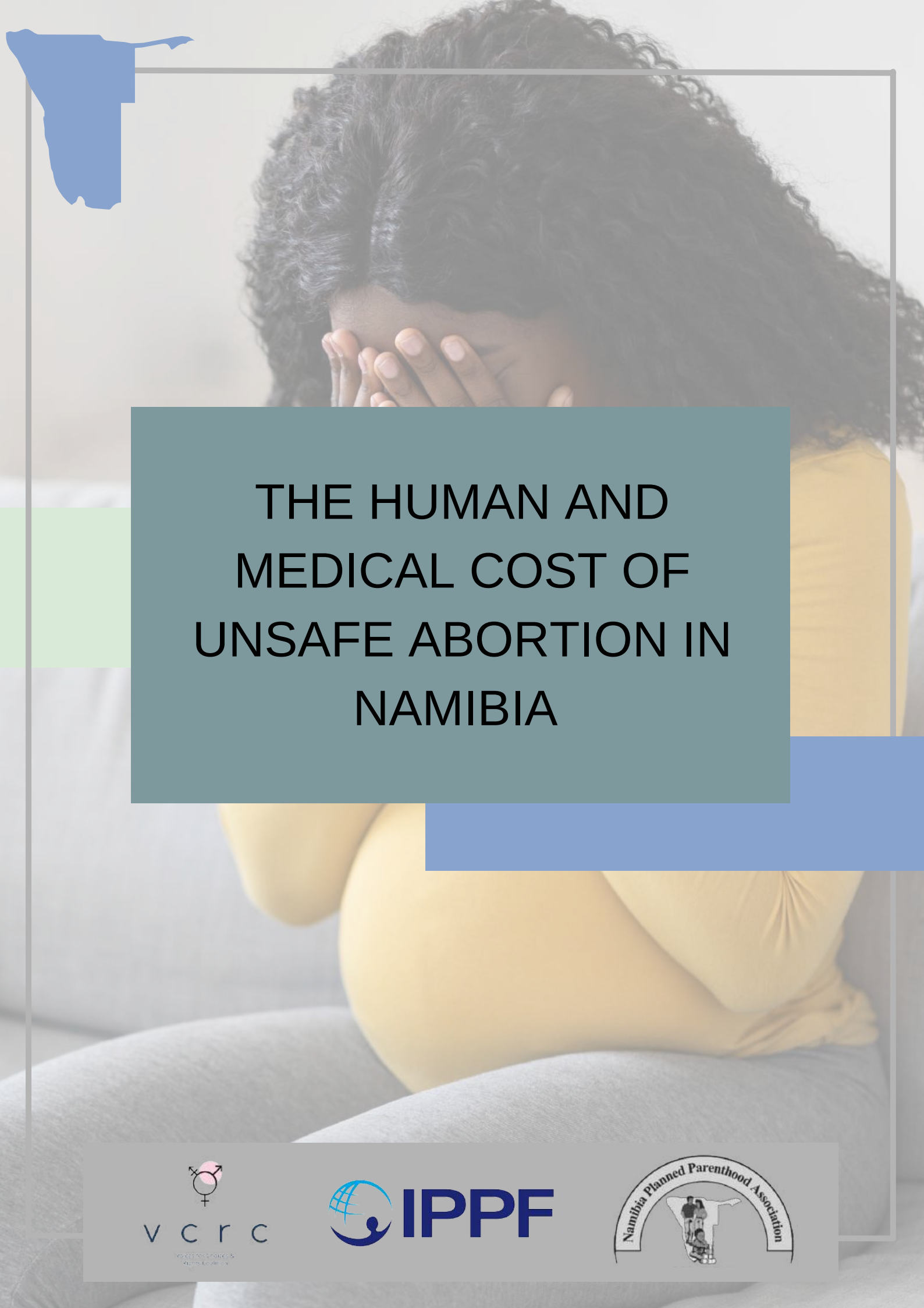


THE HUMAN AND MEDICAL COST OF UNSAFE ABORTION IN NAMIBIA

vcrc

IPPF

Namibia Planned Parenthood Association

Method and Background

The research for this report was carried out by the Alkimia Consulting Team for the Voices for Choices and Rights Coalition (VCRC), with financial support from the Namibia Planned Parenthood Association (NAPPA). A desk review of existing literature was combined with consultations with two medical practitioners, and a personal testimony of a Namibian woman who had an abortion in South Africa. The research was conducted over a period of 8 days during January and February 2022.

There is limited understanding on the human and economic costs of the current legal restrictions on accessing a safe abortion in Namibia, including the ways in which it is exacerbating already high levels of maternal morbidity. However, what we do know is that there are severe disparities and inequities in who experiences and carries the burdens of these costs. In most instances, it is the black, younger, uneducated women, women in rural settings and women who are living in poverty who are more likely to experience the negative maternal health outcomes and to suffer the subsequent complications and impacts. In other words, the current abortion law is not class, or race neutral.

This report is a step towards accounting for such costs. It also aims to foster an understanding of access to safe abortion as an urgent and pressing concern – not only for securing reproductive, human and women's rights in Namibia, but also for securing health and social equity and justice for all.

© ***Copyright Voices for Choices and Rights Coalition 2022***
Researched and written by Elsemi Olwage, Alkimia
Edited and designed by Tulimelila Shityuwete, Alkimia

ALKIMIA

The Facts and Figures

Almost all abortions result from unplanned and unintended pregnancies. The Guttmacher Institute notes that about 121 million unplanned pregnancies occurred globally each year between 2015 and 2019. Of these, about 61% of all unplanned pregnancies (somewhat less than 2 out of 3) end in abortion. In total, approximately 73 million abortions took place each year during that time.

Abortion legality is strongly associated with abortion safety: 75% of abortions in legally restrictive settings are unsafe, compared to 13% in settings where abortion is available without legal restrictions.

Abortion carries more risk in sub-Saharan Africa (SSA) than in any other region in the world. Women here have a higher risk of unintended pregnancies that are more likely to be terminated, most of which are done through unsafe methods. As of 2010-2014, 77% of abortions in the region are unsafe, compared with the global average of 45%. In 2019, sub-Saharan Africa had the highest abortion case-fatality rate of any world region, at roughly 185 deaths per 100,000 abortions – **a total of 15,000 preventable maternal deaths every year.**

High rates of unsafe abortions place a major burden, not only on women and communities, but on the public health systems. Estimates from 2012 indicate that in developing countries alone, **7 million women per year were treated in hospital facilities for complications from an unsafe abortion.**

Estimates from 2006 show that complications from unsafe abortions cost health systems in developing countries **US$ 553 million per year** for post-abortion treatments. Such cost-considerations do not fully consider the long-term health and economic impacts for women, households, and communities.

In Namibia, rates of unwanted and unplanned pregnancy are high, including rates of teenage pregnancy. The United Nations Population Fund (UNPF) in Namibia, reports that between 2003 and 2018 the adolescent birth rate per 1,000 girls aged 15-19 was 64 – a number which has further increased since the onset of the Covid-19 pandemic.

Although the reasons for such high rates are complex, there are clear and closely related factors: an unmet need for family planning and contraception; dismal rates of sexual, gender based (SGBV) and domestic violence; failure of men to take responsibility for their sexual activity and for child support; poverty; limited access to comprehensive sexuality education and reproductive autonomy for all girls and women, and pervasive patriarchal structures and values.

The 2013 Namibia Demographic and Health Survey (NHDS) found that among all women aged 15-49, almost 12% had an unmet need for family planning, while 18% of married women and 14% of sexually active unmarried women stated that their family planning needs were not met. The women with significant unmet needs for family planning were women residing in rural areas (15%), women with no formal education (24%), and women in the lowest wealth quintile (18%). A medical officer based at a state hospital in Windhoek noted that, almost 10 years later, such needs remain unmet – with the supply regularly unable to meet the demand and women unable to access their contraceptives of choice.

Unplanned and unwanted pregnancy affects a woman's life in every sense, including her livelihood, educational pursuits, employment, social status and physical and mental well-being. Avoiding the social and economic repercussions and the shame associated with an unintended/unwanted pregnancy, can be a particularly strong motivation among young and unmarried women. Globally, sexually active adolescents have far higher rates of abortion than all women of reproductive age.

Given Namibia's high rates of teenage and unplanned pregnancies and the criminalisation of abortion, a large percentage of women deal with these pregnancies without access to comprehensive information or any support services. This can have dire consequences, including high rates of unsafe abortions. Data available suggests that **unsafe abortions may account for 12-16% of Namibia's annual maternal deaths.**

Legal Realities

Evidence from across the world shows that **restrictive laws on abortion do not discourage women from having abortions.** In fact, in most countries that legally restrict access to abortion, abortion rates are rising. Legally restricting access to abortion does not prevent abortion, it only drives "abortion underground and into backstreets, with tragic consequences for women's health and wellbeing", particularly for women from poorer and more disadvantaged backgrounds.

Abortions are taking place, and will continue to take place, no matter the legal, socio-economic, cultural, and geographic context. **What the laws and the context do influence are the circumstances under which abortion takes place and whether access to abortion services is safe and dignified.** A landmark case study in Romania showed that the lifting of the abortion ban in 1989 resulted in a 50% decline in maternal mortality in less than a year.

Legal reform, although crucial, is not enough. It must be accompanied by structural and social changes which address other access-barriers to abortion services in general. These include those shaped by social stigma, poverty, inequalities and patriarchal norms.

Medical Realities

Abortion is among the safest medical procedures when performed according to the World Health Organisation's (WHO) recommended guidelines. However, the risk of complication or death increases substantially when it involves unsafe methods oris performed during an advanced stage of the pregnancy. Unsafe abortion is a principal – **but preventable** – cause of maternal deaths and morbidities globally. According to WHO, global estimates from 2010-2014 demonstrate that 45% of all induced abortions are unsafe, with at least one third performed under the least safe conditions, i.e., by untrained persons using dangerous and invasive methods.

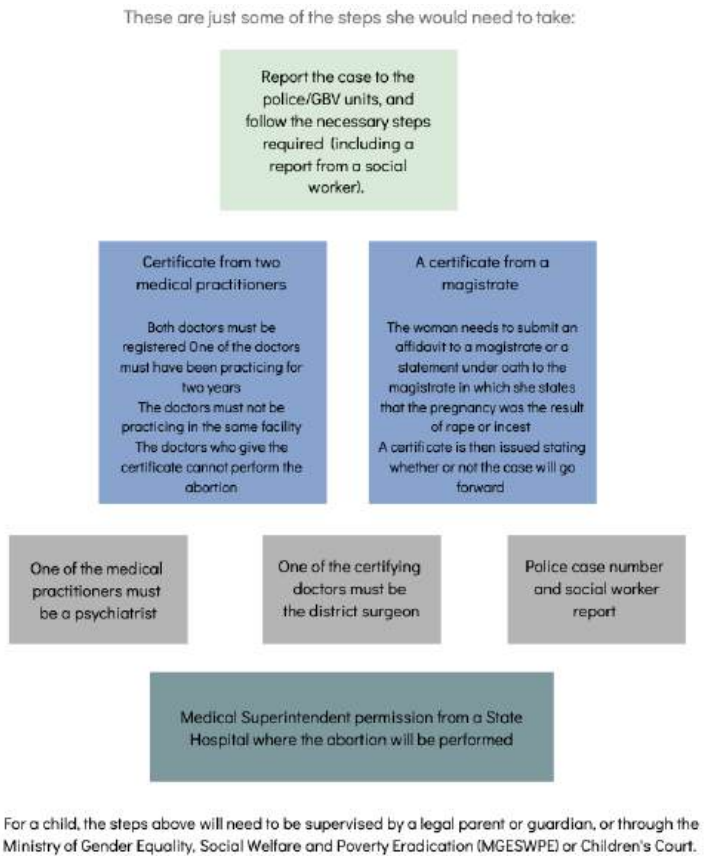
Unsafe abortion methods come with enormous health risks, especially if the abortion is incomplete. The physical complications are critical and mitigating long-term effects require comprehensive post-abortion care, which is both costly, resource-intensive and traumatic.

Barriers and the System

The Abortion and Sterilization Act 2 of 1975 was inherited from apartheid South Africa at Independence and is extremely restrictive. It allows for abortion, but only in the following cases:

the pregnancy endangers the woman's life,
physical or mental health
serious risk to the child
pregnancy resulted from rape or incest

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. To access a legal abortion under the circumstances listed above, a girl/woman must follow a set of complex procedures.



For a child, the steps above will need to be supervised by a legal parent or guardian, or through the Ministry of Gender Equality, Social Welfare and Poverty Eradication (MGESWPE) or Children's Court.

Although these steps seem straightforward, they must be situated within the Namibian context and existing social and structural access barriers.

The law does not prevent abortion, what it does do is restrict access to safe and legal abortion for women with the least resources.

These are women and girls who are in the most vulnerable positions in society, often living in poverty and in rural settings, and are black, uneducated, adolescent, and survivors and victims of sexual violence.

For women and girls from poorer backgrounds, or who reside far from public health facilities, access can be costly and difficult. About 21% of Namibians live more than 10 km from a health care provider and must travel long distances to access basic and emergency obstetric care services. Overall, the 2013 NDHS found that the most common barrier for women accessing health care was distance to the health facility (31%), followed by money for treatment (28%), not wanting to go alone (15%), and failure to get permission (6%).

For girls and women in rural areas, those living in poverty, and who wish to terminate their pregnancy because of rape/or incest, this means organising the resources to travel between primary and referral health care centres, the police station, the magistrate's office, and between urban centres and their rural homes. It can also mean waiting for transport to the referral hospital to become available. Women potentially have to undergo the process far from home or are forced to make difficult decisions on a time-sensitive and complex matter without the needed support.

A medical officer based at a State Hospital in Windhoek noted that many women who do not have a formal education background are uncomfortable with the process, given that it involves a number of forms and bureaucratic hurdles. Girls and women from poorer backgrounds are also less likely to access quality care. In the end, these services might not meet their cultural and socio-emotional needs, including the need for secrecy and confidentiality.

Health practitioners can also exercise immense influence to discourage a girl or woman from having an abortion or deny them information, based on their own beliefs, or simply due to being misinformed. For example, a crucial barrier to accessing a legal abortion is the widespread belief that abortion is completely illegal. Although progress has been made to sensitise health care workers, state service providers and communities, there is still much to be done, including breaking down the social stigma. If a girl or woman is bombarded with messaging that signals to her that abortion is morally wrong and criminal, she is much less likely to ask the right questions and to access the information she needs to make an empowered and safe decision.

These "nonclinical aspects" can be strong motivating factors for seeking abortion services in the informal sector, despite the heightened health risks.

Barriers in the Namibian justice system also prevent many women from reporting SGBV cases and from receiving the support needed in the case of an unwanted pregnancy. Women without the means and the necessary information are then pushed into continuing unwanted pregnancies or to having abortions by unsafe methods. In contrast, women with the financial means have options: they can access the morning after pill or travel to South Africa for a safe and legal abortion, one that meets their demands for privacy and quality care. As Dianne Hubbard of the Legal Assistance Centre (LAC) in Namibia said more than 20 years ago, "This is the practical reality, and it is manifestly unfair."

Some women, out of desperation, make immense financial and economic sacrifices to access a safe abortion in South Africa, including selling their belongings or homes. Costs for this can easily add up to between N$10 000 to N$20 000, including the cost of travel (including the recent requirements for Covid-19 testing), accommodation, and the procedure itself (costs range from R3500 upwards, depending on the gestation stage of the pregnancy and whether it's a medical or procedural abortion).

Additionally, although the current Abortion Act makes provision for a legal abortion if the pregnancy poses a serious threat to a woman's mental health, what constitutes such a threat is not clearly defined or explained in the legal framework. This means that the power to define and assess the risk is largely in the hands of the referring health care worker and/or physician. There are only a limited number of psychiatrists in the country and very few state facilities have psychiatrists. A publication in 2017 noted that there were only seven psychiatrists in Namibia, of which four were in private practice in Windhoek, two employed by the government, and one in private practice in Swakopmund.

Moreover, talking openly about unwanted pregnancies and mental health problems in Namibia is riddled with cultural and intergenerational taboo and stigma and is still vastly misunderstood. This excludes many girls and women for whom an unwanted pregnancy creates chronic mental health struggles, including anxiety, depression, suicidal thoughts, and the inability to lead constructive lives.

The Human and Medical Cost of Denial of Abortion

Restricted access to safe and legal abortion services comes at great human and medical cost. The more unsafe abortions are performed, the higher the risk for maternal morbidity and severe complications, and the higher the burden on Namibia's already highly unequal, under resourced and overburdened health system. Apart from the direct costs to women and to the public health system, including pressure on our health workers, there are a multitude of indirect social and economic costs.

One medical officer, based at a State Hospitals' Obstetrics and Gynaecology Department, shared that in the last two weeks alone she treated four women who were severely ill and needed critical care due to abortion-related complications – with all four suspected of having been induced through unsafe methods.

One of them was a young woman in her early twenties, a student, whose complications were so severe she almost died and had to have a hysterectomy.

Given the criminalisation of abortion, when women suffer post-abortion complications, many wait too long to seek help and are reluctant to disclose their procedure for fear of being reported or mistreated.

As one doctor expressed it:

"by the time they seek help they have already been bleeding for a week."

Among those who experience complications, women living in poverty, in rural areas, young women and those who struggle to access health care facilities, especially referral facilities, are the least likely to access post abortion care on time – often with deadly consequences.

A recent study in Namibia in 2019 found that the most common causes for maternal near misses (i.e., the number of women who almost died) over a 6-month period were obstetric haemorrhage (30.9%), hypertensive disorders (30,9%), and pregnancy with abortive outcomes (16,4%). In the last category, five women suffered septic miscarriages after self-induced abortions. Of these, two were complicated by a ruptured uterus and one needed a hysterectomy.

One woman also had a perforated uterus after a self-induced abortion using a branch. Among the women who experienced these severe maternal outcomes, 18.1% were between the ages of 13 and 19.

The long-term implications of becoming infertile or disabled in your adolescence or early twenties are manifold and include lifelong mental health struggles. The immediate impact includes a long recovery period and being unable to pursue ones' studies, or engage in work. Being unable to bear children can affect a young woman's social status and her options for marriage. This has a lasting impact on her sense of self and community. Again, it is mostly women and communities who are already living in structurally marginalised conditions who are most affected by these outcomes, and whose livelihoods are severely diminished.

In the case of loss of life, the other children and family members might lose their primary care-giver and their mother, sister or daughter. This increases the burden of care for other family members. This burden of care also increases substantially where "backdoor" abortions are unsuccessful and result in the disability of both the mother and child. This can drastically alter the economic security and well-being of the household.

Apart from unsafe abortions, adolescent girls and women of all ages are forced to give birth in a context where there is a lack of financial, emotional and family resources to properly care for and protect the child. This can result in immense consequences to the well-being of those involved, including growing incidences of "baby dumping" and neglect, infanticide, and the growing number of Namibian orphans.

Who would access to legal abortion be saving?

The current Abortion Act and legal framework is creating health and social inequities and negative public and maternal outcomes. This cements discrimination and existing socio-structural injustices in Namibia – not only based on sex and gender, but also on race and class.

Given that Namibia is the second most unequal country in the world, and that 43,3% of the population are living in multidimensional poverty, this means a further entrenchment of existing structural inequalities. Moreover, it reinforces vulnerabilities amongst those already marginalised – including women and girls in general. However, the impacts and costs are not only felt or carried by girls and women: it reverberates out, to our communities and to our health systems – most of whom are already battling on multiple fronts.

For more information, please contact VCRC Namibia, the IPPF, NAPPA or Alkimia Consulting:

liberalizeabortionnamibia@gmail.com
info@ippfaro.org
info@nappa.org
tulimelila.alkimia@gmail.com

Bibliography

Abortion and Sterilization Act 2 of 1975 (RSA). Republic of Namibia. March 12, 1975.
Adde, Kenneth Setorwu, Kwamena Sekyi Dickson, Edward Kwabena Ameyaw, and Joshua Amo-Adjei. "Contraception Needs and Pregnancy Termination in Sub-Saharan Africa: A Multilevel Analysis of Demographic and Health Survey Data." Reproductive Health 18, no. 1 (2021): 177. https://doi.org/10.1186/s12978-021-01227-3. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-021-01227-3.
ARASA/NAPPA/NWHN/SAfAIDS/Women's Solidarity Namibia. ""I Was Afraid That People Might Read It from My Face": Information and Women's Testimonies on Abortion in Namibia." Namibia Women's Health Network, Windhoek, Namibia, 2011. https://salamandertrust.net/wp-content/uploads/2016/05/NWHNstorybooklet2011.pdf.
Bankole, Akinrinola, Lisa Remez, Onikepe Owolabi, Jesse Philbin, and Patrice Williams. "From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress." 2020. https://doi.org/10.1363/2020.32446. https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa.
Bell, Suzanne O., Mridula Shankar, and Caroline Moreau. "Global Epidemiology of Induced Abortion." In Oxford Research Encyclopaedia of Global Public Health. Edited by Suzanne O. Bell, Mridula Shankar and Caroline Moreau. Oxford: Oxford University Press, 2021.
Emvula, David N., DR. "Termination of Pregnancy in Namibia: A Clinician's Perspective." Presentation for Parliamentary Hearings, Windhoek, Namibia, October 19, 2021.
Gender Research & Advocacy Project, Legal Assistance Centre Namibia. "Law Reform on Abortion." Submission for Parliamentary Hearings, October 2021.
Guttmacher Institute. "Unintended Pregnancy and Abortion Worldwide: Fact Sheet." Accessed January 10, 2022. https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide.
Hamata, Sylvia. Interview, January 17, 2022.
Harris, Christian, and Beverley Silas. "Presentation by the Ministry of Justice." Parliamentary Hearings, October 2021.
HEARD. "Unsafe Abortion in Namibia: Country Factsheet." Health Economics and HIV/AIDS Research Division/ University of KwaZulu-Nata, Durban, 2016.
Heemelaar, Steffie, Mirjam Josef, Zoe Diener, Melody Chipeio, Jelle Stekelenburg, Thomas van den Akker, and Shonag Mackenzie. "Maternal Near-Miss Surveillance, Namibia." Bulletin of the World Health Organization 98, no. 8 (2020): 548–57. https://doi.org/10.2471/BLT.20.251371.
Hubbard, Diane. "Morality and the Law: The Abortion Question." Legal Assistance Centre Namibia, Windhoek, Namibia, 1997.
Legal Assistance Centre Namibia. "Abortion Facts." Windhoek, Namibia, 2020.
Legal Assistance Centre Namibia. "Becoming Pregnant from Rape Your Options." Legal Assistance Centre Namibia; Hans Seidel Foundation, Windhoek, Namibia, 2021.
Levandowski, Brooke A., Linda Kalilani-Phiri, Fannie Kachale, Paschal Awah, Godfrey Kangaude, and Chisale Mhango. "Investigating Social Consequences of Unwanted Pregnancy and Unsafe Abortion in Malawi: The Role of Stigma." International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics 118 (2012): S167-S171. https://doi.org/10.1016/S0020-7292(12)60017-4.
Medical Officer. Interview (Anonymous), February 28, 2022.
Mwatilifange, Sarah, and Lucy Edwards-Jauch. "Reproductive Justice in the Face of Conservatism: Youth Attitudes Towards Abortion on Demand." Journal of Studies in Humanities and Social Sciences 6, no. 2 (2017): 233–47. https://repository.unam.edu.na/handle/11070/2124.
Namibia Statistics Agency. "Namibia Mortality and Causes of Death Statistics Report, 2016 and 2017." Windhoek, Namibia, 2020. https://d3rp5jatom3eyn.cloudfront.net/cms/assets/documents/Causes_of_Death_Report.pdf.
Namibia Statistics Agency. "Namibia Multidimensional Poverty Index (MPI) Report 2021." Namibia Statistics Agency, Windhoek, Namibia, 2021. https://d3rp5jatom3eyn.cloudfront.net/cms/assets/documents/Namibia_Multidimensional_Poverty_Index_(MPI)_Report_2021.pdf.
Ngwako, Karabo, and Aduragbemi Banke-Thomas. ""I Guess We Have to Treat Them, but ... ': Health Care Provider Perspectives on Management of Women Presenting with Unsafe Abortion in Botswana." *Global Public Health* 15, no. 9 (2020): 1308–21. https://doi.org/10.1080/17441692.2020.1751863.
Owolabi, Onikepe O., Ann Biddlecom, and Hannah S. Whitehead. "Health Systems' Capacity to Provide Post-Abortion Care: A Multicountry Analysis Using Signal Functions." *The Lancet Global Health* 7, no. 1 (2019): e110-e118. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30404-2/fulltext.
Singh, Susheela, Lisa Remez, Gilda Sedgh, Lorraine Kwok, and Tsuyoshi Onda. "Abortion Worldwide 2017: Uneven Progress and Unequal Access." Guttmacher Institute, 2018. https://www.guttmacher.org/report/abortion-worldwide-2017.
Temmerman, Marleen. "Missed Opportunities in Women's Health: Post-Abortion Care." *The Lancet Global Health* 7, no. 1 (2019): e12-e13. https://doi.org/10.1016/s2214-109x(18)30542-4.
The Namibia Ministry of Health and Social Services, and ICF International. "Namibia Demographic and Health Survey 2013." MoHSS and ICF, Windhoek, Namibia, Rockville, Maryland, USA, 2014. https://dhsprogram.com/pubs/pdf/fr298/fr298.pdf.
World Bank. "Namibia Health Sector Public Expenditure Review." World Bank, Washington, DC, 2019. https://openknowledge.worldbank.org/handle/10986/32111.
World Health Organization. "Fact Sheet: Abortion." Accessed January 10, 2022. https://www.who.int/news-room/fact-sheets/detail/abortion.

The human and medical cost of unsafe Abortion

approximately 121 million unplanned pregnancies occur each year

61% of unplanned pregnancies end in abortion

75% of abortions in legally restrictive settings are unsafe

a total of 15,000 preventable maternal deaths occur every year

in 2012, 7 million women per year were treated in hospital facilities for complications from an unsafe abortion in developing countries

complications of unsafe abortions cost health systems in developing countries US$ 553 million per year for post-abortion treatments

Such cost-considerations do not yet fully consider the long-term physical and mental health impacts of unsafe abortions for women, households, and communities.

vcrc