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HEADLINE: Is a safe, legal abortion a human right?

Blurb: Abortions became legal in South Africa almost three decades ago. Yet we still have plenty of unsafe, illegal abortions. Why? Mia Malan speaks to physician Tlaleng Mofokeng in this podcast.

Bullet points:

- Tlaleng Mofokeng is a South African doctor and a United Nations special rapporteur on the right to health.
- She believes the right to a safe, legal abortion is a human right.
- Abortions became legal in South Africa in 1996, yet dangerous, illegal terminations of pregnancy are still taking place.
- Mofokeng says this is because abortion medication is expensive, too few health workers have been trained in how to perform the procedure and many aren't prepared to conduct it. She spoke to Mia Malan.

Mia Malan
Danny Booysen

PODCAST SCRIPT

INTRO

The right to a safe, legal abortion, became a reality in South Africa in 1996 when the Termination of Pregnancy Act became law.
Until 12 weeks into a pregnancy anyone in the country can have an abortion without having to provide a reason for it.
For a pregnancy between 13 and 20 weeks women can get legal abortions for special reasons such as financial circumstances or if the pregnancy will affect the woman's mental health.
After 20 weeks a legal abortion can still be performed, but only if there's a serious threat to the life of the pregnant woman or if the fetus has congenital problems.

Tlaleng Mofokeng is a well-known South African doctor and also a United Nations special rapporteur on the right to health. She's also a Catholic, and believes a safe abortion is a human right. She regularly performs terminations of pregnancy herself.

I recently caught up with Tlaleng in New York and asked her why she thinks that.

Tlaleng Mofokeng

Abortion is a human right, because firstly, it is a medical procedure that is well researched, that is appropriate when people do not want to be pregnant anymore up to 20 weeks of gestation. And it's a human right because people have a right to access timeous, dignified healthcare. The right to health in the United Nations definition encompasses also social determinants of health. So the fact that someone wants an abortion in order for them to still continue with their education or, you know, go back into work and earn a living or play sport, or relocate, you know, people have rights to freedom, people have rights to occupation, and education. So abortion is a human right, because access to it enables and unlocks access to so many other human rights.

Mia Malan
There's lots of studies that show safe abortion saves lives, and it improves maternal health, can you break that down for us?

Tlaleng Mofokeng
So we have to think about abortions as being safe or unsafe, because abortions happen, even the ones that are spontaneous, that are naturally happening without being induced. And so I always like to start from that framing. Therefore, then, when you intervene and offer a safe abortion by a trained healthcare worker within a health facility, you are absolutely contributing to better outcomes in terms of maternal health, because when there is no access, people who are pregnant will find a way to have an abortion. And this is where unsafe abortion providers, the street pill sellers, people using social media, or people who are using health facilities that do not have adequate, you know, for example, the pills required for the abortion or the instruments required for the manual vacuum aspiration. Those abortions that are unsafe can lead to some complications, right, heavy bleeding, continuous bleeding, some infections, some perforations of the uterus. And what we are seeing is a safer abortion is good for the people who are pregnant, but a safer abortion is also good for the management of the budget and the health systems resources. Research has also shown that abortion is not just only safe, and one of the simplest procedures, but it's also cost effective. So rather than governments waiting to respond to complications of unsafe abortions, because they will happen, rather focus your efforts on increasing access to safe abortion, so people can get an abortion first time around, and be guaranteed that the quality of that abortion will be safe and complete.

Mia Malan
In South Africa, we have legal abortions. And we have worked to make it safe. But we still see so many of those things that you've mentioned now — ads on poles for illegal abortions. And we still see unsafe abortions. Why is that?

Dr Tlaleng Mofokeng
The right to health demands and places an obligation on states to have a national health plan and a policy that supports the plan and budgeting. What you have in South Africa is one part of that equation, you have a policy. It's good that it's there, because we know that the right to abortion is always contested. So the protection in law to have an abortion is very, very good. Where we are failing is that we are not training enough healthcare workers, and that lack of actual healthcare providers who are trained means that we have more demand than people who can assist. So no matter how well meaning you are, there will always be people who are unable to get access to abortion, because there are not

enough doctors and nurses who can provide it. So we need to focus on making sure that the undergraduate programme, the curriculum, covers as well the human rights aspects of abortion. Key principles, such as non-discrimination, equality, dignity, privacy, right, confidentiality, are very, very important for people who are seeking abortions. I proudly tell people that I'm an abortion provider, to try and deal with that issue of stigma, that I can be an abortion provider, I can be a UN special rapporteur, I can be all of these things, there's no contradiction in my principles or in my morals, or in what I stand for, just because I give and support people who need abortions. The other thing I think that the government should be doing is actually really seriously having specialised units that are going to deal with the people who are selling pills, on the streets, on social media. People who want abortions are desperate, and people take that vulnerability, and monetise it, and therefore take advantage of people. The other thing, which is really a health system issue, is that we need enough commodities. We need generic medications in South Africa. Right now, if you need to use the pill, that, you know, is the first step of medical abortion. It's an imported pill, it's very expensive, three pills costs close to 4 000 rands.

Mia Malan
So if you want a medical abortion in South Africa, do you need all three pills, in other words, just the pills will cost you 4 000 rands?

Tlaleng Mofokeng
So as a healthcare provider who runs a clinic, from my suppliers, that's how much I'm paying, so in order to do a successful abortion, you need a combination of pills. You need the first pill, which is the most expensive one, which stops the growth hormone. Then you follow with four pills, that will actually then itself start the bleeding process and the cramping and that people often will experience, right. If you then require a manual vacuum expiration, that only happens once the pills have been given. So everyone, regardless of whether you have a manual vacuum aspiration or not, the abortion starts with medical pills. That's why I'm a fierce advocate for changing the language around medical versus surgical. There's no surgical intervention per se right.

Mia Malan
Can you just explain what is the difference between a medical and a surgical abortion and when do you get which one.

Tlaleng Mofokeng
So a medical abortion is an abortion that is started and completed by the use of medication only, the pills. And research has shown that medical abortion, the pills-only regimen works in a pregnancy of less than 12 weeks. Beyond 12 weeks, you then have a higher risk that the product of conception may not all of them fully be evacuated from the uterus, just by the pills. And therefore we have this manual vacuum aspiration, which is basically a suction unit. It doesn't get plugged into the wall, it's just a manual suction unit that is then used to empty and literally just suck out and use the vacuum process to suck out whatever products are left in the uterus. And so that would be a surgical abortion. But it also starts with the pills, you have to make sure that the uterus is soft, that the, you know pregnancy hormones have been blocked by the hormones and that the bleeding, you know, can start and has started by using the other four medicines. The difference is that a surgical abortion can be done all the way up to 20 weeks, in South Africa up to 24 weeks with particular strict clauses and requirements that

people need to meet. And that you end the abortion with a manual vacuum aspiration, whereas a medical abortion, it starts and ends only with the pills being used.

Mia Malan
You've spoken a lot about stigma when it comes to abortions now and that you are a safe abortion provider and a proud one. So what do you tell people who say you're murdering babies?

Tlaleng Mofokeng
I don't have time to even answer that. Because I am a medical expert and I went to school. I did embryology at school, I studied gynaecology, and I studied bioethics. And I am an expert in human rights and the right to health. I rather focus on giving information to people who may require abortions, on how to know when you think you may be pregnant, how and where to go to confirm if you're pregnant, why it's important to seek help sooner rather than later. And what are the things you can expect. That kind of information and engagement I have all the time for but not the other stuff because it's arguments that have been used over and over again, it's exhausting. We have international human rights laws and standards. We have ethical standards in medicine, with world federations and world bodies of gynaecology who have for decades been explaining what these issues are. And even as a Catholic, I can tell you now that, you know, people used to have abortions using indigenous you know health methods up until the stage of quickening and quickening meant when you can feel the foetus starting to move. And that usually happens around the 24th week, right? So it's not coincidence that we are able to offer safe abortions up to the area of 24 weeks. So even these religious references it's like it makes no sense because even in those times, women were having abortions up to the point of quickening. We don't do abortions on pregnancies that are unwanted just because people were having one night stands. Many abortions are actually being done and requested by married couples, because life happens. People get retrenched. They have to relocate, they are stressed, they thought they wanted a pregnancy. And suddenly, when it happens, like actually, we can't do this, right. And even the stigma and this myth that abortions are just something that young, reckless girls do. It's incorrect. You know, in many clinics, when we look at our demographics, many of them are not young, reckless girls. They're professional women who have career aspirations and a pregnancy happened in a time where, you know, it was inconvenient for her and so contraceptives fail.

Mia Malan
When someone comes to you as a patient, and they're not sure they're pregnant, and they're not sure whether they want to keep their baby, how do you counsel them?

Tlaleng Mofokeng
So I prefer the word foetus, right? Because babies are born at term, and that's not my area. But what's important is first and foremost, to acknowledge what the person is saying to you. I think a lot of the times when people come to seek an abortion, something has happened, there's always a behind the story. And that's where I would often like to start, it's you know, what are the reasons that are making you feel so overwhelmed that you can't do this, because a lot of them will tell you that I'm just so overwhelmed. I'm just, so much is happening and to acknowledge that emotion, some come and just

say, I tested pregnant, and I want an abortion and they're very clear about it. And so you have to gauge your patient and meet them emotionally where they're at. Sometimes it's couples, and there's a lot of sadness about it, because perhaps they went through you know, their antenatal care and there are some severe, you know, malformations of the foetus and congenital, you know, malformations, which would be incompatible with life. And you know, their gynae would refer them to us, or some gynaes phone us for advice. And so it's a whole system approach, depending on what the needs are. Some patients would have gone for example, through intravenous fertilisation, right, IVF and they get pregnant, and then the relationship has broken down so much that they're in a process of divorce. That has happened, those are like real life stories, right. The other important thing is to go through what to expect. A lot of anxiety for people around abortion is is what they've read, or what they've seen on YouTube, or what they've been told. One of the first things they say is I want an abortion, but I'm so scared of the pain. And so it's to reassure them that we have a pain management protocol that we follow in the clinic. You know, this idea that women don't feel pain or the procedures that we do just feel like a bad period cramp like it's rubbish, you know, we need to change that. Often, you will get a patient who says, I want the abortion now, today, we can help that person. Some say thank you for the information, you've answered all their questions. And they say, we'll call you and they call and they make an appointment. Some phone and say, thank you so much for the information, we actually want to do antenatal care now, can you help us? We say fabulous come, we do that as well. I have a good relationship with another gynae. So when some of my patients are giving birth, and they have a caesarean, I go and assist in that caesarean, right when the babies are born, so it's not just about abortion, some patients choose antenatal care. And when it's time to give birth, often they will ask me to be there. And I come.

Mia Malan
For the past few years, you've been a special rapporteur for the right to health at the United Nations. What does that mean? And what is the most meaningful lesson you've learned during this time about the right to health?

What the work involves is monitoring the situation on the right to health and its realisation throughout the world, reporting to the United Nations Human Rights Council and General Assembly every year, conducting country visits to get firsthand exposure and analysis of a particular situation in a country officially. I can do consultations as well, I'm encouraged by the UN to do, you know, to do expert panels and academia. And the most exciting, I suppose, something that has happened in this time, is that through my work in human rights and international human rights law, I have been appointed a distinguished lecturer at Georgetown University.

Mia Malan
Lastly, what do you think is the biggest thing standing in our way to reach better health for everyone?

Tlaleng Mofokeng
What I think is the one thing that's holding us back, especially for the right to health, but realising true wellness is that we are very focused and governments are focused on health systems and health facilities, and not enough of an understanding of social determinants and corporate commercial

determinants of health. And what I mean by that is, for example, during COVID people have been told to wash their hands regularly for 20 seconds. Where I come from in QwaQwa, you don't even have safe drinking water to cook with and clean with and wash your clothes with. So when the message is wash your hands regularly for 20 seconds, with which water must that community wash their hands regularly for 20 seconds? And when we say we want young women in science, technology and engineering and mathematics, and we celebrate them at varsity when they graduate. Yet we are judging poor people for wanting a grant, for wanting social support. So how will that child who graduates and becomes a STEM graduate, and we talk about gender equality and parity in science, how will her brain mature and grow, if she's malnourished? So I feel that we are fixated on the outcomes, and we are not doing enough to get outcomes that are of quality. This is a very long answer, but ultimately, the short answer is we need governments who are going to resource in the long term successfully, programmes that deal with underlying determinants of health because we need those in order to get positive health outcomes.

OUTRO: That was Dr Tlaleng Mofokeng who's a United Nations special rapporteur on the right to health and also a practising medical doctor in South Africa. Tlaleng specialises in reproductive and sexual healthcare.

If you have feedback on this podcast, please email me on health@bhekisisa.org, I'd love to hear from you.

I'm Mia Malan, thanks for joining me. Until next time.

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