*, p.325, Cotonou: INSAE

25. APHRC, Rutgers, ABPF, (2022), *Experiences of abortion in Benin: Social determinants and care pathways in the Atlantique department,* Nairobi: APHRC.

26. Rutgers and CERRHUD, (2025) *Caught between their rights and reality: the maze women face*, Utrecht: Rutgers.

27. Goyaux, N. et al., (2001), Complications of induced abortion and miscarriage in three African countries: a hospital-based study among WHO collaborating centres, *Acta Obstet Gynecol Scand.*, 80 (6), 568–573.

28. Benin Ministry of Health, (2021), Yearbook of Health Statistics 2020, Cotonou: MoH.

29. Benin Ministry of Health, (2022), Yearbook of Health Statistics 2021, Cotonou: MoH.

30. Benin Ministry of Health, (2023), Yearbook of Health Statistics 2022, Cotonou: MoH.

31. Benin Ministry of Health, (2018), Medical Abortion in Benin: Guide and Standards, Cotonou: MoH.

32. Coast, E., Murray, S.F., (2016), '"These things are dangerous": understanding induced abortion trajectories in urban Zambia', *Soc Sci Med*, 153, 201–209.

33. Cresswell, J.A., et al., (2018), 'Does supportive legislation guarantee access to pregnancy termination and post-abortion care services? Findings from a facility census in Central Province, Zambia', *BMJ Glob Health*, 3 (4), e000897.

34. Freeman, E., Coast, E., (2019), 'Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices', *Soc Sci Med.*, 221, 106–114

35. Harries, J., Constant, D., (2020), 'Providing safe abortion services: experiences and perspectives of providers in South Africa', *Best Pract Res Clin Obstet Gynaecol.*, 62, 79–89.

36. Raoul, A.S., et al., (2023), 'Healthcare staff adherence to the new law legalising abortion in Benin', *Eur Sci J.*, 23, 225.

37. Ibid.

38. Government of the Republic of Benin, (2023) *Decree No. 2023-151 of 19 April 2023 setting out the conditions for voluntary termination of pregnancy*, Cotonou: Gov of Benin

39. Gonçalves, F.J., (2022), *Availability, knowledge and practices relating to comprehensive abortion care in five maternity hospitals in Cotonou in 2021* [thesis], Benin: University of Abomey-Calavi.

40. Ibid.

41. Chemlal, S., Russo, G., (2019), 'Why do they take the risk? A systematic review of the qualitative literature on informal sector abortions in settings where abortion is legal', *BMC Women's Health,* 19, 55.

42. Hodes, R., (2016), 'The culture of illegal abortion in South Africa', J South Afr Stud, 42 (1), 79–93.

43. Frederico, M., et al., (2020), 'Induced abortion: a cross-sectional study on knowledge of and attitudes towards the new abortion law in the cities of Maputo and Quelimane, Mozambique' *BMC Women's Health*, 20 (1), 129.

44. Dias, T.Z., et al., (2015), 'Association between educational level and access to safe abortion in a Brazilian population', *International Journal of Gynaecology and Obstetrics*, 128, 224–227.

45. Ghimire, R.,, et al., (2025), 'Barriers to accessibility and availability of safe abortion services among young women in Nepal: a mixed-methods study', *BMC Public Health*, 25, 4113.

46. Atreya, A., et al., (2024), 'Striving towards safe abortion services in Nepal: A review of barriers and facilitators', *Health Sci Rep*, 7 (2), e1877.

47. Turner K.L., et al., (2018), 'Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries', *Reproductive Health*, 15 (1), 40.

48. Guiahi, M., et al., (2021), 'Influence of a values clarification workshop on residents' training in Catholic hospital programmes', *Contraception X*, 3, 100054.

49. Ntihinyurwa, P. et al., (2024), 'Values clarification and attitudes transformation workshops and provider support for safe abortion care in Rwanda: Evidence from a participatory evaluation', *Afr J Reprod Health,*

28 (4), 55–68.

50. Wollum, A., et al., (2025), 'Does a values clarification and attitudes transformation (VCAT) workshop influence provider attitudes, knowledge, and service provision related to abortion care? Evidence from a mixed-methods longitudinal randomised controlled trial in Ethiopia', *Glob Public Health*., 20 (1), e2465643.

51. Gupta, Pallavi, et al. "Can community health workers play a greater role in increasing access to medical abortion services? A qualitative study." *BMC Women's Health* 17.1 (2017): 37. Ngo, Anh, et al. "Effectiveness of mHealth intervention on safe abortion knowledge and perceived barriers to safe abortion services among female sex workers in Vietnam." *Mhealth* 9 (2023): 3.

52. Strong, J., (2022), 'Men's involvement in women's abortion-related care: a scoping review of evidence from low- and middle-income countries', *Sex Reprod Health Matters*; 30 [published online ahead of print]; doi10.1080/26410397.2022.2040774.

53. Atreya, Alok, et al. "Striving toward safe abortion services in Nepal: A review of barriers and facilitators." *Health Science Reports* 7.2 (2024): e1877.

54. World Health Organization, (2022), Abortion care guideline, Geneva: WHO

55. Ghimire, R., et al., (2025), 'Barriers to accessibility and availability of safe abortion services among young women in Nepal: a mixed-methods study', *BMC Public Health*, 25 (1), 4113.

56. Amoussou, E.S.A., et al., (2025), 'Safe abortion in Benin: community perceptions of the law regulating voluntary termination of pregnancy in the municipality of Bohicon', *Rev Afr Sci Soc Santé Publique*, 7 (2), 190–202.

57. APHRC, Rutgers, ABPF, (2022), *Experiences of abortion in Benin: Social determinants and care pathways in the Atlantique department,* Nairobi: APHRC

58. Assignon, C., (2022), 'Abortion: a sensitive issue in Africa too'[article], Berlin: Deutsche Welle.

59. World Health Organization, (2024), Abortion care guideline, second edition, Geneva: WHO.

60. International Federation of Gynaecology and Obstetrics, (2021) 'FIGO Statement – Conscientious objection: a barrier to care' [online statement]. Link: Conscientious objection: a barrier to care | Figo [accessed July 2026].

61. In South Africa, for example, conscientious objection is invoked without regard for legal obligations, limiting the effective provision of public services; see Harries, J., et al., (2014), 'Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study', *Reprod Health*., 11, 16.

62. Bankole, A., et al., (2020), From unsafe to safe abortion in sub-Saharan Africa: slow but steady progress, New York: Guttmacher Institute.

63. APHRC, Rutgers, ABPF, (2022), *Experiences of abortion in Benin: Social determinants and care pathways in the Atlantique department*, Nairobi: APHRC.

64. Ibid.

65. Singh, S., Maddow-Zimet, I., (2016), 'Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries', *BJOG*, 123 (9), 1489–1498.

66. Bankole, A., et al., (2020), From unsafe to safe abortion in sub-Saharan Africa: slow but steady progress, New York: Guttmacher Institute.

67. Cartwright, A.F., et al., (2024), 'Characteristics and circumstances of adolescents obtaining abortions in the United States', *Int J Environ Res Public Health*, 21 (4), 477.

68. Bankole, A., et al., (2020), From unsafe to safe abortion in sub-Saharan Africa: slow but steady progress, New York: Guttmacher Institute.

70. The Conversation, (30 September 2022), 'Abortion in Kenya and Benin: medical safety is not enough—girls and women must also feel socially safe' [online article, accessed July 2026], London: The Conversation Trust.

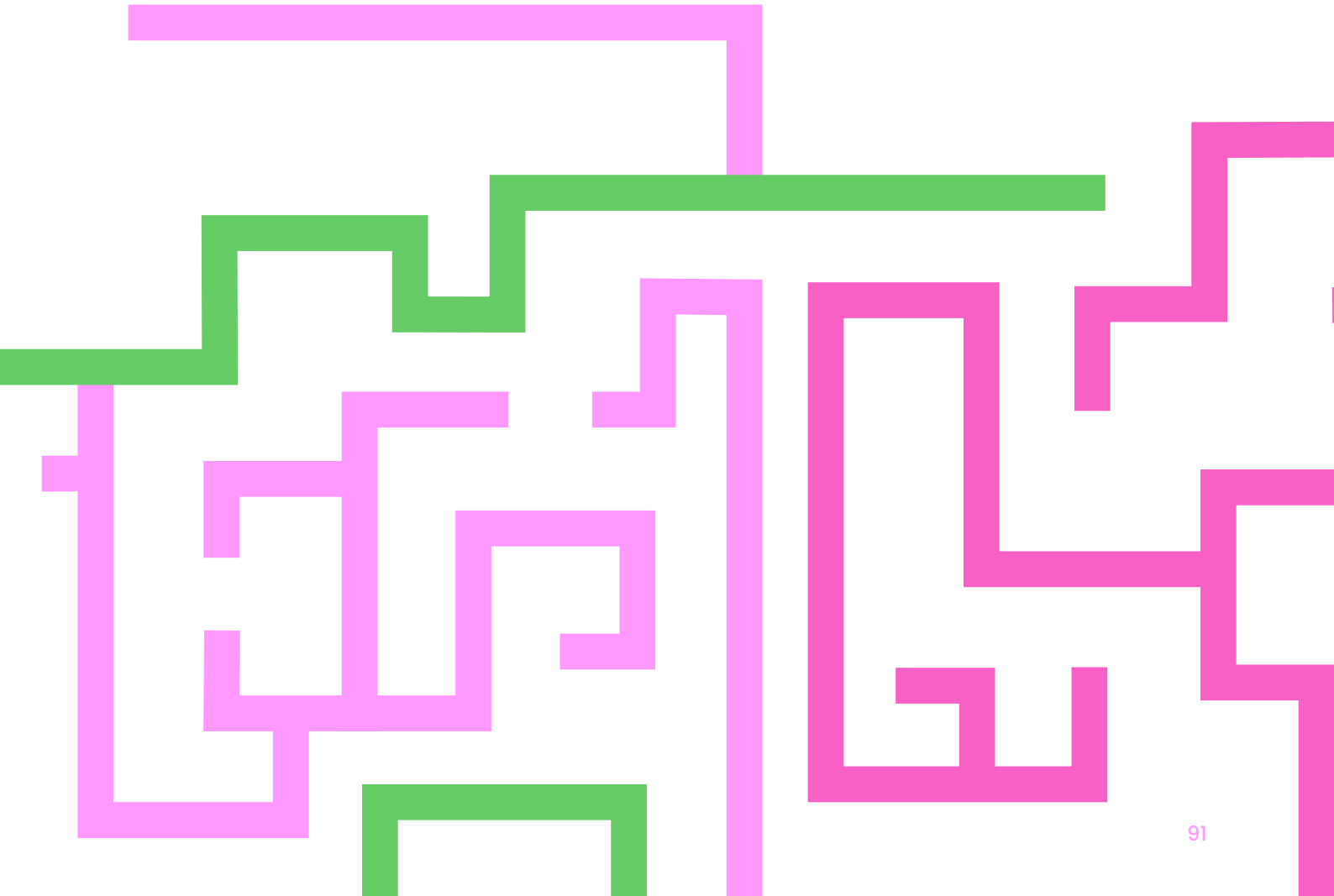
Behind the report

This report was made possible thanks to the dedication and creativity of many talented partners and collaborators. Together, their collective efforts have transformed the research into a living story, which we hope will inform, inspire and spur action.

A huge thank you to the people and communities featured in the photographs. Your openness and courage bring this report to life and remind us why this work is important.

Design: Rewire Design

Photography: Yanick Folly



Published by Rutgers © 2026 in partnership with APHRC and ABPF.

Rutgers is the Dutch centre of knowledge and expertise in sexual health, safety and wellbeing. For further information, please visit rutgers.international

APHRC is a leading research institute dedicated to improving health and well-being in Africa. For further information, please visit aphrc.org

ABPF is an organisation committed to promoting respect for the rights of women, men, young people and vulnerable people to make free and informed choices regarding their sexual and reproductive health. Visit abpf.org

Rutgers

APHRC
African Population and Health Research Center

ABPF Association Béninoise Pour la Promotion de la Famille