ACCESS TO SAFE ABORTIONS IN NAMIBIA: A REVIEW OF LAW AND POLICY AND RECOMMENDATIONS FOR REFORM

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Contents

1. Introduction

Whether and in what circumstances abortion should be legal is highly debated in many parts of the world, with arguments based on religious, moral, political, human rights and public health grounds. Given the emotionality of the debate, it is crucial to shed light on why, how many and under what conditions women around the world have abortions. With the best available information, individual countries can engage in a balanced discussion of how to both reduce the levels of unintended pregnancy that lead to abortion and deal with the sometimes deadly health and other consequences of unsafe abortion for women.

This paper seeks to provide a global and regional overview of unsafe abortion data and trends, the laws in place that govern access to abortions law and the impact of these laws on access to safe abortions, as well as the situation in Namibia regarding access to safe abortion. In so doing, this paper seeks to provide information as a basis for and to promote discussion in Namibia on improving access to safe abortion in Namibia.

2. Abortion: A Global Perspective

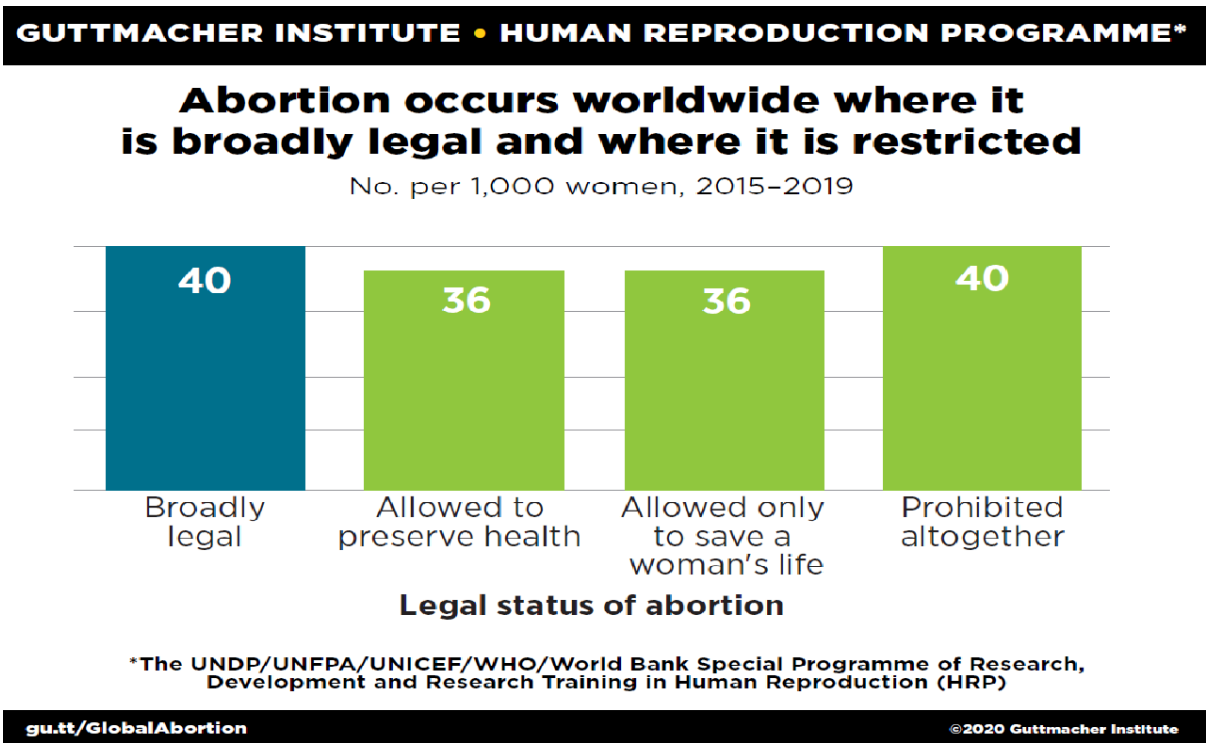
2.1 Global Abortion Incidence and Trends

Unintended pregnancy and abortion are experiences shared by people around the world. Roughly 121 million unintended pregnancies occurred globally each year between 2015 and 2019. Of these unintended pregnancies, 61% ended in abortion. This translates to 73 million abortions per year.[1]

Abortion is sought and needed even in settings where it is legally restricted—that is, in countries where it is prohibited altogether or is allowed only to save the women's life or to preserve her physical or mental health. Unintended pregnancy rates are highest in countries that restrict abortion access and lowest in countries where abortion is broadly legal and the abortion rate is actually higher in countries that restrict abortion access than in those that do not. In countries that restrict abortion, the percentage of unintended pregnancies ending in abortion has increased during the past 30 years, from 36% in 1990–1994 to 50% in 2015–2019[2].

Of all unintended pregnancies that ended in an induced abortion, 1 out of 3 were carried out in the least safe or dangerous conditions. 3 out of 4 abortions that occurred in Africa and Latin America were unsafe and the risk of dying from an unsafe abortion was the highest in Africa. Estimates from 2010 to 2014 showed that around 45% of all abortions were unsafe. Almost all of these unsafe abortions took place in developing countries.[3]

[1] Guttmacher Institute, Unintended Pregnancy and Abortion Worldwide, 2020, accessed at https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide on 27 January 2021
[2] ibid
[3] Ganatra B, Gerdts C, Rossier C, Johnson Jr B R, Tuncalp Ö, Assifi A, Sedgh G, Singh S, Bankole A, Popinchalk A, Bearak J, Kang Z, Alkema L. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. The Lancet. 2017



Abortion occurs at the same rate in countries where abortion is broadly legal as in countries where it is prohibited completely – a clear indication that legalising abortion does not increase the incidence of abortions. There is a proven correlation between countries' restrictive abortion laws and high rates of maternal deaths and injuries. The countries with the most restrictive abortion laws also have the highest incidence of unsafe abortions[4].

2.2 Why do women seek abortions?

A woman's decision to terminate a pregnancy might be in response to any of a number of circumstances. For some women, the decision may be necessitated by the fact that the pregnancy will place her mental or physical health or life at risk or the foetus is abnormal. It may be because the pregnancy was a result of rape or incest. For others the choice to terminate a pregnancy may be shaped by broad social influences or economic circumstances: the value placed on premarital chastity or marital fidelity, the unacceptability of childbearing outside marriage, or disapproval of having children late in life or too close together; or the inability to care for a child.

Throughout the world, the reasons women give for deciding to end an unplanned pregnancy are similar. Basically, women decide to have an abortion because they are too young or too poor to raise a child, they are estranged from or on uneasy terms with their sexual partner, they are unemployed, they do not want a child while they are trying to finish school, they want to be able to work or they must work to help support their family. These reasons are not frivolous or unconsidered.

In every part of the world, women who have had an abortion give broadly similar reasons for their decision[5]:

[4] Berer M. National laws and unsafe abortion: the parameters of change. Reproductive Health Matters 2004; 12: 1–8.
[5] The Allen Guttmacher Institute, Sharing Responsibility: Women, Society and Abortion Worldwide: https://www.guttmacher.org/sites/default/files/pdfs/pubs/sharing.pdf

To stop childbearing	I have already had as many children as I want. I do not want any children. My contraceptive method failed.
To postpone childbearing	My most recent child is still very young I want to delay having another child
Socioeconomic conditions	I cannot afford a baby now. I want to finish my education. I need to work full-time to support [myself or] my children.
Relationship problems	I am having problems with my husband [or partner] I do not want to raise a child alone. I want my child to grow up with a father. I should be married before I have a child.
Age	I think I am too young to be a good mother. My parents do not want me to have a child. I do not want my parents to know I am pregnant. I am too old to have another child.
Health	The pregnancy will affect my health. I have a chronic illness. The fetus may be deformed.
Coercion	I have been raped. My father [or other male relative] made me pregnant. My husband [or partner or parent] insists that I have an abortion.

2.3 Global consequences of unsafe abortion

The consequences of unsafe abortion vary depending on the context and the environment, reflecting existing conditions of abortion provision, safety and legality. In countries where abortion is highly legally restricted, or where access to safe services is poor even though the law permits abortion under broad criteria, it is common to find that women who are financially better-off are able to obtain safe, clandestine abortion procedures because they can afford the services of a trained provider, while poorer women and other disadvantaged groups (such as adolescents and women in rural areas) willoften go to providers who lack formal training, or attempt to induce the abortion themselves, resulting in health complications.[6]

Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion[7]. Around 7 million women are admitted to hospitals every year in developing countries, as a result of unsafe abortion [8] and the annual cost of treating major complications from unsafe abortion globally is

[6] Singh S, Wulf D, Hussain R, Bankole A, Sedgh G: *Abortion Worldwide: a Decade of Uneven Progress*. Guttmacher Institute, New
York, NY, USA (2009).

[7] Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, Gülmezoglu AM, Temmerman M, Alkema L. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health. 2014 Jun; 2(6):e323-33.

[8] Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. BJOG 2015; published online Aug 19.

estimated at USD 553 million[9].

In 2015 United Nations member states adopted the Sustainable Development Goals (SDGs)[10] for 2030, which renewed governments' commitments to reduce maternal mortality; achieve universal access to sexual and reproductive health information, education and services; ensure reproductive rights; and achieve gender equality as a matter of women's and girls' human rights. Advancing women's access to safe and legal abortion is a priority for women's reproductive health and rights, in accordance with the new SDGs focused on health and gender equality. Goal 3 of the SDGs is to ensure healthy lives and promote wellbeing for all at all ages. Targets set to reach this goal include reducing the global maternal mortality ratio to less than 70 per 100,000 live births (Target 3.1) and ensuring universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030 (Target 3.7). These targets will not be met if universal access to legal and safe abortions is ensured.

The economic impact of unsafe abortion falls into two categories – the direct costs of providing medical care for women who are hospitalized as a result of complications of unsafe abortion, and the indirect costs to women, households, the community and society. Direct costs are generally highly subsidized by the public sector, although women and their families bear a proportion of these costs, and in some countries this can be a very large proportion. The indirect costs include: the loss of productivity from abortion-related morbidity and mortality among women and other household members; the negative impact on children's health, education and well-being due to the ill health or death of their mother; and the loss of alternative health services caused by the use of scarce medical resources for the treatment of abortion complications. These consequences have an impact not only on health systems and the public sector, but also affect the economic status of households and families, since a sudden expenditure can push a household into poverty[11].

The criminalisation of abortion and social and religious resistance to abortion contributes to high levels of stigma and fear, which deter women from asking for information about abortion, accessing safe abortion and seeking post abortion care, even where abortion is legal.

While it is likely that the social consequences will be more severe where abortion is highly restricted by law and is unsafe compared with where it is legal and safe, studies are needed to make such comparisons and assess differences across contexts[12].

Possible social consequences include the effect on the stability of marriages and quality of relationships including intimate partner violence (e.g., a relationship or marriage may break-up if a woman becomes infertile as a result of an unsafe abortion; or if she is suspected of having the abortion because she became pregnant by another man); the impact of a mother's ill health and/or death (due to unsafe abortion) on the well-being of her children and family; and the impact of stigma. Stigma is manifested in many different ways, including how women who have had an abortion are treated by their family, community and healthcare providers. Stigma can be very consequential for unmarried and young women because of the strong social sanctions against sexual activity among these groups, as well as their lack of resources and inexperience in seeking

DOI:10.1111/1471-0528.13552.

[9] Vlassoff et al. Economic impact of unsafe abortion-related morbidity and mortality: evidence and estimation challenges. Brighton, Institute of Development Studies, 2008 (IDS Research Reports 59)

[10] https://sdgs.un.org/2030agenda

[11] Singh S. Global Consequences of Unsafe Abortion. Women's Health. November 2010:849-860. doi:10.2217/WHE.10.70

[12] ibid

healthcare. Potential consequences for unmarried young women suspected of having had an abortion include difficulty finding a partner to marry. Married women may also experience stigma because their husband and others may suspect them of infidelity; socio-psychological consequences can also be important, and may result from the attitudes of others, as well as from individuals' own feelings of guilt and shame[13].

2.4 Abortion laws around the world

Laws that govern abortion can be classified into the following five categories[14]:

Category 1: Completely Prohibited

The laws of the countries in this category do not permit abortion under any circumstances, including when the woman's life or health is at risk. 26 countries globally fall within this category.

Category 2: To Save a Woman's Life
The laws of the countries in this category permit abortion when the woman's life is at risk. 39 countries fall within this category.

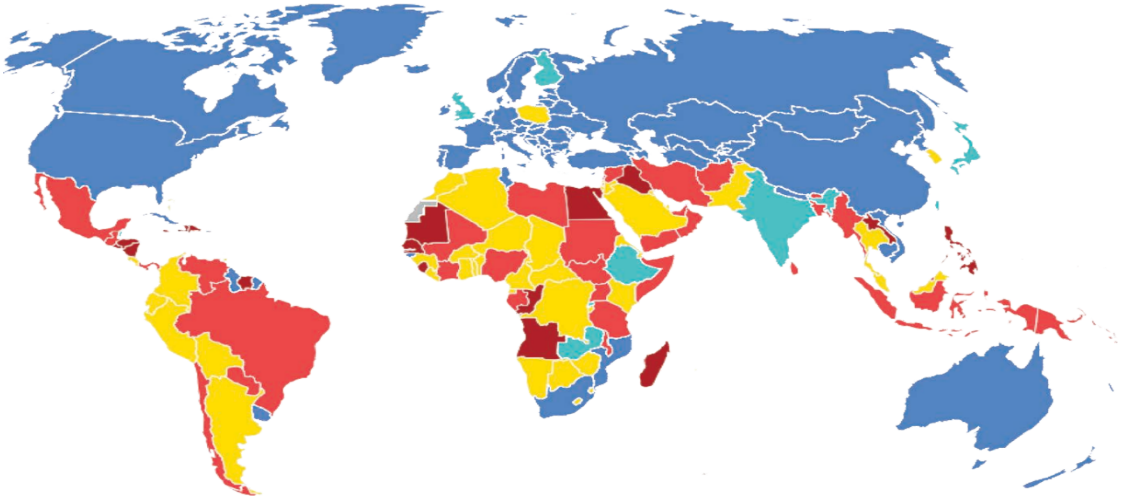
Category 3: To Preserve Health
The laws of countries in this category permit abortion on the basis of health or therapeutic grounds.

Category 4: Broad Social or Economic Grounds
These laws are generally interpreted liberally to permit abortion under a broad range of circumstances. These countries often consider a woman's actual or reasonably foreseeable environment and her social or economic circumstances in considering the potential impact of pregnancy and childbearing.

Category 5: On Request (Gestational Limits Vary)
These laws permit abortion on request. 67 countries globally fall within this category.

The most common gestational limit for countries in this category is 12 weeks. Gestational limits are calculated from the first day of the last menstrual period, which is considered to occur two weeks prior to conception. Where laws specify that gestational age limits are calculated from the date of conception, these limits have been extended by two weeks.

[13] ibid
[14] See https://reproductiverights.org/worldabortionlaws, accessing on 27 January 2020



Prohibited altogether

To save the woman's life

To preserve health

Broad social or economic grounds

On request (gestational limits vary)

There are currently 26 countries in the world where all abortions are illegal and 39 countries where abortion is illegal unless it saves the life of the mother. Abortion is available on request in 67 countries[15]

2.5 International Human Rights Framework

The right to health has been part of international human rights since the adoption of the Universal Declaration of Human Rights (UDHR) by the General Assembly (GA) of the UN on 10 December 1948. Reproductive health was explicitly recognised as a key aspect of the right to health and other human rights during ICPD in Cairo in 1994, where participating countries recognised that reproductive rights are grounded in human rights already recognised in national laws and international human rights treaties, and governments were therefore obliged to protect reproductive rights under their existing treaty obligations.

Reproductive rights are defined as the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. These rights also include the right to the highest attainable standard of SRH and the right of all people to make decisions concerning reproduction, free from discrimination, coercion and violence[16].

All human rights are interrelated and indivisible and thus reproductive rights are essential to the realization of all human rights and are critical to good health, survival, dignity, poverty reduction, equality, and the enjoyment of a wide range of human rights. They encompass a variety of civil, political, economic, and social rights, from the rights to health and life, to the rights to equality and non-discrimination, privacy, information, and the right to be free from torture or ill- treatment. They

[15] ibid

[16] UN Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994, Para 7.3

are enshrined in human rights treaties such as the International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the Convention on the Rights of Persons with Disabilities (CRPD), and the Convention against Torture (CAT)[17].

States' obligations to guarantee these rights require that women and girls not only have access to comprehensive reproductive health information and services, but also that they experience positive reproductive health outcomes such as lower rates of maternal mortality and have the opportunity to make fully informed decisions—free from violence, discrimination, and coercion—about their sexuality and their reproductive lives[18].

Restrictive abortion laws result in a variety of human rights violations and treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality[19] and found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.[20]

The CEDAW Committee has found that criminalization of abortion, denial or delay of safe abortion and post-abortion care and forced continuation of pregnancy are forms of gender discrimination and gender-based violence.[21]

The Human Rights Committee has, in General Comment No. 36 on the right to life, reaffirmed that States have a duty to ensure that women and girls do not have to undertake unsafe abortions as part of preventing foreseeable threats to the right to life. Paragraph 8 calls for a right to safe abortion and prohibits any restriction that might lead to an unsafe abortion or risk of death from unsafe abortion. This formulation allows for a broad interpretation of the minimum grounds under which abortion should be made legal and also calls on states to take affirmative steps to provide access to abortion.

The CEDAW Committee has noted that denial of access to abortion may be based on gender stereotypes about the traditional roles of women primarily as mothers and caregivers, which may

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[17] Centre for Reproductive Rights, Breaking Ground, Treaty Monitoring Bodies on Reproductive Rights, 2020 accessed at https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf on 27 January 2021

[18] ibid

[19] CESCR Committee*, Gen. Comment No. 22*, *supra* note 1, paras. 10, 28.*;* Human Rights Committee, *Gen. Comment No. 36, supra* note 11, para. 8.; *See also*, Human Rights Committee, *Concluding Observations: Nigeria,* para. 22, U.N. Doc. CCPR/C/NGA/CO/2 (2019).; CEDAW Committee, *Concluding Observations: Paraguay*, paras. 30, 31, U.N. Doc. CEDAW/C/ PRY/CO/6 (2011).; CEDAW Committee, *Concluding Observations: Sierra Leone,* para. 32(d), U.N. Doc. CEDAW/C/SLE/CO/6 (2014)*.;* CESCR Committee, *Concluding Observations: Argentina,* para. 55, 56, U.N. Doc. E/C.12/ARG/CO/4 (2018).

[20] Mellet v. Ireland, Human Rights Committee, Commc'n No. 2324/2013, paras. 7.6, 7.7, 7.8, U.N. Doc. CCPR/C/116/D/2324/2013 (2016).; Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014, paras.7.7 - 7.9, 7.12, U.N. Doc. CCPR/C/119/D/2425/2014 (2017).; K.L. v. Peru*,* Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/ C/85/D/1153/2003 (2005).; L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).; CESCR Committee, *Gen. Comment No. 22*, *supra* note 1, para. 10.; Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).; CAT Committee, *Concluding Observations: El Salvador*, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009).; CAT Committee, *Concluding Observations*: *Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).

[21] CEDAW Committee, *Gen. Recommendation No. 35, supra* note 22, para. 18.; CEDAW Committee, *Gen.Recommendation No. 24,* paras. 11, 14.

also constitute or exacerbate gender discrimination and undermine gender equality.[22] Both the CEDAW and the Human Rights Committees has also expressed concern about situations where abortion is legal but stigmatized, which may lead women to resort to unsafe and clandestine abortions.[23]

The Committee against Torture, the Human Rights Committee, and the CEDAW Committee have found that denying or delaying safe abortion or post-abortion care may amount to torture or cruel, inhuman or degrading treatment.[24]

Treaty monitoring bodies have noted that in addition to liberalising abortion laws, States must ensure that legal abortion services must be available, accessible, affordable, acceptable, and of good quality. [25] Thus it falls on States to ensure that all barriers, including economic and institutional that deny effective access by women and girls to safe and legal abortion should be removed.

Both the CESCR and CEDAW Committees have recognized that abortion services must be economically accessible. [26] Both of these Committees together with the Human Rights Committee have affirmed that States have an obligation to eliminate and refrain from adopting medically unnecessary barriers to abortion, including mandatory waiting periods, biased counselling requirements, and third-party authorization requirements[27] and have also recently paid increasing attention to States' obligations to regulate the practitioners' refusal of care based on grounds of conscience, if they allow the practice [28] in order to ensure that conscientious objection does not effectively result in no access to safe abortion services.

[22] Committee on the Elimination of Discrimination against Women, United Kingdom of Great Britain and Northern Ireland Inquiry Summary (Article 8 of Optional Protocol to Convention on the Elimination of All Forms of Discrimination against Women), paras. 73, 74, U.N. Doc. CEDAW/C/OP.8/ GBR/1 (2018).; Committee on the Elimination of Discrimination against Women, Philippines Inquiry Summary (Article 8 of Optional Protocol to Convention on the Elimination of All Forms of Discrimination against Women), para. 43, U.N. Doc. CEDAW/C/OP.8/PHL/1 (2014).; L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/ C/50/D/22/2009 (2011).; CESCR Committee, Gen. Comment No. 22, supra note 1, paras. 27, 31, 55.

[23] CEDAW Committee, Concluding Observations: Hungary, para. 30, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).; Human Rights Committee, Gen. Comment No. 36, supra note 11, para. 8

[24] CEDAW Committee, Gen. Recommendation No. 35, supra note 22, para. 18.; CAT Committee, Concluding Observations: Poland, para. 33(d), U.N. Doc. CAT/C/POL/CO/7 (2019).; CAT Committee, Concluding Observations: United Kingdom of Great Britain and Northern Ireland, para. 46, U.N. Doc. CAT/C/GBR/CO/6 (2019).

[25] CESCR Committee, Gen. Comment No. 22, paras. 11- 21.

[26] CEDAW Committee, Concluding Observations: Germany, paras. 37(b), 38(b), U.N. Doc. CEDAW/C/DEU/CO/7-8 (2017).; CESCR Committee, Center for Reproductive Rights 37 Concluding Observations: Slovakia, para. 24, E/C.12/SVK/CO/2 (2012).; CEDAW Committee, Concluding Observations: Austria, paras. 38, 39, CEDAW/C/AUT/CO/7-8 (2013)

[27] Human Rights Committee, Gen. Comment No. 36, supra note 11, para. 8.; CESCR Committee, Gen. Comment No. 22, supra note 1, para. 41.; CEDAW Committee, Gen. Recommendation No. 24, supra note 12, para. 14.

[28] Human Rights Committee, Gen. Comment No. 36, supra note 11, para. 8.; CESCR Committee, Gen. Comment No. 22, supra note 1, para. 14.; CEDAW Committee, Gen. Recommendation No. 24, supra note 12, para. 21.

3. Abortion: A Regional Perspective

3.1 Regional Abortion Incidence and Trends

Accurately measuring the incidence of induced abortion poses a challenge. The majority of countries in sub-Saharan Africa do not keep national statistics regarding the number of induced abortions. In addition, the fact that abortion is illegal in the majority of countries means that where induced abortions do take place they are hidden and not reported.

As of 2015–2019, an estimated eight million abortions occur each year in Sub-Saharan Africa.[29] The annual rate for Sub- Saharan Africa is estimated to be 33 abortions per 1,000 women aged 15–49, a rate far lower than that seen in Asia (45), roughly the same as that in Latin America and the Caribbean (32), and much higher than the rates in Europe (20) and Northern America (12).[30] Despite an initial increase between 1990–1994 and 1995–1999, the regional abortion rate has remained virtually the same over the past 25 years (at 31–33 abortions per 1,000 women).[31]

Overall, abortion rates in Sub-Saharan Africa vary little by subregion (30–35 per 1,000 women). Middle and Southern Africa share virtually the same abortion rate (30–32 per 1,000), even though abortion is legal without restriction as to reason for 88% of women aged 15–49 in Southern Africa and for fewer than 1% of those in Middle Africa. This finding affirms the worldwide finding that abortion incidence is by and large unrelated to legality.[32]

The limited information available from women who disclose having had an abortion or who seek care for abortion complications (as opposed to those seeking postabortion care for a miscarriage) shows that Sub-Saharan Africa follows a general pattern: Women seeking abortions are mostly young, unmarried, still in school, not yet a mother, living in an urban area and—compared with the general population of women—better educated and wealthier.[33]

Women have varied—and often multiple—reasons for interrupting a pregnancy. A 2016 study of postabortion care patients in Kinshasa,DRC, found that the top two reasons women gave for having had an abortion were related to avoiding stigma: Forty- two percent mentioned that they sought an abortion because they were unmarried (affirming the belief that abortion is common among

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[29] Bearak J et al., Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019, *Lancet Global Health*, 2020, 8(9):E1152–E1161, doi:10.1016/ S2214-109X(20)30315-6.

[30] Special tabulations of data from Bearak JM et al., Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019, *Lancet Global Health*, 2020, 8(9):E1152–E1161, doi:https://doi.org/10.1016/S2214- 109X(20)30315-6.

[31] Bearak J et al., Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019, *Lancet Global Health*, 2020, 8(9):E1152–E1161, doi:10.1016/ S2214-109X(20)30315-6.

[32] ibid

[33] Bankole A et al., *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress,* New York: Guttmacher Institute, 2020, https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa. doi:10.1363/2020.32446

unmarried women, whose marriage prospects may be hurt if word gets out[34] [35]), and 23% said they wanted to protect family honor.[36]Financial pressures were mentioned next most often. Being unmarried and wanting to continue studying were the most common reasons for abortion given by women who were treated after an unsafe abortion at three hospitals in Chad in 2015–2016.[37]

Nationally representative trend data from Ghana, where abortion is broadly accessible despite a moderately restrictive law[38], show that about one-third of women in both 2007 and 2017 sought an abortion for reasons mentioned above related to just starting out in life.[39] [40] This is a good example of the data revealing a mismatch between legal grounds on which abortion is offered[41] and women's needs as onlyt 4–7% of Ghanaian women said that they had had an abortion based on the grounds set out in the law.

WHO classifies abortion in three categories. Safe procedures are those that use a WHO-recommended method appropriate to the pregnancy duration and are done by a trained provider; less-safe abortions meet just one of these criteria; and least-safe abortions meet neither criterion.[42]

There is no doubt that there is a strong correlation between restrictive abortion laws and the incidence of unsafe abortions. According to WHO, as of 2010–2014, about three-quarters (77%) of abortions in Sub-Saharan Africa are considered unsafe (the sum of less safe and least safe). Applying this proportion to the annual average of abortions estimated for 2015–2019[43] means that some 6.2 million women each year contend with the possible health consequences of unsafe abortions—consequences that would be avoided with safe procedures that adhere to WHO standards. Roughly half (49%) of abortions in Sub-Saharan Africa qualify as least safe.[44] In Southern Africa however only 7% of abortions qualify as least safe. This is not surprising given that South

[34] Yegon EK et al., Understanding abortion-related stigma and incidence of unsafe abortion: experiences from community members in Machakos and Trans Nzoia counties Kenya, *Pan African Medical Journal*, 2016, 24(258), doi:10.11604/pamj.2016.24.258.7567.

[35] Appiah-Agyekum N, Abortions in Ghana: experiences of university students, *Health Science Journal*, 2014, 8(4):531–540.

[36] Lince-Deroche N et al., *Unintended Pregnancy and Abortion in Kinshasa, Democratic Republic of Congo: Challenges and Progress*, New York: Guttmacher Institute, 2019, https://www.guttmacher.org/report/unintended-pregnancy-abortion-kinshasa-drc.

[37] Foumsou L et al., Problematic of clandestine induced abortions in three maternity hospitals of Chad, *Open Journal of Obstetrics and Gynecology*, 2017, 7(9):937–943, doi:10.4236/ojog.2017.79094.

[38] if the pregnancy is the result of rape, incest or "defilement of a female idiot;" if continuation of the pregnancy would risk the life of the woman or threaten her physical or mental health; or if there is a substantial risk the child would suffer from a serious physical abnormality or disease

[39] Ghana Statistical Service (GSS), GHS and ICF, *Ghana Maternal Health Survey 2017*, 2018, https://dhsprogram. com/pubs/pdf/FR340/FR340.pdf.

[40] GSS, GHS and Macro International, *Ghana Maternal Health Survey 2007*, 2009, https://dhsprogram.com/pubs/ pdf/FR227/FR227.pdf.

[41] Republic of Ghana, Criminal Code (Amendment), Law 102, 1985.

[42] Ganatra B et al., Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, *Lancet*, 2017, 390(10110):2372–2381, doi:10.1016/S0140-6736(17)31794-4.

[43] Bearak J et al., Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019, *Lancet Global Health*, 2020, 8(9):E1152–E1161, doi:10.1016/S2214-109X(20)30315-6.

[44] Special tabulations of data from Ganatra B et al., Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, *Lancet*, 2017, 390(10110):2372–2381, doi:10.1016/S0140-6736(17)31794-4.

Africa, which decriminalized abortion in 1996, accounts for nearly 90% of the subregion's population.

3.2 Regional consequences of unsafe abortions

3.2.1 Mortality from abortions

If treated too late or not at all, severe complications from unsafe abortions can lead to death. Many Sub-Saharan African studies present the percent- age of women who died in health facilities from abortion-related complications. However, these values fluctuate widely, both over time and across countries. The annual abortion case-fatality rate, or the number of maternal deaths per 100,000 abortions, is a more useful and comparable measure. This value also includes the deaths of women who never received treatment. As of 2019, Sub-Saharan Africa has the highest annual case-fatality rate of any world region, at roughly 185 maternal deaths per 100,000 abortions. Rates for other regions of primarily low- and middle-income countries, such as Asia and Latin America and the Caribbean, are just 14 and 16 deaths per 100,000 abortions, respectively[45].

Sub-Saharan Africa's rate translates to nearly 15,000 preventable and untimely maternal deaths each year.[46] The subregion of Middle Africa has the highest case-fatality rate (about 260 deaths per 100,000 abortions), with Western Africa close behind (roughly 225 per 100,000). Fewer women die for every 100,000 abortions in Eastern Africa (about 160), and unsafe abortion leads to the lowest case-fatality rate in Southern Africa, the sole subregion where legal abortion predominates (roughly 30 deaths per 100,000 abortions each year).

The percentage decline since 2000 in case-fatality rates was largest East Africa (a decline of 53%) as a result of improvements in access to safe abortion services in Ethiopia, where more than one-quarter of the subregion's population lives.[47] A study that compiled mortality data from several sources estimated that the proportion of maternal deaths that were linked to abortion in that country declined from 31% in 1980–1999 to 10% in 2000–2012.[48]

3.2.2 Impact of postabortion care costs

Ensuring the availability and affordability of safe abortion services is not only critical to women's health and well-being. It is also cost- effective. As of 2019, an estimated $228 million is spent in Sub-Saharan Africa each year on treatment for complications from unsafe abortion.[49] Given the subregion-specific proportions of abortions that are unsafe and the relative sizes of the populations of reproductive-age women, Eastern Africa and Western Africa make up the bulk of this amount ($88 million and $87 million, respectively), followed by Middle Africa ($43 million) and Southern Africa ($10 million). The magnitude of the costs for individual countries' health systems to treat abortion complications likely varies depending on the incidence of unsafe abortion, the population size and

[45] Special tabulations of case-fatality rates based on data on deaths from abortions from the Global Health Data Exchange; number of maternal deaths from WHO; and numbers of abortions from Bayesian model from http:// ghdx.healthdata.org/gbd-results-tool.
[46] Sully E et al., *Adding It Up: Investing in Sexual and Reproductive Health 2019—Appendix Tables*, New York: Guttmacher Institute, 2020, https://www.guttmacher.org/ report/adding-it-up-investing-in-sexual-reproductive-health-2019.
[47] Department of Economic and Social Affairs, UN Population Division, *World Population Prospects, the 2019 Revision,* 2020, https://esa.un.org/unpd/wpp/.
[48] Berhan Y and Berhan A, Causes of maternal mortality in Ethiopia: a significant decline in abortion related death, *Ethiopian Journal of Health Sciences*, 2014, Special Issue, pp. 17–28, doi:10.4314/ejhs.v24i0.3S.
[49] Sully E et al., *Adding It Up: Investing in Sexual and Reproductive Health 2019—Appendix Tables*, New York: Guttmacher Institute, 2020, https://www.guttmacher.org/ report/adding-it-up-investing-in-sexual-reproductive-health-2019.

the protocols for maximizing the use of midlevel practitioners and for decentralizing care to primary-level facilities[50].

Studies consistently show that treating abortion complications costs far more than paying for a safe abortion to begin with. In Sierra Leone, which bans abortion outright, health system costs to treat an unsafe abortion are twice as high as the costs of a safe procedure.[51] In Zambia research shows that treating complications costs 2.5 times as much as providing a safe procedure.[52] In essence increasing access to abortion services that use *any* safe method will always save lives and costs relative to clandestine, unsafe abortions.[53]

3.2.3 Abortion Laws

The safety of abortion depends largely on the extent to which it is legal. Where laws prohibit entirely or severely restrict the circumstances in which abortion is permissible, the general lack of formal abortion services, together with the desire to avoid judgment and arrest, drives women to seek clandestine abortion services, which are often unsafe. In addition, the gap between what the law says and what actually occurs in practice is often large. In some countries where abortion is legal, actual access to safe abortion services is limited by barriers other than the law, including lack of information about services that are theoretically accessible, long distances between facilities where safe abortion facilities are offered and high levels of conscientious objection on the part of medical personnel to providing safe abortions.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (''the Maputo Protocol"), which was adopted in 2003, recognises abortion under certain conditions as a woman's human right. Article 14(2)(c) of the Protocol stipulates that in order to protect women's health and reproductive rights, safe abortion should be authorized when continuing the pregnancy endangers the woman's life; when her physical or mental health is threatened; when the pregnancy results from sexual assault, rape or incest; and when the fetus has a grave anomaly.[54]

In 2016, the African Commission on Human and Peoples' Rights and the Special Rapporteur of the Rights of Women in Africa launched a campaign to decriminalise abortion in Africa. The campaign aims to reduce the number of deaths related to unsafe abortions and to prevent women and girls from being criminally charged for having abortions. At the launch of the campaign, the Special Rapporteur called on all states to honour their commitments in terms of the Maputo Protocol and the African Charter on Human and People's Rights. She emphasised that "criminalising abortion violates many basic human rights, including the right to: life, liberty, security, health, and freedom from torture. Criminal abortion laws discriminate on the basis of sex – they penalise a health service only women need."[55]

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[50] Bankole A et al., *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress,* New York: Guttmacher Institute, 2020, https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa. doi:10.1363/2020.32446

[51] Paul M et al., Unsafe abortion in Sierra Leone: an ex- amination of costs and burden of treatment on healthcare resources, *Journal of Women's Health Care*, 2015, 4(2):228, doi:10.4172/2167-0420.1000228.

[52] Parmar D et al., Cost of abortions in Zambia: a comparison of safe abortion and post abortion care, *Global Public Health*, 2017, 12(2):236–249, doi:10.1080/17441692.2015.1 123747.

[53] Hu D et al., Cost-effectiveness analysis of unsafe abortion and alternative first-trimester pregnancy termination strategies in Nigeria and Ghana, *African Journal of Reproductive Health*, 2010, 14(2):85–103

[54] https://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf

[55] *International Campaign for Women's Right to Safe Abortion, Statement by the Special Rapporteur on the Rights of Women in Africa, 2016, http://www.safeabortionwomensright.org/africa-statement-by-the-special-rapporteur-on-the-rights-of-women-in-africa/*

Despite that campaign to decriminalise abortion in Africa and the fact that 42 of the 55 Member States of the African Union have ratified the Maputo Protocol and are thus obliged to amend their laws to legalise abortion, at least on the grounds provided for in the Protocol, very few countries in Africa have laws that promote access to safe and legal abortion. A 2020 study estimated that 92% of women in Sub-Saharan Africa live in countries with restrictive abortion laws that either prohibit abortion completely or only allow it in very limited circumstances.[56],

There has however been some progress: 13 countries moved away from absolute bans since 2000. Seven countries—Chad, DRC, Eswatini, Mauritius, Mozambique, Rwanda and Sao Tome and Principe—have moved to various degrees to comply with the grounds set out in the Maputo Protocol's Article 14. Sao Tome and Principe's 2012 penal code reform decriminalised abortion allowing it without restriction as to reason.

In Southern Africa, only 6 countries have abortion laws that meet or exceed the requirements laid down in the Maputo Protocol (Mozambique and South Africa permit abortion without restriction as to reason, and Botswana, Mauritius, Namibia and Seychelles permit abortion on the grounds set out in the Maputo Protocol. The remaining 9 countries do not permit abortion on all of the grounds set out in the Maputo Protocol. Whilst Zambia is amongst these, it does stand out as the only country in Southern Africa that permits abortion on the grounds of social or economic circumstances.

Countries	No restrictions	To save the life of the woman	On grounds of sexual violence	Foetal impairment	To protect the physical and mental health of the woman	Socio-economic circumstances	Maputo Protocol Compliant
Angola		X					
Botswana		X	X	X	X		X
DRC		X					
Lesotho		X					
Madagascar		X					
Malawi		X					
Mauritius		X	X	X	X		X
Mozambique	X (up to 12 weeks)		X (up to 16 weeks)	X (up to 24 weeks)			X
Namibia		X	X	X	X		X
Seychelles		X	X	X	X		X

[56] Bankole A et al., *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress,* New York: Guttmacher Institute, 2020, https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa.

South Africa	X						X
Swaziland		X					
Tanzania		X			X		
Zambia		X		X	X	X	X
Zimbabwe		X	X	X			

4. Case studies

South Africa

In an effort to reduce abortion related deaths, South Africa legalized abortion in 1996, through the Choice in Termination of Pregnancy Act, which gives women, regardless of age or marital status, the right to access to abortion services within the first 12 weeks of pregnancy. The act can also extend access to 20 weeks of pregnancy in specific cases. The act served as one of the most liberal examples of abortion legislation globally and was fuelled by findings from a national study on the epidemiology of incomplete abortion in 1994. According to adjusted estimates from that study, approximately 45,000 women were admitted to hospitals for spontaneous abortions or complications of induced abortions in 1994. Of these, more than 12,000 had moderate-to-severe complications resulting from clandestine abortions, and more than 400 died from septic abortions[57]. The study also showed that women under the age of 20 were three times more likely to present at a hospital with incomplete abortions than were older women. Women from this age-group were also at greater risk of medical injury during clandestine abortions, perhaps because of the common use of objects such as catheters or sticks inserted into the vagina, uterus or cervix to induce an abortion[58].

The study brought to light the scale of the problem of unsafe abortion and repealed the 1975 Abortion and Sterilization Act that restricted access to abortion services by requiring approval for the procedure from a physician, and in some cases a court magistrate. The law's passage was a crucial advancement for women, as it represented the recognition of reproductive rights.

Since the enactment of the Choice in Termination of Pregnancy Act in 1996, there has been a significant decrease in morbidity for women in South Africa who have undergone unsafe abortion, especially younger women. Number of women presenting for treatment of severe complications resulting from incomplete abortions decreased significantly[59]. In late 1997, the first official report of maternal deaths in South Africa cited only nine deaths resulting from septic abortions, compared with the Medical Research Council's reports of more than 400 in 1994[60].

Ethiopia

[57] Rees H et al., The epidemiology of incomplete abortion in South Africa, *South African Medical Journal,* 1997, 87(4):432-437

[58] https://www.guttmacher.org/journals/ipsrh/1998/12/abortion-reform-south-africa-case-study-1996-choice-termination-pregnancy-act#11

[59] Department of Health, Republic of South Africa, *Epidemiological Comments*, 1998, 24(3):2-9.

[60] National Committee on Confidential Enquiries into Maternal Deaths, First interim report on confidential enquiries into maternal deaths in South Africa, Department of Health, April 1998, p. 6.

While still classified as illegal in the country's Criminal Code, the revised abortion law of 2005 allows women to terminate pregnancies that result from rape or incest, if the fetus has a severe defect, or if a girl is under the age of 18. This implied a significant change from the previous act which allowed abortion only to save the mother's life. An additional clause in the law states that the woman's word is sufficient evidence of rape or incest, and the Technical and Procedural Guidelines for Safe Abortion Services affirms that 'stated age' is all that is needed to authorize an age-based abortion. There was a consensus among our informants that there was a high level of political commitment behind the revision of the law in 2005. The mandate given to the Ministry of Health to interpret and operationalise the law in procedural guidelines indicates this; *It (abortion) is not on demand, but if you look at the official interpretation of the law (referring to the Ministry of Health), more or less every woman who requests safe abortion care can access the service … As much as possible barriers to services are reduced. If she is a minor then no proof (is required) for age* (INGO E).[61] Ethiopia stands out for having reformed its penal code to enable women to obtain legal abortion on the basis of their own assertion that their pregnancy has resulted from rape or incest. Further, its *Technical and Procedural Guidelines for Safe Abortion Services* (first issued in 2006[63] and updated in 2013[64]) set evidence-based procedure and counseling guidelines for abortion and postabortion care. These guidelines mandate that to prevent repeat abortion, contraceptive services and counseling must be provided as an essential component of both types of care.

From the provider side, Ethiopia's guidelines authorize nurses and midwives to be trained in and provide first-trimester abortions using vacuum aspiration and the combination medication protocol (mifepristone plus misoprostol). As a result, the proportion of procedures done by such midlevel practitioners rose considerably between 2008 and 2014, from 48% to 83%.[65] The guidelines further specify that minors who qualify for an abortion by virtue of their age do not have to present proof of age.

As a result of the Ministry of Health's firm commitment to improving access to all medical services, including abortion, the number of public health centers increased by 250% between 2008 and 2014.[66] The overall impact of these reforms—a trend toward safer procedures—likely contributed to the decline in obstetric admissions for complications of unsafe abortions, which fell from 47% of all such admissions in 2008 to 39% by 2014.

In the far more permissive legal context in Ethiopia, linked to the power vested in the claims of the woman, clinical guidelines have been developed to guide safe abortion procedures, health workers increasingly receive training, and services are gradually rolled out to the population. However, rather than encountering a context of ready access to safe abortion services for those who fulfill the criteria in the law, our material indicates that a number of factors continue to seriously limit access. The government's fear of informing the public about the law so as not to appear as a state promoting induced abortion which could cause uproar at grassroots level, has caused information to be held back, limiting both knowledge about the law and the full roll-out of services. Even when public services are available, women may refrain from using them for the fear of disclosure in the community, while health workers act as gatekeepers and may dismiss women because of religious conscience. The increasing availability of safe abortion services thus to some extent remains silenced, the law is not widely known, and high numbers of young women continue to resort to unsafe abortion procedures[62]

[61] Blystad, A., Haukanes, H., Tadele, G. *et al.* The access paradox: abortion law, policy and practice in Ethiopia, Tanzania and Zambia. *Int J Equity Health* **18,** 126 (2019). https://doi.org/10.1186/s12939-019-1024-0
[62] ibid

Zambia

Zambia is the only Sub-Saharan country where abortion is legally permitted on all survival, health and socio- economic grounds[63]. While this has been the law since 1972, it has tended to be a"paper law" rather than one that ensures widespread access. The continued high prevalence of unsafe abortion despite such a liberal law[64] shows how hard it is to overcome the stigma that prevents women from openly seeking—or even talking about— legal abortions[65]. The country's 2017 *Standards and Guidelines for Comprehensive Abortion Care* contains many positive elements[66]. After acknowledging the scarcity of high-level medical personnel, the guidelines extend authorization to provide abortions to trained midlevel practitioners. The guidelines are unusual in asserting that women must be informed about the range of abortion methods to choose from and that counseling must be empathetic, non-judgmental and respectful.

Zambian providers cannot claim conscientious objection in an emergency. Should they do so under normal circumstances, they must "respectfully" refer the woman to a willing provider. Further, the guidelines mandate that precautions be taken to ensure women's confidentiality and that the best interests of a minor take precedence over the interests of her parents or guardian. However, women cannot benefit from these standards if they remain unaware of when they qualify for an abortion and a lack of available information and knowledge on the part of women as to where they can access safe abortion services remains extremely problematic. Four decades after reform, only a small minority of women know the specifics of Zambia's abortion law.[67]

5. Access to Abortion in Namibia

Access to abortion in Namibia is governed by the **Abortion and Sterilization Act 2 of 1975** inherited from South Africa at independence. This law allows abortion only in the following circumstances:

- where continuing the pregnancy will endanger the woman's life or constitute a serious threat to her physical or mental health (section 3(1)(a) and (b));
- there is a serious risk that the child will suffer from a physical or mental defect that will result in an irreparable and serious handicap (section 3(1)(c));
- the pregnancy resulted from rape, incest or unlawful carnal intercourse with a woman who has a severe mental incapacity (section 3(1)(d)).

The conditions to be by a woman seeking an abortion are onerous. Two medical practitioners must provide a certificate verifying the grounds for abortion and where the ground for abortion is a threat to the woman's mental health, one of these must be a psychiatrist. Where the basis for the abortion is unlawful intercourse (rape or incest), one of the certifying doctors must be the district surgeon and in addition a certificate issued by a magistrate is required to the effect that he has satisfied himself

[63] Bankole A et al., *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress,* New York: Guttmacher Institute, 2020, https://www.guttmacher.org/report/ from-unsafe-to-safe-abortion-in-subsaharan-africa. doi:10.1363/2020.32446

[64] Owolabi OO et al., Incidence of abortion-related near-miss complications in Zambia: cross-sectional study in Central, Copperbelt and Lusaka Provinces, *Contraception*, 2017, 95(2):167–174, doi:10.1016/j. contraception.2016.08.014.

[65] Geary CW et al., Attitudes toward abortion in Zambia, *International Journal of Gynecology & Obstetrics*, 2012, 118:S148–S151, doi:10.1016/S0020-7292(12)60014-9.

[66] Ministry of Health, *Standards and Guidelines for Comprehensive Abortion Care in Zambia*, Lusaka, Zambia: Government of the Republic of Zambia, 2017, https:// abortion-policies.srhr.org/documents/countries/11-Zambia-Standards-and-Guidelines-for-Comprehensive- Abortion-Care-2017.pdf#page=38.

[67] Bankole et al op cit

that a complaint relating to the alleged unlawful carnal intercourse in question has been lodged with the Police or, if such a complaint has not been so lodged, that there is a good and acceptable reason why a complaint has not been so lodged and that the woman concerned alleges, in an affidavit submitted to the magistrate or in a statement under oath to the magistrate, that the pregnancy is the result of that rape or incest, as the case may be (section 3(4)). In addition to being required to obtain these certificates from doctors and in the case of rape or incest from a magistrate, the woman seeking an abortion is required to get the permission of the Medical Superintendent of a state hospital for the abortion to be performed at that hospital (section5). Abortion in any other circumstances is a criminal offence for both the woman who seeks it and the person who performs it. The punishment is a fine of up to N$5 000 or imprisonment for up to five years, or both (section 10).

In a country where many women live great distances from health facilities, meeting these requirements is practically impossible, particularly for women living in rural areas. Should the ground for abortion be the mental health of the woman, she faces even greater practical difficulties in meeting the legal requirements as very few state health facilities have psychiatrists. Where the grounds for abortion are rape or incest, women face an even greater barrier as they require a certificate from a magistrate and if they have not initially reported the rape or incest to the police, they face interrogation by a magistrate as to the reasons why the rape or incest was not reported.

The restrictive abortion law is not class or racially neutral. It impacts most severely on poor and black women who often lack the means to provide a dignified life for themselves and their children, due to structural injustices. Many also lack the means to seek safe, legal abortions outside the borders of the country and the legal limitations placed on access to abortion in Namibia has resulted in women resorting to unsafe abortions [68].

Whilst little data is available on the rate of unsafe abortions in Namibia or the contribution of unsafe abortion to maternal deaths a multisource survey of facility-based maternal and neonatal mortality in the five southern regions of Namibia (Erongo, Hardap, //Karas, Khomas, and Omaheke) covering the time period from January 2010–June 2012 (two and a half years) found that approximately 12% of the 57 maternal deaths recorded were as a result of abortion[69]

An attempt to liberalise Namibia's abortion law was initiated by the then Minister of Health in 1996. The draft Abortion and Sterilisation Bill (1996) sought to legalise abortion without reason within the first three months of pregnancy and made provision for abortion after three months on grounds of threat to the physical or mental health of the women, serious risk that the child will suffer from a physical or mental defect that will result in an irreparable and serious handicap or rape or incest. The Bill was never enacted into law due to strong opposition from members of the public. The negative attitudes towards abortion and a woman's right to make decisions about her fertility and reproduction are often shaped by conservative patriarchal gender norms, which take precedence over women's reproductive autonomy[70].

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[68] Mwatilifange and Edwards-Jauch Reproductive justice in the face of conservatism: youth attitudes towards abortion on demand 2017 at http://repository.unam.edu.na/bitstream/handle/11070/2124/mwatilifange_reproductive_2017.pdf?sequence=3&isAllowed=y

[69] MoHSS, Report of the Prevalence and Contributing Factors of Facility-Based Maternal and Neonatal Deaths in Five Regions of Namibia (Erongo, Hardap, //Karas, Khomas, Omaheke) during 2010–2012 at https://www.intrahealth.org/sites/ihweb/files/files/media/report-of-the-prevalence-and-contributing-factors-of-facility-based-maternal-and-neonatal-deaths-in-five-regions-of-namibia-erongo-hardap-karas-khomas-omaheke-during-2010-2012/NamibiaMMRStudy.pdf

[70] Mwatilifange and Edwards-Jauch op cit

Public debate on abortion in Namibia has resurfaced in the last few years and in June 2020, calls for legalising abortion in Namibia intensified. A petition to amend the law to increase access to legal abortion in Namibia has attracted over 60000 signatures by September 2020[71]. The authors of the petition proposed that the right to access legal abortion should be accompanied by education relating to sexual health and reproductive rights to prevent unwanted pregnancies and baby dumping[72]. Attempts to liberalise the law on abortion have however once again been met with strong opposition from religious groups and some women's groups and politicians.

6. Conclusion and Recommendations

Criminal laws that penalise and restrict access to safe abortion are impermissible barriers to the realization of women's right to health. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, these laws consistently generate poor physical health outcomes, resulting in deaths that could have been prevented, morbidity and ill-health, as well as negative mental health outcomes, not least because affected women risk being thrust into the criminal justice system[73].

Even though the **Abortion and Sterilization Act 2 of 1975** on the face of it permits legal abortions on the grounds outlined in the Maputo Protocol, the requirements to be met by women seeking a legal abortion are extremely onerous and in the majority of cases, it is suggested, almost impossible to meet. Moreover, the law does not reflect the reasons most women terminate their pregnancies. As illustrated by this desk review, women choose abortion most often not because their lives or health are endangered by the pregnancy or as a result of rape or incest but for socioeconomic reasons.

Recommendations:

1. Law Reform

The **Abortion and Sterilization Act 2 of 1975 should be repealed and replaced with new legislation similar to the** Choice in Termination of Pregnancy Act **enacted in South Africa, whi**ch permits abortions to be performed upon the woman's request through the first trimester of pregnancy, without any need for the approval of doctors, psychiatrists or magistrates. Minors are counselled to notify their parent or guardian of their decision but are not required to receive consent for the procedure. Victims of rape or incest are not required to provide any documentation in order to obtain an abortion. Women between 13 and 20 weeks of gestation can obtain an abortion if a medical practitioner believes that the pregnancy threatens the mental or physical health of the woman or foetus, if the pregnancy resulted from rape or incest, or if it affects the woman's socioeconomic situation. After the 20th week, termination of pregnancy is permissible if a doctor or

[71] "Legalize Abortion in Namibia", <www.change.org/p/honorable-dr-kalumbi-shangula-minister-of-health-and-social-services-legalize-abortion-in-namibia>.
[72] "NAMIBIA – A true story of unsafe abortion & a petition to make abortion safe and legal", International Campaign for Women's Right to Safe Abortion, 2020, <www.safeabortionwomensright.org/namibia-a-true-story-of-unsafe-abortion-a-petition-to-make-abortion-safe-and-legal>.
[73] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General,* para. 65(h),(i), U.N. Doc. A/66/254 (Aug. 3, 2011)

trained midwife finds that continuation of the pregnancy would threaten the health of the woman or cause severe handicap to the foetus.

2. Provision of services and counselling

Safe abortion care

In order to ensure that access to safe abortions is a practical reality for women in Namibia under a new legislative framework, it should be ensured that legal abortion services are in fact provided. To this end:

- national service guidelines should be developed, disseminated and implemented that are consistent with the latest WHO recommendations to ensure that legal abortions have the benefit of evidence-based safety standards.
- Safe services must include comprehensive counseling and postabortion contraception to help women avoid another unintended pregnancy.
- All health care professionals who provide abortion must be trained in WHO-recommended techniques, and the use of dilation and curettage must be discontinued without delay. This invasive and costly method should be completely replaced by either medication abortion or vacuum aspiration.
- The use of medication abortion—the combination regimen of mifepristone and misoprostol when available, and misoprostol alone when it is not—is as safe as vacuum aspiration for first- trimester abortion.

Contraceptive services

The unmet need for contraception, including emergency contraception, particularly for young women and adolescents must be addressed. Accessible and affordable contraceptive services should be nonjudgmental, so those who need them are not deterred from seeking them.

3. Information, education and training

Law reform means little unless the new criteria for legal abortion are widely communicated to the general public, medical professionals, legal professionals and law enforcement officials.

Abortion is such a stigmatized subject that reluctance to talk about it publicly is at least part of the reason why women remain largely uninformed about legal criteria. To address this better public information campaigns are needed to more widely inform all parties of their rights and responsibilities.

Abortion services should be youth-friendly and non-judgemental. To this end health professionals should be provided with values clarification and sensitivity training to ensure that all women seeking abortion services are treated without judgment and with dignity.

Comprehensive sexuality education in school is essential for raising awareness among adolescents and young people of how to negotiate protected sex and obtain and correctly use contraceptives to prevent pregnancy. It is also important to develop ways to reach out-of-school youth with this information.