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Tackling Obstetric Violence in South Africa through Legal Reform: Exploring an Integrated Rights-Based Solution

by

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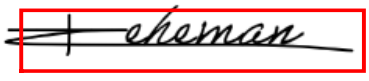
Signed: 

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ABSTRACT

Nearly 830 women die every day worldwide from preventable pregnancy-related causes.[1] Recent statistics have indicated that approximately 40 per cent of such deaths at South African health care facilities are linked to poor medical attendance and related complications which can be avoided.[2] The growing global attention toward the violence experienced by birthing women and girls during facility-based care has resulted in certain countries criminalising such disrespectful behaviour, termed 'obstetric violence.'

This dissertation aims to determine the public policy around this issue in South Africa by examining the current stance on the topic in both the legal and medical sectors. Specific focus is also given to ascertaining whether criminalisation through the enaction of legislation is a feasible option given the health care climate in the country and by reference to the success of approaches taken in other countries.

Looking at the problem through a legal and human rights lens, it is concluded that whilst obstetric violence should be recognised as a crime and a form of gender-based violence, the law alone cannot prevent its occurrence. Thus, a human rights-based approach is explored as a foundation for shaping the strategies and solutions, one of them being legal reform, necessary for the repression of obstetric violence in South African maternity wards.

[1] 'Maternal Health' available at: *https://www.figo.org/what-we-do/maternal-health*, accessed on 15 June 2020.
[2] S Mabena 'SA's maternal death ratio stats shock' (14 December 2019), available at: *https://citizen.co.za/news/south-africa/society/2049827/south-africas-maternal-death-ratio-stats-shock/*, accessed on 12 March 2019.

An Ode to Women

by Zakiyya Reheman

With a roaring cry I enter this world
A cry that is stifled by oppression, patriarchy, anarchical views
Knocked until I am shaped into a malleable, pliable, submissive being
Knock
Close your mouth, be seen and not heard
Knock
Women's places are in the home
Knock

I birth your progeny
Yet you still mock me.
I birth the future generation
Yet when I am in your care you disregard me.
My body births humans
Yet denying me my rights makes me wonder if there is any humanity left.

My babies will be born with roaring cries too
Cries that you will try to turn into whimpers
But you will not be able to staunch the flow of the revolution
We will rise up
We will be your equals
Hear us roar!

For all the women who have been told to grin and bear it a little longer
For all the women who have been told to know their place
Know that you are not lesser than and you never were
For those whose words, voices, concerns have been silenced
Let this be an ode to you
You are a woman, a revolution, and it is high time the world accepted that
Grin and bear no more.

ACKNOWLEDGEMENTS

My success in completing this dissertation is only possible through God's will.

Writing this dissertation felt like a production, now it is time to roll the credits. Brace yourself for many, albeit equally well-deserved, thank-yous.

To my Reheman and Mayet families, I am glad that I can be part of your tribe. Thank you does not begin to express the extent of my gratitude to each and every one of you for always having my back and pushing me to achieve my dreams. I could not have reached this goal without you being my pillars of strength. Fasiha, thank you for your epiphany that law was the correct career for me, although deep down we both knew you just wanted to be the Harvey Specter to my Mike Ross. Yumna, thank you for always wanting the best for me and passing on your love for books to me – Look, I can now string big words together! Mariam, thank you for ingraining the inspiring words of William Arthur Ward into my mind – I am dreaming it, I am achieving it.

My supervisors deserve a world of thanks for their expertise, encouragement and unwavering support. Never have I come across such selfless individuals who inspire you to be a better person. Thank you to the both of you for taking me on as your protégé and I hope that I have done you proud!

Dr Badul, I am grateful for the years over which I have gotten to know you and am glad that I can now call you my sister and mentor. Thanks for cheering me across the finish line! You truly were just a phone call away whenever I needed assistance and I will never be able to thank you enough for all that you have done for me.

Mr Ramdhin, you are proof that to some a job is not merely a job but a passion. Thank you for motivating me to seek the same passion in whatever I strive to achieve. As promised, I will remember you when I reach the Presidency.

To my friends-turned-sisters, Henna; Nadia; Radha; Sabeehah and Kashmita, I am blessed indeed to have you all in my life. May we continue to motivate each other as we reach and overcome the milestones and mountains that the world told us were insurmountable. Girl power! To MuHoo, thank you for being the Cristina Yang to my Meredith Grey. Thank you for being my voice of reason.

The women whose accounts of births have helped contribute to this research are brave indeed. May their voices never be silenced, and may their woeful accounts lend to a brighter future for mothers worldwide.

Oh, and to Mum, thanks for bringing me into existence; now let's make it count…

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List of Pertinent Abbreviations

CGE	Commission for Gender Equality
DoH	Department of Health
FIGO	International Federation of Gynecology and Obstetrics
HPCSA	Health Professions Council of South Africa
HRBA	Human Rights-Based Approach
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NCCEMD	National Committee for Confidential Enquiry into Maternal Deaths
NHA	National Health Act
OHSC	Office of Health Standards Compliance
RMC	Respectful Maternity Care
SALRC	South African Law Reform Commission
SGDs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
WRA	White Ribbon Alliance
UN	United Nations
UNTG	United Nations' Technical Guidance

List of Diagrams and Tables

CHAPTER 1

INTRODUCTION

'…. Of all the forms of inequality, injustice in health is the most shocking and inhuman.'[1]

- Martin Luther King

1.1. BACKGROUND AND OUTLINE OF THE RESEARCH PROBLEM

The joy, happiness and giggling babies of maternity ward imagery quickly gets replaced by scowling nurses, crying babies and frightened, neglected mothers when one steps into reality. Rather than being attended to by compassionate hospital personnel, expecting mothers are often greeted and mistreated by overworked, frustrated obstetric unit staff.[2] This behaviour by medical personnel under these circumstances paves the way for multifarious rights violations.

Research spanning over the last twenty years has documented that women in South African maternity wards have experienced physical and psychological abuse when accessing reproductive health services.[3] These patients have made comments such as, '*Yes, they're rude… they will shout at you, ugly remarks'*[4]*; 'I basically gave birth alone'*[5]*; '[T]hey forgot about me, they didn't even know I was there'*[6] and *'I was messing and she told me… 'Go and get a mop there and make your mess clean.*''[7]

Given similar accounts of mistreatment being experienced worldwide, there has been a growing international awareness of the need to recognise and categorise this form of abuse in maternity care units.[8] This has propelled some countries to take action and introduce legal

[1] Martin Luther King, speaking before the Second National Convention of the Medical Committee for Human Rights in Illinois on 25 March 1966. See: C Galarneau 'King's Words on Health Injustice: What did he actually say?' (19 April 2018), available at: *https://www.ijfab.org/blog/2018/04/kings-words-on-health-injustice-what-did-he-actually-say/*, accessed on 24 August 2019.
[2] L Kruger & C Schoombee 'The other side of caring: abuse in a South African maternity ward' (2010) 28(1) *Journal of Reproductive and Infant Psychology* 84; 95; Vogel et al. 'Promoting respect and preventing mistreatment during childbirth' (2015) *BJOG* 671, 672.
[3] Commission for Gender Equality *Obstetric Violence in South Africa: Violence against women in reproductive health & childbirth* (2019) at 1.
[4] Ibid 9.
[5] R Chadwick; D Cooper & J Harries 'Narratives of Distress about Birth in South Africa Public Maternal Settings: A Qualitative Study' (2014) 30(7) *Midwifery* 862, 865.
[6] Ibid.
[7] Ibid 864.
[8] RJ Chadwick 'Obstetric violence in South Africa' (2016) 106(5) *S Afr Med J* 423.

reform. Countries such as Mexico and Venezuela have gone so far as criminalising this type of mistreatment, termed obstetric violence.[9]

1.1.1. Identification of Obstetric Violence as a Rights Issue

Obstetric violence was a term first coined in Venezuela in 2007.[10] The behaviour it encompasses has been referred to in literature as 'mistreatment of women during childbirth', and it is sometimes also referred to as 'birth abuse' or even the more extreme term 'birth rape'.[11]

The recent inclusion of the word 'violence' in some definitions has been a point of controversy.[12] Nevertheless, this study argues that it is important to frame this issue as a form of 'violence' as firstly, this is a victim-centred approach. Secondly, legislatures are increasingly defining both physical and psychological abuse as violence.[13] Thirdly, the use of the word 'violence' denotes the growing seriousness with which countries are viewing this treatment of women in maternity wards.

South Africa's first recorded account of such abuse appears to date back to 1998.[14] South Africa has no specially designated law to deal with this type of abuse and the violent behaviour women experience during labour and childbirth. Currently, patients do have access to civil remedies when a breach of contract arises, or a delict is committed. The judiciary, thus, deals with these cases in terms of the South African common law when the conduct in question deviates from the reasonably required standard of patient care. This type of behaviour will either be classified as medical negligence or malpractice, depending on the type of fault present.[15] This will be discussed in Chapter Three.

Criminal law is currently invoked when the violence presents itself in the form of a common law crime. For example, culpable homicide when a birthing woman dies in theatre; or assault when a birthing woman is slapped by nurses.

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[9] Ibid.
[10] Ibid.
[11] Chadwick (note 8 above) 423.
[12] V Savage & A Castro 'Measuring mistreatment of women during childbirth: a review of terminology and methodological approaches' (2017) 14(138) *Reproductive Health* 1, 5.
[13] For example, the Domestic Violence Act 116 of 1998 recognises these types of abuse as a form of domestic violence in Section 1. Psychological, verbal and emotional abuse are defined as degrading or humiliating conduct in the definitions section of Act (*s* 1), which further states that physical abuse consists of 'any act or threatened act of physical violence.'
[14] R Jewkes; N Abrahams & Z Mvo 'Why do nurses abuse patients? Reflections from South African obstetric services' (1998) 47(11) *Soc Sci Med* 1781.
[15] See: LC Coetzee & P Carstens 'Medical Malpractice and Compensation in South Africa' (2011) 86(3*) Chicago-Kent Law Review* 1263, 1284.

Further, administrative law remedies provide an avenue for laying complaints against the respective health facility or addressing complaints to the relevant health professionals' body providing oversight. Nevertheless, it is argued that the current approaches are unsatisfactory and there has been a call for South Africa to tackle this *lacuna* through more specific legal mechanisms.[16] The current approach being used by South African courts will be discussed further in Chapter Three.

The need for law reform becomes clearer when taking a closer look at the treatment women receive in maternity wards.[17] The rationale for law reform is based on four arguments. First, South African law recognises that every person has the right to equality; dignity; life; freedom from cruel, inhuman or degrading punishment; bodily and psychological integrity; privacy; and access to health care.[18] However, these are nothing but words on paper when women are slapped by nurses; left unattended; are insulted; undergo unnecessary episiotomies and are even denied access to facilities without bookings.[19] Secondly, this is a significant human rights violation. These instances are just the tip of the iceberg regarding the forms that obstetric violence can take. Thirdly, the perpetuation of such behaviour by maternity ward staff without repercussions from senior managers creates fertile ground for the abuse of patients' human rights and it undermines the rule of law. Fourthly, Section 7 of the Constitution requires the state to 'respect, protect, promote and fulfil' the rights enshrined in the Bill of Rights. Thus, failure to act will result in South Africa lagging behind other countries in implementing its Bill of Rights in the context of childbirth.[20]

1.1.2 How Does Obstetric Violence Fit into the South African Human Rights Scheme?

An estimated 40 per cent of maternal deaths can be prevented as they are connected to 'community, administrative and clinical factors'.[21] Furthermore, approximately 59 per cent of maternal deaths which arise from direct causes, such as sepsis; haemorrhage and poorly

[16] C Pickles 'Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa' (2015) 54(1) *SA Crime Quarterly* 5, 13.
[17] See generally: C Pickles (note 16 above) 9; Jewkes, Abrahams & Mvo (note 14 above) 1785.
[18] Sections 9; 10; 11; 12; 14; 27 of the Constitution of the Republic of South Africa, Act 108 of 1996 respectively. Hereinafter referred to as 'the 1996 Constitution.'
[19] Jewkes, Abrahams & Mvo (note 14 above) 1785.
[20] C Pickles 'Sounding the alarm: *Government of the Republic of Namibia v LM* and Women's Rights during Childbirth in South Africa' (2018) 21 *PER* 1, 21.
[21] S Mabena 'SA's maternal death ratio stats shock' (14 December 2019), available at: *https://citizen.co.za/news/south-africa/society/2049827/south-africas-maternal-death-ratio-stats-shock/*, accessed on 12 March 2019.

skilled medical staff, can avoided by good quality clinical care.[22] Against this background it is indubitable that the behaviour envisaged by obstetric violence constitutes human rights violations in that it results in violations of the fundamental rights in the Bill of Rights and of South Africa's international human rights commitments.[23] This breaches the fundamental tenets of South Africa's Constitution including life; dignity (emotional and verbal abuse); equality (patrimonial and economic abuse); privacy (non-confidential care); bodily integrity (physical and sexual abuse), and most importantly reproductive health.[24] Furthermore, South Africa is a signatory to the International Covenant on Economic, Social and Cultural Rights, which provides that everyone, inclusive of women, are the holders of the right to the highest attainable standard of health.[25] By ratifying this Covenant, South Africa is bound by its principles.

1.2. RESEARCH PROBLEMS AND OBJECTIVES: KEY QUESTIONS TO BE ASKED

Research problem: The main problem is the high levels of violence experienced during childbirth and whether the absence of specially dedicated laws to combat this issue are needed.

The objective of this study is to explore the following sub-problems:

(i) What human rights are infringed by acts of obstetric violence?
(ii) What is a working definition for obstetric violence?
(iii) Is the criminalisation of obstetric violence the best way forward?
(iv) How can an HRBA be applied to maternal settings in South Africa?
(v) In the absence of South African obstetric violence case law, what can guide courts in responding to anticipated future litigation?

[22] Chadwick; Cooper & Harries (note 5 above) 862.
[23] See generally: Pickles (note 16 above) and Chadwick (note 8 above).
[24] See note 18 above. Section 27 of the Constitution, 1996 specifically provides that everyone has the right to have access to health care services, including reproductive health care and that no one may be refused emergency medical treatment.
[25] Article 12 of the International Covenant on Economic, Social and Cultural Rights (hereinafter referred to as the 'ICESCR').

1.3. PRELIMINARY LITERATURE STUDY AND REASONS FOR CHOOSING THE TOPIC

1.3.1. What is Obstetric Violence?

Many authors have dealt with the complexity of defining 'obstetric violence.'[26] Looking at the term itself, it can be loosely defined as referring to the mistreatment or abuse of women and girls by health care providers during childbirth.[27] The World Health Organization (WHO) has recognised that '[m]any women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities.'[28] The wide spectrum of behaviour that women undergoing obstetric care are subjected to by medical staff and that is usually recognised as obstetric violence includes, but is not limited to: physical abuse; sexual abuse; non-consensual examinations; non-dignified treatment such as verbal abuse, neglect; discrimination; inappropriate and unnecessary 'routine' procedures and non-consensual intrapartum sterilisations.[29]

Kukura has divided the above behaviour into three categories. First, *abuse* which can consist of forced surgeries; c-sections; physical restraints; and sexual abuse.[30] Secondly, *coercion* which can be played out through court-ordered procedures; withholding of treatment and manipulation.[31] Thirdly, *disrespect* which can take the form of insults; humiliating treatment and being ignored.[32] However, obstetric violence needs to be properly defined to better understand exactly what behaviour encroaches any laws that may be passed.

Currently, there is no standard globally-accepted definition that is used for obstetric violence. In the quest for an adequate definition, it is submitted that such a definition needs to adequately encapsulate the human rights of the affected women; their health and the legal, social and cultural dimensions of the phenomenon. This dissertation intends to explore the various definitions that have been formulated and suggest a definition that is conducive to South Africa's unique Constitutional democracy.

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[26] See generally: Freedman et al. 'Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda' (2014) 92(12) *Bulletin of the World Health Organisation* 915; Savage & Castro (note 12 above) 1.

[27] M Bohren et al. 'The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review' (2015) 12(6) *PLoS Med* 1.

[28] World Health Organization *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth* (2015) available at: *http://www.who.int/reproductivehealth/topics/maternal_perinatal/ statement-childbirth/en/*, accessed on 15 February 2019. Hereinafter referred to as 'WHO Statement'.

[29] Pickles (note 16 above) 7.

[30] E Kukura 'Obstetric Violence' (2018) 106(721) *Georgetown Law Journal* 721, 730.

[31] Ibid 738.

[32] Ibid 753.

First, the term obstetric violence itself needs to be unpacked. 'Obstetrics' refers to the medical care that women are given during their pregnancy, childbirth and immediate postpartum period.[33] This branch of medicine is specifically aimed at creating a safe, dignified environment for the welfare of expecting mothers and their babies.[34] Thus, when looking at the subject matter of this dissertation, it not only concerns the way women are treated during childbirth but also the periods before and after they give birth, whilst receiving facility-based care.

Authors also refer to how 'violence' in the South African criminal law context has been defined by McKendrick and Hoffman as 'the use of force to harm, injure, or abuse others.'[35] Exploring this definition further, 'force' is therefore 'a feature of violence, whether force denotes the use of strength or physical or mental power...'[36] Thus, when nurses or other medical staff in maternity ward settings use such force to negatively impact a patient's mental or physical state, it constitutes obstetric violence. Critics of the 'violence' nomenclature find that it denotes intention on the part of the health provider.[37] Thus, these critics prefer the 'mistreatment' terminology as they argue that it better encompasses the way these women are treated and removes the intention element.[38] However, the researcher agrees with criticism levelled against the 'mistreatment' typology as being too wide since it is inclusive of both intentional and unintentional conduct.[39]

Kukura argues that the inclusion of the word 'violence' can be problematic as it may create tensions in the patient-hospital relationship.[40] Further, she finds that using such a strong word as violence to refer to extreme cases such as non-consensual c-sections and to refer to minor insults alike, does not distinguish the severity of the abuse.[41] It is the researcher's submission that the law in this regard can take a similar approach as it does to other forms of legally intolerable acts, for example, sexual harassment which ranges from mild to extreme and the punishment is determined on a case-by-case basis. However, the researcher is in agreement with Kukura's warning that obstetric violence should be used only

[33] 'What is The Difference between Obstetrics and Gynecology?' (4 August 2016), available at: *https://www.virginiabeachobgyn.com/blog/what-is-the-difference-between-obstetrics-and-gynecology/*, accessed on 17 February 2019.
[34] Ibid.
[35] B McKendrick & W Hoffman (eds.) *People & Violence in South Africa* (1990) 3.
[36] Ibid 20.
[37] JP Vogel et al. (note 2 above) 672.
[38] Savage & Castro (note 12 above).
[39] Ibid; R Jewkes & L Penn-Kekana 'Mistreatment of women in childbirth: time for action on this important dimension of violence against women' (2015) 12(6) *PLoS Med.* 1.
[40] Kukura (note 30 above) 764.
[41] Ibid 765.

in appropriate cases and should be heeded, lest the law unknowingly brings about counter-productive consequences.[42]

Further, obstetric violence has been referred to by academics as the 'bullying and coercion of pregnant women during birth by health care personnel.'[43] When considering who the instigators of obstetric violence are, it is not merely limited to nurses. It is accepted that 'health care personnel' not only refers to obstetricians and nurses but also staff such as the administration staff; psychologists; and social workers at health care facilities.[44]

Venezuelan law defines obstetric violence as: '… the appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanising treatment, abusive medicalisation and pathologisation of natural processes, involving a woman's loss of autonomy and of the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life.'[45]

Dehumanised treatment and care entails 'cruel, dishonourable, dismissive, humiliating or threatening treatment provided by health personnel'[46] which causes physical or psychological harm. Over-medicalisation refers to the recent trend to perform unnecessary 'routine' procedures such as routine enemas, episiotomies and caesarean sections when they are not required. 'Pathologisation' refers to medicalisation. This occurs, for example, when women can give birth naturally but are forced to have c-sections; or when medical techniques are used to speed up the birthing process.[47]

Thus, from the above definitions, the far-reaching implications of obstetric violence on a woman can be seen. It is submitted that such behaviour inhibits a woman's status as an autonomous rights-bearing patient. Whilst the Venezuelan definition can encompass the variety of abuse that constitutes obstetric violence, it is submitted that the ramifications are too wide.

In line with the reasoning of Jewkes and Penn-Kekana, the researcher argues that a narrower definition is necessary in order to operationalise obstetric violence.[48] The definition

[42] Ibid.
[43] F Diaz-Tello 'Invisible wounds: obstetric violence in the United States' (2016) 24(47) *Reproductive Health Matters* 56.
[44] CH Vacaflor 'Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina' (2016) 24 *Reproductive Health Matters* 65, 67.
[45] Article 15(13) of the Organic Law on the Rights of Women to a Life Free of Violence, 2007.
[46] Vacaflor (note 44 above) 66.
[47] This is acknowledged in Article 51 of the Organic Law on the Rights of Women to a Life Free of Violence, 2007.
[48] Jewkes & Penn-Kekana (note 39 above) 2.

should be one that can be applied easily to the behaviour that it comprises of. Thus, it is submitted that obstetric violence, when applied in terms of the law, should be restricted to the intentional conduct of health care personnel.[49] By doing so, it restricts the broad obstetric claims that may arise from unintentional conduct. Pickles argues from a criminal law perspective that the definition should be adapted to fit into common law crimes of assault, murder; culpable homicide where applicable.[50] This will be explored further under Chapter Three.

Notably, Freedman et al. embarked on a project to define the disrespect and abuse that birthing people experience.[51] They built up a definition as a common starting point, aimed at being in line with human rights norms. Their three building blocks consisted of (i) the behaviour that is locally agreed upon as being abusive and disrespectful; (ii) subjective experiences of individuals and (iii) intentionality.[52] The researcher finds this approach to be the most appropriate going forward since it accounts for different situational views on abuse and provides for the intention element. Thus, this dissertation agrees that going forward obstetric violence should be defined as the 'interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified.'[53] This caters for South Africa's unique position of having the world's most progressive Constitution[54] and the recognition of seventeen listed grounds of discriminatory behaviour.[55]

Now that a good grasp of the subject matter of the dissertation has been obtained, it is necessary to look at why obstetric violence occurs and the recognised root causes. It is only once the infestation has been identified that a blight can be cured.

1.3.2. Identifying the Reasons Behind the Manifestation of Obstetric Violence

Numerous studies have taken place to ascertain what conditions allow disrespectful maternal health care to prevail.[56] These studies, however, will not form the main concern of this dissertation, as the focus will be on the solution rather than the cause. However, it is necessary to know the causes so that they may be eradicated through the solutions. Often a

[49] Pickles (note 16 above) 11.
[50] Ibid.
[51] Freedman et al. (note 26 above) 915.
[52] Ibid.
[53] Ibid.
[54] K Meshoe 'Praise for SA's Progressive Constitution' *Cape Times* 20 March 2017 at 9.
[55] Section 9 of the Constitution, 1996.
[56] See generally: Bohren et al. (note 27 above).

point of conflict is not entirely one-sided. Staff being overworked; lack of job satisfaction; inadequate staff support and supervision; hierarchical organisational structures creating low morale; unequal staff-patient power relations and lack of adequate hospital infrastructure have been identified as some of the key reasons for nurses abusing maternity patients.[57] The underlying causes will be further explored in Chapter Five.

Other external factors such as a country's population and Gross Domestic Profit (GDP) could influence the state of health systems and consequently the maternal mortality rate and pregnancy-related deaths.

Below is a table of relevant statistics of the countries that will be assessed in Chapter Four.

Table 1: Relevant Statistics of Selected Countries

Country	*Population* [58]	*GDP (in billions of US dollars)* [59]	*Country credit rating*[60]	*Fertility rate*	*MMR per 100 000 live births*[61]	*%GDP spent on healthc-are*[62]	*% of skilled assisted delivery (2015)*[63]
South Africa	59 308 690	369 854	Non-investment grade speculative	2.4	119	8.11	96
Venezuela	28 435 940	62 921	In default	2.3	125	3.22	98
Argentina	45 195 774	443 249	Substantial risks	2.3	39	7.55	98

[57] S Honikman; S Fawcus & I Meintjies 'Abuse in South African maternity settings is a disgrace: Potential solutions to the problem' (2015) 105 (4) *S Afr Med J* 284.
[58] All population statistics retrieved from: 'Countries in the world by population (2020)', available at: *https://www.worldometers.info/world-population/population-by-country/*, accessed on 21 March 2020.
[59] All GDP statistics retrieved from: 'List of Countries by Projected GDP', available at: *http://statisticstimes.com/economy/countries-by-projected-gdp.php*, accessed on 21 March 2020.
[60] 'Sovereigns Rating List', available at: *https://countryeconomy.com/ratings*, accessed on 21 March 2020.
[61] Maternal mortality rate as at 1 January 2019 retrieved from: 'Country comparison: Maternal mortality rate', available at: *https://www.indexmundi.com/g/r.aspx?v=2223*, accessed on 21 March 2020.
[62] 'Current health expenditure (% of GDP)' (2016), available at: *https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS*, accessed on 21 March 2020.
[63] 'Global Health Observatory Data' (2015), available at: *https://www.who.int/gho/countries/en/*, accessed on 21 March 2020.

Brazil	212 559 417	1 893 010	Non-investment grade speculative	1.7	60	11.77	99
Italy	60 461 826	2 013 670	Low-medium	1.3	2	8.94	100
India	1380 004 385	3 202 180	Low-medium	2.2	145	3.66	60
Nigeria	206 139 589	494 830	Highly speculative	5.4	917	3.65	45
Ghana	31 072 940	69 757	Highly speculative	3.9	308	4.45	68
Kenya	53 771 296	109 128	Highly speculative	3.5	342	4.55	53

From the above, it can be seen that whilst South Africa does have a high maternal mortality rate, it is not as high as other African countries. Furthermore, the percentage spent by the South African government on health care ranges on the higher end when compared to the other countries listed above. This then raises the alarm as to why the budget is not assisting with improved health care and consequently reducing maternal deaths. These concerns will be looked at later in this dissertation.

1.3.3. Consequences of the Continuation of Obstetric Violence and The Quest to Find a Legal Solution

Tackling the factors that provide stimuli for disrespectful obstetric care necessitates finding a feasible solution. Whilst the obvious solution would be for the medical field to enforce their code of professional ethics on health care workers who breach it; this has not been successful.[64] There has been a reluctance by managers and heads of hospitals to strictly

[64] Jewkes, Abrahams & Mvo (note 14 above) 1793.

enforce their codes of conduct as they are sympathetic to the poor working conditions of their employees and colleagues.[65]

Allowing violent and disrespectful care to persist has had a negative impact on the psyches of health workers. These staff members have developed an attitude of entitlement and no longer perceive their violent behaviour as being uncalled for but merely part and parcel of their job.[66] In fact, in interviews conducted by Jewkes *et al.*, a senior midwife opined that she did not think that there was any nurse working in the maternity ward who had not slapped a patient.[67] Assessing these behaviours and outlooks emphasises the need to find a solution to dismantling this misperceived mindset before it becomes too far ingrained to root out. If the above is not enough cause for concern, obstetric violence is already being described as 'ritualised; sanctioned; normalised and institutionalised.'[68]

South African academics such as Pickles, Chadwick and Jewkes have been at the forefront of the initiatives to gain momentum for a legal intervention for obstetric violence in the South African legal system. This dissertation draws from their activism and adds to their legal discourse surrounding this *lacuna* in South African law. Due to this gap in the law, it is necessary to brainstorm ideas from foreign countries that have taken positive measures in an attempt to overcome the problem plaguing their health care facilities.

Latin-American countries such as Mexico and Venezuela have made perpetrators of obstetric violence liable for a fine or subject to imprisonment. This drastic measure of criminalisation resonates with the idea put forward by Pickles, who suggests that obstetric violence can easily be slotted into the definition of murder; culpable homicide; crimen injuria; assault or assault with intent to commit grievous bodily harm depending on the gravity of the unethical behaviour by medical staff.[69]

It is submitted that whilst criminalisation may be the best solution, prima facie, the results in practice show otherwise. It is well and good to have legislation that clearly states that certain behaviour is unacceptable; but if it is not put into effect it is rendered useless. That is the curveball that these countries are facing, as there is little or no evidence of

[65] Ibid.
[66] Ibid 1790.
[67] Ibid.
[68] Kruger & Schoombee (note 2 above) 84.
[69] Pickles (note 16 above) 10.

implementation.[70] Thus, an evident gap has emerged in the adoption and effective implementation of the criminal laws in countries that have incorporated the crime of obstetric violence into their law.[71] Furthermore, critics of an approach that primarily uses criminal law to address obstetric violence question whether such a strategy will lead to defensive medicine.[72] To do so may lead to a tricky situation whereby claims against medical providers increase and pose a threat to private practice. Thus, there is a need to draw the line regarding liability for clinical negligence to prevent futile claims against health care facilities. Accountability will be further discussed in Chapter Two.

The downside to a purely criminal law response begs the question as to whether there is another legal avenue that can ensure deterrence as well as implementation. In response to this, the researcher suggests that an HRBA may be appropriate to addressing the problem.

When human rights are violated, the state as the protector of these rights needs to step in and remedy the infringements. A human rights approach looks at how accountability can be allocated. Fawcus suggests that adopting a rights-based approach can assist in fostering accountability for substandard and disrespectful provision of health services.[73] When the law becomes involved, laying the blame becomes a daunting exercise. Thus, institutional accountability of medical facilities needs to be weighed against individual accountability.

Furthermore, obstetric violence has been identified as part of the gender-based violence that women face; lending to the broader system of 'sexism and classism.'[74] Social norms contribute to the uneven power relations faced by vulnerable women in maternity settings and this lends to the broader abuse of women in general.[75] The World Health Organisation has recognised women who are more susceptible to experiencing obstetric violence, namely; adolescents; those who are unmarried; the indigent; indigenous women; immigrants and those women who are HIV-positive.[76] An HRBA is alive to the discrimination that women face in all facets of their lives and will be able to address the gendered side of the dilemma.

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[70] I Barbosa & R Reingold 'Rethinking Obstetric Violence: Is Criminalisation Really the Only Way Forward?' (04 November 2018), available at: *http://oneill.law.georgetown.edu/rethinking-obstetric-violence-is-criminalization-really-the-only-way-forward/*, accessed on 07 January 2019.
[71] Ibid.
[72] MS Sekhar & N Vyas 'Defensive Medicine: A Bane to Healthcare' (2013) 3(2) *Ann Med Health Sci Res.* 295.
[73] S Fawcus 'Respectful Maternity Care' (2016) 4 *Obstetrics & Gynaecology Forum* 32.
[74] Chadwick (note 8 above) 424.
[75] Savage & Castro (note 12 above) 6.
[76] World Health Organisation (note 28 above).

Although critics state that there is little evidence of implementation of obstetric violence laws in Latin-American countries, Mexico received 112 reports between 2009 and 2012 regarding such claims.[77] Further, the United States and India have shown an increase in such claims going to court.[78] Most of these cases centre on non-consensual caesarean sections. It is submitted that this trend shows evidence of the increased advocacy to protect women's rights leading to increased awareness of such rights. Thus, it is likely that the precedent that is being set will soon reach South African courts; and this dissertation examines some of these foreign cases and how they were dealt with in Chapter Four.

Therefore, this dissertation takes a closer look as to how the law can step in to prevent the continuance of such behaviour. Whilst the research question is multi-disciplinary, this dissertation focuses mainly on the best legal approach to dealing with the obstetric violence crater in South African law using human rights and criminal law. In order for change to be meaningful, it needs to take place at the individual, social and organisational levels; and this can be achieved by utilising an HRBA.

1.3.4. Reasons for and Importance of Investigating Obstetric Violence

The best way to show the importance of finding a solution to obstetric violence is to draw examples from real life case studies and statistics. Like a scene out of a horror movie, these women undergo inhumane abuse daily that one would think emanates from fiction.

An incident in Kenya broke headlines when a woman in the throes of labour was beaten by hospital staff and forced to deliver on a concrete floor.[79] This case seems extreme. However, only when reading available similar recounts of abuse does it become clear how frequently this happens. In August 2015 at the Rahima Moosa Hospital in Gauteng, South Africa, a woman prematurely gave birth with no assistance from nurses who merely insulted her and told her to wash herself afterwards.[80] As a result of the lack of assistance, the baby

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[77] 'Obstetric Violence' (2014), available at: *http://www.may28.org/obstetric-violence/*, accessed on 12 February 2019.

[78] The case of Kimberly Turbin made headlines in the United States when a doctor performed an episiotomy on Turbin without her consent. Turbin proceeded to sue her doctor for assault and battery. See: 'What is obstetric violence and what if it happens to you' (20 July 2018), available at: *https://www.lamaze.org/blog/what-is-obstetric-violence-and-what-can-you-do-about-it*, accessed on 07 March 2019. See generally for cases in India: *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others* (Delhi High Court, Writ Petition (Civil) 8853 of 2008); *Sandesh Bansal v Union of India & Others* (M.P. H.C., Write Petition (Civil) 9061 of 2008).

[79] 'Obstetric Violence' (2014), available at: *http://www.may28.org/obstetric-violence/*, accessed on 12 February 2019.

[80] M Lindaque 'Horror as woman loses baby while nurses look on at JHB hospital' (2015), available at: *https://ewn.co.za/2015/08/17/First-on-EWN-Horror-as-woman-loses-baby-while-nurses-look-on-at-JHB-hospital*, accessed on 09 March 2019.

died in the woman's arms. Looking closer at interviews held with patients from South African hospitals, the experiences of women in obstetric care becomes harrowing.

Women have spoken out about being slapped on their faces and buttocks; having their legs prised open when they are not ready to push; having sarcastically lewd comments hurled at them as well as being called demeaning words such as 'stupid', and having to clean up their own 'mess'.[81] The accounts from patients indicate that nurses use their authority to punish patients if they do not follow their instructions.[82] A woman relayed how she began pushing without being told to do so and the nurse ordered her to give birth herself.[83] Women have described being neglected and having their views of imminent birth brushed aside by uninterested maternity ward staff so that they end up giving birth on their own.[84]

During one of the interviews, a maternity ward patient at a private hospital mentioned: *'…the human factor is just completely missing… [they need to] remember they are working with a mum here… a person.*'[85] This opinion sums up the importance of this dissertation. The law can be used as a tool to create an eye-opener in the obstetrics field regarding women's rights that health care personnel committing these inhumane acts appear to have forgotten.

Whilst some may argue that these women only experience the hospital mistreatment for the short birthing period, Kukura highlights the long-term negative impact that obstetric violence has on these patients. Not only does the abuse affect women emotionally and psychologically but can also impact on the bond between the child and the mother.[86] Some mothers even display symptoms of post-traumatic stress disorder (PTSD) after a terrible birthing experience.[87] The increase in routine medical interventions during birth has been identified by researchers as leading to a 'cascade of secondary interventions' in order to remedy the effects of the original techniques.[88] Thus, the domino-effect of obstetric violence is extensive.

Furthermore, obstetric violence poses an impediment to women seeking facility-based health care services. The women would rather choose to avoid facility-based care than to go

[81] Jewkes, Abrahams & Mvo (note 14 above) 1786; Chadwick; Cooper & Harries (note 5 above) 864.
[82] Jewkes & Penn-Kekana (note 39 above) 1.
[83] M Hastings-Tolsma; AGW Nolte & A Temane 'Birth stories from South Africa: Voices Unheard' (2018) 31 *Women and Birth* 42; 44.
[84] Chadwick; Cooper & Harries (note 5 above) 865.
[85] Hastings-Tolsma; Nolte & Temane (note 83 above) 45.
[86] Kukura (note 30 above) 754.
[87] Ibid 756.
[88] Ibid.

to a hospital and receive harsh treatment.[89] This poses a barrier to the realisation of the Bill of Rights and South Africa's goal of transformation. The problem has exacerbated to such an extent that obstetric violence poses a greater barrier to access to health care than geographical and financial impediments.[90] Yamin points out that in some countries, the likelihood of a girl dying in childbirth due to not receiving emergency obstetric care is greater than her completing her primary school education.[91]

1.3.1.1. Study conducted in the Tshwane District of South Africa

In keeping with promoting respectful maternity care, research was conducted regarding the experiences of mothers at ten low-income midwife-led facilities in Tshwane, South Africa.[92] A survey (with 653 participants) and anonymous post-natal follow-up questionnaire method was used to assess the treatment of patients.[93] The researchers point out that although health practitioners are aware of the respectful maternity care movement, patient abuse still occurs.[94] This reflects the low impact clinical practice guidelines regarding care is having. Only 48 per cent of women who participated in the study found that they had been treated respectfully.[95] The study found that disrespectful maternal care occurred more frequently when mothers were between the ages of 17-24; were not educationally advanced; could not converse in the prominent district language and were not originally from that province or from South Africa.[96]

This study highlights the discriminatory features of obstetric violence. Language, age and nationality form a barrier to receiving quality hospital care. The South African Constitution explicitly provides that discrimination may not occur on any of the above grounds.[97] To flout the quality maternity care guidelines does not only breach ethical responsibilities but also the Bill of Rights.

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[89] Jewkes, Abrahams & Mvo (note 14 above) 1785.
[90] 'Obstetric Violence' (2014), available at: *http://www.may28.org/obstetric-violence/*, accessed on 12 February 2019.
[91] AE Yamin 'Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care' (2008) 10 *Health and Human Rights* 45.
[92] SJ Oosthuizen 'It does matter where you come from: mothers' experiences of childbirth in midwife obstetric units, Tshwane, South Africa' (2017) 14(151) *Reproductive Health* 1.
[93] Ibid.
[94] Ibid 2.
[95] Ibid 48.
[96] Ibid 9.
[97] Section 9 of the Constitution of the Republic of South Africa, 1996.

1.3.1.2. Study conducted at a KwaZulu-Natal public hospital

A study[98] undertaken by researchers in December 2015 focused on the experiences of midwives in a selected hospital in the KwaZulu-Natal province.[99] The nursing profession is expected to provide quality ethical care, without compromising patients' rights and confidentiality; the observation of which is overseen by the South African Nursing Council (SANC).[100] The SANC has found that complaints against maternity ward nurses have tripled from 1996 to 2016.[101]

The study found that nurses did not adhere to medical guidelines.[102] This non-adherence is referred to as practice breakdown as the ethical and professional medical guidelines and protocols are not complied with.[103] Staff morale was low, with nurses becoming disillusioned due to the belief that hospital management did not sympathise with their poor working conditions.[104] Due to the deviation from practice guidelines and negligent care, the South African Department of Health faces numerous litigation suits for health workers' unprofessional conduct.[105] It is submitted that clinical guidelines are not assisting to combat obstetric violence, hence, the law is already being used as a tool by aggrieved maternity ward patients in South Africa.

The authors of the study suggest that in order for substandard midwifery to be remedied, nurses should not have to deal with matters outside of their job description.[106] The negative 'I do not care' attitude of nurses together with facilities holding nurses accountable for their unprofessional or negligent conduct has resulted in the resignation of many midwives from their jobs.[107] This exacerbates the already overwhelming problem of overworked staffing units due to staff shortages.[108] This study highlights that a cog in the system, such as an antipathetic working environment, has the ability to affect the entire process and outcome of quality maternal health care.

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[98] NM Mhlongo, MN Sibiya & RM Miya 'Experiences of Midwives Regarding Nursing Practice Breakdown in Maternity Units at a Selected Public Hospital in KwaZulu-Natal' (2016) *Africa Journal of Nursing and Midwifery* 162-178.
[99] The hospital is located in the uThungulu Health District and specialises in obstetric care.
[100] Mhlongo, Sibiya & Miya (note 98 above) 168.
[101] Ibid 164.
[102] Ibid 162.
[103] Ibid 165.
[104] Ibid 172.
[105] Ibid 164.
[106] Ibid 175.
[107] Ibid 171.
[108] Ibid 171.

1.4. PRINCIPAL THEORIES UPON WHICH THE RESEARCH PROJECT IS CONSTRUCTED

Theoretical perspective: A Human Rights-Based Approach

> *'... too often, human rights are seen only as standards contained in treaties and declarations. However, human rights have concrete contributions to make in guiding policy formulation and implementation, and constructively addressing major global challenges.'*[109]

Every individual is the bearer of human rights. These rights are recognised as being fundamental; indivisible; inalienable; interrelated; interdependent and universal.[110] Women have historically been denied many of these rights on the basis of their sex and gender. Proponents of women's rights have advocated for the equal rights of women. Although some leaps have been made to advance women's rights, there are still certain areas that are lacking. Health, in this case maternal and reproductive health, is one such area.

Maternal health rights, emanating from core human rights, are found in international treaties and consensus documents.[111] Attentiveness is paid to maternal rights in the ICESCR which states that 'special protection should be accorded to mothers during a reasonable period before and after childbirth.'[112] The Convention on the Elimination of all Forms of Discrimination Against Women echoes this sentiment by providing that women should be granted equal access to health services, should receive 'appropriate services in connection with pregnancy, confinement and the post-natal period' and be given free medical attention where necessary.[113]

Attention has been brought to ghastly health care that women endure under birthing conditions. The springboard for action regarding improving maternal health was its identification as a Millennium Development Goal. Drawing global attention to this quandary,

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[109] UNOCHR 'Scenario and talking points for High Commissioner on Human Rights Event to Launch the Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies' (14 September 2012), available at: *https://newsarchive.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12559&LangID=E*, accessed on 12 March 2019.

[110] United Nations Population Fund 'Human Rights Principles' available at: *https://www.unfpa.org/resources/human-rights-principles*, accessed on 14 March 2019.

[111] Centre for Reproductive Rights *Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care* (2018) 10.

[112] Article 10(2) of the ICESCR.

[113] Article 12 of the Convention on the Elimination of all Forms of Discrimination Against Women (hereinafter 'CEDAW').

the World Health Organisation issued a statement[114] in 2015 to foster more research and interventions in the effort to eliminate obstetric violence.

The United Nations, a key body in addressing this issue, issued report A/HRC/21/22 (The UN Technical Guidance) in 2012 to assist with implementing better maternal care.[115] The approach taken provides a good guideline as to how an HRBA should be implemented in the health sector, in this case, obstetric violence. The UN Technical Guidance will form the main framework for adopting an HRBA in this dissertation. An HRBA is unique in that it not only suggests a solution but ensures it is viable in the long-term.

It is submitted that human rights can be used as a tool to drive women's advocacy regarding their sexual and reproductive health.[116] An HRBA to health does not view health as a commodity but rather claims relating to sexual and reproductive health, goods, services and information are viewed as rights.[117] Thus, this outlook asserts that obstetric violence is a matter of justice.[118]

First, the HRBA identifies the underlying conditions that cause the infringement of a right. A situational analysis assists with finding the causes so that they can be rooted out.[119] Thereafter, it identifies solutions and applies policies at all organisational levels that contribute to the attainment of that remedial action. After designing a system based on human rights principles, an HRBA does not abandon the fledgling project to flounder on its own. Rather, it plans ahead for the implementation, monitoring and evaluation of the design in relation to any problems that may arise. Thus, this enhances the sustainability of such measures and ensures effective outcomes by not only focusing on the end result but how to obtain that result.

From the Technical Guidance, it can be gleaned what the key elements of such a framework are. Although diverse human rights approaches have been adopted in various countries; there are four linchpins that filter through. These are: availability; accessibility;

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[114] World Health Organisation (note 28 above).
[115] United Nations 'Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality' (2 July 2012), available at: *https://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf,* accessed on 08 February 2019.
[116] AE Yamin 'From Ideals to Tools: Applying Human Rights to Maternal Health' (2013) 10(11) *PLOS Medicine* 1.
[117] Ibid 47.
[118] Yamin (note 91 above) 53.
[119] 'What value does a human rights-based approach add to development?', available at: *https://hrbaportal.org/faq/what-value-does-a-human-rights-based-approach-add-to-development*, accessed on 28 February 2019.

accountability and quality.[120] The government is responsible for ensuring that health care facilities are up to par; they are available; they must meet quality standards and the government must be accountable.

As previously mentioned, women are the right-holders of the right to the highest attainable standard of health.[121] Every right has a corresponding obligation. The state, in human rights terminology, is the 'duty-bearer' and is required to protect, implement and respect the rights of 'right-holders.'[122] This obligation is, thus, part of international human rights law.

An HRBA does not only provide a solution when violations occur; which a purely criminal law approach to obstetric violence would. Rather, an HRBA addresses how decisions are to be made at the various levels that have an impact on these women's lives.[123] This approach looks at how policies, institutions and resources can be mobilised to improve facility-based health care that birthing women and girls receive. To adopt this approach would require the working together of multiple sectors to devise a plan of action and allocate an adequate budget.

Due to the gender-related issues that obstetric violence dredges up, feminists have joined the obstetric violence fray regarding the connection to androcentrism, sexism, medical authoritarianism and power relations during facility-based childbirth.[124] Thus, obstetric violence is centred on the links between gender, race, ethnicity, knowledge, and class.[125] Some feminist schools view obstetricians as treating the body of females as a machine rather than a human being; the control of which lies in the hands of the obstetrician rather than the autonomous patient.[126] It is submitted that an HRBA to maternal health can be used to empower women, advocate non-discrimination and promote the equality of women; which will assist with the cause these feminists are fighting for.

One of the main aims of following an HRBA is to find solutions to tackling the uneven power relations that face women in all aspects of their lives.[127] To fulfil the definition of being healthy, women undergoing obstetric care need to be 'in a state of complete

[120] K Hawkins et al. *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* (2005) 10.
[121] Article 12 of the ICESCR.
[122] Hawkins et al. (note 120 above) 3.
[123] Yamin (note 116 above) 3.
[124] N Peterson *De Facto Feminism: An Analysis of the Respectful Movement in Hungary* (unpublished dissertation, Central European University, 2017) 17.
[125] Ibid.
[126] Ibid.
[127] HRBA Portal (note 91 above).

physical, mental and social well-being, and [this is] not merely the absence of disease or infirmity.'[128] The emphasis on 'social' wellbeing highlights the need for the absence of the unequal power relationship between medical staff and their patients.

An HRBA is cognizant of the chasms that exist in the communication and interaction between woman as rightsholders and health service providers as duty-bearers. Thus, rather than adding to the tenuous relationship, it seeks to reduce the disparities that exist which contribute to the hindrance of women's progressive rights.

Yamin proposes using an HRBA to change ideals into realistic goals and tools.[129] This approach can be 'operationalised' though promoting social accountability and judicial enforcement.[130] Through analysing obstetric violence from a human rights perspective, the 'capacity gaps in legislation, institutions, policies and voice'[131] can be identified. The HRBA is built on foundational human rights principles such as accountability; transparency; participation; empowerment; non-discrimination; equity and universality.[132] Thus, by applying this framework to obstetric violence, it targets the inequalities; discrimination and uneven power relations that obstruct development.

Diagram 1 above: Model of the HRBA

[128] Preamble to the *Constitution of the World Health Organisation* as adopted by the International Health Conference, (June 1946), available at: *http://whqlibdoc.who.int/hist/official_records/constitution.pdf*, accessed on 04 March 2019.
[129] Yamin (note 116 above).
[130] Ibid 2.
[131] 'How do human rights help with situation analysis?', available at: *https://hrbaportal.org/faq/how-do-human-rights-help-with-situation-analysis*, accessed on 28 February 2019.
[132] Centre for Reproductive Rights (note 111 above) 14.

Source: F Kayser 'The Human Rights-Based Approach in German Development Cooperation' (17 February 2012) available at: *https://slideplayer.com/slide/6819140/*, accessed on 04 March 2019.

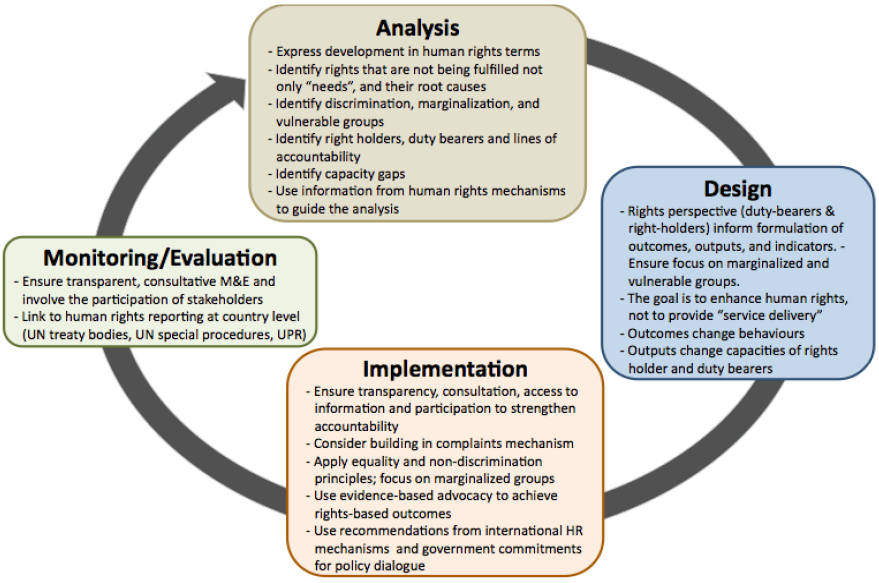

Diagram 2 above: HRBA in the Programming Cycle. This diagram shows exactly how the HRBA is put into effect.

Source: 'Human Rights-Based Approach' (23 September 2018), available at: *https://www.shareweb.ch/site/Conflict-and-Human-Rights/startpage-tools/human-rights-based-approach*, accessed on 04 March 2019.

1.5. RESEARCH METHODOLOGY

A doctrinal legal approach will be used to ascertain the current legal principles and concepts surrounding obstetric violence. The research paradigm for this study is library-based research derived from primary and secondary legal sources. However, these will not be taken at face value but will be critically analysed through inductive analytical research methods. Applied research rather than fundamental research best suits this research topic as it allows for the conjecture of possible solutions to the obstetric violence conundrum rather than merely adding to the existing body of law.

A comparative research approach is alive to the distinction between the law in action and the social reality of those that it affects. Drawing comparisons with other countries allows South Africa, the area in which this project is conducted, to learn from their experiences. This approach not only draws parallels between existing laws but also provides solutions to the research problem. In order for accurate comparisons to be made, countries

with similar socio-economic conditions to South Africa, such as Ghana, Nigeria and Kenya, will be utilised in finding these solutions.

The topic explores a multi-disciplinary area of law, necessitating a socio-legal research approach. This approach allows for the exploration of influences of gender and power relations on the law. To take a socio-legal approach rather than a purely theoretical approach allows for the current research to address the gap between what the legally accepted norms are and the gap in practice. Thus, rather than adopting a research methodology that merely assesses the situation on the basis of primary legal sources, the research will be alive to the dynamics of the law; the impact it has on the subject group and how it influences social behaviour.

Through a diagnostic study of available material, the researcher aims to find a legal solution to prevent the occurrence of obstetric violence. The current research aims to use the above methodologies to fill in the gap between what the law ought to be and the protection that the intended subject group ought to reap from the law. Inductive reasoning will be used to collate the results after critically appraising the data.

1.6. STRUCTURE OF THE DISSERTATION

Chapter One: Introduction

Chapter Two: Exploring the Applicability of a Human Rights-Based Approach to Resolving Obstetric Violence

Applying an HRBA to health has been a recent development.[133] The United Nations has suggested such an approach to improve maternal health, which the researcher suggests should be applied in South Africa. An HRBA will not only provide a solution at state level but all organisational levels. This chapter will explore in detail how to go about fulfilling each step of such an approach, namely; ensuring accessibility; accountability; availability and quality. This assures that duty-bearers play their role in making certain that right-holders receive dignified health care.

[133] A Smith-Estelle; L Ferguson & S Gruskin 'Applying Human Rights-Based Approaches to Public Health: Lessons Learned from Maternal, Newborn and Child Health Programs' (2015) *African Population Studies Special Edition* 1713.

*Chapter Three***:** Debates on Using the Criminal, Civil and Administrative Law to Address Obstetric Violence

Nulla poena sine lege… There is no crime without a law. This is a basic principle of South African law. However, despite obstetric violence not being declared a crime in its own right in South Africa, it can still be classified as one of the common law crimes depending on the case.[134] Each crime will be looked at in greater depth. Criticism will be levelled as to whether adopting a solely criminal response is the best strategy in the fight against obstetric violence.

Chapter Four: Exploring Global Interventions towards the Implementation of Legal Sanctions and Practical Solutions to Curb the Incidence of Obstetric Violence

This chapter will investigate what has been done in South Africa to address the mistreatment in maternity wards and the studies that have been conducted. A comparative analysis will be drawn between African countries with similar medical settings to South Africa such as Ghana, Namibia and Kenya. Foreign countries, especially those in Latin-America, that have made significant strides in embodying obstetric violence in their statutes will also be closely scrutinised on their advancements. International mobilisation toward improving maternal health care will pave the way for South Africa's legal development.

Since the *Government of the Republic of Namibia v LM* [135] case, it is anticipated that similar cases may filter through to South African courts. Should South Africa incorporate obstetric violence into its law, it can use previous cases as a guideline to deal with the new terrain of obstetric violence. This chapter will look at some of these cases and the lessons that can be taken away for future reference.

Chapter Five: Outlining the Way Forward for the Practical Application of an HRBA to Address Obstetric Violence ― An Integrated Rights-Based Solution

This chapter addresses the application of an HRBA to obstetric violence. Interventions at various levels are necessary to address this form of gender-based violence, which is looked at in greater detail.

Chapter Six: Conclusion

An integration of the criminal law together with human rights law ensures the feasibility of a long-term solution to obstetric violence in South Africa.

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[134] Pickles (note 16 above) 10.
[135] [2014] NASC 19.

1.7. LIMITATIONS

This study is limited by the fact that the researcher will not be able to consider literature and cases on the topic of obstetric violence that are not available in English due to the language barrier. However, many of these articles and cases have been considered in studies written in English and these will form part of this contribution.

Given the vast amount of content available on the research topic, the researcher will limit the research to pertinent legal issues that arise out of obstetric violence, rather than being waylaid by medical technicalities. Notably, the law is limited in the approach it can take to the obstetric violence problem and should be looked at practically. Thus, although the dissertation is law-based, regard must be had to supporting mechanisms from institutions apart from the legislature.

Due to the reliable empirical research that has already been conducted and time constraints, the researcher will not undertake new primary empirical research on the topic.

Although obstetric violence is prevalent in both public and private medical facilities, the research will focus on public health care facilities since more research has been conducted at such institutions. The researcher is aware of the occurrence of obstetric violence through traditional practices and by traditional healers, however, the research will be limited to facility-based care.

1.8. CONCLUSION

This dissertation aims to counter the growing violence against women in South African maternity wards by drawing policymakers' attention to the reality of disrespectful care which patients are being subjected to. Finding a legal solution to the problem becomes a priority when there is a flagrant disrespect of human rights occurring. The dissertation explores the possible legal avenues ─ an important option being criminalisation ─ that can be taken to place obstetric violence within the South African legal framework. The ultimate finding and solution will suggest the best way to improve women's experiences in this area of maternal health in order to safeguard their rights.

CHAPTER 2

EXPLORING THE POSSIBILITY OF ADOPTING A HUMAN RIGHTS-BASED APPROACH TO ADDRESSING OBSTETRIC VIOLENCE

'*Year after crippling year.*

Where should be laughter,

We witness slaughter!

Where fruitful toil and health –

Decay, despair and death!'[1]

2.1. INTRODUCTION

The foundational aspects of a Human Rights-Based Approach ('HRBA'), framed within the maternal health context, will be set out in this Chapter. This approach is used as it rests on acknowledging that human rights are infringed when obstetric violence occurs.

2.2. WHAT ARE HUMAN RIGHTS?

Human rights are those fundamental entitlements that ascribe to every person from birth merely by being born human.[2] These rights have been embodied in international human rights instruments. The ratification and accession of human rights through agreements amongst states and the codification of human rights within national legislation creates legal rights that can be claimed by citizens.[3]

These rights are universal as they apply to everyone in equal measure irrespective of status or creed.[4] Further, they are inalienable as they are non-transferrable, interdependent as they are not mutually exclusive, and indivisible.[5] Notably, it is submitted that when addressing the right to health in the context of obstetric violence, it should not be boxed into the category of second-generation rights. Rather, due to rights being interdependent and indivisible it is necessary to note that the right to access health care is also affected by certain

[1] HIE Dhlomo *Malaria* (2002) 1.
[2] A Dhai & DJ McQuoid-Mason *Bioethics, Human Rights and Health Law: Principles and Practice* (2010) 36.
[3] Ibid.
[4] Dhai & McQuoid-Mason (note 2 above) 37.
[5] Ibid.

civil and political rights, for example, non-discrimination, living in an open and democratic society and having transparent and accountable governance. [6]

2.2.1. Relevant Human Rights Treaties and Instruments in the Context of Maternal Health Rights

The main instruments embodying human rights are the Universal Declaration of Human Rights in addition to the two international covenants[7] which together are dubbed the International Bill of Rights.[8] South Africa has signed and ratified these treaties.

Furthermore, the Vienna Conference on Human Rights, held in 1993, was pivotal in placing women's rights on the international law agenda, which is seen in the direction of state goals in the years that follow.[9] CEDAW, for example, has been described as 'the international bill of rights for women.'[10] The provision for reproductive health rights in Article 12 of this treaty has been used to advocate for non-discriminatory access to maternal health care. The CEDAW Committee, in General Comment No. 30, draws on states' duties to respect, protect, promote and fulfil human rights by calling on states to hold perpetrators that are non-state actors responsible for crimes against women.[11]

Further, the Charter on the Universal Rights of Childbearing Women is an important document that legitimatises the link between maternal health to the broader theme of human rights. This Charter navigates grounds on which human rights can be implicated in the childbearing process and affirms the status of childbearing women as holders of these fundamental, inalienable rights. Although this document is not binding, it is a turning point for maternal health rights as it is the first document that provides guidelines as to how human rights are implicated in the childbearing process.[12] The rights outlined in the Charter are based on rights contained in international treaties.[13] Thus, by aligning the right to dignified maternal care with international human rights goals, it illustrates the legit entitlement of

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[6] AE Yamin 'Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care' (2008) 10 *Health and Human Rights* 45, 48.
[7] The ICCPR and the ICESCR are the two international Covenants referred to.
[8] Dhai & McQuoid-Mason (note 2 above) 37.
[9] AE Yamin 'From Ideals to Tools: Applying Human Rights to Maternal Health' (2013) 10(11) *Plos Medicine* 1.
[10] JT Dunn, K Lesyna & A Zaret 'The role of human rights litigation in improving access to reproductive health care and achieving reductions in maternal mortality' (2017) 17(Suppl 2):367 *BMC Pregnancy and Childbirth* 71, 73.
[11] Centre for Reproductive Rights 'Factsheet: Sexual and Reproductive Health and Rights in Conflict' (2017), available at:*https://reproductiverights.org/sites/default/files/documents/GLP_GA_SRHR_FS_0817_ Final_Web.pdf,* accessed on 14 August 2019.
[12] T Windau-Melmer *A Guide for Advocating for Respectful Maternity Care* (2013) 5.
[13] Ibid.

women to such humane treatment. Accordingly, it is submitted that this Charter can also be used as the basis for a rights-based approach to maternal health.

2.3. HEALTH AND HUMAN RIGHTS

The right to access health care has been recognised as a human right and has informed South African health policy since 1994.[14] The right to health is linked to a person's physical and mental wellbeing.[15] This right is necessary for the realisation of other fundamental rights, such as the right to an adequate standard of living.[16] The importance of the right to access health care is to be emphasised, as not being in prime health limits one's ability to develop.

Human rights become important in the medical sector when patient rights are implicated or have the potential of being infringed, especially when the resultant consequences affect the broader public health system.

A thread of principles relating to health can be found in the International Bill of Rights, the African Charter of Human and People's Rights, the South African Bill of Rights and the South African Patient Charter. These principles include autonomy (respecting a patient's decisions), beneficence (promoting the well-being of others), non-maleficence (doing as little to no harm as possible) and justice.[17] A principal duty that emerges is the obligation of the health provider to ensure the patient's best interests are met, without causing the patient any harm.[18] This is echoed in the pledge medical practitioners take when being admitted to their field.[19]

As previously stated in Chapter One, South Africa's Constitution acknowledges the universal access to health care in Section 27. This Section provides for the progressive realisation of the right to health care and that no one can be turned away in cases of emergency medical situations.[20] Section 7(2) of the Constitution forms the basis for holding the state accountable for failing to 'respect, protect, promote and fulfil' their obligations in terms of maternal and reproductive health rights. Section 239 of the Constitution defines an 'organ of state' as comprising of the national, provincial and local spheres of government.

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[14] Ibid 18.
[15] South African Human Rights Commission *4th Economic and Social Rights Report: Right to Health – Period: April 2000 - March 2002* (2002) 95.
[16] Ibid 95.
[17] Dhai & McQuoid-Mason (note 2 above) 14.
[18] Ibid 15.
[19] Ibid 16.
[20] Section 27(3) of the Constitution, 1996.

The inclusion of the right to health in the Constitution, however, does not mean that it cannot be limited as the realisation of the right is dependent on the state's budgetary allocation.[21] This has led to court cases to determine whether the state is fulfilling its duties in the area of health rights by taking 'reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.'[22]

In terms of the interpretation of socio-economic rights before South African courts, the *Grootboom*[23] case interpreted 'reasonable measures' as not meeting the criteria for reasonableness when the needs of vulnerable sectors of society are not met.[24] Furthermore, the Constitutional Court found that unreasonable strategies for implementation would be contrary to the state's obligations in terms of s 7(2) of the Constitution.[25] The Court stated that 'a reasonable government programme should 'clearly allocate responsibilities and tasks to different spheres of government and ensure that the appropriate financial and human resources are available.''[26] However, the limitation of the right to access health care due to lack of resources was found to be acceptable in the *Soobramoney*[27] case. From these two cases it can be seen that each case is determined on its own facts. The components of a reasonable government programme as per *Grootboom* should be borne in mind when devising a plan to combat obstetric violence.

2.3.1. The Importance of the Link Between Health and Human Rights

Childbearing women are entitled to respectful maternal health care.[28] This outlook is given credibility by the UN Human Rights Council linking health to human rights regarding maternal health.[29] The Council has drawn the spotlight to important aspects of this topic such as 'voice, gender equality, and accountability.'[30] During their facility-based care, women need to be safeguarded from being marginalised or being rendered vulnerable due to their

[21] A Hassim, M Heywood & J Berger *Health and Democracy: a guide to human rights, health law and policy in post-apartheid South Africa* (2007) 10, 18.
[22] Section 27(2) of the Constitution, 1996.
[23] *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC).
[24] South African Human Rights Commission (note 15 above) 96.
[25] *Grootboom* supra (note 23 above) 42.
[26] *Grootboom* supra (note 23 above) 39.
[27] *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).
[28] White Ribbon Alliance *Respectful Maternity Care Charter: The Universal Rights of Childbearing Women* (2011).
[29] AE Yamin 'Applying human rights to maternal health: UN Technical Guidance on rights-based approaches' (2013) 121 *International Journal of Gynecology and Obstetrics* 190.
[30] Ibid.

status; such as being of a minority group, being mentally ill, being HIV-positive or being a teenage pregnancy statistic.[31]

Looking closer at the right to health, the Committee on Economic Social and Cultural Rights in General Comment No. 14 has enunciated what the normative content of the right to health through access of health facilities, goods and services should be.[32] This includes, amongst others:

> '*The creation of conditions which would assure to all medical service and medical attention in the event of sickness…both physical and mental, includes the provision of equal and timely access to basic preventative, curative, rehabilitative health services, and health education.*'[33]

The Committee goes on to state that the right to health encompasses equal access to non-discriminatory health care; health facilities; goods and services.[34] Further, these products and institutions need to be sufficiently available; accessible to everyone despite physical and financial barriers; be acceptable by ethical and cultural standards and be of a quality that meets medically approved standards.[35]

The maternal health rights provided for in the ICESCR gain more credence through the Limburg Principles on the Implementation of the ICESCR.[36] This document explains that whilst states must progressively realise the rights contained in the ICESCR, they must immediately take steps to implement them.[37] This reflects the need for states to deal with the right to health as a matter of immediate concern, with other measures being taken as soon as possible, rather than placing it on the backburner due to lack of resources.

The ICCPR, markedly, does not specifically provide for the right to health.[38] However, the right to life has been the basis on which human rights litigators have argued

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[31] Department of Health *Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and beyond* (2011) 6.
[32] UN Committee on Economic, Social and Cultural Rights (CESCR) *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)* (2000) UN Document E/C.12/2000/4 available at: *https://www.refworld.org/docid/4538838d0.html*, accessed 15 November 2019.
[33] Ibid par 17.
[34] K Moyo 'Realising the right to health in South Africa' in *Socio-Economic Rights –progressive realisation?* (2016) 9.
[35] Moyo (note 34 above) 9.
[36] See: The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (1987) 9 *HUM. RTS. Q.* 122.
[37] Ibid.
[38] Dunn, Lesyna & Zaret (note 10 above) 74.

that if interpreted broadly, this right includes the right to 'maternal health.'[39] This argument is based on the fact that a woman's right to life is linked to her right to dignity, equality and non-discrimination, privacy and freedom from torture.[40]

Sen has argued that health is shown as being of 'special importance' and affected by social influence when it is phrased as an issue of human rights.[41] The nexus between health and human rights becomes important in transforming the quality of maternal health and facility-based care. Consequently, utilising a human rights framework assists in the promotion and protection of public health.[42]

2.4. HOW DOES OBSTETRIC VIOLENCE AFFECT HUMAN RIGHTS?

Respectful maternal care is deemed to be a universal human right that every childbearing woman is entitled to globally.[43] This right focuses on the interactions between birthing women and health workers to ensure a safe, dignified birthing experience for women.

Obstetric violence, drawing on international and national obligations, necessitates that the state has a four-fold duty to 'respect, protect, promote and fulfil'[44] the implicated civil rights of pregnant women, such as the right to dignity; and their socio-economic rights, such as the right to access health care.

The duty to *respect* entails citizens' rights not being directly interfered with by the state through the denial or limitation of access to health care to any woman.[45] This duty relates to services being non-discriminatory.[46] Protection herein extends to ensuring equal access to health care facilities and medicines and to make certain that they are available, acceptable and of a good quality.[47] Protecting citizens from having their rights interfered with by others is also an obligation of the state.[48] Private health systems should also not pose a barrier to accessing health care services.[49] The duty to *promote* places an obligation on the state to encourage research; support advocates of women's rights and to provide women with

[39] Ibid.
[40] Ibid.
[41] Yamin (note 6 above) 46.
[42] Ibid 36.
[43] Windau-Melmer (note 12 above) 1.
[44] Section 7(2) of the Constitution, 1996.
[45]South African Human Rights Commission (note 15 above) 96.
[46] Ibid.
[47] South African Human Rights Commission (note 15 above) 96.
[48] Ibid.
[49] Ibid.

necessary health-related information that empowers them to claim their rights.[50] The obligation to *fulfil* women's health care rights places a duty on the state to use legislative and other mechanisms to address health rights.[51] The duty to fulfil, thus, encompasses the state's obligation to carry out the necessary actions to realise a right.[52]

The state is further required to remove the social barriers that result in discrimination, such as through religion, race and culture.[53] Special attention should be given to those obstacles that impact upon the information and services pregnant women receive at health facilities and the allocation of health resources to women.[54]

When obstetric violence occurs, the following human rights can potentially be affected, namely, equality and non-discrimination; dignity; freedom and security of person; access to health care services; information; redress; privacy; participation; and freedom from torture and cruel, inhuman, or degrading treatment. These rights are also echoed in the Respectful Maternity Care Charter and are broken down hereunder.

Table 2: Rights Threatened by Obstetric Violence Occurrence

Right	*Provision in Constitution, 1996*	*Content of Right*
Equality and non-discrimination	Section 9	Everyone is equal before the law and has equal protection and benefit of the law. This applies to the enjoyment of all rights and freedoms.
Dignity	Section 10	A person's intrinsic worth depends on their dignity. If a person is stripped of their dignity, their worth diminishes. Dignity is linked to having access to quality health care services.[55]

[50] Ibid 96.
[51] Ibid 96.
[52] Ibid 96.
[53] A Yamin & D Maine 'Maternal Mortality as Human Rights Maternal Issue' (1999) 21(3) *Human Rights Quarterly* 583.
[54] Ibid.
[55] Hassim, Heywood & Berger (note 21 above) 18.

Freedom and security of person	Section 12	This acknowledges that each individual has the right to bodily and psychological integrity, security and control over one's body, as well as freedom to make reproductive health decisions.
Access to health care services	Section 27	This right includes access to reproductive health services, including emergency obstetric care.
Information	No constitutional provision. However, the National Patients' Rights Charter provides for informed consent being necessary after the patient has been made aware of diagnosis, treatment options and costs.[56]	Reproductive health care is dependent on informed decision-making on the part of the birthing woman.
Redress	No constitutional provision. However, the National Patients' Rights Charter provides that 'everyone has the right to complain about the health care and to have such complaints investigated and receive a full response on such investigation.'[57]	This right is available to individuals who are not being treated as worthy of respect.[58] Remedies need to be available to victims of obstetric violence.
Privacy	Section 14	The personal information imparted to health facilities should not be communicated to any third party without the patient's consent or only

[56] South African Department of Health *National Patients' Rights Charter* (2007) available at: *http://www.justice.gov.za/VC/docs/policy/Patient%20Rights%20Charter.pdf*, accessed on 15 November 2019.
[57] Ibid.
[58] A Yeatman 'The Right of Redress' (1990) 9(3) *Australian Journal on Ageing* 27.

		when allowed by the law.
Participation	No constitutional provision. However, the National Patients Rights' Charter provides that 'everyone has the right to participate in decision-making on matters affecting one's health.'[59]	Patient autonomy and input is important in making decisions regarding the patient's state of health and proposed treatment. [60]
Freedom from torture and cruel, inhuman, or degrading treatment	Section 12	Birthing women's freedom from this type of negative treatment may be subverted by health professionals' treatment of their patients during the prenatal, childbirth and postnatal periods.[61] For example, denying women access to treatment during pregnancy, thereby resulting in her emotional distress may possibly amount to inhuman and degrading treatment. This classification of treatment that negatively impacts on a birthing woman, physically or mentally, has been accepted by the UN Special Rapporteur on Torture in 2013.[62]

It is submitted that by virtue of the above rights being acknowledged on an international platform in terms of the UDHR, ICCPR, ICESCR and CEDAW, a solid

[59] South African Department of Health *National Patients' Rights Charter* (2007) available at: *http://www.justice.gov.za/VC/docs/policy/Patient%20Rights%20Charter.pdf*, accessed on 15 November 2019.
[60] R Khosla et al. 'International Human Rights and the Mistreatment of Women During Childbirth' (2016) 18(2) *Health and Human Rights Journal* 131, 136.
[61] Ibid 134.
[62] Ibid134.

foundation is provided on which to frame the obstetric violence dilemma as a human rights violation and spur the global drive to address this type of violence.

2.4.1. Contextualising Obstetric Violence Within the Scheme of Sexual and Reproductive Health Rights

During the 1990s the death of women in childbirth was linked to governmental incompetency.[63] The South African state, as a duty-bearer, at that time as well as currently, had clear obligations under its Constitution and international law to safeguard against the infringement of women's rights, especially reproductive health rights.

The Millennium Declaration was adopted by 189 member states of the United Nations in 2000, South Africa being one of them.[64] Consequently, the Millennium Development Goals ('MDGs') were created to put the Declaration into action.[65] The MDGs are regarded as soft law mechanisms.[66] MDG 5 targeted improving maternal health.[67] Despite the MDGs addressing maternal mortality and morbidity, the Declaration failed to address sexual and reproductive health rights ('SRHR') specifically.[68] Obstetric violence straddles both of these categories of rights. Thus, Yamin has said that human rights frameworks centring on maternal health have become the 'Trojan horse' through which SRHR can be snuck in.[69]

Sexual and reproductive rights allow citizens to embrace and make autonomous decisions regarding their sexuality and reproductive choices without being subjected to violence, non-consensual procedures and discrimination.[70] These rights translate into healthy women being in state of physical, emotional, social and mental well-being when it comes to their sexual and reproductive health.[71]

Reproductive health rights allow a woman to determine how often, when and if she will procreate.[72] These rights also give woman a choice to prevent a pregnancy through safe contraceptives or to have an abortion in the case of an unwanted pregnancy.[73] These rights

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[63] Yamin (note 9 above) 1.
[64] AE Yamin & VM Boulanger (2013) 'Embedding sexual and reproductive health and rights in a transformational development framework: lessons learned from the MDG targets and indicators' (2013) 21(42) *Reproductive Health Matters* 74.
[65] Ibid.
[66] Moyo (note 34 above) 8.
[67] AE Yamin 'Toward Transformative Accountability: Applying a Rights-Based Approach to Fulfil Maternal Health Obligations' (2010) 7(12) *SUR - International Journal on Human Rights* 95.
[68] Yamin & Boulanger (note 64 above) 74.
[69] Yamin (note 9 above) 2.
[70] Ibid.
[71] Ibid 2.
[72] Ibid 3.
[73] Ibid 3.

are protected in the Sterilisation Act[74] and Choice on Termination of Pregnancy Act.[75] For the purposes of this dissertation, the right of pregnant women to safe, quality clinical care is the focal right. The environment must not only be amenable for the birthing woman but also for the delivery of a safe, healthy baby.

Health providers' understanding of SRHR has been criticised as being too narrow and not embracing diverse sexualities and marginalised groups.[76] These rights are not limited to women's reproductive and maternal rights but also their protection from the stigmas and discrimination that pregnancy brings to members having statuses or ascribing to a particular group that is socially frowned upon. Thus, Pickles brings in this criticism when she looks at how obstetric violence laws can come to the aid of not only women, but also girls and those who identify as intersex or transgender.[77] Given this, she speaks of 'birthing people' rather than 'birthing women.'[78] The researcher is in agreement with this critique. If obstetric violence has occurred, the law should come to the aid of the person who has been victimised, irrespective of gender identification and expression. Therefore, although the researcher utilises the term 'birthing women' in this project, it is not intended to exclude the above-mentioned categories of people from within its ambit.

2.5. THE UNITED NATIONS' TECHNICAL GUIDANCE ON THE APPLICATION OF A HUMAN RIGHTS-BASED APPROACH TO THE IMPLEMENTATION OF POLICIES AND PROGRAMMES TO REDUCE PREVENTABLE MATERNAL MORBIDITY AND MORTALITY[79]

Women's health rights in the context of preventing maternal mortality and morbidity were given priority by the UN Human Rights Council which acknowledged that such occurrences are violations of human rights.[80] This resulted in states accepting their obligation to strengthen their strategies to address these public health concerns and filter their budgetary

[74] Act 44 of 1998.
[75] Act 92 of 1996.
[76] C Pickles 'Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa' (2015) 54(1) *SA Crime Quarterly* 5,11.
[77] Ibid.
[78] C Pickles 'Reflections on obstetric violence and the law: What remains to be done for women's rights in childbirth?' (08 March 2017), *Oxford Faculty of Law* available at *https://www.law.ox.ac.uk/research-and-subject-groups/international-womens-day/blog/2017/03/reflections-obstetric-violence-and*, accessed on 20 February 2019.
[79] UN Human Rights Council *Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality* (2012) UN Doc. A/HRC/21/22.
[80] D Shaw & RJ Cook 'Applying human rights to improve access to reproductive health services' (2012) 119 *International Journal of Gynecology and Obstetrics* S55, S56.

funds and resources to the public health system.[81] This culminated in the United Nations' Technical Guidance being adopted in 2012 by the UN Human Rights Council to address maternal mortality and morbidity.[82] It has been used as an innovative guide to improve women's health and as the driving force for engineering the enjoyment of such rights.

This document provides guidelines on utilising human rights at each stage of implementing policies and programmes to address maternal mortality and morbidity.[83] Whilst the Technical Guidance is directed at addressing maternal mortality and morbidity, it looks at the subject-matter within the broader framework of SRHR.[84] It does so by adopting an HRBA that is alive to the social determinants[85] of women's health; and which shapes the multisectoral planning and budgeting stages going forward. The researcher asserts that the occurrence of obstetric violence contributes to the maternal mortality and morbidity rate in South Africa when birthing women lose their lives or have negative birthing outcomes. Thus, it is submitted that by aligning the strategies used in this Guidance with the tackling of obstetric violence, it is possible to orchestrate a similar plan to assist with the latter maternal rights issue.

The UN Technical Guidance clearly sets out the different stages involved in an HRBA and how such an approach works in practice. The process begins with the initial analysis of the situation.[86] Once the problem has been analysed, a plan of action is formulated to deal with protecting the affected rights; in this case, strategies at national level to protect maternal and reproductive rights.[87] Thereafter, a budget is drawn up to assist with resource allocation and the implements needed in putting the plan into motion.[88] After this implementation, the progress of the approach taken is monitored and evaluated.[89] Hence, the entire process resonates with a 'circle of accountability.'[90]

From the Technical Guidance it can be seen how rights-based approaches give accreditation to women's agency by viewing women's perspectives, voice and participation

[81] Ibid.
[82] Ibid.
[83] Yamin (note 9 above) 3.
[84] Yamin (note 9 above) 3.
[85] Social determinants of health are defined as 'the social and economic factors that influence health, and include income, education, social safety networks, employment and working conditions, unemployment and job security, early childhood development, gender, race, food insecurity, housing, social exclusion, access to health services, and disability.' See: Moyo (note 34 above) 431.
[86] UN Technical Guidance at [28].
[87] Ibid.
[88] UN Technical Guidance at [44].
[89] UN Technical Guidance at [5], [9].
[90] UN Technical Guidance at [68].

as being central to the process of health planning that has an impact on their sexual and reproductive health rights. Thus, it is submitted that human rights are not merely supplementary aids to the already existing health strategies but rather shape the revolution of women's health.

2.6. BACKGROUND TO THE WORKINGS OF A HUMAN RIGHTS-BASED APPROACH

Advocates for women's health rights are increasingly drawing on human rights to bring states to heel for failure in meeting their legal obligations of ensuring the provision of adequate, accessible services that are essential for safe reproductive health care. [91]

Human rights measure the compliance of states with their international obligations through certain indicators.[92] The UN has provided guidelines which determine the indicators and standard of expected care.[93] In order for the law to transform from a public health tool to a human rights mechanism, there needs to be a shift from the focus on a positive birth outcome — that is, survival of the baby and mother — to the injustice of disrespectful birthing experiences and the cumulative concerning consequences that follow.[94]

An HRBA diverts from the usual clinical approach based on 'biological individualism'[95] by looking at obstetric violence contributors such as lack of accountability and social inequalities. Such an approach can be said to 'expose the hidden priorities and structures behind violations.'[96] Viewed from this angle, maternal rights are no longer based on biological factors but now become a beacon for justice. This results in an important turning-point regarding how health is viewed in the medical sector and by those researchers and policy-makers contributing to developing health rights. It does not delineate the issue by only looking at immediate problematic areas but looks at other contributory causes stemming from social and justice issues.

Importantly, the adoption of a rights-based approach does not mean an anti-clinical stance is taken.[97] Rather, bringing human rights into the picture helps to protect the rights that

[91] Shaw & Cook (note 80 above) S55.
[92] For example, MDG 5. See: Yamin & Boulanger (note 64 above) 81.
[93] See generally: Yamin & Maine (note 53 above).
[94] Ibid.
[95] Yamin (note 6 above) 48.
[96] Ibid.
[97] Ibid 47.

become implicated when inequalities arise as the evolution of medicine takes place.[98] It places the experience of obstetric violence not only within a clinical setting but looks at the surrounding social, political, historical and economic factors that relate to the problem.[99] It is submitted that when the underlying causes of a situation are not addressed by a resolutive strategy, it is unlikely to be effective.[100] Hence, this approach is favourable.

An HRBA is critical in identifying the gaps in legislation and policies that are having a negative effect on health.[101] Thus, it calls on governments to fulfil their obligations, it clarifies the mechanisms used to measure states' compliance regarding the provision of quality health care and ensures that positive change is followed through with.[102]

An HRBA is important in empowering and educating not only women to claim their rights but also the community to engage in and commit to rights promotion.[103] Women receiving goods and maternal services from facilities are not passive receivers of care.[104] Rather, they are empowered with the ability to contribute to decisions affecting their health. Not only does participation contribute to realising women's rights under a rights-based approach but also allows women to influence the outcome of implementing such an approach through meaningful dialogue and engagement with women regarding the future of their care.[105] Participation, thus, contributes to birthing women's agency. Notably, when a rights-based approach considers participation, the voices of health professionals are not silenced but also are given a platform to find a common ground with those being affected by their services.[106]

2.7. PRINCIPLES OF A HUMAN RIGHTS-BASED APPROACH

Under human rights law, the provision of sexual and reproductive health services at health facilities need to be available, accessible, acceptable and of a good quality.[107] These four principles are the foundational pillars of an HRBA.

[98] See further: C Clesse 'The evolution of birth medicalisation: A systematic review' (2018) 66 *Midwifery* 161, 163.
[99] Yamin (note 6 above) 47.
[100] See: Yamin (note 9 above) 2.
[101] Centre for Reproductive Rights (note 11 above).
[102] Ibid.
[103] Department of Health (note 31 above) 24.
[104] Yamin (note 6 above) 49.
[105] Centre for Reproductive Rights (note 11 above).
[106] Yamin (note 6 above) 49.
[107] Yamin (note 29 above) 190.

a. Availability of Health Care Services

Health facilities providing maternal health care services need to be sufficiently available to birthing people.[108] Not only do these facilities need to be equipped with essential drugs needed for the birthing process but also staffed with well-trained medical professionals and health care personnel earning an appropriate salary.[109]

b. Accessibility of Health Care Services

Accessibility means that all women citizens need to have access to health facilities and services physically; with care and treatment being affordable.[110] Financial disparities between rich and poor citizens should not affect access to maternal health care.[111] Further, women should be able to easily seek, receive and impart information affecting their health.[112] This right to information, however, should not put the patient's confidentiality and privacy at stake.[113]

The care women receive should be on an equal basis, free from discrimination.[114] This principle targets marginalised and vulnerable groups of women specifically to ensure that their status does not affect their accessibility to essential health services and rights.[115] Thus, this accessibility principle of an HRBA focuses on the opportunity of women to utilise health care facilities free of socio-economic barriers. Unfortunately, whilst international instruments, such as the Beijing Declaration, acknowledge that women's maternal and reproductive rights are limited by barriers; they fail to enunciate as to what these barriers entail.[116] An HRBA assists in identifying these obstacles to accessing health care.

c. Acceptability of Health Care Services

Health care services need not only be legally and medically acceptable but also ethically acceptable from a gender and cultural perspective.[117] Maternal health care is acceptable when it is 'delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.'[118] The less acceptable the provision of health care services is, the less likely are citizens to

[108] Moyo (note 34 above) 388.
[109] Ibid.
[110] Ibid.
[111] Ibid 389.
[112] Ibid.
[113] Ibid.
[114] Ibid 388.
[115] Ibid 389.
[116] Yamin & Maine (note 53 above) 598.
[117] Moyo (note 34 above) 390.
[118] Khosla et al. (note 60 above) 137.

utilise these services.[119] This principle is important as studies have shown that public maternal health systems in South Africa are rampant with disrespectful and undignified treatment of patients; with respectful treatment being the exception rather than the norm.[120]

d. Good Quality Health Care Services

Shortage of skilled medical professionals, shortage of essential drugs, poor sanitation and tenuous patient-professional relationships affect experiences of quality health care.[121] The overall quality of care is dependent on the both the 'provider's provision of care' as well as the 'patient's experience of care.'[122] It is submitted that falling short on meeting this principle spurs on the incidence of obstetric violence at health facilities.

The above fundamental principles of an HRBA, therefore, inform the process of adopting an HRBA when resolving health care issues.

2.8. STAGES INVOLVED IN THE PROCESS OF APPLYING A HUMAN RIGHTS-BASED APPROACH

The three stages involved in the application of an HRBA to maternal health planning are set out hereunder.

Stage 1: Planning and budgeting

The situational analysis stage of the planning process necessitates gathering local feedback and conducting research to answer the questions relating to whom the problem affects and why it is occurring.[123] It analyses the responsible sources of the cause of the problem and what measures can be put in place by the duty-bearers to address the situation. A 'bottom-up diagnostic exercise' is suggested to engage in a critical brainstorming technique during this stage.[124]

The Technical Guidance provides that this stage should 'include a broadly participatory review of the legal framework and the enactment, modification or rescission of

[119] Windau-Melmer (note 12 above) 1.
[120] Moyo (note 34 above) 390.
[121] See: Moyo (note 34 above) 388, 421.
[122] MB Hastings 'Pulling Back The Curtain on Disrespect and Abuse: The Movement to Ensure Respectful Maternity Care' (September 2015) available at: *https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Policy-Brief-Pulling-Back-the-Curtain-on-DR.pdf*, accessed on 22 May 2019.
[123] Yamin (note 29 above) 192.
[124] H Ratcliffe 'Creating An Evidence Base for The Promotion of Respectful Maternity Care' (Master of Science unpublished thesis, Harvard School of Public Health, 2013) 24.

laws, policies, regulations and guidelines, as required.'[125] This review is what the researcher aims to provide in Chapters Three and Four that follow.

However, the HRBA does not only assess the situation but needs to have a follow-up procedure to ensure that there is compliance with the action plan. Whilst the Technical Guidance acknowledges that certain health rights must be immediately attended to, it does not merely focus on and limit strategies to only address these problems.[126] It also provides that long-term action goals to transform the achievement of the broader category of affected rights should be borne in mind concurrently.[127]

An HRBA does not assess a situation based on preconceived notions. Rather, it conducts a proper analysis of the issue and the current operations to determine which areas are meeting the needs of women and which areas are lacking.[128] Thus, such an exercise is not 'technocratic' but a fresh perspective and reorganisation of the decision-making process.[129]

The budgeting stage of an HRBA requires the state to dedicate 'the maximum available resources to sexual and reproductive health.'[130] Identifying the areas of maternal health that require financing will be the responsibility of the National Department of Health.[131]

Focusing on reasons for obstetric violence occurrence, the normalisation of abuse materialises when health workers justify their disrespectful treatment of birthing women by feeling the need to take control and 'save' women from themselves since this is their field of expertise.[132] This mindset follows the notion of outdated 'medical paternalism' of 'the doctor knows best; the patient has no say.'[133] The result of this is continued gender-based prejudice and subjecting women to inhumane treatment.[134] Ongoing forms of violence have resulted in some women remaining unaware of what safe, respectful maternity care warrants.[135] The rigid attitude of errant health care workers not only entails physical and psychological consequences for the mistreated patient but also poses a barrier to women's legal protection

[125] UN Technical Guidance at [30].
[126] Yamin (note 29 above) 192.
[127] Ibid 192.
[128] Ibid 191.
[129] Ibid.
[130] UN Technical Guidance at [45].
[131] UN Technical Guidance at [44].
[132] R Schiralli et al. 'Obstetric Violence' 2nd Panel – Gender Violence and Sexual and Reproductve Rights at the Women's Human Rights Summit (2018).
[133] Schiralli et al. (note 132 above).
[134] Ibid.
[135] Ibid.

in terms of their human rights.[136] A relationship that should be founded on trust and care is converted into one filled with power-hungriness and aggression.

The pyramid below indicates the growing trend of normalisation of obstetric violence. Tolerance of the behaviours lower down provides the basis for tolerance of greater infringement of rights higher up.

Diagram 3 above: Pyramid illustrating Obstetric Violence Culture
Source: Birth Monopoly 'Obstetric Violence' available at: *https://birthmonopoly.com/obstetric-violence/*, accessed on 29 August 2019.

This is better reflected in the iceberg of abuse shown below. There are types of obstetric violence that are visible and there are the types that are forming the cracks, hidden under the culture of silence, so that they continue not to be addressed and will lead to the eventual breakdown of the values of the health system.

[136] R Schiralli et al. (note 132 above).

Diagram 4 above: Iceberg of Obstetric Violence
Source: The Reproductive Justice Story Project 'Iceberg of Obstetric Violence', available at: *https://reproductivejusticestories.org*, accessed on 29 August 2019.

For example, the overt forms of obstetric violence that are largely dominating health systems, thereby garnering concerned attention from authors, are forced or coerced sterilisations and unnecessary caesarean sections.[137] Caesarean sections have been found to result in many postnatal risks.[138] Recently, in South Africa, a study found that the process of injecting women with a common contraceptive could possibly make women more susceptible to contracting tuberculosis.[139] Thus, when such injections are administered without consent, not only is a woman's autonomy, dignity and bodily integrity and reproductive rights put in jeopardy but also her immune system and future health.

Poverty; gender inequality; violence; lack of repercussions and poor management of public health facilities; and lack of information that leads to planning, monitoring and decision-making processes have been identified as key contributors to hindering the

[137] See: Khosla et al. (note 60 above) 131; R Schiralli et al. (note 132 above) and the WHO Statement.
[138] R Schiralli et al. (note 132 above).
[139] N Krige 'Common contraceptive could raise TB risk' (15 April 2019), available at: *https://www.news.uct.ac.za/article/-2019-04-15-common-contraceptive-could-raise-tb-risk*, accessed on 17 November 2019.

promotion of SRHR,[140] thereby, exacerbating obstetric violence as well. Thus, it is submitted that these factors can be appropriately dealt with under an HRBA.

Stage 2: Implementation

Aspects relating to implementation entail ensuring that there is adequate leadership; governance; budgets; clinical services; equipment and technologies; available and accessible service delivery; skilled and ethical health facility managers, providers, personnel; as well as the necessary mind- and skillset for job competency.[141] All of these aspects are vital to reforming the health system.

The Technical Guidance does not turn a blind eye to the rights of health care workers. The Guidance acknowledges that whilst these workers are obliged to respect the rights of their patients; the workers are also holders of rights.[142] Thus, for an effective strategy to be put in place and implemented, the overall treatment and working environment of health workers need to be addressed.[143] They need to be given a fair salary; incentives such as benefits; a platform to voice their concerns; and a process to discipline those who infringe their rights should be enforced.[144]

Stage 3: Monitoring, Evaluation and Accountability

Processes need to be put in place to monitor whether states are complying with their international obligations in this area of women's rights. Without this oversight, duty-bearers cannot be brought to account. It is submitted that by virtue of knowing they will be answerable, duty-bearers are kept on their toes. Hence, they will not readily discriminate in their prioritisation of care and misappropriate funds dedicated to health care without thinking twice.

The bedrock of an HRBA is the 'circle of accountability.'[145] Various oversight bodies can put into play a system of checks and balances. These bodies should not only emanate

[140] Department of Health (note 31 above) iii.
[141] Department of Health (note 31 above) iv.
[142] Yamin (note 6 above) 49.
[143] A Manning & M Schaaf *Respectful Maternity Care and Human Resources for Health (2018) https://www.healthynewbornnetwork.org/resource/respectful-maternity-care-and-human-resources-for-health/*
[144] Ibid.
[145] UN Technical Guidance at [68].

from the health sector as there also needs to be accountability through political, administrative, national and international legal levels as well.[146]

The Technical Guidance emphasises that without effective remedies, accountability is rendered ineffectual.[147] Remedies, importantly, can take the form of reform in legal and political processes.[148] The remedy suggested in this dissertation is legal reform. Thus, this is in line with the recommendations of the Technical Guidance. Legal reform can assist with addressing the rights violations of the affected women and to ensure such actions are not repeated.[149]

2.9. DISCUSSION: THE USE OF HUMAN RIGHTS TO GUIDE TACKLING OBSTETRIC VIOLENCE

The basis for the suggestion of adopting an HRBA to address obstetric violence stems from the right of women to the 'enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity'[150] and the UN Technical Guidance. Thus, from the principles of an HRBA explained in this Chapter it can be derived that maternal facilities; care; goods and services need to be easily available for ease of access of women. This access must not be obstructed by physical and economical barriers but should be available and accessible to everyone irrespective of race or creed. The services and provision of care must be acceptable at both ethical and cultural levels. Lastly, the quality of care must be appropriate from both a medical and legal perspective.

The UN Technical Guidance assists in providing substantive content to a human rights-based approach as it addresses inherent structural inadequacies relevant to maternal health. Legislative action forms part of the assessment in determining fulfilment of human rights goals.[151] Precedents that have been set by health litigation in this area of law display the seriousness with which states need to address these maternal health and reproductive health care rights.[152] These cases will be discussed in Chapter Four. When international monitoring committees apply human rights to issues related to maternal and reproductive health, they are proudly declaring women as rights-bearing humans who are entitled to

[146] Yamin (note 29 above) 192.
[147] Yamin (note 9 above) 3; UN Technical Guidance at [69-73].
[148] Yamin (note 29 above) 192.
[149] Ibid.
[150] Article 12 of the ICESCR.
[151] Yamin & Maine (note 53 above) 591.
[152] See for example, *Alyne da Silva Pimentel v. Brazil* (Communication No. 17/2008) CEDAW/C/49/D/17/2008.

adequate and essential, respectful health care. However, this Chapter brings to light that obstetric violence has not yet been comprehensively discussed on political and legal domains.[153]

HRBAs have been used to address maternal mortality and morbidity.[154] This health rights issue is closely linked to obstetric violence which is a form of sexual and reproductive health rights violations. To utilise human rights as the springboard for promoting respectful maternal care helps to imbue the understanding of obstetric violence as a matter of justice, not merely circumstances, that duty-bearers are bound to ameliorate and address.

Due to the birthing process being gender specific, gender inequality and violence against women also pose a concern in health care. This viewpoint recognises the relationship between women and health facility workers and how interpersonal tensions can lead to obstetric violence.[155] If women are treated with the respect they deserve, the birthing experience can be empowering and be a pleasant one for women. However, disrespectful care results in negative experiences and possible post-traumatic stress.[156] The latter experience does not only stop with the affected woman but can have widespread implications.[157] Experiences of birth are often shared amongst women and negative experiences are likely to cause women to evade obtaining professional health care due to fear of being stigmatised or disrespected.[158] This in turn poses a barrier to access to health care which is an important constitutional right.

Medical practices and behaviour consisting of abusive care lends to the violation of women's human rights and gender imbalances. The occurrence of obstetric violence jeopardises a woman's autonomy — her choices regarding her reproductive processes. Instead of being viewed as a legal subject with full capacity and autonomy, her decision-making regarding her birth is undermined. Thus, having a right provides women with a tool, which correctly wielded, can slash through social constructs that precipitate the continuation of obstetric violence.

An HRBA, thus, does not only seek to improve maternal health but will also address the transformation of various factors that contribute to birthing women's rights being

[153] R Schiralli et al. (note 132 above).
[154] Such as the UN Technical Guidance. See further: Khosla et al. (note 60 above).
[155] Khosla et al. (note 60 above) 136.
[156] Windau-Melmer (note 12 above) 24.
[157] Ibid.
[158] Ibid.

violated. One such factor identified in this Chapter is the discrimination of birthing women when accessing health care. Since an HRBA questions the marginalisation of sectors of society,[159] it takes cognisance of this form of inequality in maternity wards and addresses the elimination of the enablers of discrimination in its programmes and planning strategies.[160]

Rights-holders, the birthing women in this exposition, need to have their maternal rights respected, protected and fulfilled by duty-bearers. An HRBA is unique as it enables effective accountability mechanisms to be put in place, as well as determining the course of action when a right is infringed. These accountability measures do not focus on individual practitioners' fault for the abuse of birthing women.[161] Rather, it also looks at the contribution of institutional and systematic failures that can be challenged and for which entities such as the state and health facilities can be answerable.[162] This emphasis on accountability increases transparency and assists with monitoring the fruition of the goal of an HRBA.

In the process of tackling obstetric violence by utilising this rights-based approach propounded for, the following questions based on the foundational principles will become pertinent to discussions amongst the relevant stakeholders:

a. **Availability and accessibility:** Are there enough health facilities and skilled workers providing obstetric care to birthing women? Are these facilities distributed evenly throughout the country?
b. **Acceptability:** Are birthing women using these facilities?
c. **Quality:** Are these facilities providing ample skilled care in proportion to the needs of the population?
d. **Adequacy:** Are the services provided at these facilities of adequate quality?

However, whilst reliance on human rights may inform the process of addressing obstetric violence, human rights alone cannot prevent the abuse and disrespect of birthing women. Without comprehending the epidemiology of obstetric violence and steps that need to be taken to prevent its occurrence, the rights will be insufficient.[163] Without understanding the background to the nexus between obstetric violence and why it manifests, legal attempts to address it will in all probability be futile. Narrowing down to the aspect of legal reform

[159] Yamin (note 6 above) 50.
[160] Centre for Reproductive Rights (note 11 above).
[161] Yamin & Maine (note 53 above) 591.
[162] Ibid.
[163] Yamin & Maine (note 53 above) 564.

mentioned previously, the next Chapter addresses the existing legal framework to determine the legal avenues available to victims of obstetric violence and exploring how the shortcomings may possibly be reformed.

2.10. CONCLUSION

Although the UN Technical Guidance is mainly aimed at policymakers for programming and planning; it is also intended to be used by various stakeholders.[164] It is, thus, the researcher's submission that lawmakers and legal advocates for respectful maternity care may also utilise the framework in their approach to overcoming the obstetric violence dilemma. Hence, this Chapter provides a necessary understanding of how the framework works before attempting to solve the issue.

South Africa, having a comprehensive Bill of Rights and being a signatory to the Universal Declaration of Human Rights and Convention on the Elimination of Discrimination Against Women has dedicated itself to respecting and promoting human rights. Obstetric violence poses a threat to numerous of these human rights. Thus, it is necessary to consider the possible legal avenues for action that allow the South African state to fulfil its obligations, as will be discussed in the Chapter that follows.

[164] UN Technical Guidance at [7].

CHAPTER 3

DEBATES ON USING THE CRIMINAL, CIVIL AND ADMINISTRATIVE LAW TO ADDRESS OBSTETRIC VIOLENCE

'*The great can protect themselves, but the poor and humble require the arm and shield of the law*.'[1]

- Andrew Jackson

3.1. INTRODUCTION

This Chapter explores the possibility of criminalising obstetric violence in South Africa. It does this through looking at the range of legal remedies available in our law by weighing up the various options. The disrespectful mistreatment of maternity patients identified in countries that criminalise obstetric violence is found in South African maternity wards.[2] A crime may be defined as a wrong that has been done against the state which results in the perpetrator breaching the law, such that the breach needs to be punished by the state.[3]

3.2. UTILISING CRIMINAL LAW TO ADDRESS OBSTETRIC VIOLENCE

Obstetric violence raises legal concerns as it breaches numerous rights protected in the South African Constitution. These rights were described in Chapter Two. South Africa does not currently have any legislation specifically addressing obstetric violence and this has led to a debate on the most appropriate way in which to address this problem. The section below outlines the arguments for and against the use of the criminal law.

States may take one of two routes. First, the existing legislative framework may be used to resolve obstetric violence cases falling within the ambit of that branch of law. Alternately, the legislature may enact specific legislation governing this unlawful behaviour

[1] 'Andrew Jackson Quotes', available at: *https://www.azquotes.com/quote/729744*, accessed on 31 October 2019.
[2] C Pickles 'Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa' (2015) 54(1) *SA Crime Quarterly* 5.
[3] DJ McQuoid-Mason 'Medical malpractice and professional negligence' in A Dhai & DJ McQuoid-Mason (eds) *Bioethics, Human Rights and Health Law* (2010) 5.

together with providing detailed sanctions. Nevertheless, one must first explore the public policy issue of: should this conduct be considered criminal?

3.2.1. Addressing Obstetric Violence Using the Existing Legislative Framework and Common Law in South Africa

If Pickles' suggestion is put into practice, instances of obstetric violence could be slotted into a common law crime depending on the nature and gravity of the offence.[4] Elements of a crime in South Africa consist of: voluntary human conduct; capacity; unlawfulness; fault in the form of intention (dolus) or negligence and causation. The common law crimes of murder, culpable homicide, assault, and crimen injuria in the context of obstetric violence will be looked at individually hereunder.

3.2.1.1. Murder or attempted murder

Murder refers to the unlawful and intentional killing of another human being. Positioned at the top of the hierarchy of crimes, coldblooded murder is seen as the most reprehensible crime requiring the most severe punishment.[5]

3.2.1.2. Culpable homicide

Unlike murder, culpable homicide allows for the crime of the unintentional and unlawful, negligent killing of another human being.[6] By the recognition of such reckless, inadvertent conduct constituting a crime, the law asserts the importance and due regard that should be had when engaging in an activity that poses a risk to another person's life.[7]

Here, the guilty party's negligence can either be inadvertent (unconscious) or advertent (conscious).[8] South Africa's punishment of this type of negligent behaviour does not require that it be of a 'gross' nature.[9]

The test for negligence is the standard of the reasonable person.[10] The 'slightest deviation' from the behaviour of the reasonable person suffices for negligence.[11] First, the medical practitioner or staff member must have foreseen the death of the mother occurring, as

[4] Pickles (note 2 above).
[5] JM Burchell *Principles of Criminal Law* 4 ed (2013) 562.
[6] Ibid 568.
[7] Ibid 568.
[8] Ibid 570.
[9] Ibid.
[10] See: *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E – F for the reasonable person test.
[11] Burchell (note 5 above) 530.

a reasonable person in his/her position would. If he/she did, steps must have been taken to guard against the occurrence of such death. If that has not been done, the accused will be deemed to have been negligent.

3.2.1.3. Assault or assault with intention to commit grievous bodily harm

Assault occurs when the guilty party unlawfully and intentionally applies force to the body or person of another.[12] It may also occur when the offender's behaviour inspires the belief in the victim that force will be applied to her immediately. Professor Snyman views an assault as the intentional, unlawful act or omission which impairs the physical integrity of another person or inspires the belief of the immediate transpiration thereof.[13] Thus, not only is a person's physical being protected but also their sentient being. Assault with intent to commit grievous bodily harm occurs when the unlawful, intentional force applied results in the physical injury of another person, excluding sexual harm.[14]

Examples of obstetric violence that may constitute an assault include unconsented caesarean sections; episiotomies; vaginal examinations or any other non-consensual procedure during childbirth. Slapping; rough-handling; pinching; stabbing of maternal patients by nurses and nurses voicing threats of abuse or neglecting patients may also constitute an assault. It is submitted that assault is the most common form in which obstetric violence presents itself.[15]

3.2.1.4. Crimen injuria

South African law values the dignity and privacy of the citizens subjected to its rules and regulations, not only through the Constitution but through the recognition of crimen injuria. This provides for recourse to persons who have had their dignity or privacy unlawfully, intentionally and seriously impaired through defamatory conduct, insults or remarks.[16]

Usually, civil measures are taken to remunerate the injured party for their suffering through damages claims.[17] However, criminal law is also invoked in more serious cases,[18] such as indecent exposure and making racist comments. For example, this crime may be invoked when nurses publicly insult patients; there is refusal of obstetric care based on a

[12] Burchell (note 5 above) 577.
[13] CR Snyman *Criminal law* 5ed (2008) at 455.
[14] Burchell (note 5 above) 585- 586.
[15] See examples: Pickles (note 2 above) 7, 9.
[16] Burchell (note 5 above) 632.
[17] Ibid 747.
[18] Ibid.

mother's social, economic or health status; or a mother's HIV status is disclosed. This is not a closed list of examples.

3.3. ADDRESSING OBSTETRIC VIOLENCE BY ENACTING SPECIFIC CRIMINAL LAWS

The alternative to utilising the common law to deal with cases of obstetric violence is to enact specific legislation dealing with the issue.

The United Nations has provided guidelines for the drafting of maternity health legislation.[19] First, a legislative goal needs to be identified.[20] In this case, the protection of women from obstetric violence. Secondly, consultations need to take place amongst the appropriate stakeholders.[21] These include obstetricians, health workers, facility managers, the South African Department of Health, the legislature, victims of obstetric violence and women's advocacy groups. Lastly, using evidence-based approaches, legislation can be drafted.[22]

The framework provides guidelines that can be applicable to obstetric violence in the context of implementation; evaluation; definitions; victim protection, support and rights; as well as the investigation; prosecution and sentencing of offenders.[23] Sentences should depend on the gravity of the offence. The framework suggests that mediation not be an option since it undermines the victim's remedy.[24] Mediation will be discussed later in this Chapter.

3.3.1. Arguments in Favour of and Against Criminalisation

(i) Appropriate medical behaviour is set out in practice guidelines issued by professional bodies and these must be followed. Professional sanctions may be imposed if doctors do not meet these standards.

Currently, a health systems approach is utilised in South Africa, which consists of practice guidelines and increased training. The South African Department of Health has issued

[19] United Nations *Ending Violence against Women: from words to action- Study of the Secretary-General* (2006).
[20] United Nations Department of Economic and Social Affairs *Handbook for Legislation on Violence Against Women* (2009) 57.
[21] Ibid.
[22] Ibid.
[23] Ibid 1.
[24] Ibid 38.

guidelines such as the Guidelines for Maternity Care in South Africa which has had many editions published over the years.[25] However, this approach is insufficient.[26]

Research has indicated that clinical guidelines are often not adhered to and implemented.[27] A review has recently found that non-adherence to clinical guidelines can be categorised into 'personal factors, guideline-related factors, and external factors.'[28] Barriers include practitioners not being aware, familiar or agreeing with the guidelines. External factors constituting barriers include lack of 'equipment, space, educational materials, time, staff, and financial resources.'[29] However, to counter this, it has been found that guidelines can be implemented successfully if the following are in place: 'dissemination, education and training, social interaction, decision support systems and standing orders.'[30] The criminal law system could possibly be one of the systems in place to ensure adherence and play an educational role.

(ii) The law and medical practice are not aligned, thus allowing for obstetric violence to slip between the gaps.[31]

Over the years, there has been population-directed health legislation enacted, as well as health legislation promoting individualised protection, creating a conflict in the standard that practitioners ought to adhere to. The rapid change that legislation brings about makes it difficult for health guidelines and policies to keep up whilst the laws advance.[32] This problem has been articulately stated as follows:

> *'The great challenge is that advances in medical practice and health policy may be making their way separately, and with little coordination, they may clash at the level of the practicing primary care physician, leading to health policies that promote outdated standards and impede clinical practice.'*[33]

[25] See further: Department of Health *Guidelines for Maternity Care in South Africa: A long and healthy life for all South Africans - A manual for clinics, community health centres and district hospitals* 4 ed (2016).
[26] United Nations Department of Economic and Social Affairs (note 23 above).
[27] F Fischer et al. 'Barriers and Strategies in Guideline Implementation—A Scoping Review' (2016) 4(3) *Healthcare (Basel).* 1.
[28] Ibid.
[29] JH Barth et al. 'Why are clinical practice guidelines not followed?' (2016) 54(7) *Clin Chem Lab Med* 1133.
[30] Fischer et al. (note 27 above).
[31] Ibid.
[32] N Laiteerapong & ES Huang 'The Pace of Change in Medical Practice and Health Policy: Collision or Coexistence?' (2015) 30(6) *J Gen Intern Med.* 848.
[33] Ibid.

Due to the rapid advances in clinical medicines, practitioners may not be adhering to 'contemporary standards of care' even though it may just be a few years into practice after their training.[34] This leads to the next argument.

(iii) Law reform is needed to address this issue

Pickles criticises the South African government for being one of the key players that could address this issue of obstetric violence through law reform, yet they fail to do so.[35] She advocates for a commitment to the existing criminal law system being adapted to cater for obstetric violence offences.[36]

The table below depicts the pros and cons of introducing a crime to punish obstetric violence occurrence.

Table 3: Weighing up the Pros and Cons of Criminalising Obstetric Violence

No.	*Arguments in Favour of Criminalisation*[37]	*Arguments Against Criminalisation*
1.	Criminalisation is a deterrent against disrespectful maternity care.	The offender is punished, rather than focussing on rehabilitation.
2.	Rule of law and the Constitution, 1996 are no longer subverted.	Having a law in place may reduce obstetric violence occurrence but will not eliminate it.
3.	There is better guidance and governance over this form of violence within a structured arrest, prosecution and sentencing process.	Police, prosecutors and judges may be reluctant to act upon a complaint of obstetric violence, and where a complaint is taken further up, follow-up and consequent punishment are lacking.

[34] Ibid 850.
[35] C Pickles 'Reflections on obstetric violence and the law: What remains to be done for women's rights in childbirth?' (08 March 2017), available at: *https://www.law.ox.ac.uk/research-and-subject-groups/international-womens-day/blog/2017/03/reflections-obstetric-violence-and*, accessed on 20 February 2019.
[36] Pickles (note 2 above).
[37] The crux of these arguments has been derived from the arguments levelled against the criminalisation of domestic violence. See: United Nations *Strategies for Confronting Domestic Violence - A Resource Manual* (1993) available at: *https://www.unodc.org/pdf/youthnet/tools_strategy_english_domestic_violence.pdf*, accessed on 17 March 2020.

4.	The victim is empowered and protected by the law (i.e. victim-centred approach)	The needs of the victim are often side-lined in a criminal matter.
5.	Practitioners exercise more caution during patient attendance, reducing the risk of obstetric violence occurrence.	Defensive medicine increases. Practitioners may be jailed as a result of obstetric violence, leading to further staff shortage.
6.	Public policy regarding the commitment toward respectful maternity care is made known.	Criminal law focuses on the offending past behaviour without having a forward outlook.
7.	Invokes stronger sense of accountability, unlike mediation which conveys the impression that the victim contributed to the problem and lessens the seriousness of the violence subjected to.	Support, rehabilitative and treatment programmes are not often catered for in a criminal system.
8.	Greater awareness spread about birthing women's rights and constitutional guarantees (i.e. it plays an educational role).	Practitioners exposed to a hostile environment during imprisonment may be more inclined to violence after their release.

3.4. CLAIMS AGAINST MEDICAL PRACTITIONERS IN SOUTH AFRICA

Medical practitioners providing their services in South Africa may be held statutorily liable under the following Acts: Inquests Act[38], Births and Deaths Registration Act[39], Choice on Termination of Pregnancy Act[40], Sterilisation Act[41], Mental Health Care Act[42], National

[38] Act 58 of 1959. See: Section 20.
[39] Act 51 of 1992. See: Section 31.
[40] Act 92 of 1996. See: Section 10.
[41] Act 44 of 1998. See: Section 9.
[42] Act 17 of 2002. See: Section 70.

Health Act[43], and the Children's Act[44]. However, the common law also comes to the assistance of a patient seeking a remedy.

3.4.1. Civil Remedies

There is no specific legislation governing medical malpractice in South Africa. Thus, there is currently no system in place to recover damages from the responsible entities without taking the avenue of making it a civil claim in terms of the common law. Notably, whilst the judiciary is not bound by the expected professional ethics of the medical profession, the decisions and standards to which such ethics committees hold members of the profession serve as a guideline to courts of law when hearing a medical matter.[45] These court cases usually present themselves as issues of medical negligence or medical malpractice. Medical negligence and medical malpractice are terms used interchangeably in South Africa.[46] However, strictly speaking, there are differences between the two.

This dissertation, however, is concerned with medical malpractice rather than medical negligence due to its focus on any form of intentional conduct of obstetric violence. For a malpractice claim to exist in South Africa, certain elements need to exist. First, there needs to be a duty on the part of the obstetrician to provide the patient with a medical service.[47] Thereafter, it needs to be proven that the obstetrician deviated from the reasonable standard of care, resulting in harm.[48]

Medical negligence claims need to be proven using the usual standard of care of a reasonably prudent person in a similar position.[49] The negligence element in medical negligence cases was discussed in *Mitchell v Dixon*[50], where Innes ACJ stated:

> '*A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill and care, he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not*.'

[43] Act 61 of 2003. See: Section 89.
[44] Act 38 of 2005. See: Section 305.
[45] LC Coetzee & P Carstens 'Medical Malpractice and Compensation in South Africa' (2011) 86(3) *Chicago-Kent Law Review* 1263, 1267.
[46] L Still 'So you want to sue your doctor?' (15 June 2016), available at: *https://www.iol.co.za/personal-finance/so-you-want-to-sue-your-doctor-2034165*, accessed on 17 May 2019.
[47] Coetzee & Carstens (note 45 above) 1271.
[48] Ibid.
[49] Still (note 46 above).
[50] 1914 AD 519 at 525.

Medical malpractice, however, covers both intentional and negligent conduct that deviates from the reasonable standard of health care a patient ought to be subjected to and which results in damage to the patient or the patient's property.[51] Medical malpractice, thus, measures the practitioner's conduct against the established standard of care in that particular medical sector. This standard is determined from the prevailing norms, conduct, protocols and teaching methods in the medical profession at that particular point in time.[52] It also establishes what the acceptable complications may have been and what a reasonable medical practitioner in the position of the implicated obstetrician would have done.[53]

In *Van Wyk v Lewis*[54], the court found that the reasonable standard of care would be 'the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.' It has been said that there is no difference between the test for negligence in criminal and civil cases.[55] It is true that the test for criminal negligence has been derived from the test laid down in the civil case of *Kruger v Coetzee*.[56] However, this test has been contextualised in the criminal law to cater for the reasonable person in the same circumstances having foresight of the 'reasonable possibility of his conduct causing a consequence which is prohibited in law, or that being in those circumstances is prohibited in law.'[57] Thus, foresight of the prohibited conduct materialising, such as causing the death of someone, is required under criminal law rather than foresight of mere injury.[58]

In terms of South African medical law, a patient only has a claim against their medical practitioner for an act or omission that resulted in injury.[59] If the medical practitioner acted reasonably and unfavourable consequences ensued, no claim arises.

Whilst a general practitioner ought to act reasonably according to the standard of someone possessing his skillset, he is not to be treated at the level of a medical specialist. The difference in expertise requires different expected standards to apply. Notably, whilst the

[51] Mcquoid-Mason (note 3 above) 92.
[52] Still (note 46 above).
[53] Ibid.
[54] 1924 AD 438.
[55] Coetzee & Carstens (note 45 above) 1284.
[56] 1966 (2) SA 428 (A).
[57] J Grant *Critical Criminal Law* (2018) 188, ebook available at: *https://africanlii.org/sites/default/files/Critical-Criminal-Law-Live-2018-RS02-ADOBE-1.pdf*, accessed on 23 March 2020.
[58] Ibid.
[59] 'Know the Basics of Medical Negligence Claims in South Africa' (13 October 2017), available at: *http://www.pbkattorneys.co.za/blog/posts/know-the-basic-elements-of-medical-negligence-in-south-africa* accessed on 17 May 2019.

court does recognise this, it should be mentioned that South African law does not pardon a person for knowingly undertaking a task for which they are underequipped.[60] Thus, the above test will not come to the aid of a practitioner who willingly undertakes a case for which they are not sufficiently qualified to handle.

Negligent or intentional conduct which may lead to medical malpractice claims in the obstetric context include discharging a woman prematurely after birth; not providing proper aftercare;[61] neglecting a patient instead of complying with proper processes resulting in injuries and complications such as seizures or post-partum haemorrhaging;[62] or performing unnecessary surgeries such as caesarean sections or performing such surgeries without informed consent. Provided there is some form of harm caused to the birthing woman that resulted from the practitioner's conduct which was wrongful,[63] such as incorrect suturing after birth, forceps injuries or even distress and pain and suffering,[64] it will constitute medical malpractice.

Acts of obstetric violence that fall within the ambit of medical malpractice would currently be dealt with in terms of the common law. Medical negligence claims may arise based on the law of obligations. This means that a patient has recourse when a breach of contract has occurred between the patient and the doctor;[65] or when a delictual claim materialises when a patient suffers damages caused by the medical practitioner or hospital personnel.[66] If a patient is successful in her claim, she will either be awarded compensatory damages for the loss she has suffered, which could include pecuniary or non-percuniary damages. Punitive damages may be granted where the practitioner's unethical conduct was intentional.[67]

However, since the introduction of the Constitution and increased use of the public health system, public law is steadily becoming incorporated into this area that was once

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[60] This is known as the imperitia culpae adnumeratur rule. WT Oosthuizen *An Analysis of Healthcare and Malpractice Liability Reform: Aligning Proposals to Improve Quality of Care and Patient Safety* (unpublished LLM dissertation, University of Pretoria, 2014) 92.
[61] 'Hospital Malpractice' (April 2019), available at: *http://www.medicallaw.co.za/articles/hospital-malpractice-04-2019.html*, accessed on 26 March 2020.
[62] C Boeschen 'Birth-Related Medical Malpractice' (n.d.), available at: *https://www.nolo.com/legal-encyclopedia/birth-related-medical-malpractice-30150.html*, accessed on 26 March 2020.
[63] 'When is it Medical Malpractice?' (2017), available at: *http://www.medicallaw.co.za/articles/experts-in-medical-malpractice-laws-112017.html*, accessed on 26 March 2020.
[64] C Boeschen (note 62 above).
[65] Coetzee & Carstens (note 45 above) 1285.
[66] Ibid.
[67] Y Brazier 'What is medical malpractice?' (05 April 2015), available at: *https://www.medicalnewstoday.com/articles/248175#what_kind_of_damages_can_the_plaintiff_get*, accessed on 26 March 2020.

thought to be governed by private law. Whilst a case of breach of contract may be made against a medical practitioner where a contract exists, or a delictual claim arises where damage has occurred; it is possible for these to overlap.[68] Furthermore, either of these may coincide with the commission of a common law crime as they are not mutually exclusive.[69] Thus, should a delictual claim arise against a doctor or hospital, they may also be liable for assault where the patient's bodily integrity is infringed or injuria when the patient's privacy was not respected.

Looking at the available remedies, as per the law of delict, a patient may recover patrimonial as well as non-patrimonial losses from the defendant.[70] However, in the case of a breach of contract, only pecuniary losses may be claimed.[71] The state may also be held liable under the State Liability Act which recognises vicarious liability on the part of the state for wrongful actions committed by any servant of the state acting within his/her capacity and scope of authority.[72]

The evidentiary burden to prove medical malpractice falls on the plaintiff in a civil case and on the prosecution in a criminal case.[73] In the former, the case needs to be proven on a balance of probabilities and in the latter, the accused's guilt must be established beyond a reasonable doubt.

3.5. ADMINISTRATIVE REMEDIES

In South Africa, the most important statute governing health practitioners is the Health Professions Act[74] (hereinafter 'HPA'). This Act provides for the establishment of an oversight body, the Health Professions Council of South Africa (HPCSA). This body ensures that the education, training, registration and practice of medical practitioners are up to standard.[75] Notably, only medical practitioners are governed by this Act. Nurses are governed

[68] Coetzee & Carstens (note 45 above) 1285.
[69] Coetzee & Carstens (note 45 above) 1274.
[70] Ibid 1285.
[71] Ibid.
[72] Ibid 1271.
[73] Still (note 46 above).
[74] Act 56 of 1974.
[75] See long title of the Act.

by the Nursing Act[76] and the Nursing Council dictates the standards, training and education applicable to them.[77]

The HPA provides for the HPCSA to conduct and investigate allegations of misconduct of professionals which deviate from the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act.[78] Notably, the investigating committee is not bound by a numerus clausus in the Act. 'Unprofessional conduct' is defined in the Act as 'improper or disgraceful or dishonourable or unworthy conduct.'[79]

The above adjectives have been used to describe unethical conduct which can relate to medical malpractice, behaviour toward patients such as breaching the confidential relationship that exists, behaviour toward fellow practitioners such as touting, as well as engaging in conduct that is unbecoming of a doctor such as committing murder.[80]

The definition of 'dishonourable or unworthy conduct' was delved into in the case of *Groenewald v South African Medical Council*[81], where guidance was sought from the English case of *Allinson v General Council of Medical Education and Registrations*[82]. The definition derived from the latter case was set out as follows:

> '*If it is shown that a medical man, in pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council to say that he has been guilty of "infamous" conduct in a professional respect. The question is not merely whether what a medical man has done would be an infamous thing for anyone else to do, but whether it is infamous for a medical man to do…*'

Thus, intentional or negligent conduct which is contrary to good practice or improper for an obstetrician to display, will constitute improper or disgraceful conduct.[83]

The enquiry in terms of the HPA is usually overseen by a professional committee appointed to deal with allegation of unprofessional conduct. The HPA (as amended) provides

[76] Act 33 of 2005.
[77] See Section 4 of the Nursing Act 33 of 2005 for the full list of functions of the South African Nursing Council.
[78] Section 49(1) of the HPA.
[79] Section 1 of the HPA.
[80] DJ McQuoid-Mason & M Dada *A-Z of Medical Law* (2011) 234.
[81] 1934 TPD 404.
[82] [1894] 1 QB Div 750.
[83] McQuoid-Mason & Dada (note 80 above) 234.

in Section 42(1) that the following findings may be made at such an inquiry, when a practitioner is found to have acted unprofessionally:

> *'(a) a caution or a reprimand or a reprimand and a caution; or*
>
> *(b) suspension for a specified period from practising or performing acts specially pertaining to his profession;*
>
> *(c) removal of his or her name from the register;*
>
> *(d) a prescribed fine;*
>
> *(e) a compulsory period of professional service as may be determined by the professional board; or*
>
> *(f) the payment of the costs of the proceedings or a restitution or both.'*

Whilst the HPCSA cannot mediate on the issue of compensation, such a complaint and the subsequent enquiry could possibly be used as the first step to resolving a matter out of court. Alternatively, it could be taken before a civil claim is lodged.

However, the inefficiency of the HPCSA has resulted in litigation being the go-to option.[84] The failure of this body was highlighted by the allocation of a task team to investigate its competence, which was diagnosed as being a 'multi-system organisational dysfunction.'[85]

Another relevant independent administrative body established in terms of the NHA is the Office of the Health Ombud which creates an accountability mechanism in the health sector to which complaints can be directed either verbally or in writing.[86] These complaints are then considered, investigated and recommendations are made.

The importance of the role of the Health Ombud was highlighted in the contribution to the Life Esidimeni tragedy in which approximately 144 mentally ill patients lost their lives through the state's 'chaotic'[87] transfer plan from a private hospital to unlicensed non-governmental organisations. Over 1400 patients were subjected to inhumane treatment,

[84] Still (note 46 above).
[85] Ibid.
[86] Section 81A of the NHA (as amended).
[87] MW Makgoba *The report into the circumstances surrounding the deaths of mentally ill patients: Gauteng Province* (2017) 5.

torture and undignified conditions.[88] This constituted a gross violation of human rights with the Ombud's report finding such circumstances to have been unlawful.[89] The consequences of lack of planning and meaningful engagement with stakeholders resulted in conduct which was deemed to have been 'negligent and reckless and showed a total lack of respect for human dignity, care and human life.'

The report led to historic arbitration proceedings in which the state was called to account. In its report, a rights-based approach was suggested in dealing with budgetary problems at health institutions and the planning process,[90] reaffirming the stance taken in this project.

Whilst still a relatively new institution, it has been suggested that the enforcement and remedial powers of the Ombud be strengthened to improve its effectiveness.[91] It is also hoped that the office will not only deal with individualised complaints but also systematic failings in the future.[92]

3.5.1. Discussion: The Practical Effects of Resorting to Litigation

When a patient intends on instituting action against their allegedly unprofessional medical attendant, the following civil process usually occurs. First, legal representation is obtained. A letter of demand is issued to the respective doctor and/or hospital stating the claim together with the date by which compliance must occur. Action proceedings are instituted at the appropriate court having jurisdiction. The patient's medical history, reports and findings, expert reports, hospital notes, witness statements and any other evidence needs to be gathered to prove the cause of action.[93] A court date is decided upon. The cases usually turn on the evidence of expert witnesses to prove damages; both sides' experts trying to discredit the other. The court adjudicates on the matter and comes to a decision.

The following key points emerge when dealing with the civil law in the obstetric violence context:

[88] E Durojaye & DK Agaba 'Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa' (2018) 20(2) *HHR* 161.
[89] M. W. Makgoba *The report into the circumstances surrounding the deaths of mentally ill patients: Gauteng Province* (2017) 39.
[90] Ibid 51.
[91] Durojaye & Agaba (note 88 above) 166.
[92] Ibid.
[93] Coetzee & Carstens (note 45 above) 1284.

(i) South Africa is facing an escalation of medical malpractice claims against medical practitioners, especially in the public sector.[94]

This avalanche of litigation suits has resulted in an alarming budgetary expenditure by the Department of Health and medical practitioner insurers' such as the Medical Protection Society.[95]

There has been an abundance of academic commentary regarding the sordid state of the South African health system.[96] It has been unblinkingly said that lawyers are unscrupulously utilising medical negligence cases to obtain lucrative opportunities.[97] A Confucius-like mentality is at play here, whereby it is hoped for a world free of lawyers and lawsuits.[98] The view expressed after the tightening of Road Accident Fund claims is that an alternative money-making area was sought by personal injury attorneys.[99] The author disagrees with this view. In order for a case to be proven, the unlawful act must have occurred. Bringing a medical practitioner to account when they have provided substandard care does not constitute taking advantage of a situation. Rather, it ensures that a patient's rights are protected.

(ii) The legal process is undoubtedly arduous, expensive, and emotionally taxing.

The general cons that apply to any litigative process applies to medical malpractice cases such as time delays; court rolls being overloaded; difficulty in witnesses availing themselves; delays in obtaining expert reports and other evidence.[100] Medical negligence cases have proven to take more than five (5) years to finalise.[101] This indicates that this area of law needs to be rectified.

The cost of paying out delictual claims utilising the 'once-and-for-all' rule which incorporates expected future loss has a detrimental effect on the government's budget. Rather than utilising the funds to improve the health system, the money is used to pay out claims,

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[94] South African Law Reform Commission Issue Paper 33 Project 141 *Medico-Legal Claims* 20 May 2017 at 4.
[95] The Medical Protection Society provides unlimited discretionary cover to medical practitioners who are members. This non-profit organisation is advantageous to practitioners as it assists them against accusations of a criminal nature.
[96] See generally: B Taylor et al. 'Medicolegal storm threatening maternal and child healthcare services' (2018) 108(3) *SAMJ* 149; WT Oosthuizen & PA Carstens 'Medical malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 269, 283.
[97] Oosthuizen & Carstens (note 96 above).
[98] '… may we live in a world without lawyers and court cases …' See: J Walters 'Mediation – an alternative to litigation in medical malpractice' (2014) 104(11) *SAMJ* 717.
[99] Oosthuizen & Carstens (note 96 above).
[100] South African Law Reform Commission (note 94 above) 22.
[101] Ibid.

resulting in the continuation in poor hospital conditions, increased claims for poor quality care and decrease in funds. This brutal cycle needs to be repaired.

Suggestions of mediation and arbitration being used by patients before resorting to litigation have been made. Those advocating for alternative dispute mechanisms[102] view litigation as not being in favour of the patient in terms of costs, especially when there has been no negligence that resulted in a negative outcome.[103] Most of the compensation in a successful case is used to pay legal costs instead of being utilised to remedy the medical error.[104] One patient winning a medical malpractice suit still does not remedy the incompetent health system. Another suggestion has been the formation of a compensatory fund, such as the United Kingdom's Clinical Negligence Scheme Trust which pays patients for their personal injuries without resorting to litigation.[105]

Apart from the above downsides of instituting litigation for medical malpractice, the trend to take such cases to court shows an increased awareness of patient rights.[106] It ensures that constitutional guarantees are being protected. It is submitted that whilst it is true that matters may be successfully resolved amongst the relevant parties with the guidance of a mediator, the severity of the case may necessitate that a court of law hear the matter.[107] When it comes to protecting the right to health as enshrined in s 27 of the Constitution; ss 34 and 38 of the Constitution come into play. Section 34 deals with access to courts and s 38 provides that should a right in the Bill of Rights be infringed or threatened, appropriate relief may be sought by the affected party by approaching a court of law.

3.5.2. Discussion: Which Route Should South Africa Take? – Weighing Up the Options

From information gathered in this Chapter, the following themes emerge when considering the various options to tackle obstetric violence:

[102] These are being adopted by the United Kingdom, USA and Canada in resolving medical disputes. See: Walters (note 98 above) 718.
[103] Ibid 717.
[104] Oosthuizen & Carstens (note 96 above) 275.
[105] S Hlabangane 'Malpractice Claims are Undermining SA's Health System' (19 April 2018), available at: *https://ehealthnews.co.za/malpractice-claims-undermining-sas-health-system/* accessed on 17 May 2019.
[106] Still (note 46 above).
[107] Walters (note 98 above).

(i) Any legal avenue taken, be it civil, criminal or administrative, is only as effective as its complaints and implementation system

Pickles acknowledges the criticism that a legal response which merely relies on common law crimes to combat obstetric violence may face. Patients will not view the obstetric violence they are subjected to as a crime if it is not specifically declared one.[108] Hence, cases will go unreported. Also, patients will not be aware of the mechanisms they may utilise in the reporting process.[109] Low reporting of accounts of abuse may also occur due to fear and stigma when going to the South African Police Services for assistance. Ill-treatment by nurses often goes unreported due to this fear of victimisation.[110]

Patients need to be able to access an effective complaints system. Without such an avenue being available, adequate recourse cannot be taken by patients to seek relief. The system in place at hospitals in the Eastern Cape province has been criticised by Human Rights Watch.[111] It has been found that patients are unaware of complaint processes and procedures; the 'suggestion boxes' are ineffective; no information is given to patients regarding the available call-centre; patients view lodging complaints as being futile, opining that no changes will take place; and patients fear stigmatisation once approaching top management.[112] Once a complaint is made, little is done to address it by the facilities.[113] Where action is taken, it usually only deals with individual accountability for the facility staff member responsible.[114] This focus results in the despondent attitude of health workers as well.

(ii) Criminalisation of obstetric violence fosters accountability

Creating a statutory mechanism to protect the rights of pregnant women fosters accountability amongst those responsible for their treatment during facility-based care. Accountability needs to be enforced both on individual perpetrators as well as at the collective level.[115] Issues of accountability arise when the wrongful act is committed by a nurse or theatre sister; not the health practitioner himself. It has been held that vicarious liability will apply depending on

[108] Pickles (note 2 above) 11.
[109] Ibid.
[110] Ibid.
[111] Human Rights Watch *Stop Making Excuses: Accountability for Maternal Health Care in South Africa* (2011) at 4.
[112] Ibid 4-5.
[113] Ibid 5.
[114] Ibid.
[115] Pickles (note 2 above) 12.

various factors, one of them being whose control the person was under.[116] Generally nurses are deemed to be employed by the health practitioner.[117] However, if the nurse is like a theatre sister who is told what to do and how to do it, then the hospital will be held liable as her employer.[118] Similarly, a health practitioner will not be held liable for the actions of an anaesthetist employed by the hospital.[119]

Pickles advocates for obstetric violence legislation to provide for substantive equality between all persons involved in the handling of an obstetric violence matter; ranging from the victim; to the perpetrator; the health facility; the community; jurists and the state.[120]

Whilst hospitals may also be held liable for the intentional wrongdoings of their employees, it has been held that excellent care cannot be expected to be provided where the medical facility lacks financial resources.[121] In the case of *S v Tembani,*[122] the judge opined that substandard medical treatment has become the norm with treatment ranging over a spectrum and usually being suboptimal. This view acknowledges the current constraints on health workers and the deterioration of health care services. Importantly, the introduction of obstetric violence as a crime in South Africa is only one solution amongst many to the problem.[123] Other interventions are necessary to allow for the smooth provision of quality health care devoid of violent, disrespectful treatment. These will be explored in Chapter Five.

(iii) Enforcing obstetric violence laws plays an educative role

On the other hand, Dr Aryal criticises the solution of introducing obstetric violence laws.[124] Rather, she suggests that women should first be made aware of their rights as a patient; and equity and respect in the interactions between patients and caregivers at health facilities should be promoted.[125] She suggests that this be done through understanding obstetric violence interventions on the part of health care personnel and trust on the part of the

[116] See: *Mtetwa v Minister of Health* 1989 (3) SA 600 (D), *Lower Umfolozi District War Memorial Hospital v Lowe* 1937 NPD 31.
[117] H Lerm 'Who is responsible for mishaps in the operating theatre at a private hospital?' (1 June 2017) available at: *http://www.derebus.org.za/responsible-mishaps-operating-theatre-private-hospital/,* accessed on 31 October 2019.
[118] See: *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W).
[119] Lerm (note 117 above).
[120] Pickles (note 2 above) 12.
[121] *Collins v Administrator, Cape* 1995 (4) SA 73 (C) at [82].
[122] 1999 (1) SACR 192 (W).
[123] Pickles (note 2 above) 12.
[124] See: S Aryal 'Things so complicated' (27 May 2017), available at: *https://myrepublica.nagariknetwork.com/news/20773/?fb_comment_id=1563107640366784_1566041703406711,* accessed on 31 October 2019.
[125] Ibid.

patient.[126] The researcher respectfully finds this solution questionable. The enforcement of obstetric violence laws does not hinder the promotion of women's rights but rather creates an advancement in the education of women of such rights. To rely on the parties to develop a respectful relationship without legal intervention leans toward a naïve hope for human decency when parties have unequal bargaining power.

(iv) The current health systems approach is inadequate

The well-placed criticism of Pickles regarding the currently utilised health systems approach is evident from the outcomes that the National Committee for Confidential Enquiry into Maternal Deaths ('NCCEMD') reveal. The mandate of this Committee will be discussed in Chapter Four. The factors revealed by the research conducted by the NCCEMD as contributing to maternal deaths, however, have not yet been addressed and birthing women continue to die due to the failures of an inept health system.[127]

(v) Criminal sanctions in this context are being viewed as punitive and counter-productive

Tamés argues that the criminalisation of obstetric violence is a drastic measure that should only occur in cases of forced sterilisation of women.[128] She bases her view on the negative effect criminal penalties have on doctors' attitudes towards patients when they themselves feel threatened.[129] Further, she points out that adopting a criminal law approach does not assist in eliminating disrespectful treatment of maternal patients.[130] The validity of Tames' viewpoint can be seen in the escalation of defensive medicine.

3.5.2.1. Defensive medicine

Whilst it is a good thing when patients exercise their rights by instituting action against medical practitioners who treat them disrespectfully, the consequences can be negative. Due to increased court cases being brought against members of the medical profession, others are starting to take a defensive stance.[131] This attitude is called 'defensive medicine.' This occurs when a medical practitioner acts in a manner to protect himself against a possible lawsuit by

[126] Ibid.
[127] Department of Health *Negotiated Service Delivery Agreement (NSDA) 2010-2014 For Outcome 2: A Long and Healthy Life for All South Africans* (2010) 7.
[128] R Tamés 'The Invisible Violence Against Women in Mexico' in A Anaya-Muñoz & B Frey (eds) *Mexico's Human Rights Crisis* (2018) 92.
[129] Ibid.
[130] Ibid.
[131] See: Oosthuizen & Carstens (note 96 above) 278.

being extremely careful, such as encouraging the patient to obtain a second opinion; performing additional tests to double-check results; or refusing to perform dangerous and risky surgeries.[132] Whilst it is better to be safe than sorry, this approach incurs extra costs for the patient. Also, ground-breaking medicine comes to a halt when surgeons are afraid of leaving their comfort zones.

A survey conducted by the MPS in South Africa showed that at least 58 per cent of doctors have changed the way they practise due to fear of litigation.[133] This increase in defensive medicine restricts the patient's access to care. Obstetricians and gynaecologists are the most insured medical practitioners since most claims arise from non-consented caesarean sections and children born with brain damage or defects that were not detected within a reasonable time.[134]

Further, by practitioners adopting this outlook, a shift occurs in the priorities of the medical practitioner. No longer is the patient viewed as the first priority, but the practitioner's protection against a lawsuit takes precedence. The entire medical profession is being reshaped from being patient-centred to adopting defensive stances.[135] However, this goes against the very Hippocratic oath that medical practitioners swear to when they are appointed. This attitude is already being seen in the field of obstetrics.[136] Many private obstetricians would rather leave practice than risk defending a legal claim.[137]

Currently, the litigation that ensues between obstetrician and patient is seen as being 'cost-inefficient.'[138] Legal fees are spiralling out of control in a way that the ailing system cannot bear the expense of any longer. The KwaZulu-Natal Department of Health has paid out its entire budget for negligence claims for the 2018/2019 fiscal year within half a year.[139] This staggering number of claims indicates 'that the service is not being given the way it should be.'[140]

It is, thus, respectfully submitted that if patients, in this case maternity patients, are treated in the way they ought to be, there would be no need to protect oneself against such a

[132] Ibid.
[133] Ibid. See further: GR Howarth 'Obstetric risk avoidance: Will anyone be offering obstetrics in private practice by the end of the decade?' 2013 *SAMJ* 513.
[134] Coetzee & Carstens (note 45 above) 1297.
[135] Ibid.
[136] Oosthuizen & Carstens (note 96 above) 278.
[137] Ibid.
[138] Walters (note 98 above).
[139] S Nsele 'Medical negligence claims out of control' (16 November 2018) *The Witness* at 2.
[140] Ibid.

possibility. The existence of such a wary mindset in medical practitioners highlights the extent of the deviation from respectful medical treatment that protects patients' rights rather than infringes them.

The attitude by medical practitioners to civil litigation brings into question the possible reaction should obstetric violence be criminalised. It is the researcher's submission that any possible patient recourse, be it civil or criminal, will result in defensive behaviour on the part of medical practitioners. To blame lawyers for increased claims is to pass the buck for the consequences of a failing health system. Rather, the law can be utilised as a tool to put pressure on the intended medical professionals it aims to govern to act in a manner befitting their profession rather than being viewed as a threat to end the profession altogether. The law viewed through this lens aims to assist in curbing disrespectful treatment of patients rather than allowing the continuance of such behaviour due to the apprehension of medical personnel.

To draw parallels between legal professionals and medical professionals in this regard, both are bound by a set of professional ethics. Clients and patients respectively are to be treated with utmost respect. Any deviation from the Legal Professional Ethics results in being reported to the legal governing body, the Legal Practice Council, and depending on the transgression, can result in being struck off the roll.[141] Criminal charges may also ensue, for example, when trust fund monies are misappropriated.[142] Medical practitioners face similar consequences. Thus, there is no reason why medical practitioners cannot be held in a similar regard and face criminal consequences.

It should be noted that although the claims against medical practitioners have increased, litigation that results in a court of law finding against the defendant still remains rare.[143] This results in perpetuation of the 'conspiracy of silence.'[144] Despite constitutional guarantees protecting the right to health, the state has yet to be successfully sued for failing to meet its obligations.[145] Being a second generation right, the state manages to evade responsibility on the basis of taking progressive steps to realise the right which is not absolute and fulfil its obligation.[146]

[141] See: Rule 43.4.1.4.1 of The South African Legal Practice Council Rules made under the authority of sections 95(1), 95(3) and 109(2) of the Legal Practice Act 28 of 2014 (as amended).
[142] Rule 43.4.1.2 of the SA Legal Practice Council Rules.
[143] Coetzee & Carstens (note 45 above) 1301.
[144] Ibid.
[145] Still (note 46 above).
[146] Ibid.

3.6. TO CRIMINALISE OR NOT TO CRIMINALISE?

Due to the criticism of criminalising obstetric violence, it is the researcher's suggestion that only intentional actions on the part of practitioners and nurses be deemed a crime. Civil liability may still arise as a result of medical negligence. This suggestion is based on the premise of South Africa's Domestic Violence Act[147]. This gender-based legislation also aims to curtail violence against victims of domestic spats. Such violence can occur in a similar form to obstetric violence such as through physical, psychological, emotional, sexual, and patrimonial abuse.[148] Remedies provide for the offender to be faced with either civil liability or criminal penalty depending on the severity of the abuse. Therefore, this Act can be used as guidance in the handling of obstetric violence cases.

There have been calls for legislative reform to ensure positive outcomes for patients as well as medical practitioners.[149] At the 2017 Medical Malpractice Workshop it was accepted that legislation will be needed to address the current medical negligence crisis.[150] The South African Law Reform Commission has also conducted research regarding the increased medico-legal claims. It has been found that there needs to be a change in the legal framework surrounding this area.[151] Legislation and policy directives need to be implemented to fill in the gap that the National Health Act does not provide guidance for. [152] Thus, comprehensive legislation regarding medical malpractice can help to address obstetric violence in South Africa. However, in the interim, the existing criminal law framework will suffice.

Pickles attributes the failure to recognise obstetric violence as a crime to the survival of the respective mother and child despite the traumatic birthing experience.[153] The prevailing mindset in the medical setting in which birth takes place appears to be that the standard of care is deemed to be up to par provided no life is lost.

3.7. CONCLUSION

Based on the movement made by WHO for respectful maternity care and the serious stance taken by countries that have opted to criminalise obstetric violence, it is submitted that

[147] Act 116 of 1998.
[148] Section 1 of the Domestic Violence Act.
[149] See: South African Law Reform Commission (note 94 above) 4.
[150] Ibid 47.
[151] Ibid 5.
[152] Ibid.
[153] Pickles (note 2 above) 11.

obstetric violence should be recognised as a crime in South Africa. This identification of such criminal behaviour conveys the seriousness with which the situation needs to be handled. Without taking drastic measures, the problem will not abate.

Criminalisation is undoubtedly drastic; however, the resultant consequences can be handled in a dignified way. This is where the researcher's next suggestion lies. Whilst criminal law is punitive and victim-centred, the failures of the health system and the unsavoury conditions under which health personnel operate need to be taken into consideration. Authors, Coetzee and Carstens, conducted research with regard to medical negligence and found that these cases can be attributed to poor management and lack of accountability.[154] The authors suggest that the wrong approach is being taken to address the problem. Instead of trying to reduce claims by finding alternative dispute resolution mechanisms, the health system inefficiencies that lead to these claims should rather be remedied.[155]

Thus, the mere criminalisation of obstetric violence itself will not make a big dent in stopping such behaviour. In order to do so, many changes need to take place at various levels. Hence, this is where implementing the human rights-based approach discussed in Chapter Two comes into play.

To play on a sentiment voiced by Dickens and Cook[156], the law can be used as a shield to protect professionals who abide by the rules and regulations and as a sword against those who try to flout it.

[154] Coetzee & Carstens (note 45 above) 1300.
[155] South African Law Reform Commission (note 94 above) 12.
[156] Quoted by Pickles in 'Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa' (2015) 54(1) *SA Crime Quarterly* 5, 8.

CHAPTER 4

EXPLORING GLOBAL INTERVENTIONS TOWARDS THE IMPLEMENTATION OF LEGAL SANCTIONS AND PRACTICAL SOLUTIONS TO CURB THE INCIDENCE OF OBSTETRIC VIOLENCE

'Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving.'[1]

- Professor Mahmoud Fathalla

4.1. INTRODUCTION

The movement to address respectful maternity care has gained momentum globally with countries making headway in implementing strategies to curtail obstetric violence. As was pointed out in Chapter Two, in order to adopt an HRBA to obstetric violence in the legal context it is necessary to conduct a situational analysis of the problem area. Part of the analysis would be to examine the existing remedies that are available to counter the problem. This Chapter will first look at laws that have been enacted and efforts that have been taken internationally to criminalise obstetric violence. Thereafter, guidance will also be drawn from regional and domestic strategies and remedies. The various trends in the sanctions imposed by different regions will be given consideration. These strategies provide templates for addressing possible points of intervention, both legal and programmatic, in South Africa.

4.2. INTERNATIONAL AND FOREIGN LEGAL AND PROGRAMMATIC APPROACHES TO OBSTETRIC VIOLENCE

International organisations, especially WHO, the International Federation of Gynaecologists and Obstetrics (FIGO), the UN and the White Ribbon Alliance (WRA), have been major role-players in the movement to address and improve the quality of maternal health care. The momentum gained from their efforts will be discussed hereunder. Thereafter, an overview of the legal and programmatic efforts made by the pioneering region – Latin America – in

[1] Quote by Professor Mahmoud Fathalla, President of the International Federation of Obstetricians and Gynaecologists. Cf: United Nations Secretary-General 'Secretary-General's remarks at High-Level Forum on Accelerating MDG-5' (23 September 2013), available at: *https://www.un.org/sg/en/content/sg/statement/2013-09-23/secretary-generals-remarks-high-level-forum-accelerating-mdg-5*, accessed on 07 June 2019.

utilising the law to tackle obstetric violence will be provided. A focal spotlight will be shone specifically on Argentina and Brazil – Argentina for its progressive laws and Brazil for its peculiar attitude toward accepting obstetric violence within its legal framework.

Furthermore, the solutions that have been implemented in Europe and Asia, focusing specifically on Italy and India respectively, will be looked at. Although Table 1 showed that Italy has a MMR of 4; the obstetric violence statistics raise a red flag, necessitating further analysis. India has been party to interesting maternal health cases which have been brought before the Delhi High Court. Thus, the insight and guidance that these judgements can provide are vital to anticipating the judiciary's future attitude to hearing obstetric violence cases going forward.

4.2.1. Utilising International Commitments to Address Obstetric Violence

As was discussed in Chapter Two, there are numerous international treaties such as the International Bill of Rights, the Convention of the Elimination of All Forms of Discrimination against Women and the International Declaration on the Elimination of Violence against Women under which member states are bound and can be held liable for failure to address the serious threat to and violation of the right to health and dignity that obstetric violence poses. Notably, whilst there is currently no binding document providing women with rights during childbirth, the Charter drawn up by the White Ribbon Alliance is a significant beacon of hope for placing these rights on the international human rights agenda.

4.2.2. Efforts by International Organisations

WHO has led a multi-country study, comprising of Ghana; Guinea; Myanmar and Nigeria, to investigate occurrences of obstetric violence after the release of its statement in 2014.[2] This study found that more than a third of women who participated in the survey in these four low-income countries were mistreated during childbirth.[3]

WHO's statement was the catapult which led to many other organisations aligning themselves with the obstetric violence cause. The International Federation of Gynaecologists and Obstetrics (FIGO) in 2014 issued guidelines to prevent the neglectful, disrespectful facility care that obstetric violence encompasses by tackling the various forms of abuse it

[2] ET Maya et al. 'Women's perspectives of mistreatment during childbirth at health facilities in Ghana: findings from a qualitative study' (2018) 26(53) *Reproductive Health Matters* 70, 78.
[3] Bohren et al. 'How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys' (2019) *The Lancet* 1.

may take; allowing women to adopt a comfortable birthing position (not merely the supine one) and allowing the intake of fluids.[4] The Baby Friendly Hospital Initiative initiated by FIGO is a scheme aimed at encouraging breast-feeding.[5] The aims are in line with curbing obstetric violence since the initiative calls for more "mother-friendly" birthing facilities.[6]

WHO and the Pan American Health Organization issued the Fortaleza Declaration on Appropriate Technology for Birth in 1985, advocating for the fact that childbirth is a normal process, not an illness that is to be treated.[7] Women's decision-making and participation in medical procedures that affect her and her child were recognised.[8] The use of routine procedures, those with no medical basis, is a form of obstetric violence that WHO tried to address from 1996, by producing the 'Care in Normal Birth' practice guide.[9] This guide lists fourteen medical interventions that are not to be performed during birth unless appropriate and necessary depending on evaluating whether the birth is high- or low-risk.[10] However, this guide has had little impact on practice.[11]

The WHO Reproductive Health Library trial was part of the research aimed at changing practice based on evidence gathered.[12] The rigid professional attitudes, however, posed a barrier since they were unlikely to change without simultaneous organisational restructuring and staff support.[13] Leape et al. argue for a shift in organisational culture.[14] They have expressed that disrespectful behaviour often stems from individual personalities and their reaction to environmental stressors; however, when disrespectful behaviour is allowed to thrive by being tolerated, it becomes learned behaviour.[15] WHO, FIGO and the

[4] S Miller & AB Lalonde 'The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother−baby friendly birthing facilities initiative' (2015) 131 *International Journal of Gynecology and Obstetrics* 49, 51.
[5] S Fawcus 'Respectful Maternity Care' (2016) 4 *Obstetrics & Gynaecology Forum* 30, 32.
[6] Ibid.
[7] M Dias & VEM Machado 'Obstetric Violence in Brazil: An Integrated Multiple Case Study' (2018) *Humanities and Social Sciences Review* 117, 124.
[8] Ibid.
[9] J Bradley *Obstetric Violence in the United States: The Systemic Mistreatment of Women during Childbirth*, (Honours Program, DePaul University, 2017) 9.
[10] Ibid.
[11] Ibid 10.
[12] World Health Organisation *Evidence-led obstetric care: Report of a WHO meeting* (2004) 14.
[13] Ibid.
[14] LL Leape et al. 'Perspective: a culture of respect, part 2: creating a culture of respect' (2012) 87(7) *Acad Med.* 853.
[15] Ibid.

Midwives Association have developed a set of attitudinal skills that obstetric unit staff ought to possess to facilitate amenable staff-patient relationships.[16]

The White Ribbon Alliance has been instrumental in the process of eliminating disrespect and abuse of women during childbirth. By developing the Universal Rights of Childbearing Women Charter in 2011, the WRA has set the foundation for standards of care health facilities ought to provide.[17] The Charter recognises that the provision of safe maternity care is not only a public health issue but also a women's rights violation when absent.[18] The Charter encompasses seven fundamental rights that health systems ought to universally apply for improved patient care.[19] A Respectful Maternity Care toolkit is also created by the WRA to assist developing countries to investigate, measure and mitigate instances of obstetric violence.[20]

The WRA has been directly involved in childbirth improvement initiatives taking place in individual countries, such as the Model Maternity Initiative in Mozambique and the RMC programmes in Ethiopia and Kenya.[21] Mozambique's decision to improve childbirth facilities came in wake of wanting to achieve the Millennium Development Goals.[22] The WRA offers its support in campaigns for national legislation change that align with the Charter's vision in countries such as Nepal, Nigeria and Malawi.[23] The Alliance has not only focussed on patient-centred care but also empowering midwives — most of whom often work in ill-disposed environments — by pioneering workshops in Uganda, Vietnam, and Peru.[24]

The Maternal Health Task Force started the Hansen Project on Maternal and Child Health, by investigating the instances of abuse and disrespect in urban Tanzania and rural Ethiopia.[25] The researchers found that by adopting a participatory approach, the prevalence of

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[16] L D'Ambruoso, M Abbey & J Hussein 'Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana' (2005) 5(140) *BMC Public Health* 1, 9.
[17] See: White Ribbon Alliance *Respectful Maternity Care: The Universal Rights of Childbearing Women* (2011), available at: *https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf*, accessed on 12 February 2019.
[18] White Ribbon Alliance *Respectful Maternity Care: The Universal Rights of Childbearing Women* (2011) 2.
[19] Ibid. These are the universal rights to non-discrimination; freedom from cruel, degrading, and inhumane treatment; right to information; right to informed consent and refusal; right to self-determination; and the right to the highest standard of physical and mental health.
[20] Fawcus (note 5 above) 33.
[21] Ibid.
[22] Ibid.
[23] S Bathala 'Addressing Disrespect and Abuse During Childbirth' (2 May 2013), available at *https://www.wilsoncenter.org/event/addressing-disrespect-and-abuse-during-childbirth*, accessed on 16 April 2018.
[24] Ibid.
[25] HL Ratcliffe et al. 'Applying a participatory approach to the promotion of a culture of respect during childbirth' (2016) 13(80) *Reproductive Health* 1.

such undignified treatment could be curbed.[26] They suggest that interventions need to be followed through with, with facilities being committed to change; managerial support must be provided; and staff involvement in the process is necessary.[27] In order for such interventions to be feasible, staff and resources need to be available.[28]

The United Nations has introduced The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) based on the Sustainable Development Goals. This strategy came into force after the 2010-2015 period, during which the goal was to make progress in achieving the Millennium Development Goals in developing countries. The Global Strategy aims for the three categories of people who are the subject matter of the project to 'survive, thrive and transform.'[29] Thus, one of the goals is the realisation of women's rights to physical and mental health and well-being by the year 2030.[30] By adopting multi-sectoral evidence-based techniques and a human rights-based approach in the Global Strategy, the United Nations aims to address women's sexual and reproductive health rights and gender-based violence.[31]

Furthermore, the Special Rapporteur of the UN, in 2015, together with other experts on human rights issued a joint statement toward achieving the 2030 goals by calling for states to 'address acts of obstetric and institutional violence suffered by women in health care facilities' and 'to take all practical and legislative measures to prevent, prohibit, and punish such acts and guarantee redress.'[32] It is submitted that is high time that South Africa heed such a call.

The above efforts are a few examples of the many international projects aimed at promoting respectful maternity care. Positive results and suggestions gathered from these projects can guide South Africa's response to obstetric violence prevention.

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[26] Ibid 6.
[27] Ibid.
[28] Ibid.
[29] Every Women Every Child *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* (2015) 6.
[30] Ibid.
[31] Ibid.
[32] UN General Assembly *Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence* A/74/137 (11 July 2019) 16.

4.2.3. Latin America

Venezuela was the first country to declare obstetric violence illegal in 2007.[33] The punishment is a fine paid by the guilty party, together with a signed document acknowledging accountability for the particular criminal sentence.[34] This set the landscape for more countries to follow its example; to differing degrees. Veracruz in Mexico promised its womenfolk a life free from all violence, including obstetric violence.[35] However, in the year after taking this step, no complaints were filed due to lack of awareness of the law surrounding obstetric violence.[36]

The Venezuelan population showed a greater knowledge of obstetric violence but the ignorance of legal recourse mechanisms led to cases not being reported.[37] Thus, the National Institute for Women in Venezuela has begun spreading awareness about what obstetric violence constitutes and how to report its occurrence through the dissemination of informative brochures.[38] This indicates that ignorance is a barrier to accessing justice when citizens are not familiarised with laws prohibiting violence against women.

Article 7 and 8 of Bolivia's Law Number 348,[39] enacted in 2013, provides that women should be free from all forms of violence; violating reproductive rights during provision of health care being one of the sixteen (16) forms of violence protected against. Women are explicitly protected against 'actions or omissions that impede, limit or otherwise violate women's rights to information, orientation, comprehensive care and treatment during pregnancy or miscarriage, labour, birth, postpartum period, and breastfeeding' and 'any discriminatory, humiliating, or dehumanising action, and anything which omits, negates or restricts access to immediate, effective care and timely information, committed by health personnel, that puts the life and health of women at risk.' This legislation is all-embracing in the promotion of women's birthing rights.

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[33] *Organic Law on the Right of Women to a Life Free of Violence* (3 April 2008) *VEN102784.E*, available at: *https://www.refworld.org/docid/49b92b1cc.html*, accessed 1 May 2019. *Ley Organica Sobre el Derecho de las Mujeres a una Vida Libre de Violencia* (Organic Law on the Right of Women to a Life Free of Violence) (as amended in 2014).
[34] Article 39-59 of the Organic Law.
[35] LZ Dixon 'Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices' (2015) 29(4) *Medical Anthropology Quarterly* 437, 443.
[36] Ibid.
[37] Ibid 444.
[38] CR Williams et al. 'Obstetric violence: a Latin American legal response to mistreatment during childbirth' (2018) 125(10) *BJOG* 1208, 1209.
[39] Comprehensive Law to Guarantee Women a Life Free from Violence in Bolivia (2013).

In 2013, Article 4 of Panama's Law 82[40] guaranteed that women live a violence-free life, including from obstetric violence, which is defined as that which is 'exercised by health personnel over women's bodies and reproductive processes, expressed as abusive, dehumanising, humiliating or vulgar treatment.' Article 27.3 provides supportive mechanisms for the detection and reporting of obstetric violations among other medical procedures.

Mexico's Law No. 118 of 2007 (as amended in 2014)[41] penalises obstetric violence, defined as 'all actions or omissions by medical and health professionals that damages, harms, denigrates or causes the death of the woman during pregnancy, birth and the postpartum period.' This broad definition provides for recourse against negligent medical practices as well as inappropriate medical procedures and unnecessary interference with the mother-child bond.[42]

Uruguay has also joined the obstetric violence movement. Legislation directed at empowering women, especially by recognising their reproductive rights, was given priority in Uruguay through the Defence to Sexual and Reproductive Health Law;[43] Voluntary Interruption of Pregnancy Law;[44] and Accompaniment in Childbirth Law;[45] amongst others.

4.2.3.1. Argentina

As early as 2004, Argentina's Ministry of Health issued guidelines for respectful maternity care in practice and continues to provide such direction in order to mitigate the usage of non-beneficial medical procedures.[46] Obstetric violence is criminalised in the Violence Against Women Statute 2009[47] which emanated from the Statute on Humanised Labour.[48] The latter legislation is aimed at preventing the overmedicalisation of childbirth and the use of invasive practices when they are not incumbent for the mother's or foetus's survival or protection. The Humanised Labour Statute vehemently promotes women's status as a person who is actively

[40] Ley que tipifica el delito de femicidio y la violencia contra la mujer (Ley 82, Panama 2013).
[41] General Law on Women's Access to a Life Free of Violence (Ley General de Accesso de las Mujeres a una Vida Libre de Violencia) 2007.
[42] Williams et al. (note 38 above).
[43] Law 18426.
[44] Law 18987.
[45] Act 17386.
[46] CH Vacaflor 'Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina' (2016) 24(47) *Reproductive Health Matters* 65, 66.
[47] National Law Number *26.485.* Article 6 defines obstetric violence as 'exercised by health personnel over a woman's body and reproductive processes, expressed as dehumanising treatment, and/or abusive over-medicalisation and medicalisation of the natural processes, in conformity with Law 25.929.'
[48] National Law 25.929.

involved in decision-making regarding her medical care and not a subjugated object.[49] Thus, women's childbirth rights are protected by recognising their rights to privacy, adequate information and respectful medical treatment.

Argentina's broad obstetric violence laws do not merely focus on women's rights during childbirth but also their right to be free from such violence when receiving health services at the abortion, prenatal, labour and post-partum stages.[50] When women are denied emergency obstetric care, either through positive conduct or an omission, it is possible that Argentinian law may hold the health provider accountable.[51]

The health practice recommendations have developed into obligations for health providers to reduce overmedicalisation.[52] However, these guidelines have not been successfully put into practice.[53] Whilst a reduction in episiotomies was recorded (41.2 per cent avoidance) in Argentinian hospitals between 2004 to 2006, only 17.9 per cent of women were given proper support during their birthing experiences.[54]

Argentina became aware of the low reports of occurrences of obstetric violence, with only thirteen (13) cases being reported in 2013 and thus acknowledged that women have the right to timeous, effective access to justice.[55] This recognition called for free legal representation provided by the state, specifically dedicated to victims of gender-based violence.[56] This removed an important barrier to women exercising their rights. The Ombudsman's Office in Buenos Aires has since developed interventions and policies for the receipt of obstetric violence complaints.[57] The first Argentinian obstetric violence trial was heard in 2018.[58]

[49] Vacaflor (note 46 above) 69.
[50] Ibid 67.
[51] Ibid.
[52] Ibid 68.
[53] Ibid.
[54] Ibid.
[55] Ibid 69.
[56] Ibid.
[57] Williams et al. (note 38 above) 1210.
[58] Ibid.

4.2.3.2. Brazil

Brazil's Federative Constitution protects motherhood and childhood.[59] In 1990, adequate and decent childbirth care was explicitly recognised when Brazil ratified the United Nations Convention on the Rights of the Child. However, despite these commitments, one in every four Brazilian birthing women experience obstetric violence.[60] In 2001, it was estimated that 90 per cent of maternal deaths could be prevented in Brazil with adequate medical care and treatment;[61] and only 16 per cent of births occurred with the assistance of a nurse in 2011.[62]

Brazil's goal to address obstetric care is clearly seen in its national policies such as the National Policy for Comprehensive Care to Women's Health; the National Programme for Humanization of Birth Care; and the Humane Care Standards for Low Birth Weight Infants. Ordinance No. 1459 was enacted to assist with the regulation and realisation of women's rights and care when it comes to reproductive planning.[63]

The Brazilian Ministry of Health, geared towards engineering dignified birthing experiences, promoted humane birth through various initiatives; such as the Baby Friendly Hospital Initiative, Kangaroo Mother Care, Sunrise Project and Human Milk Bank.[64] The idea of 'Normal Birth' facilities has also taken root in Brazil.[65] Programmes aimed at assisting with the obstetric violence cause by encouraging reproductive planning and facilitating normal births were developed in Brazil, such as the *Projeto Parto Adequado* (Proper Delivery Project) and *Projeto Cegonha* (Stork Project).[66] A non-governmental organisation, Artemis' vision is to eradicate violence in all forms it occurs against women, obstetric violence included.[67] The Central and Latin America Centre for Perinatology (CLAP) in Latin America has also played a role in the movement for dignified childbirth.[68]

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[59] Constitution of the Federative Republic of Brazil, 1988.
[60] Dias & Machado (note 7 above) 119.
[61] HMF Jorge & MY Makuch 'Nursing Training and Practice on Humanization Actions in Monitoring the Delivery in Brazil' (2016) 9(212) *International Archives of Medicine* 1, 7.
[62] Ibid 2.
[63] Ibid.
[64] Ibid 7.
[65] Ibid 7.
[66] R Cerqueira 'Obstetric violence: dehumanization of labor and evidences of silenced pain' (1 April 2019), available at: *http://isags-unasur.org/en/obstetric-violence-dehumanization-of-labor-and-evidences-of-silenced-pain/*, accessed on 16 April 2019.
[67]CSG Diniz et al. 'Disrespect and abuse in childbirth in Brazil: social activism, public policies and providers' training' (2018) 26(53) *Reproductive Health Matters* 19, 22.
[68] Williams et al. (note 38 above) 1208.

Committed to humanising birth as early as 2002, Brazilian nurses were given the opportunity to attend a training programme regarding obstetric care in Japan.[69] The results in practice showed improvement in patient treatment as well as reduction in the tendency to resort to medicalised obstetric practices by finding alternative less-invasive methods.[70] This is commendable as these innovative techniques protect patients' rights to not be subjected to intrusive medical procedures that jeopardise their privacy and bodily integrity.

During studies conducted in hospitals in Curitiba, maternity ward patients emphasised the need for obstetric nurses to be the turning point for change in humane patient care.[71] Research conducted indicated that undergraduate medical programmes are not sufficiently equipping health personnel with the interpersonal empathetic skills required for humanised births to occur.[72]

Brazil's Federal Public Prosecutor's Office on 4 December 2018 recognised obstetric violence as a form of sexual violence.[73] This ground-breaking classification places obstetric violence within the broad scheme of gender-based violence. The implications of this on women's rights will be discussed in Chapter Five.

Therefore, the above Latin American countries have been the pioneers for protecting women's maternal rights in the context of respectful childbirth through legal mechanisms. It is submitted that South Africa should be cognisant of the approach taken by these countries when finding a solution to obstetric violence.

4.2.3.3. Sanctions Imposed for Obstetric Violence in Latin America

The punishment meted out by the Latin American countries for the commission of obstetric violence differ. Venezuela and Argentina specifically define obstetric violence as a crime in their national laws. Mexico[74] and Brazil have laws in various states that deal with obstetric violence prevention. As mentioned previously, the sentence for obstetric violence is usually a fine together with a written and signed acknowledgement of liability by the perpetrator

[69] Jorge & Makuch (note 61 above).
[70] Ibid.
[71] Ibid 8.
[72] Ibid 9.
[73] Dias & Machado (note 7 above) 118.
[74] The Mexican states of Colima (2016), Hidalgo (2016), Guanajuato (2015), Durango, Veracruz, and Chiapas have addressed obstetric violence through legislation.

himself and/or the facility.[75] Disciplinary proceedings are also provided for.[76] The legislation adopts a health system approach in conjunction with criminal liability.[77]

Mexico's Access of Women to a Life Free of Violence Statute, 2007 prohibits violence against women and sanctions its occurrence in all forms.[78] By the recognition of institutional violence in Chapter IV of this Act, an obligation is placed upon the three levels of government to protect the rights contained therein.[79] Contravention of Veracruz's obstetric violence laws results in a maximum sentence of 6 years imprisonment or a fine amounting to 300 days of the offender's salary.[80]

Argentina's Comprehensive Protection Law[81] serves to safeguard women against direct or indirect violent acts or omissions in all domains of their lives whereby women are in an unequal power relationship.[82] The protection extends to protection of women's lives; liberty; dignity; physical, psychological, sexual, patrimonial and economic integrity; security of person and freedom from discriminatory practices.[83] Behaviour of the state and its agents falling within this catchment is punishable as well.[84] Article 6*(e)* protects women specifically against obstetric violence. Article 6 of Argentina's Humanisation of Birth Statute, 2004 provides for the civil or criminal liability of health professionals who do not comply with the Act.

Brazil provides for the provision of information and protection of pregnant and parturient women against obstetric violence in State Law No. 17.097 of 17 January 2017. Non-compliance with this law and the National Obstetric and Neonatal Care Policy results in an administrative proceeding by the respective agency to determine the sanction.[85] Notably, Brazil's Ministry of Health considered the possible abolishment of the term 'obstetric violence', viewing it as a 'connotation wrong' that is not valuable to the humanisation of

[75] RJ Chadwick 'Obstetric violence in South Africa' (2016) 106(5) *S Afr Med J* 423.
[76] C Pickles 'Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa' (2015) 54(1) *SA Crime Quarterly* 5, 8.
[77] Ibid.
[78] Article 3 of the Access of Women to a Life Free of Violence Statute.
[79] Article 19 of the Access of Women to a Life Free of Violence Statute.
[80] Pickles (note 76 above).
[81] Comprehensive Protection Law to Prevent, Punish and Eradicate Violence Against Women Within Their Interpersonal Relationship Environments, Ley 26.485.
[82] Article 4 of Law 26.485.
[83] Article 5 of Law 26.485.
[84] Article 4 of Law 26.485.
[85] Article 1 of the State Law on Obstetric Violence in Santa Catarina, Brazil.

birth movement.[86] The researcher views this hesitancy to accept obstetric violence as a legal term as a reversion to neglecting women's sexual and reproductive rights in the medical sector. This, unfortunately, results in an illustration of one step forward and many steps back.

Due to the criticism the Brazilian Ministry of Health received after its decision to backtrack, they conceded that they would accept the usage of the term obstetric violence by women, but they refused to alter the approach to the term in government documents and affairs.[87]

Importantly, Brazil was held accountable by the Committee on the Elimination of Discrimination against Women for its failure to prevent the death of Alyne da Silva.[88] The death of this mother resulted from denial of quality health care when she was undergoing obstetric complications. After seeking medical attention when she was six months pregnant, she was not properly diagnosed as having a high-risk pregnancy. When she still continued to experience pain, she returned to the facility and it was found that a stillbirth of her child would have to be induced since no foetal heartbeat could be found. A piece of the placenta was not removed, and she developed an infection. The private hospital at which she was admitted was not equipped to deal with her complications, as she required a blood transfusion, so it was decided that she would be transported to a public facility. However, the public hospital refused to allow its only ambulance to be used to transfer the patient to their facility. After waiting for eight hours to be attended to, the patient was transferred to the public hospital whereby she was neglected for twenty-one hours in the hospital hallway. She eventually haemorrhaged and became another maternal death statistic.

CEDAW acknowledged the underlying factors, including neglect and non-implementation of State policies, that led to the violation of the Alyne's rights. It was found that Articles 10*(h)* (access to educational health-related information); 12.1 (protection from discrimination), 12.2 (access to appropriate services during pregnancy) and 16(1)*(e)* (measures are to be taken by state parties to eliminate discrimination) of the Convention on the Elimination of All Forms of Discrimination against Women were violated.[89] Her death

[86] F Paes 'Why extinguish[ing] the term 'obstetric violence' violates constitutional and international law' (08 May 2019), available at: ***h****ttp:/Why%20extinguish%20the%20term%20'obstetric%20violence'%20violates%20constitutional%20and%20international%20law%20_%20HuffPost%20Brasil%20CRIMINAL.html*, accessed on 14 May 2019.
[87] A Ignacio 'Brazil's Debate Over 'Obstetric Violence' Shines Light On Abuse During Childbirth' (08 September 2019), available at *https://www.huffpost.com/entry/obstetric-violence-brazil-childbirth_n_5d4c4c29e4b09e72974304c2*, accessed on 09 October 2019.
[88] *Alyne da Silva Pimentel Teixeira ('Alyne') v. Brazil*, CEDAW/C/49/D/17/2008.
[89] Ibid at [11.5].

could have been avoided had it not been for her race (she was of Afro-Brazilian descent), gender and her socio-economic circumstances. Brazil eventually settled on an amount to pay as compensation to Alyne's family. This ground-breaking decision was the first decision in which an international treaty body had issued such a judgement holding a government accountable for its failure to prevent a maternal death.

In a case concerning Bolivia before the Inter-American Commission, the forum found the non-consensual sterilisation of a Bolivian woman to be a violation of the rights to personal integrity; personal freedom; private and family life; access to information and to be free from cruel, inhuman and degrading treatment. [90] The Commission has also released a statement calling on 'states to document, investigate, and punish emerging forms of violence against women, girls and adolescents,' including obstetric violence.[91]

Notably, all of the above American countries are signatories to the Belém do Pará Convention[92] which obliges signatory states to take action; including creating legislation to punish, investigate and prevent violence against women. The enforcement body of the Belem do Para Convention, MESECVI, encourages all signatory countries to criminalise obstetric violence.[93]

4.2.4. Europe

4.2.4.1. Italy

Although Table 1 in Chapter One indicates that the MMR in Italy is only 4 per 100 000 live births, the Italian National Health Institute argues that such figure is significantly 'underestimated by 60%' since there are almost 1259 'near miss' cases every year.[94]

In 2014, a study with a sample group of five million Italian mothers, revealed that one million women in Italy have been subjected to obstetric violence over the span of the

[90] *I.V. v. Bolivia*, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-American Court of Human Rights (ser. C) No. 329 (2016).
[91] Inter-American Commission on Human Rights 'The IACHR Urges States to Refrain from Adopting Measures that Would Set Back Respect for and Protection of Women's Rights' (8 March 2018), available at: *http://www.oas.org/en/iachr/media_center/ PReleases/2018/044.asp*, accessed on 09 October 2019.
[92] Organization of American States *Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Convention of Belem do Para")* (9 June 1994) available at: *https://www.refworld.org/docid/3ae6b38b1c.html*, accessed 31 May 2019.
[93] I Barbosa & R Reingold 'Rethinking Obstetric Violence: Is Criminalisation Really the Only Way Forward?' (04 November 2018), available at: *http://oneill.law.georgetown.edu/rethinking-obstetric-violence-is-criminalization-really-the-only-way-forward/*, accessed on 07 January 2019.
[94] 'First Data on Obstetric Violence in Italy' (04 November 2017), available at: *https://ovoitalia.wordpress.com/2017/11/04/first-data-on-obstetric-violence-in-italy/*, accessed on 09 October 2019.

preceding fourteen years.[95] The results indicated that four (4) out of every ten (10) women were subjected to practices that impaired their dignity or psychophysical integrity.[96] Further, one (1) out of three (3) women felt excluded from the decision-making process related to childbirth choices.[97] 61 per cent of the mothers who had participated in the survey had not given their informed consent to an episiotomy.[98] Also, many accounts of abuse revealed that the obstetrician physically jumped onto the birthing woman to propel the birth, causing damage to her body such as a ruptured uterus and broken ribs.[99]

A member of the Italian Parliament, Adriano Zaccagnini, in March 2016 proposed that obstetric violence be criminalised through enacting a specific law[100] creating an offence. Four proposals are being utilised by Parliament to draft a bill.[101]

An attorney who had undergone an unconsented episiotomy in Italy, Battisti, was driven by her own unpleasant birthing experience to start the Obstetric Violence Observatory (OVO), with co-founder Elena Skoko.[102] This body aims to give obstetric violence the attention it requires on legal and political platforms.[103] The OVO empowers women to talk about their experiences and tries to garner support from other institutions to intervene when injustices occur. The OVOItalia is the brainchild of the #batacere ('break the silence') social media campaign that was launched in April 2016. Battisti has voiced her support for the criminalisation of obstetric violence as she says: 'without judicial recognition it is very difficult for women to seek legal redress.'[104]

Victims of obstetric violence have, thus, been influential in consultations with legislatures to address the problem. For example, Gloria Zappitani from Paraguay, an obstetric violence survivor, assisted in the drafting of Act 5777[105] in her country.[106] This

[95] A Cicali 'How Italian women are organising against "obstetric violence"' (4 January 2018), available at *https://www.opendemocracy.net/en/5050/how-italian-women-are-organising-against-obstetric-violence/*, accessed on 16 April 2019.
[96] Ibid.
[97] Ibid.
[98] Ibid.
[99] C Paganelli 'Women´s reproductive rights in Italy: obstetric violence as a human rights violation' (16 November 2018), available at: *https://blog.wave-network.org/obstetric_violence_italy*, accessed on 09 October 2019.
[100] This law proposal was called 'Norms for the Protection of the Rights of Women and Newborns in Childbirth and Regulation for the Promotion of Physiological Birth.' See: Cicali (note 95 above).
[101] Cicali (note 95 above).
[102] Ibid.
[103] Ibid.
[104] Ibid.
[105] Comprehensive Protection of Women against All Forms of Violence, Act 5777 of 2016.

legislation, enacted in December 2017, criminalises obstetric violence and puts in place measures to assist survivors; such as free legal representation, provision of shelter and skills training for the victims.[107]

4.2.4.2. Sanctions Imposed for Obstetric Violence in Europe

From the above discussion, Italy is clearly leaning toward the criminalisation of obstetric violence rather than merely relying on civil compensation and remedies.

Looking at the European approach generally, cases revolving around childbirth, such as forced sterilisations, have come before the European Court of Human Rights ('ECHR'). The ECHR found the conduct complained of to constitute violations of the right to private life and to be free from torture or inhuman or degrading treatment.[108] The forced sterilisation of women (a form of obstetric violence), especially vulnerable sects of women, has been identified by the ECHR as being a 'gross disregard for her right to autonomy and choice as a patient.'[109]

The ECHR elaborated on the right to life protected in Article 2 of the European Convention on Human Rights by explaining that states are required to 'make regulations compelling hospitals… to adopt appropriate measures for the protection of their patients' lives'[110] and 'an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable …'[111]

The entertainment of such cases by this human rights treaty body indicates the willingness to allow obstetric violence cases to be dealt with on legal platforms from a human rights angle.

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[106] 'Paraguay passes new law to end violence against women, including femicide' (12 March 2018), available at: *http://www.unwomen.org/en/news/stories/2018/3/news-paraguay-criminalizes-femicide*, accessed on 16 April 2019.
[107] Ibid.
[108] See: *N.B v Slovakia*, no. 29518/10, 12 June 2012 (sterilisation of minor without her consent nor her guardian's consent); *V.C v Slovakia*, no. 18968/07,08/11/2011 *(sterilisation of Roma woman during a caesarean section without informed consent)*and *I.G. v Slovakia*, no. 15966/04, 29/04/2013 (sterilisation of the first and second applicants, both of whom were Roma women, without obtaining proper informed consent). *See further regarding forced sterilisation: A.S. v. Hungary*, Communication No. 4/2004, CEDAW/C/36/D/4/2004 *(compensation to be paid by Hungary to the affected patient).*
[109] UN General Assembly (note 32 above) 9.
[110] XA Ibañez & T Dekanosidze 'The State's obligation to regulate and monitor private health care facilities: the Alyne da Silva Pimentel and the Dzebniauri cases' (2017) 38(17) *Public Health Rev*. 1, 3.
[111] Ibid.

4.2.5. Asia

4.2.5.1. India

India does not have a specific obstetric violence law. The country, however, has adopted a cash incentive whereby mothers are paid to use hospital birthing facilities in an effort to reduce India's maternal mortality rates.[112] In a study conducted between 2015 and 2017 in an Indian state with the highest maternal mortality rate (Assam), it was found that obstetric violence was predominant in the care given in hospitals.[113] A study conducted in India has found that indigent rural women giving birth naturally at Indian public health facilities are more likely to experience mistreatment by the person attending to their birth and are consequently more likely to not survive the birth. This is due to the fact that these health care providers are not qualified doctors. Further, it has been found that women in India having a low socio-economic status are 3,6 times more likely to experience the disrespectful treatment that obstetric violence comprises of.[114]

An Indian project that involves the community's input to address disrespectful maternal health care, SAHAYOG, is comprised of women at grassroots level.[115] This organisation has a say in decisions regarding their maternal facilities. The project has had a positive outcome in empowering women, holding facilities accountable, creating greater awareness of rights and identifying aspects of practice requiring improvement.[116] It is submitted that South Africa should have a similar network of women who interact directly with health facilities and are able to express the exact procedures that are not serviceable. This network can provide direct insight to law- and policymakers when drafting Bills.

4.2.5.2. Sanctions Imposed for Obstetric Violence in Asia

Indian courts have delivered important judgements regarding the rights of birthing women that have been brought before them.

Two important cases involving denial of access to health care and services to pregnant women were heard before the High Court of Delhi in *Laxmi Mandal v Deen Dayal*

[112] S Chattopadhyay, A Mishra & S Jacob 'Safe', yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India' (2017) 20(38) *Culture, Health & Sexuality* 1.
[113] Ibid.
[114] UN General Assembly (note 32 above) 14.
[115] International Initiative on Maternal Mortality and Human Rights *Human Rights-based Approaches to Maternal Mortality Reduction Efforts* (2010) 11.
[116] Ibid.

Harinagar Hospital and Others[117] and *Jaitun v Maternal Home MCD, Jangpura and Others*[118] (‘*Laxmi Mandal’*).

The first case revolved around Shanti Devi, a mother who had passed on soon after her sixth child was born prematurely. She had not been attending prenatal check-ups because of the fear she would encounter similar barriers to health care that she did during her fifth pregnancy.[119] Before the birth of her fifth child, four different public hospitals refused to provide her with the necessary obstetric care, even though she qualified for public health benefits.[120] Eventually a hospital in Delhi admitted her so she could give deliver the stillborn child that she had been carrying in her womb for five days.[121] Shortly after delivering her stillborn child, she was discharged even though she was not in a fit condition to be released. Thus, upon the birth of her sixth child, she gave birth at home and died due to complications that would have been easily prevented at a health facility.[122]

The second case centred on Fatema, a homeless pregnant woman who was denied access to medical services and gave birth to her baby girl without assistance, under a tree in open public view.[123]

The public health system was deemed to be accountable for the violation of these two women’s rights to life[124] and health under the Indian Constitution. The family of Devi was awarded compensation in the first case. Fatema was awarded 50 000 rupees in the second case. The relevant Indian states responsible for the failing maternal health benefits scheme were tasked with remedying the situation.

These are landmark judgements that have sparked commentary by scholars and other countries. Importantly, the decisions serve to indicate how maternal health rights can be protected and supported by a country’s constitution, as well as how these rights can be relied upon to hold a government accountable for its health system failures.

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[117] W.P.(C) No. 885/2008.
[118] W.P. No. 10700/2009.
[119] *Laxmi Mandal* (supra note 117 above) [28.3] – [28.5].
[120] Ibid.
[121] Ibid.
[122] Ibid [28.8].
[123] Ibid [29.2].
[124] This right was elaborated upon in the case of *Paschim Banga Khet Mazdoor Samity & Ors v. State of West Bengal & Anor.* whereby the Supreme Court of India held that the right to life in the Indian Constitution ‘included an obligation to provide timely medical treatment necessary to preserve human life.’

4.3. REGIONAL EFFORTS IN SELECTED AFRICAN COUNTRIES

Looking at countries closer to home, efforts made by countries such as Nigeria, Ghana and Kenya to address obstetric violence will be explored hereunder. These countries, like South Africa have a high MMR (as identified in Table 1). Since South Africa has similar socio-economic conditions to these countries, the progress that they have made through their efforts would likely have a similar effect in South Africa.

4.3.1. Utilising Regional Commitments to Address Obstetric Violence

In terms of the Optional Protocol to the Convention on the Elimination of all Forms of Discrimination against Women, states have a duty to create, implement and monitor laws that prevent violence against women.[125] Similarly, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa provides for legal reform.[126] South Africa, being a signatory to the Charter, has an obligation to 'enact and enforce laws that prohibit' violence against women in all its forms.[127] In addition to legislative measures; administrative, social and economic measures need to be taken to prevent, punish and eradicate such gender-based violence.[128] Article 5 also provides for legislative measures to be taken to prevent harmful practices.

The African Charter protects the rights to life[129] and to be free from torture and cruel, inhuman and degrading treatment.[130] These rights are further enshrined and fortified in General Comments 3[131] and 4[132] on the African Charter respectively. This depicts the region's commitment to the prevention of conduct, within which it is submitted obstetric violence falls, which infringes or has the potential of infringing the above-mentioned rights. The Charter, thus, requires state parties to take a proactive role in preventing, responding to and redressing such violations.

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[125] United Nations Department of Economic and Social Affairs *Handbook for Legislation on Violence Against Women* (2009) 6.
[126] Ibid 9.
[127] Article 4(2) of the Protocol to the African Charter.
[128] Ibid.
[129] Article 4 of the African Charter.
[130] Article 5 of the African Charter.
[131] African Commission on Human and Peoples' Rights *General Comment No. 3* on the African Charter on Human and Peoples' Rights: The Right to Life (Article 4) (18 November 2015) available at: *https://www.achpr.org/public/Document/file/English/general_comment_no_3_english.pdf,* accessed on 05 December 2020.
[132] African Commission on Human and Peoples' Rights *General Comment No. 4* on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5) (2017), available at: *https://www.achpr.org/legalinstruments/detail?id=60,* accessed on 05 December 2020.

The African Commission on Human and People's Rights has also said that gender stereotyping that presents itself in reproductive health care settings needs to be eliminated through efforts that 'address patriarchal attitudes, as well as the prejudices of health care providers.'[133] Obstetric violence, evidently a form of gender-based violence, can fall within the landscape of laws punishing violence against women in general. Thus, South Africa's obligation to protect its women citizens can be called into account through its international and regional commitments.

4.3.2. Nigeria

Nigeria, a country that has built its Constitution on South Africa's foundational legal principles, provides a good example when it comes to rights-related issues. Having a large population, Nigeria suffers a high maternal mortality rate, with 19% of global maternal deaths in 2015 occurring in Nigeria alone.[134] A significant contributory factor is that only 45% of Nigerian women are attended to by skilled maternity staff.[135] More than 50 000 Nigerian women die from complications that arise during pregnancy every year.[136]

In light of the above statistics, Nigeria was open to the values of the White Ribbon Alliance Respectful Maternity Care Charter and has had several projects occurring within its borders to research disrespectful maternal care with the aim of finding solutions.[137] The Kwara state adopted the ideals promoted by the Charter in an attempt to implement them in state hospitals.[138] Health providers were also trained in the administration of proper treatment to their patients.[139]

Most births in Nigeria occur in rural areas, where women are not attended to by skilled medical professionals.[140] The Midwives Service Scheme (MSS) was set up in rural Nigeria in 2009 to address this problem, with 2500 midwives being sent out nationally.[141]

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[133] African Commission on Human and Peoples' Rights *General Comment No. 2* on Article 14.1 *(a), (b), (c)* and *(f)* and Article 14. 2 *(a)* and *(c)* of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (28 November 2014), available at: *https://www.achpr.org/legalinstruments/detail?id=13.*, accessed on 09 October 2019.
[134] F Ishola, O Owolabi & V Filippi 'Disrespect and abuse of women during childbirth in Nigeria: A systematic review' (2017) 12(3) *PLOS ONE* 1, 2.
[135] Ibid.
[136] EN Okeke 'The Better Obstetrics in Rural Nigeria (BORN) Study Evaluating the Nigerian Midwives Service Scheme' (2015), available at *https://www.rand.org/pubs/research_briefs/RB9857.html* accessed on 08 April 2019.
[137] Ishola, Owolabi & Filippi (note 134 above) 12.
[138] Ibid.
[139] Ibid.
[140] Okeke (note 136 above).
[141] Ibid.

The Better Obstetrics in Rural Nigeria (BORN) study was conducted to assess the progress of the MSS.[142] To Nigeria's dismay, the scheme had not been successful.[143]

4.3.3. Ghana

Research conducted in Ghana has revealed that women who have a negative childbirth experience are unlikely to utilise facility-based obstetric services for subsequent births.[144] Ghana is regarded as a low-income country, correlating with the fact that more than half of births are not attended to by skilled professionals.[145] Further, 50 per cent of mothers in Ghana who do not give birth at institutions are not provided with postnatal care.[146]

Many interviews and focus group discussions have been conducted in Ghana to gain an insight into the treatment women receive upon childbirth.[147] When research was being carried out in Koforidua and Nsawam, it was discovered that most of the mistreatment of women takes place at the second stage of the birthing process (labour), especially when it comes to teenage pregnancies.[148]

The studies conducted indicate that fear of disrespect and abuse at Ghanaian facilities, either through own experience or word of mouth, makes women less inclined to utilise obstetric services, creating a barrier to their right to health care.[149] This in turn can reverse any progress that Ghana has made in reducing its maternal mortality rate.

4.3.4. Kenya

The Heshima Project evaluated the extent of disrespect and abuse at thirteen Kenyan birthing facilities[150] between 2011 and 2014. This project is notable in bridging the gap between health providers and patients through communication and accountability. The values of respectful maternity care were implemented, and medical practitioners underwent training. The project recognised the Respectful Maternity Care Charter as a rights-based approach and

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[142] Ibid.
[143] Ibid.
[144] D'Ambruoso, Abbey & Hussein (note 16 above) 6.
[145] Ibid 2.
[146] Ibid 2.
[147] See: Ibid 3; Maya (note 2 above) 70.
[148] Maya (note 2 above) 70.
[149] Ibid 78.
[150] These facilities were located in Kisumu, Kiambu, Nyandarua and Uasin Gishu counties and rural Nairobi. See: T Abuya et al. 'The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya' (2015) 15(224) *BMC Pregnancy and Childbirth* 1, 2.

included the Charter's core tenets in the Maternal Health Bill.[151] Alternative dispute resolutions were provided for issues arising between health care facilities and their patients.[152] This approach allows patients to obtain appropriate redress without undergoing arduous litigation. Anonymous complaints could be laid against health providers by unsatisfied mothers.[153] Gender-based violence was also addressed in workshops that sought to evoke empathy in health care workers.[154]

The results of the Heshima Project confirmed that mistreatment of birthing women is commonplace.[155] Researchers observing the interactions between patients and facility staff noticed that women did not report any violence they were subjected to, and this could be attributed to their acceptance of such behaviour.[156]

4.3.5. Sanctions Imposed for Obstetric Violence in Africa

The above discussion indicates that African countries appear to be tackling obstetric violence through programmatic efforts. However, there are cases that have been brought before African courts that are of value to the obstetric violence discourse.

Centre for Health Human Rights and Development (CEHURD) v Attorney General[157] is a pivotal judgement in Uganda heard in 2011 revolving around the high MMR in Uganda.[158] It was filed in the Constitutional Court of Uganda by the Centre for Health, Human Rights and Development. The aim was to address the government's obligation to provide essential maternal health services as well as quality medical services to expecting mothers. Two women were involved in the case, namely Sylvia Nalubowa and Jennifer Anguko; both of whom had died whilst giving birth.

Nalubowa gave birth to one child in 2009, however, the emergency services needed to deliver the unexpected accompanying twin were not available at that particular health facility. Once she was transferred to a district health facility, admittance was denied unless she provided the nurses with the necessary payment. Nalubowa promised some land to the nurses

[151] ML Betron et al. 'Expanding the agenda for addressing mistreatment in maternity care: a mapping review and gender analysis' (2018) 15(143) *Reproductive Health* 1, 8.
[152] Ibid.
[153] Ibid.
[154] Ibid.
[155] Abuya et al. (note 150 above).
[156] Ibid 10.
[157] Constitutional Petition No. 16 of 2011.
[158] The MMR in Uganda is 343 per 100 000 live births as at 2015. See statistics available at: *https://data.unicef.org/wp-content/uploads/country_profiles/Uganda/country%20profile_UGA.pdf*.

but unfortunately, she died before her second baby could be born.[159] Anguko, on the other hand, was neglected by staff at a public hospital for more than ten hours when she came in requiring emergency care; eventually dying from a ruptured uterus.[160]

When the matter came before the Constitutional Court, it was dismissed for being a question of resources and budgetary allocation, invoking the political question doctrine.[161] This meant that the issue was best left to the legislature and executive to determine, not the judiciary. However, the Centre took the decision on Appeal to the Supreme Court of Uganda. The judgement of the Constitutional Court was overturned as the matter was clearly a constitutional issue requiring constitutional interpretation that was within the power of the judiciary to determine.[162] The court relied on the interpretation of the right to health in two judgements, namely *Minister of Health v Treatment Action Campaign*[163] and *Paschim Banga.*[164] The Supreme Court provided the Constitutional Court with guidelines for determining the issue by looking at whether the facts of the case were indeed true and whether the non-delivery of maternal health services to the respective deceased women was a constitutional violation of the right to access medical services.[165] The case was reopened in 2016. This case reflects the importance that having the right to health being constitutionally recognised has on a country's MMR.

A case close to home, *LM and Others v Government of Republic of Namibia*[166], dealt with coerced sterilisation of three HIV-positive women. The court's decision in this case is pivotal as the court found such sterilisation to be unlawful[167] and ordered damages to be paid. The High Court's judgement was reaffirmed by the Supreme Court of Namibia on appeal.[168] Although the women had signed the sterilisation paperwork whilst in the throes of labour, they had not understood the implications, thus nullifying any *prima facie* consent that was alluded by their signatures.[169] This judgement, although criticised for certain questions left

[159] JT Dunn, K Lesyna & A Zaret 'The role of human rights litigation in improving access to reproductive health care and achieving reductions in maternal mortality' (2017) 17Suppl 2(367) *BMC Pregnancy and Childbirth* 71, 78.
[160] Ibid.
[161] Ibid.
[162] Ibid.
[163] *Minister of Health & Others v. Treatment Action Campaign & Others* 2002 (5) SA 703.
[164] *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor.* AIR SC 2426/ (1996) 4 SCC 37 (Supreme Court of India 1996).
[165] Dunn, Lesyna & Zaret (note 159 above) 79.
[166] (I 1603/2008) [2012] NAHC 211 (30 July 2012).
[167] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014) at 80.
[168] Ibid.
[169] Ibid [102].

unanswered[170], has nevertheless been hailed for its protection and acknowledgement of women's rights during childbirth.[171] The court's willingness to make such a favourable decision for women, indicates that similar litigation will filter through to the courts. In the absence of South African case law on obstetric violence, it is likely that the South African judiciary will turn to this Namibian case for guidance.

A litigious suit was brought on behalf of a Kenyan woman who had been subjected to serious neglect and abuse during her birthing experience at a hospital.[172] It was held that the systemic failures which enabled such treatment as well as the poor health care quality in the medical sector constituted human rights violations.[173] The court found in favour of the ill-treated woman. This judgement is a major victory for the rights of obstetric violence victims, protects their right to access to justice and ensures accountability through legal redress.

Thus, whilst African countries have not yet enacted any obstetric violence specific laws, they have shown a willingness to allow legal recourse when conduct falling within the ambit of obstetric violence takes place. However, the African approach based on the outcome of the above cases tends to lean toward imposing civil remedies on the perpetrator rather than criminal sanctions.

4.4. SOUTH AFRICAN EFFORTS AND LAWS

Part of the analysis for the implementation of an HRBA is to assess the current situation surrounding the problematic area. Thus, before South Africa can devise a plan to tackle obstetric violence, it needs to assess what legal and programmatic solutions have already been established and tested. In this way, efforts will not be duplicated.

4.4.1. Utilising South Africa's Constitutional Obligations to Address Obstetric Violence through Health Programmes

The South African Constitution provides the starting point for addressing the obstetric violence conundrum. The Bill of Rights enshrines health rights; the most important protection being encapsulated in section 27(1)*(a)* which provides for the universal access of everyone to

[170] See: C Pickles 'Sounding the Alarm: *Government of the Republic of Namibia v LM* and Women's Rights during Childbirth in South Africa' (2018) (21) *PER* 1 – 34.
[171] C Badul & A Strode '*LM and Others v Government of the Republic of Namibia*: The first sub- Saharan African case dealing with coerced sterilisations of HIV-positive women – Quo vadis?' (2013) 13 *AHRLJ* 214, 223.
[172] G Sen et al. 'Addressing disrespect and abuse during childbirth in facilities' (2018) 26(53) *Reproductive Health Matters* 1, 3. See: *J O O (also known as J M) v Attorney General & 6 others* [2018] eKLR.
[173] Ibid.

health care services, including *reproductive health care*. Linked to the protection of reproductive health rights, section 12(2) protects the right to bodily and psychological integrity, which includes the right to make reproductive decisions; to security in and control over one's body; and the right not to be subjected to medical or scientific experiments without one's informed consent.

Notably, the right to health is a second-generation right that is progressively realisable by the state.[174] Nevertheless, the provision for the right to reproductive health and bodily integrity in the cornerstone of South Africa's legal system emphasises that women's health rights are entitlements that ought to be protected rather than mere privileges. Thus, it is necessary to explore the steps that South Africa has taken to protect these rights in the context of obstetric violence, especially legal efforts.

South Africa's commitment to improving sexual and reproductive health rights can be gleaned from legislation, policies and the constitutional right centred on the protection of health rights, more importantly in this case; reproductive health rights. However, majority of the focus remains on dealing with the HIV/AIDS epidemic and making improvements to the primary health care sector.[175] The consequences of strategies which cater for this has resulted in 92 per cent of South African women attending antenatal care.[176] Further, South Africa grants free access to public maternity health facilities and provision of abortion services is legal.[177]

4.4.2. Efforts in South Africa

4.4.2.1. Department of Health

Millennium Development Goal 5 was created to reduce countries' maternal mortality[178] ratios by three quarters by the year 2015; to improve antenatal care for mothers and to enhance the level of skills that health personnel possess when attending to patients.[179] In order for countries to meet this goal, an increase in facility-based care by skilled medical staff was

[174] Section 27(1)*(b)* of the Constitution, 1996.
[175] Human Rights Watch *Stop Making Excuses: Accountability for Maternal Health Care in South Africa* (2011) 3.
[176] Ibid.
[177] Ibid.
[178] Maternal mortality refers to the death of pregnant women or women who have terminated their pregnancies within the last 48 hours, due to any cause or aggravating factors of pregnancy; or its management; and not a merely accidental occurrence.
[179] Statistics South Africa *Millennium Development Goals 5 Report: Improve maternal health* (2015) v.

required;[180] the positive result being addressing the disrespectful treatment patients are subjected to in maternity wards.

Reducing maternal mortality has been on the South African policy-making agenda for decades.[181] Whilst this dissertation does not concern reduction of maternal mortality, obstetric violence is one of the contributory factors linked to such a cause. Thus, such efforts in turn help to reduce the incidence of obstetric violence.

In 1998, a National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) was assigned to investigate the causes of birthing women's deaths, in line with the goals of the National Policy Health Act.[182] Due to general confusion amongst maternity staff regarding the level of care to be provided at different stages of birth, national guidelines were issued in 2001 by the Department of Health.[183] The Maternal, Child and Women's Health Directorate tasked with producing these documents released the 'National Maternal Health Guidelines' and the 'Saving Mothers; Policy and Management Guidelines for Common Causes of Maternal Deaths'.[184] These policies, though not binding, provide better guidance to practitioners and have the potential to effectively reduce the maternal mortality rate when followed. The National Department of Health has also launched the Ideal Clinic Documents and Checklists in April 2017 to assist in enforcing the health guidelines and providing facilities with targets to meet for the provision of standardised quality health care.[185]

The Saving Mothers' Lives triennial reports have been instrumental in identifying the causes of maternal deaths.[186] The NCCEMD gathers confidential data based on individual deaths by following a thorough process, including filling in a Maternal Death Notification Form.[187] Through these techniques, it has been discovered that majority of maternal deaths

[180] Ibid.
[181] In 1994 women were given free access to health care in South Africa. In 1997, a confidential enquiry into maternal deaths was carried out, with maternal deaths becoming notifiable by law. See: J Moodley et al. 'The confidential enquiry into maternal deaths in South Africa: A case study' (2014) *Royal College of Obstetricians and Gynaecologists* 53.
[182] Act 116 of 1990. See further: J Moodley et al. (note 181 above).
[183] L Penn-Kekana & D Blaauw *A Rapid Appraisal of Maternal Health Services in South Africa: A Health Systems Approach* (2002) 14.
[184] Ibid.
[185] National Department of Health 'Ideal clinic definitions, components and checklists' (2017), available at: *https://www.idealclinic.org.za/docs/v17/Final%20Ideal%20Clinic%20Framework%20%20version%2017%20on%203%20Aug%202017.pdf*, accessed on 9 April 2019.
[186] Moodley et al. (note 178 above) 54.
[187] Ibid.

which occur in South Africa are linked to inadequately trained medical staff.[188] This significantly impacts on the quality of care facilities provide and the occurrence of obstetric violence that women fall victim to in such facilities.

4.4.2.2. Better Births Initiative (BBI)

The Better Births Initiative is a global programme, introduced in South Africa, aimed at gathering evidence regarding obstetric practices that are beneficial and those that are harmful, to generate improvements in clinical practice.[189] Research methods employed consists of educational programmes and workshops conducted by obstetricians familiar with evidence-based standards.[190] The data collected is utilised in ascertaining which areas of obstetrics can be updated so as to provide women with a dignified and humanised birthing experience that is beneficial to their health and is committed to providing satisfactory professional services when put into practice.[191]

Research was conducted concerning the efficacy of the BBI at ten (10) hospitals in the Gauteng province in a pilot study in 2004.[192] The BBI was found to be successful in influencing change in certain obstetric practices.[193] The results showed that evidence-based medicine could make a difference provided practitioners were open to evolving present methods.[194] Evidence-based obstetric care integrates knowledge of clinical practice with well-researched studies and reviews. Practitioners are often wary when it comes to evidence-based medicine and are reluctant to implement suggested changes.[195] This may be attributed to the social influence theory, whereby professionals are likely to adopt the views of persons in their field rather than 'outsiders'.[196] This dogmatic approach hinders the campaign for respectful maternity care. The more willing practitioners are to implement changes, the easier suggested transitions will be.

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[188] National Committee for Confidential Enquiry into Maternal Deaths *Saving Mothers 2011-2013: Sixth report on the Confidential Enquiries into Maternal Deaths in South Africa - Short Report* (2013) 23.
[189] H Smith et al., 'Evidence-based obstetric care in South Africa – influencing practice through the "Better Births Initiative"' (2004) 94(2) *South African Medical Journal* 117.
[190] Ibid 118.
[191] This is based on the core principles of the BBI: Humanity, Benefit, Commitment and Action. See: 'How to have a successful government birth' *Your Pregnancy* (2015) 68.
[192] Smith et al. (note 189 above).
[193] Some of the hospitals at which the study was conducted implemented the reduction of enemas, shaving and episiotomy, and increased intake of oral fluids and birthing companions during labour. See: Smith et al. (note 189 above) 118.
[194] Ibid 119.
[195] Ibid 117.
[196] Ibid 118.

Smith et al. identify the various strata -social, organisational and individual- at which change needs to take place to improve obstetric care.[197] By fostering wholesome amenable working relationships and having a staffing unit that is passionate about their jobs, makes leaps in changing obstetric care for the better.[198] The researcher is in agreement with this view which has been expressed by many other researchers in the field.[199] Obstetric violence does not only have an impact at an individual level. Its effects filter through the various levels identified. Therefore, by only addressing the problem from the clinical side puts the solution on shaky ground. Legal barriers to quality maternity services need to be addressed through legislative mechanisms.[200] Any legal intervention needs to work hand-in-hand with the other points of entry where the violence presents itself.

4.4.2.3. Cape Metro: Patient-centred maternity care

After widespread disrespect and abuse of women in maternity settings being reported by patients and witnessed by fourth year medical students in the Western Cape province, the Cape Metro introduced a code.[201] The Code for Patient-Centred Maternity Care hinged off an idea for patient care that had been introduced for general hospital treatment in the province[202] and the Code was adapted to be applicable specifically to maternity patients. Key features of the Code are to provide women with dignified treatment; providing necessary information; facilities that are responsive to patients' needs and allowing birthing companions. This code is being gradually inculcated as a policy in Cape hospitals, the progress of which is still being monitored.[203]

It is submitted that any legal mechanisms regarding obstetric violence in South Africa that could possibly be introduced should draw guidance from this initial step. Patient Charters have been introduced in some countries.[204] South Africa is one of them, providing for the protection of twelve patient rights in its National Patient Charter which was introduced in

[197] Ibid 119.
[198] Ibid.
[199] See: M Sadler 'Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence' (2016) 24(47) *Reproductive Health Matters* 47, 52.
[200] Ibid.
[201] S Honikman; S Fawcus & I Meintjies 'Abuse in South African maternity settings is a disgrace: Potential solutions to the problem' (2015) 105 (4) *S Afr Med J* 284.
[202] Core values of which are caring, competence, accountability, integrity, responsiveness, and respect. Fawcus (note 5 above) 34.
[203] Honikman; Fawcus & Meintjies (note 201 above) 284.
[204] D Bowser & K Hill *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis* (2010) 49.

1997.[205] The aim of the Patient Charter is to provide good quality health care receptive to the focus on the human rights of patients.[206] Importantly, the Charter gives patients the right to complain.[207] However, the Charter is restrictive in its focus of protecting 'consumer's rights,' not encompassing the rights of those who do not have access to health services.[208] Further, the Charter has been criticised for making curative care its focal point with promotive and preventative measures in the health system lagging behind.[209]

Whilst South Africa does not have specific obstetric violence legislation, it does have the Bill of Rights, the National Patient's Rights Charter and this newly introduced medical Code. Law and policymakers may use the relevant rights and principles protected in these instruments, which may be integrated to protect maternal rights.

4.4.2.4. Respectful Maternity Care: Essential Steps in the Management of Obstetric Emergencies (ESMOE) Module

In order to reduce maternal mortality, the ESMOE training programme was developed to provide skills and practical hands-on experience through drill-training for dealing with obstetric emergencies in South Africa.[210] This initiative resulted in the Respectful and Safe Childbirth module which specifically addresses the promotion of dignified treatment of women in labour and tools needed to ensure such goals.[211] The module focuses on instilling empathy in health care providers through the usage of good communication skills, support and encouragement.[212] All trainee doctors, nurses and specialist physicians, such as obstetricians, are required to undergo this training.[213]

Since obstetric violence occurs in conflict-ridden relationships between the health provider and patient, this module indicates that building empathy is likely to reduce the hostility between the two parties.

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[205] K Moyo 'Realising the right to health in South Africa' in J Dugard et al. *Socio-economic rights–progressive realisation?* (2018) at 397, available at: *https://www.fhr.org.za/files/8015/1247/0285/Socio_Economic_Rights.pdf*, accessed on 27 May 2019.
[206] Ibid.
[207] Ibid.
[208] Ibid.
[209] Ibid.
[210] Fawcus (note 5 above) 34.
[211] Ibid.
[212] Ibid.
[213] 'ESMOE Vision', available at: *https://www.esmoe.co.za/*, accessed on 09 October 2019.

4.4.3. Sanctions Imposed for Obstetric Violence in South Africa

As was explained in Chapter Three, obstetric violence remedies in South Africa are either dealt with in terms of criminal law, civil law, or available administrative remedies. The Commission for Gender Equality's recent acknowledgement of obstetric violence occurring in South Africa indicates that these matters will likely be entertained in South African courts.[214]

4.5. DISCUSSION

4.5.1. Certain Notable Similarities Found in South African Obstetric Care

Without delving into an in-depth comparison, it is important to note that there are certain stark similarities between South Africa's obstetric care trends and some of the third world countries mentioned in this Chapter.

The Indian class and caste systems makes the uneven power relations a weighty factor in the standard of care patients receive at birthing facilities in India.[215] Similarly, South African mothers are also subjected to racial and cultural discrimination.[216] Furthermore, monetary factors have also resulted in discrimination in South African maternity wards whereby women are detained when they cannot pay their hospital bills after childbirth.[217] These are factors that play a role in obstetric violence occurrence.

Despite the futuristic goals adopted by Nigeria in tackling disrespectful maternity care, there is still a lack of translation of them in practice.[218] South Africa faces similar problems with the reluctance to implement the findings of the Better Births Initiative.[219] Taking guidance from other countries in overcoming implementation challenges will prove to be useful.

The BORN study in Nigeria highlighted the hurdles faced by policymakers when attempts to improve health care are made by increasing medical attendance. A similar question applies to South Africa as to whether increasing skilled medical attendance during

[214] Commission for Gender Equality *Obstetric Violence in South Africa: Violence against women in reproductive health & childbirth* (27 May 2019) at 3.
[215] Chattopadhyay, Mishra & Jacob (note 112 above) 3.
[216] L Kruger & C Schoombee 'The other side of caring: abuse in a South African maternity ward' (2010) 28(1) *Journal of Reproductive and Infant Psychology* 84, 95. See also: Bowser & Hill (note 200 above) 21.
[217] R Yates; T Brookes & E Whitaker *Hospital Detentions for Non-payment of Fees A Denial of Rights and Dignity* (2017) 4.
[218] Ishola, Owolabi & Filippi (note 134 above) 12.
[219] Smith et al. (note 189 above).

births will have any effect on the reduction of maternal deaths linked to obstetric violence causes. If not, then a legal solution is necessary to counter these effects.

Similar to Ghana, adolescents being discriminated against for their pregnancies has also been recorded in South African accounts of ill-treated patients.[220] The data collected in Ghana also indicated an attitude of acceptance of the mistreatment by women during their birthing experiences.[221] Similarly, research in South African hospitals reflected the same perception by patients who had been subjected to obstetric violence.[222] Likewise, in South Africa, mothers indicated that they would not use a health care facility again after being a victim of obstetric violence.[223] These recurring concerns impede the efforts made to improve maternal health care and safety.

By following Italy's precedent, South African women, victims and supporters alike, can assist in bringing any obstetric violence legislation to be tabled before Parliament. However, women must be willing to step up and let their voices be heard without fear of stigma. As was seen in the Latin American countries, a law that is not utilised cannot help in addressing a problem.

4.5.2. Research Findings from Efforts Conducted in the Area of Obstetric Violence Providing Insight into the Problem

The various laws and strategies adopted by the countries discussed in this Chapter enables them to lead by example. South Africa can especially gain insight from the results of efforts taken by other African countries, as well as research conducted within its own borders.

The call for further research in the area of disrespect and abuse during childbirth by WHO resulted in an increase of investigations on the topic. Tabulated below is a summary of some of the studies that have been conducted and conclusions that can be used as a guide in this dissertation as well as future research and interventions.

[220] R Jewkes, N Abrahams & Z Mvo 'Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services' (1998) 47(11) *Soc. Sci Med* 1781, 1785.
[221] Maya (note 2 above) 76-77.
[222] Jewkes, Abrahams & Mvo (note 220 above).
[223] M Hastings-Tolsma; AGW Nolte & A Temane 'Birth stories from South Africa: Voices Unheard' (2018) 31 *Women and Birth* 42; 45.

Table 4: Summary of Findings from Selected Systematic Reviews, Studies and Articles Conducted in the Area of Obstetric Violence Interventions

No.	*Year*	*Authors*	*Research aim*	*Research Methodology*	*Main findings and solutions for practice*
1	1998	R Jewkes, N Abrahams & Z Mvo[224]	Investigating why nurses abuse patients in maternity wards through research conducted in Cape Town, South Africa.	Qualitative research gathered through 103 in-depth interviews and four focus group discussions with patients and facility staff.	Violence inflicted by nurses on patients is ritualised.[225] Nurses have developed a patient inferiority complex, no longer respecting the patient's autonomy with their own need to assert control.[226]
2	2004	H Smith et al.[227]	Gathering evidence on the effects of the implementation of the Better Births Initiative on practice in hospitals in Gauteng.	Observations at 10 hospitals in Gauteng; educational workshops and exit interviews used to gather data.	Health provider behaviour needs to change.[228] Workers in the obstetric field are likely to treat patients better if their working environments are more satisfactory and they are motivated.[229]
3	2010	D Bowser & K Hill[230]	Reviewing research in the area of childbirth abuse to identify contributory factors, impact,	Review of grey literature surrounding abuse of women during childbirth at health	Categorisation of the phenomena into seven overlapping groupings.[231] These categories take into account human rights principles. Interventions

[224] Jewkes, Abrahams & Mvo (note 220 above) 1781.
[225] Ibid 1790.
[226] Ibid 1791.
[227] Smith et al. (note 189 above).
[228] Ibid.
[229] Ibid 119.
[230] Bowser & Hill (note 204 above).
[231] These categories consist of physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in facilities. See*:* Ibid 3.

			interventions and research gaps.	facilities.	used should be similar to those in other health areas such as HIV stigma.[232] Evidence-based research is seldom followed up on by impact studies.[233]
4	2015	MA Bohren *et al.*[234]	Synthesis of qualitative and quantitative data on mistreatment during childbirth to assist with evidence-based development.	Databases and grey literature searched. Mixed-methods approach used; 65 studies from 34 countries assessed.	Mistreatment typology suggested.[235] Evidence gathered to be used in further discourse. Mistreatment occurs at interpersonal level between health providers and patients, as well as due to systematic health failures.[236]
5	2015	S Miller & AB Lalonde [237]	Reviewing global interventions to address obstetric violence, particularly FIGO's initiative.	Desktop literature review.	Interventions by all stakeholders are necessary to overcome barriers to dignified maternal health care.[238] The strategy by FIGO's Mother-Baby Friendly Birth Initiative to utilise criterion-based and rights-based approaches is suggested.[239]

[232] Ibid 4.
[233] Ibid.
[234] MA Bohren et al. 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review' (2015) 12(6) *PLoS Medicine* 1.
[235] Ibid 5.
[236] Ibid 21.
[237] Miller & Lalonde (note 4 above) 49.
[238] Ibid 52.
[239] Ibid 51.

6	2015	HE Rosen et al.[240]	Reporting on the prevalence of disrespectful maternity care as observed in hospital facilities in five African countries, namely, Ethiopia, Kenya, Madagascar, Rwanda, and the United Republic of Tanzania	Observation of treatment of women at hospital facilities at the labour and delivery stages through the completion of a total of 2164 structured checklists.	Whilst some women were treated with dignity and respect, and given relevant information; abandonment, neglect, physical and verbal abuse were still observed.[241] Structural defects at facilities contributed to such behaviour.[242] The authors call for further research regarding barriers to patient-centred care to determine appropriate solutions.[243]
7	2016	T Stokes et al.[244]	Identification of barriers and enablers influencing improved obstetric care in low-and middle-income countries.	Qualitative systematic review utilising the 'best fit' framework. Nine studies based on hospital facilities in Sub-Saharan countries included.	Low cost suggestions made (such as multidisciplinary meetings); [245] lack of resources poses a problem;[246] further research necessary to determine improvements needed at various organisational levels and to guide intervention implementation.[247]

[240] HE Rosen et al. 'Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa' (2015) 15(306) *BMC Pregnancy and Childbirth* 1.
[241] Ibid 8.
[242] Ibid 10.
[243] Ibid 10.
[244] T Stokes et al. 'Barriers and enablers to guideline implementation strategies to improve obstetric care practice in low- and middle-income countries: a systematic review of qualitative evidence' (2016) 11(144) *Implementation Science* 1.
[245] Ibid 9.
[246] Ibid 9.
[247] Ibid 9.

8	2016	S Bradley et al.[248]	Research undertaken in Sub-Saharan Africa to identify drivers of disrespectful intrapartum care in facilities.	PRISMA (Preferred Reporting Items for Systematic Review and Meta-Analysis) methods guided search of databases from 1990 to 6 May 2015. 25 studies included in thematic discussion.	Increased facility-based births lose sight of the human aspect of birth, rather seeing birth as a medical procedure.[249] Midwives can be instrumental in remedying this.[250] Women and nurses have fallen into the difficulty of interacting between the social and medical models of birth. Prevailing idea of institution-centred care rather than patient-centred care revealed.
9	2017	D Sando et al.[251]	Review of studies conducted that quantify disrespect and abuse during childbirth to extract lessons that have been learned.	PRISMA guidelines used in reviewing five studies with comparative analysis techniques.	Measuring the occurrence of the phenomenon by relying on studies already conducted is tricky due to differing methods used and biases.[252] Difficult to quantify the problem and draw comparative analysis when there are different definitions; methods; instruments and sample groups.[253]

[248] S Bradley et al. 'Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and thematic synthesis of women's perceptions and experiences' (2016) 169 *Social Science & Medicine* 157.
[249] Ibid 167.
[250] Ibid 167.
[251] D Sando et al. 'Methods used in prevalence studies of disrespect and abuse during facility-based childbirth: lessons learned' (2017) 14(127) *Reproductive Health* 1.
[252] Ibid 13.
[253] Ibid 2.

10	2017	K Austad et al.[254]	Finding a solution to increasing accessibility to emergency obstetric care of vulnerable populations that are unlikely to utilise facilities due to disrespect and abuse.	Analysis of data gathered from pilot study in rural Guatemala.	Drawing from a tool used in oncology, care navigators are suggested to create a humanised birthing environment and providing support to patients through an informative, consensual, dignified birthing experience.[255]
11	2018	C Clesse et al.[256]	Reviewing increased medicalisation of birth, the impact of such evolution and the effects on humanisation of birth and women's birth experiences to guide development for best patient care.	Literature review of 112 English and French studies utilising the PRISMA method.	More research required as birth medicalisation increases;[257] society to keep up with psychological effects of evolution of birth on women and to continue providing comfortable births.[258]
12	2018	MA Bohren et al.[259]	Developments of tools to measure the extent of mistreatment and	A two-phased mixed-method design was used to quantify the	Measuring the extent of the prevalence of the mistreatment during childbirth will assist in

[254] K Austad et al. 'Obstetric care navigation: a new approach to promote respectful maternity care and overcome barriers to safe motherhood' (2017) 14(148) *Reproductive Health* 1.
[255] Ibid.
[256] C Clesse et al. 'The evolution of birth medicalisation: A systematic review' (2018) 66 *Midwifery* 161.
[257] Ibid 165.
[258] Ibid 165.
[259] MA Bohren et al. 'Methodological development of tools to measure how women are treated during facility-based childbirth in four countries: labor observation and community survey' (2018) 18(132) *BMC Medical Research Methodology* 1.

			abuse during labour and childbirth in four countries (Ghana, Myanmar, Guinea and Nigeria) in an effort to address the research lacunae.	occurrence of the mistreatment. A total of 2016 women participated in the labour observation tool and 2672 women contributed to the community survey data tool.	designing tools to combat its occurrence.[260] Countries are urged by the researchers to utilise the measurement tools developed in this study.[261]
13	2018	ML Betron et al.[262]	Determining the effect disrespectful maternal care has on the gendered power relations between hospital staff and patients.	127 peer-reviewed articles utilised in this study, originating from January 1995 to September 2017.	Gender inequalities contribute to disrespectful maternity care.[263] Obstetric violence is normalised by hospital staff and patients alike.[264] Women who assert their rights to dignified health care are stigmatised.[265] The study found that 'pregnant and labouring women lack information and financial assets, voice, and agency to exercise their rights.'[266] Rights-based interventions required to address the issue.[267]

[260] Ibid 12.
[261] Ibid 12.
[262] Betron et al. (note 151 above) 1.
[263] Ibid 2.
[264] Ibid 5.
[265] Ibid 5.
[266] Ibid 1.
[267] Ibid 11.

14	2018	S Dowe et al.[268]	Determining the effectiveness of interventionist policies promoting respectful intrapartum care.	Searching of databases, along with ongoing trials registers, and the WRA RMC Repository. All five studies included were carried out in Africa (Kenya, Tanzania, Sudan, South Africa)	The introduction of Respectful Maternity Care policies shows promising outcomes, with a reduction in obstetric violence, especially physical abuse.[269] The authors are sceptical about the longevity of the difference the policies will make.[270] More rigorous research in the area of RMC implementation is called for.[271]

4.5.2.1. Analysis

From the table above, it can be seen that obstetric violence is not a surface problem that can be resolved with a simple solution. Rather, the multifactorial problem has taken root at various stages of the birthing process and in various forms. The research conducted has revealed that the human side of obstetric care is absent.[272]

When obstetric violence takes place, there are insufficient legal remedies and redress in place for women to take the matter further.[273] Moore et al. echo this line of thought by postulating that lack of accountability and ineffective policies have led to continued unrestrained disrespect and abuse of women.[274]

Obstetric violence is a human rights violation.[275] However, despite countries being committed to protecting the rights of the population, mothers' rights are often not specifically

[268] S Dowe et al. 'Effectiveness of respectful care policies for women using routine intrapartum services: a systematic review' (2018) 15(23) *Reproductive Health* 1.
[269] Ibid 2.
[270] Ibid 12.
[271] Ibid 12.
[272] Bradley et al. (note 248 above) 169.
[273] Ishola, Owolabi & Filippi (note 134 above) 10.
[274] Ibid 10.
[275] See: CL Tach 'Obstetric Violence as a Human Rights Violation of Women' (14 April 2019), available at *https://www.rug.nl/rechten/onderzoek/expertisecentra/ghlg/blog/obstetric-violence-as-a-human-rights-violation-of-women-14-04-2019*, accessed on 29 April 2019.

provided for.[276] This can be seen by the meagre number of countries that have codified obstetric violence. Jewkes and Penn-Kekana argue that women's health rights are not given priority and are often not placed on policymakers' agendas.[277] Without having proper legal mechanisms in place and enforcement of policies, the problem continues to persist. It is submitted that based on the discussion of an HRBA, such an approach can provide the framework to assist with the longevity of a feasible solution that targets structural defects, redress and ensures an accountable process.

4.6. CONCLUSION

Whilst the Latin American and European countries appear to favour criminalisation of obstetric violence, the Asian and African countries appear to be slow on the uptake; preferring to compensate the victim rather than impose punitive measures on the offender. South Africa's lack of obstetric violence legislation places it within the latter category. The cases that have been discussed in this Chapter deal with the overt forms of obstetric violence in the main. This indicates that legal recourse is seldom sought for the more subtle forms of obstetric violence which fall through the gaps of legal implementation. It will need to be determined as to how an HRBA can address these shortcomings.

After gaining insight through the broad overview of the various strategies through which obstetric violence has been addressed in different countries, these can provide guidelines for devising a plan for South Africa's approach to obstetric violence and the possibility of legal reform.

[276] Penn-Kekana & Blaauw (note 183 above) 39.
[277] Betron et al. (note 151 above) 7.

CHAPTER 5

OUTLINING THE WAY FORWARD FOR THE PRACTICAL APPLICATION OF AN HRBA TO ADDRESS OBSTETRIC VIOLENCE — AN INTEGRATED RIGHTS-BASED SOLUTION

'*No woman should die while giving life*.'[1]

- Ban Ki-moon

5.1. INTRODUCTION

The previous chapters have explored what an HRBA entails and have provided a situational analysis of the current law and the efforts that have been made to address obstetric violence. This Chapter builds on those explorations by describing how an HRBA can materialise in practice through an integrated approach. First, this Chapter draws on the state's obligation to take steps to curb obstetric violence, using this obligation as the starting point for addressing such disrespectful maternity care in South Africa. Secondly, contributors to the problem and possible solutions that have already been put forward by learned authors are set out thereafter. Thirdly, various interventions required on a three-fold scale; namely at the individual, facility and systemic levels, are suggested. Notably, these suggested interventions and changes do not only emanate from the legal sphere, as a multifactorial problem necessitates a multilateral solution. Thus, the researcher aims to pave the possible way forward through the solutions proffered in this Chapter.

5.2. THE STATE'S OBLIGATION TO ADDRESS OBSTETRIC VIOLENCE

To put the maternal health crisis into perspective, approximately 800 women worldwide die every day during their pregnancy or childbirth experiences.[2] The majority of whom this statistic comprises hail from low- and middle-income countries.[3] Ninety-nine percent (99%) of pregnancy-related deaths occur in developing countries,[4] South Africa being one of them.

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[1] Ban Ki-moon ''No Woman Should Die While Giving Life,' Secretary-General Says at Event on Ending Maternal Mortality' (28 June 2014), *United Nations* available at: *https://www.un.org/press/en/2014/sgsm15984.doc.htm*, accessed 19 December 2019.

[2] N van den Broek 'Happy Mother's Day? Maternal and Neonatal Mortality and Morbidity in Low- and Middle-Income Countries' *International Health* (2019) 11(5) 353.

[3] Ibid.

[4] AE Yamin & DP Maine 'Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations' (1999) 21(3) *Human Rights Quarterly* 563, 564.

Sexual and reproductive health rights that are linked to maternal health rights are contained in international and regional human rights treaties to which South Africa has bound itself, as explained in Chapter Two. South Africa, as a signatory to the human rights instruments that protect reproductive health rights, has the obligation to respect, protect and fulfil these entitlements given to women.[5] This state obligation includes bringing national law in accordance with the standards laid out in these international instruments.[6]

Furthermore, the state's obligation to combat gender-based violence which is advanced by obstetric violence is also brought to the fore, as the CEDAW Committee has defined 'gender-based violence' as 'violence that is directed against a woman because she is a woman or that affects women disproportionately.'[7]

Research has highlighted the non-fulfilment of state obligations in respect of the realisation of health rights.[8] Awareness has been drawn to the 'sad' state of hospitals in South Africa after a woman who gave birth in an Eastern Cape facility sued the health department for damages allegedly caused to her baby.[9] Although she was unsuccessful, the Supreme Court of Appeal made scathing remarks regarding the hospital's competence, finding that '[t]hose reliant upon their services are receiving substandard care' and that 'the situation is to be deprecated.'[10]

The above finding is corroborated by the Global Lancet High Quality Commission study which was conducted in 137 countries in 2018, of which South Africa was also analysed.[11] The study found that 'an estimated 85 709 (56,3%) deaths occurred due to poor quality of care and an estimated 66 410 (43,7%) deaths occurred due to no access to health care.'[12] On the bright side, this study found South Africa's Ideal Clinic initiative to be laudable.[13] Given the growing awareness around suboptimal health care as evidenced by the

[5] Section 7(2) of the Constitution, 1996.
[6] Amnesty International *The State as a Catalyst for Violence Against Women: Violence Against Women and Torture or Other Ill-Treatment in The Context Of Sexual and Reproductive Health in Latin America and The Caribbean* (2016) 62.
[7] Committee on the Elimination of Discrimination against Women *General Recommendation No. 19 on Violence Against Women* (1992) at [6].
[8] See: A Dhai 'A Health System That Violates Patients' Rights to Access Health Care' (2012) 5 *South African Journal of Bioethics and Law* 2.
[9] *AN v MEC for Health, Eastern Cape* (585/2018) [2019] ZASCA 102 (15 August 2019) at [28].
[10] Ibid.
[11] 'Presidential Health Summit 2018 Report' (2018), *South African Government* available at: *https://www.gov.za/sites/default/files/gcis_document/201902/presidential-health-summit-report.pdf*, accessed on 13 September 2019.
[12] Ibid.
[13] Ibid.

above statistics, in October 2018, a Presidential Summit was held in Boksburg, South Africa, to deliberate on the critical state of the country's health system.[14]

Notably, the Constitution contains provisions through which the state can be held accountable for the non-fulfilment of its obligations. For example, the South African Human Rights Commission, a Chapter Nine institution, is mandated to receive a report provided by the State regarding the fulfilment of progressively realisable socio-economic rights, one of them being health care, annually.[15]

In South Africa, health service delivery falls under the jurisdiction of both the national and provincial levels of government.[16] Municipalities are responsible for local health service provision.[17] The National Department of Health is, thus, tasked with legislating on health issues, as well as determining policies, norms and standards, and equity in health care. The provincial levels, however, focus on planning, budgeting and service delivery.[18]

In order to comply with its international law commitments and its obligation to fulfil the right of South African women to respectful maternal care, the government is required to implement measures, which could be legislative, to address obstetric violence.[19] Further, this obligation includes assigning an adequate budget and resources for the realisation of this right.[20]

Ultimately, applying the rights codified in South Africa's Constitution, as well as international human rights law in general, is one of the key solutions to addressing obstetric violence in South Africa and off which this dissertation hinges. This can be incorporated in the law through legal reform based on an HRBA, as will be explained further in this Chapter. It is the researcher's submission that if the state fails to address the concerns that have been raised by previous researchers and which have been enunciated in this dissertation, it is not fulfilling its international obligations. In such a case, the denial of birthing women to their nationally and internationally given rights infringes their rights to life, dignity, access to adequate health care, and provision of non-discriminatory health services.[21]

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[14] Ibid.
[15] Section 184(3) of the Constitution, 1996.
[16] Department of Health *eHealth Strategy South Africa 2012-2016* (2012) 10.
[17] Ibid.
[18] Ibid.
[19] S Gruskin et al. *Perspectives on Health and Human Rights* (2005) 45.
[20] Ibid.
[21] These rights were discussed individually in Chapter Two.

5.3. UTILISING AN HRBA IN THE COURSE OF FULFILLING STATE OBLIGATIONS

The state and state actors, as duty-bearers, hold the principal obligation to protect women from obstetric violence. The HRBA propounded for throughout this project aims to increase the capacity of duty-bearers to fulfil their obligations.[22] Likewise, the capacity of rights-bearers should also be built upon to know and claim their rights in the context of maternal health care.[23] The HRBA is alive to the interrelatedness, indivisibility and interdependence of human rights, thus recognising that women's right to the highest attainable standard of health care is dependent on the realisation of other relevant rights such as the rights to life; dignity, equality; reproductive health care; and the provision of health care services and medicines that are accessible, affordable and appropriate.[24]

An HRBA differs from the health systems response route taken by the medical sector to tackle abuse and disrespect of birthing women. The latter response focuses on strategies and programmes utilising evidence-based medicine to reduce the occurrence of obstetric violence.[25] Whilst these programmes are based on human rights advancement, they take a futuristic approach to prevent the violence occurring henceforward. Thus, the women who have already experienced violations do not have recourse. An HRBA can address obstetric violence on a broader scale as it not only focuses on improving birthing experiences of women in the future through guidelines and policies; but also holding the responsible parties accountable when women have been intentionally subjected to such mistreatment, the repercussions that arise when guidelines are not adhered to, and when the resources and budget allocated by the state do not reflect the motivation to address health care concerns.[26]

Thus, the reason for adopting an HRBA in relation to obstetric violence can be expressed through the following sentiment: 'human rights abuses can dramatically affect health, health can be dramatically worsened when human rights are ignored, and health and human rights can act synergistically with each other for global human betterment.'[27] The individual stages of an HRBA as applied to obstetric violence will be looked at hereunder.

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[22] UN Technical Guidance at [19].
[23] UNTG at [19].
[24] UNTG at [24].
[25] C Pickles 'Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa' (2015) 54(1) *SA Crime Quarterly* 5, 7.
[26] AE Yamin 'Toward transformative accountability: a proposal for rights-based approaches to fulfilling maternal health obligations' (2010) 7(12) *Sur Int J Hum Rights* 95, 102.
[27] Gruskin et al. (note 19 above) 1.

5.3.1.1. Planning: Analysis of the contributors to obstetric violence which need to be addressed

Studies attempting to measure and identify the contributors to obstetric violence have been conducted.[28] Obstetric violence is a concern due to medical negligence being the third leading cause of death worldwide.[29] The sordid state of the public health system is shaped by a myriad of enablers of obstetric violence, and consequently the violation of patients' rights.

Bowser and Hill have identified the following contributors to the continuation of behaviour constituting obstetric violence as well as seven forms in which this violation of rights may present itself. This is indicated in the diagram below.

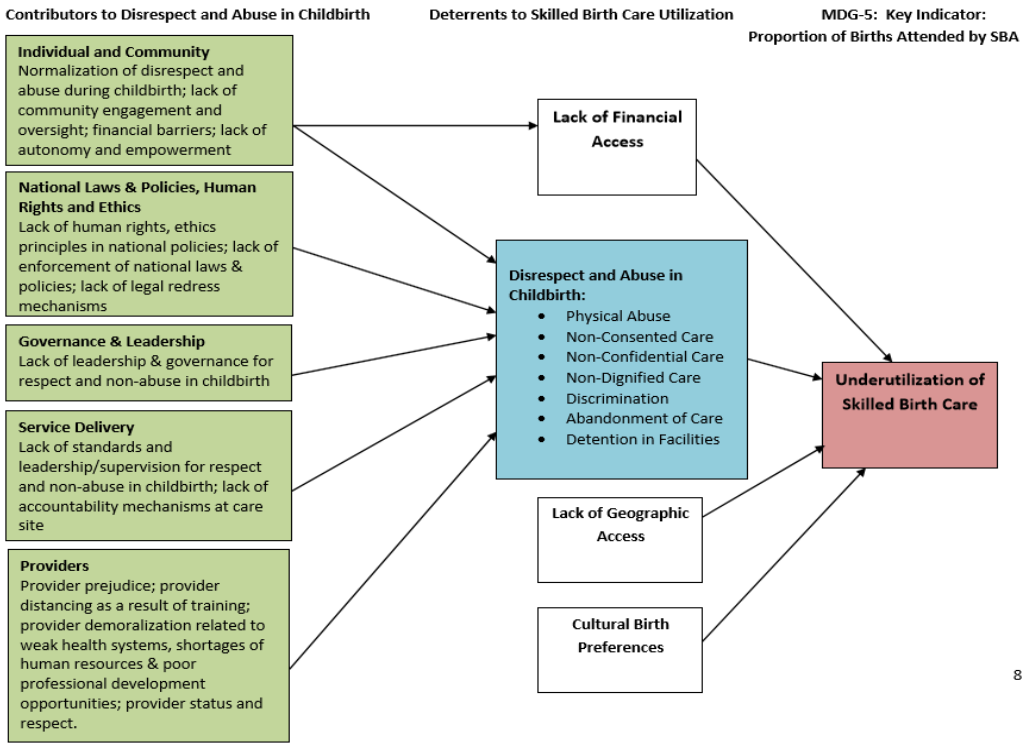

Diagram 5 above: 'Potential Contributors to and Impact of Disrespect and Abuse in Childbirth on Skilled Care Utilization.'

Source: D Bowser & K Hill *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis* (2010) 8.

[28] See for example: D Bowser & K Hill *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis* (2010); MA Bohren *et al.* 'Methodological development of tools to measure how women are treated during facility-based childbirth in four countries: labor observation and community survey' (2018) 18(132) *BMC Medical Research Methodology.*

[29] 'Presidential Health Summit 2018 Report' (2018), *South African Government* available at: *https://www.gov.za/sites/default/files/gcis_document/201902/presidential-health-summit-report.pdf*, accessed on 13 September 2019.

A further situational analysis of obstetric violence reveals that some of the key contributors to poor quality health care have been identified as the under- and over-utilisation of health services, lack of resources, resources not being utilised effectively, poor rapport of human dignity, information barriers, referral systems being ineffective, continuance of avoidable mistakes, and poor delivery systems.[30] These failures to operate optimally have a negative effect on overall productivity at facilities, constituting a danger to the lives and safety of health system users.[31]

A study conducted by the National Department of Health in South Africa across two hundred (200) hospitals found that quality of care is negatively impacted by lack of action when deficiencies in the health system have been identified; accountability measures not being enforced; disciplinary procedures remaining inadequate; corruption contaminating the system and health workers being absent from their jobs and having negative attitudes when they are present.[32]

As derived from Diagram 5 above, weaknesses in management, governance and leadership at health facilities contribute to quality of care diminishing. In addition to this, the problem is compounded by mismanagement, inefficiencies and incompetence across the various strata of health care provision. The organisational structure at hospitals currently can be described as 'top heavy.'[33]

The bodies regulating health care workers, such as the HPCSA and the Nursing Council of South Africa are riddled with inner governance deficiencies,[34] without rectification of which, will render their contribution to dealing with obstetric violence almost obsolete.

'Freezing of posts' and placing moratoriums on hiring of facility staff also impedes the ability of facilities to have adequate staffing units.[35] Furthermore, professionals leaving their jobs in the public health system for private practice creates an uneven burden of staff shortages with 'more health professionals per 10,000 in the private sector than in the public

[30] National Department of Health *Policy on Quality in Health Care for South Africa* (2007) 3.
[31] Ibid 3.
[32] 'Presidential Health Summit 2018 Report' (2018), *South African Government* available at: *https://www.gov.za/sites/default/files/gcis_document/201902/presidential-health-summit-report.pdf*, accessed on 13 September 2019.
[33] Ibid.
[34] South African Lancet National Commission *Confronting the right to ethical and accountable quality health care in South Africa: A consensus report* (2019) 9.
[35] N Marawa *Health Ministerial Task Team Hospital Mismanagement and Poor Service Delivery Closure Report* (2017) 7.

sector.'[36] Staff shortages are concerning as 'there are inadequate posts to meet statutory obligations and poor service planning results in mal-distribution of posts according to need.'[37] These human resource shortages result in staff being overworked and medical errors occur when doctors undergo burnout.[38]

Thus, the purpose of identifying the above contributors assists with identifying the underlying causes of the multifaceted obstetric violence problem. This analysis is the initial step in the process of an HRBA.

5.3.1.2. Planning: Strategising to overcome the barriers to respectful maternal care

A plan of action to tackle obstetric violence needs to be devised. Such plan should be sound and coherent for it to be implemented.

The National Department of Health has identified three key factors in bringing about the development of the health system; namely, strong leadership, education and organisational change.[39] The basis for strategies adopted going forward can be encapsulated in the realisation that '[n]ot all change is improvement, but all improvement requires change.'[40]

The lack of political will to address a problem is usually a hindrance to progress. However, South Africa's National Commission has been upfront about the poor performance in the medical sector and its willingness to attribute the failings to the inadequate system.[41] The Commission in its recommendations suggests that 'stronger governance' is required from the health department level right down to the clinic in order to improve quality of care.[42]

The Department of Health has also acknowledged that is has historically taken a reactive approach to addressing complications in the health sector.[43] It has now changed its stance to a more proactive strategy for intervention. This includes providing better clinical training, integrated planning, better defined targets, improved performance management,

[36] Presidential Health Summit 2018 Report (note 11 above) 29.
[37] Ibid 28.
[38] Ibid14.
[39] National Department of Health (note 30 above) 14.
[40] Ibid.
[41] South African Lancet National Commission (note 34 above) i.
[42] Ibid.
[43] Department of Health *Negotiated Service Delivery Agreement (NSDA) 2010-2014 For Outcome 2: A Long and Healthy Life for All South Africans* (2010) 23.

managing non-clinical staff more effectively, and better planning for service delivery and workforce planning.[44]

5.3.1.2.1. Ensuring that health care is available, accessible, adequate and of a good quality

The African Commission, in the case of *Purohit and Moore v Gambia*[45] found that the 'enjoyment of the right to health is crucial to the realisation of other fundamental rights and freedoms and includes the right of all to health facilities, as well as access to goods and services, without discrimination of any kind.'[46]

The World Health Report, published in 2008, found that laws and policies that constitute 'barriers to the availability, accessibility, acceptability and quality of sexual and reproductive health services (whether for the entire population or only for certain population groups), are a serious area of concern.'[47] These four key principles thus form the basis of an HRBA, as discussed in Chapter Two. Thus, they can inform the process of catering for maternal health rights as explained below.

a. Availability

Not only must maternal facilities be ideally located and established, but obstetric emergency services need to be available day and night to assist birthing women. To assist with staff shortages, task-shifting is necessary amongst the doctor, nurse and other health personnel teams to ensure the availability of staff.[48]

b. Accessibility

Difficulty in accessing health facilities poses a barrier to the early detection of sepsis, iron deficiency and haemorrhage.[49] Although these can be easily treated, the fractured health system with low staff counts and poor clinical management struggles to render adequate treatment before fatalities occur.[50] To tackle accessibility problems, it has been suggested that referral systems be strengthened, ambulances be available and effective, and that some layouts of facilities be redesigned for ease of access to the ward by women in labour.[51]

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[44] Department of Health (note 43 above) 23-4.
[45] *Purohit and Moore v. The Gambia*, Communication No. 241/2001 (2003).
[46] *Purohit* supra (note 45 above) at [80].
[47] J Cottingham et al. 'Using Human Rights for Sexual and Reproductive Health: Improving Legal and Regulatory Frameworks' (2010) 88(7) *Bulletin of the World Health Organization* 551.
[48] Department of Health (note 43 above) 18.
[49] Ibid 8.
[50] Ibid.
[51] Ibid 17.

Improved access through the introduction of the National Health Insurance system remains to be seen.

Notably, even if efforts are taken to improve access to health facilities, this will not have a positive impact if treatment of patients does not satisfy quality standards, for example, when provider behaviour constitutes mistreatment and abuse.[52] Therefore, the current blot on the image of the health system poses a great barrier to access to health care which cannot be erased without significant change in the quality of services.

c. Adequacy

In ensuring the adequacy of health facilities, it is notable that the South African DoH has undertaken to improve the 'physical infrastructure' of these institutions through the provision of better technology and equipment, with the aim of improving the overall experience for birthing women and the job satisfaction of health workers.

d. Good Quality

In the context of abating obstetric violence occurrence, the provision of good quality health care services is the most important HRBA principle and is thus the focal principle. A health system that is of a high-quality is 'a driver of successful universal health coverage.'[53]

Whilst efforts to address quality improvement at health facilities have been made, the overall progress falls short of being effective since they are fragmented in their approaches to different health issues and the different levels of health care.[54] Poor quality of care at facilities has been identified as a bigger barrier to reducing maternal mortality than lack of access to facilities.[55] It has been found that through quality improvement, access to health facilities and health outcomes also improve, having a positive effect on the overall population life expectancy.[56] Thus, it is submitted that without good quality care, achieving the other principles of an HRBA becomes impeded.

In order to improve quality of care, three points of intervention are necessary: quality planning, quality control and quality improvement.[57] A plan for improving the quality of

[52] E Shakibazadeh et al. 'Respectful Care during Childbirth in Health Facilities Globally: A Qualitative Evidence Synthesis' (2018) 125(8) *BJOG: An International Journal of Obstetrics & Gynaecology* 932.
[53] South African Lancet National Commission (note 34 above) ii.
[54] Ibid xvii, 64.
[55] N van den Broek (note 2 above) 355.
[56] K Begg et al. 'Development of a national strategic framework for a high-quality health system in South Africa' in LC Rispel & A Padarath (eds.) *South African Health Review 2018* (2018) 78.
[57] Ibid.

maternal health care should include **'**policy decisions, with clear goals, responsibilities, resourcing and checks to ensure accountability.'[58] Quality control provides the oversight function for the implementation of the plan.[59] Quality improvement is the final translation of quality goals into reality through effecting changes for the better.[60]

For health care to fit the quality bill, it needs to be 'safe, effective, timely, efficient, equitable and people-centred.'[61] The entire pathway of care which includes 'promotion, prevention, treatment and rehabilitation'[62] should resound with quality treatment and services. Measures have been taken by the NDoH to improve health quality such as through the 10-Point Plan for Improvement of the Health Sector, and the Negotiated Service Delivery Agreement and the Quality Improvement Guide.[63] However, the barriers mentioned above in this Chapter did not allow these efforts to have much impact.[64] Furthermore, these guidelines were unclear about the roles of actors and caused confusion rather than abatement of existing issues.[65] It will perhaps be useful to take guidance from the WHO Handbook for developing a National Quality Policy and Strategy (NQPS).[66]

Furthermore, the Office of Health Standards Compliance[67] is a body that can play an active role in the revolution of quality maternal health care in South Africa. The compliance with provision of quality service at maternal facilities can be measured against the standards provided by the Independent Body for Accreditation and Compliance which the DoH has undertaken to establish.[68]

When looking at providing accessible and quality care it is important to bear the following in mind: 'The question should not be why do women not accept the service we offer, but, why do we not offer a service that women will accept?'[69] Thus, in order to achieve this, changes need to take place at the individual; health facility and health systems level.[70]

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[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] Ibid.
[63] Ibid 79.
[64] A Gray & Y Vawda 'Health Legislation and Policy' in LC Rispel & A Padarath (eds.) *South African Health Review 2018* (2018) 79.
[65] Ibid.
[66] *See in general*: World Health Organization *Handbook for National Quality Policy and Strategy: a practical approach for developing policy and strategy to improve quality of care* (2018).
[67] This body is established in terms of s 78 of the National Health Amendment Act 2013.
[68] Department of Health (note 43 above) 22.
[69] Quote of Professor Mahmoud Fathalla cf: N van den Broek (note 2 above) 355.
[70] Shakibazadeh et al. (note 52 above) 938.

5.3.1.3. Planning: Suggested interventions at individual, facility and systems levels

a. Interventions directed at the individual level

Training of health care providers ranging from nurses, counsellors to doctors and obstetricians needs to incorporate and promote human rights in the care of patients; especially ethical values that ensure patients are respected.[71] It is submitted that such training should not end upon the completion of medical studies but be continued whilst in practice so that ethical values are reiterated and adhered to.

Obstetricians should participate in the continuing medical education conference so that they are kept abreast of latest developments in the field of obstetrics.[72] Studies have shown that outreach programmes aiming to educate members of the medical profession can be more effective when headed by leaders in the field and are individualised in their approach to each practitioner.[73]

Maternity ward health care workers should participate in the ESMOE programme.[74] There is evidence available which indicates that training health workers in the provision of emergency obstetric care improves the outcomes of the birthing process and the patient's overall experience.[75]

A patient-centred approach needs to be adopted by health care workers in their interactions with patients.[76] Not only will this help to bridge the gap in the relationship between health care personnel and patients but it will also enable the provision of quality health care.[77] Health care personnel need to provide dignified care to their patients without allowing any negative working conditions or preconceived notions to affect the relationship between themselves and the patient. These relationships should be based on care, trust, confidence, support, empathy and empowerment.[78] Once again, training can assist with

[71] The International Childbirth Initiative *12 Steps to Safe and Respectful MotherBaby-Family Maternity Care* (2018) 5.
[72] National Department of Health (note 30 above) 6.
[73] Ibid 7.
[74] National Department of Health *Guidelines for Maternity Care in South Africa: A manual for clinics, community health centres and district hospitals* 4ed (2015) 14.
[75] A Banke-Thomas, B Madaj, and N van den Broek 'Social Return on Investment of Emergency Obstetric Care Training in Kenya' (2019) 4 *BMJ Global Health* 1.
[76] Begg et al. (note 56 above) 78.
[77] V Oliveira & CM de Mattos Penna 'Discussing Obstetric Violence Through the Voices of Women and Health Professionals' (2017) 26(2) *Texto & Contexto - Enfermagem* 1, 8.
[78] CP Pitter 'Disrespectful Maternity Care: A Threat to the Maternal Health 2030 Agenda in Jamaica' (2017) 3(3) *International Journal of Women's Health and Wellness* 1, 2.

changing provider behaviour.[79] Good patient attendance by health practitioners should be rewarded; with disrespectful care being sanctioned.[80]

Nurses are key in fighting for patients' rights. This view is supported by the FIGO Report released in 2009[81] which provides that 'Obstetricians-Gynaecologists have an ethical duty to be advocates for women's health care… [and that] this obligation is increased by the unique vulnerability of women because of their reproductive function and role.'[82]

Education is salient in actively changing the mindset of members of society. Thus, not only do health workers need to be taught to eliminate abusive practices in their treatment of patients but women need to also be educated about their status as an autonomous rights-bearing patient. It is submitted that educating and empowering women to claim their SRHR not only promotes the need for quality maternal facility-based care based on human rights but also unveils gender-based violence.

b. Interventions directed at facility level

Skilled birth attendance needs to be provided throughout the 'continuum of care' comprising of antenatal care, emergency obstetric care, early new-born care and postnatal care.[83] Working hours of health care workers need to be reasonably proportionate to the needs of the community, as health services are in demand every hour of every day.[84] Staff appointments should be processed expeditiously by provincial MECs.[85] Staff should have a morale boost through better incentives, rewards and improved working conditions that enhance job satisfaction.[86]

Structured encounter forms being used at facilities have been identified as a method to improve patient satisfaction with care.[87] The forms, such as a prenatal care form, guide the practitioner's interactions with patients by making the practitioner adhere to certain standards and have proven to improve the overall experience for patients.[88] Further, when practitioners

[79] Department of Health (note 43 above) 18.
[80] Ibid 24.
[81] See: FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health *Ethical Issues in Obstetrics and Gynecology* (2012).
[82] Ibid 8.
[83] Van den Broek (note 2 above) 354.
[84] 'Presidential Health Summit 2018 Report' (2018), *South African Government* available at: *https://www.gov.za/sites/default/files/gcis_document/201902/presidential-health-summit-report.pdf,* accessed on 13 September 2019.
[85] Marawa (note 35 above) 8.
[86] Shakibazadeh et al.(note 52 above) 938.
[87] National Department of Health (note 30 above) 7.
[88] Ibid.

receive feedback as to how they can improve their approach to carrying out their jobs, it is likely to enhance the quality of care provided.[89]

The organisational strata at health facilities need to be strengthened.[90] Accountability calls for adequate leadership and stewardship at health facilities.[91] Managers at public maternity facilities should be supervised and led by health managers for the respective district.[92] This not only contributes to accountability but also combined planning, streamlined service delivery, adequate training; as well as strong supervision and monitoring. The separation of powers as set out in the Public Finance Management Act[93] as amended and the Public Service Act[94] and other relevant legislation regarding the powers and functions of management and political office holders should be interpreted correctly and enforced.[95]

Audits of maternity care compliance need to be carried out periodically at all district and provincial health facilities providing such services.[96] Audits conducted when women die during pregnancy or childbirth, or almost die, as well as the overall experience of childbirth can assist with identifying what is working within the health system, what needs improvement and how this can occur.[97]

Given the alarming state of malpractice claims, a Medico-Legal Summit was held in 2015 to address the threat that these claims pose to the health profession.[98] It was found that accountability and patient safety should be made a priority through the enforcement of the Patient's Rights Charter.[99] The CEO, as the head of the hospital, is tasked with ensuring the fruition of the patient safety goals.[100]

c. Interventions directed at the systemic level

According to WHO, an estimate of one in three women are victims of violence globally.[101] If the SDGs are to be achieved by 2030, one of the main targets to reach is empowering women

[89] Ibid7.
[90] Department of Health *Sexual and Reproductive Health and Rights: Fulfilling our Commitments* 24.
[91] Marawa (note 35 above) 9.
[92] Ibid 10.
[93] Act 1 of 1999.
[94] Act 103 of 1994.
[95] Marawa (note 35 above) 8.
[96] National Department of Health *Guidelines for Maternity Care in South Africa: A manual for clinics, community health centres and district hospitals* 4 ed. (2015) 16.
[97] Broek (note 2 above) 355.
[98] Medico-Legal Task Team *Declaration Medico-Legal Summit* (2015) 1.
[99] Ibid.
[100] Ibid.
[101] L Tolton & MC Signorelli 'Obstetric violence and human development: knowledge, power and agency in Colombian women's birth stories' (2018) *Guaju* 4(2) 164, 165.

and enabling them to live dignified lives free from gender inequality.[102] South Africa's Constitution enables its citizens to claim the right to quality health care.[103] The Constitution can, thus, be used as the basis for enacting legislation for improved quality maternal care and eliminating inequalities in maternal wards.[104]

Although the Department of Health has been issuing guidelines to assist with better maternal care, these national strategies can only be effective with supporting legal mechanisms in place to protect birthing women.[105] When health authorities enforce guidelines, it may be necessary to first identify what goals need to be met, whether the steps taken to achieve these goals are working and lastly, whether the process is taking place on a non-discriminatory basis.[106]

Therefore, laws and policies necessary for the protection of women's rights to respectful maternal health care need to be put in place. Without having these measures in place at national level, the law- and policymakers cannot enforce respectful maternal care.[107] Although South Africa has policies in place, the implementation of these fall short. There is no specific official to ensure that there is compliance with maternal health ethics and that laws are being enforced.[108] The weak complaints systems at health facilities need to be strengthened.[109] The professional bodies regulating medical professionals need to be more effective.[110] When there is a lack of legal authorities that are proficient in health care law it becomes difficult to bring those responsible for obstetric violence to account.[111]

Due to the lack of repercussions for disrespectful health care services, such behaviour persists. Through the implementation of an HRBA, responsible parties are called to account. The HRBA does not only hold states liable for failing to address the gaps in health care but also those entities and individuals responsible for the provision of such care. Thus, by virtue of this, it is submitted that sanctions be enforced to address cases of obstetric violence. This is where the legal solutions discussed in Chapters Three and Four come into play. Legal reform and education of health care workers regarding the critical importance of providing respectful

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[102] Ibid. See: United Nations *Transforming our world: the 2030 agenda for sustainable development* (2015).
[103] Begg et al. (note 56 above) 78.
[104] Ibid 77.
[105] Bowser & Hill (note 28 above) 18.
[106] Yamin & Maine (note 4 above) 566.
[107] Bowser & Hill (note 28 above) 18.
[108] Ibid.
[109] Ibid.
[110] The shortcomings of bodies such as the HPCSA were discussed in Chapter Three.
[111] Bowser & Hill (note 28 above) 19.

maternity care necessitates that these workers abide by the rules. Failure to do so will lead to them being held liable for obstetric violence in terms of South African common law or a specially designated law that can be enacted to provide sanctions in such cases.

Since South Africa is a participatory democracy, when considering introducing legislation to govern the consequences of obstetric violence occurrence, public participation and consultations are important. Section 195 of the Constitution requires that all public servants, including health care professionals, must ensure that 'people's needs must be responded to, and the public must be encouraged to participate in policy-making.'[112] Furthermore, community clinics consisting of members of the public, created under the auspices of the NHA allow for the community to be involved in health centres.[113]

The standards and guidelines to which professionals need to adhere should be kept in line with the latest medical evidence available.[114] This is vital as judiciaries in cases of delict turn to these standards in determining medical negligence.[115] Examples of this is seen in the United States' tort law whereby standards are followed irrespective of whether they are in accordance with the 'best available evidence.'[116] Thus, when developing 'fit-for-purpose' indicators and goals to measure obstetric violence denunciation, care should be taken to avoid limiting these and removing them from the goals of promoting wider 'social, political and gender justice.'[117]

Although evidence-based maternity care practices are important, judiciaries and other authorities deciding maternal health issues, should take care not to alienate the respective birthing woman's own views and agency in deciding a case.[118] This follows the line of argument that the 'concerning judicial narrative of heroic medicine and reckless motherhood further distorts and diminishes the birthing woman.'[119] The prevailing legal conditions and

[112] S Stevenson *National Health Act: A Guide* (2019) 12.
[113] Section 42 of the NHA.
[114] E Kukura *Contested Care: The Limitations of Evidence-Based Maternity Care Reform* (2016) 31 *BerkeleyJ. GenderL. & Just.* 241, 296.
[115] Ibid.
[116] Ibid.
[117] AE Yamin & VM Boulanger 'Embedding sexual and reproductive health and rights in a transformational development framework: lessons learned from the MDG targets and indicators' (2013) 21(42) *Reproductive Health Matters* 74.
[118] Kukura (note 114 above) 242.
[119] Ibid 289.

context are important in shaping decisions surrounding women's bodies and health, but reform should not be restrained by dogmatic reliance on evidence-based approaches.[120]

Laws, programmes and future strategies need to incorporate the principles of the Respectful Maternity Care Charter. During the planning and evaluating stages of the HRBA, the RMC Toolkit is a helpful instrument which can be used by countries.[121] Findings and recommendations from the RMC Global Council can assist countries in implementing RMC successfully.[122]

The Charter on Respectful Maternity Care suggests that by virtue of the identification of human rights being implicated in maternal health care, this rights-centred language can be translated into goals and programmes necessary to address respectful maternity care. Furthermore, to put maternal health quality in line with human rights standards, places an obligation on states to provide such standards of care and women in turn have the right to claim such levels of care.

Hence, research into addressing obstetric violence should hinge off the movement for respectful maternity care. The more research conducted in this area of rights; the more information will be available to devise better solutions.

The co-ordination of health information systems and dissemination of information is the duty of the National Department of Health.[123] There are, however, gaps that have been found in health information systems.[124] These systems measure and monitor the quality of health service provision based on inputs, processes involving such service delivery, and outputs in order to ascertain the impact.[125] Inputs include the necessary medicines, training of health professions and equipment. Outputs focus on patient satisfaction. The processes involve the administration of clinical services and treatment and the interactions between patients with their health providers.[126] The existing systems are straggling behind on

[120] Ibid 246.
[121] Maternal and Child Health Integrated Program 'Respectful Maternity Care Toolkit' (2013), available at: *https://www.mchip.net/technical-resource/respectful-maternity-care-toolkit/*, accessed on 18 January 2020.
[122] M O'Connor, K McGowan & RR Jolivet 'An Awareness-Raising Framework for Global Health Networks: Lessons Learned from a Qualitative Case Study in Respectful Maternity Care' (2019) 16 *Reproductive Health* 1, 2.
[123] *See*: Section 74(1) NHA.
[124] South African Lancet National Commission (note 34 above) xvii.
[125] Ibid.
[126] Rosen et al. 'Direct Observation of Respectful Maternity Care in Five Countries: A Cross-Sectional Study of Health Facilities in East and Southern Africa' (2015) 15(306) *BMC Pregnancy and Childbirth* 1, 2 .

determining impact and have been criticised as not being person-centred.[127] Fortunately, South Africa does have 'an enabling legislative and policy environment for the development of a health information system to measure quality.'[128] The Department of Health has committed itself to developing the information systems responsible for assessing and measuring quality health care and the resultant improvements.[129]

Social mobilisation is important in addressing obstetric violence. Given globalisation and the current trends of using media to initiate change, it is suggested that mass media campaigns regarding obstetric violence awareness are necessary in order to gain a wide outreach.[130] These must be led not only by the government but also other development partners and community rights advocates.

An organisation of networks is necessary to spread awareness of obstetric violence. By utilising an approach based on human rights and focusing on quality of care, proponents for curbing obstetric violence are placed in the ideal position to utilise networks, resources and languages that already exist in this area of maternal health rights advocacy.[131] When spreading awareness about obstetric violence, the efforts should tick all five of the following boxes: (i) the intervention should be strategically planned, (ii) it should directed at drawing the attention of primary stakeholders, (iii) it should send a strong unwavering message, (iv) it should create an environment that is open to its aims and (v) should put all available resources to maximum use.[132] Other organisations in South Africa may also help rally advocacy for dealing with obstetric violence, such as Treatment Action Campaign and Section 27.[133]

Therefore, reforms need to take place through legal mechanisms, and at institutional, programmatic and policy levels. Steps need to be taken for the capacity-building of civil society and the government. At the various levels at which birthing women have the potential of facing obstetric violence, effective complaints and accountability mechanisms need to be formed and implemented. This issue of accountability will be discussed later in this Chapter.

[127] South African Lancet National Commission (note 34 above) xvii.
[128] South African Lancet National Commission (note 34 above) xvii.
[129] National Department of Health (note 30 above) 16.
[130] Department of Health (note 43 above)18.
[131] O'Connor, McGowan & Jolivet (note 122 above) 10.
[132] Ibid 6.
[133] Stevenson (note 112 above) 11.

5.3.2. Budgeting

Budgeting refers to the 'process of raising, allocating and evaluating the expenditure of public money.'[134] This process is headed by the National Treasury.[135] Public participation in budgeting processes are necessitated by the Constitution and PFMA.[136] Consequently, South Africa's budgeting system is said to be one of the most transparent in the world.[137]

As was discussed in Chapter Two, states need to fulfil the progressive realisation of the right to health by using the maximum available resources.[138] This obligation remains withal the current political, financial climate and emergency crises.[139] Thus, the national budget should reflect the commitment toward the realisation of this obligation.[140] Assistance in the form of international funding toward the anti-obstetric violence cause is vital.[141] Taking stock of a state's budget often provides 'the best evidence of whether governments are actually making maternal health a priority.'[142]

Despite a hefty budget being allocated to the health sector, it is still underfunded. The problem is compounded by the incompetence of provincial departments in managing their finances, as was found by the Auditor-General.[143] Although a large chunk of the national budget is allocated to the Department of Health, the distribution of such funds within the health sector is problematic.[144] The ideal split of the funds provided should be 60 percent for hospital personnel and the remainder for hospital goods and services.[145] Currently, the split is allowed to be in the region of 75 percent for staffing expenses and the remainder for facility use.[146] This reduces the finances available to allow the effective operation of health facilities, impacting on the adequacy of care provided.

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[134] Ibid 20.
[135] Ibid.
[136] Ibid 20-21.
[137] Ibid 21.
[138] Human Rights Council *Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age* (2014) UN Doc. A/HRC/27/31 at [14]. Hereinafter referred to as 'Children's TG.'
[139] Children's TG at [14].
[140] UNTG at [47].
[141] Children's TG at [52].
[142] Yamin (note 26 above) 100.
[143] South African Lancet National Commission (note 34 above) 14, cf: AGSA Auditor-General of South Africa. 'PFMA 2016-17: Consolidated General Report on National and Provincial Audit Outcomes', available at: http://www.agsa.co.za/Reporting/PFMAReports/PFMA2016-2017.aspx; accessed on 08 June 2020.
[144] Marawa (note 35 above) 7.
[145] Ibid 7.
[146] Marawa (note 35 above) 7.

An open and transparent budgeting system provides the platform on which governments can be asked to justify the allocation of funds and the enforcement of policies that result in a shortage of available resources being dedicated to improving maternal health.[147] Thus, information laws that enable the public to assess the effectiveness of budgetary expenditure are vital to the process of participation, transparency and accountable governance.[148] Consequently, an open process of budgeting is more effective in targeting and responding to the needs of citizens, especially women in this case.[149] Civil society organisations must, therefore, ensure that this open process remains transpicuous through budget monitoring.[150]

The 2019 Budget Review indicates that provincial health departments have experienced a sweeping increase of medico-legal claims from R 28.6 billion in March 2015 to R 804 billion in March 2018.[151] The budgetary implications of medical malpractice claims speak for themselves. The South African Law Reform Commission in 2016 found that such claims were estimated to put a strain on the already overburdened health system, with contingent liabilities based on provincial malpractice suits being near forty (40) billion rand.[152]

The State Liability Act[153] is proposed to be amended by the State Liability Amendment Bill of 2018 which alters the current lump sum payment of medical malpractice claims to an 'alternative settlement structure.'[154] However, the professional misdemeanours which give rise to the patient's loss is not addressed by this legislative amendment.[155]

The DoH has been tasked with providing a 'financial turnaround plan' to monitor the budgetary expenditure of health departments in the provinces and detect a financial crisis before it occurs.[156] Approximately 38 percent of the total provincial budget should be

[147] Yamin (note 26 above) 102.
[148] Ibid.
[149] Ibid.
[150] Ibid.
[151] Stevenson (note 112 above) 23 fn 4.
[152] South African Lancet National Commission (note 34 above) 98.
[153] Act 20 of 1957.
[154] Gray & Vawda (note 64 above) 7.
[155] Ibid.
[156] Department of Health (note 43 above) 25.

allocated to departments of health.[157] It is recommended that once a budget has been decided upon, it should not be exceeded by health departments.[158]

Resources for an efficient, quality health care system need to be allocated adequately at district, provincial and national levels. Whilst most of the health sector budget will be utilised to implement HRBA strategies initially, in the long-term the overall effects of an HRBA will reduce malpractice litigation, thereby positively impacting the government's budget.

5.3.3. Monitoring

The monitoring and evaluating stage of the HRBA can take place through assessing data gathered on obstetric violence in South Africa. Such data needs to be collected regularly and carefully. The results of these evaluations can be used to shape future goals, laws, programmes, policies and health care services dedicated to addressing obstetric violence.

For the proposed HRBA to obstetric violence to be effective, targets need to be set against which progress can be measured. A set of indicators have been developed by United Nations Children's Fund (UNICEF) and the Centre for Population and Family Health (CPFH) which may prove to be useful.[159]

Persons with oversight functions over the state of health services, such as the Health Ombudsman,[160] should investigate and monitor the treatment of women in maternal facilities, provide reviews of his/ her overall observations and where areas are lacking, recommend remedial action.[161] The report and recommendation on the course of action are then required to be issued to the CEO.[162] In the same manner of members of the Chapter Nine institutions, the Ombudsman and his assistants must also remain independent and impartial;[163] and 'must perform his or her functions in good faith and without fear, favour, bias or prejudice.'[164] It is also worth considering appointing a specific Maternal Health Ombudsman to oversee issues relating to maternal health rights and respectful maternity care.

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[157] Marawa (note 35 above) 9.
[158] Ibid 9.
[159] Yamin & Maine (note 4 above) 565.
[160] The office of the Ombudsman for Health is established in terms of section 81A(1) of the NHA.
[161] See: Section 81A of the NHA.
[162] Section 81A(9) of the NHA.
[163] Section 81B(a) of the NHA.
[164] Section 81B(b) of the NHA.

The government's compliance with its international legal obligations, through the assessment of the progressive realisation of the right to health, can be monitored.[165] Human rights advocacy groups should ensure that state policies regarding obstetric violence are progressive and that laws that are applicable to this area of rights violations are not regressive.[166]

5.3.4. Accountability

The 'raison d'etre of the rights-based approach is accountability.'[167] Drawing upon the legal imperative of a participatory process that an HRBA creates, a system of accountability and stakeholder involvement throughout the process of fulfilling human rights obligations is fostered.[168]

For accountability to be enforced effectively, it is dependent on the necessary administrative, political, social and legal levels to monitor; provide oversight; review and allow for redress in their responses to obstetric violence.[169] Thus, when a health system is being developed to meet maternal health needs, accountability not only exists on these dimensions but also entails having legal recourse.[170] The state needs to ensure that the government actors and health service providers are fulfilling their commitments toward women in maternity settings. Accountability measures that are implemented need to be functional and mechanisms for redress need to be accessible to ensure that duty-bearers are answerable for their actions, or lack thereof. Without accountability, the goal of 'zero tolerance' for obstetric violence cannot be achieved.[171]

> The consequences of lack of repercussions can be seen in the following quote by a senior South African physician:
>
> '*Two months ago there was a nurse who pulled a pregnant woman by the ear from the floor. I think she might have fallen because of pains…, she cried out to the nurse for help. The nurse went there already annoyed and pulled her by the ear… Do you know they delivered with the woman on the floor? They [nurses] made her deliver on the*

[165] Yamin (note 26 above) 103.
[166] Ibid.
[167] Ibid 96.
[168] Children's TG at [28].
[169] Children's TG at [32].
[170] Yamin (note 26 above) 97.
[171] J Rucell 'Ethics Review and the Social Powerlessness of Data: Reflecting on a Study of Violence in South Africa's Health System' in CI Macleod et al. *The Palgrave Handbook of Ethics in Critical Research* (2018) 291, 294.

floor… I think she was a foreigner. …It was criminal. …They [medical students] took it up the channels but I won't be surprised if it won't just die. When I had to pull out the files I realised that they [midwives] didn't even report that she gave birth on the floor. … I never see the results [of reports], that's my issue with it. In the end there is no accountability.'[172]

For rights to be effective, remedies need to be available to deal with violations of those rights.[173] Remedies can be used to strengthen the current available laws, programmes and policies through promoting the implementation of these. These instruments dealing with maternal health can be reformed to cater for the protection of women against obstetric violence, remove barriers toward the achievement of safe, quality maternal health care and provide victims with adequate redress should a violation of their rights occur.

International human rights law has been said to enable citizens to determine what governments 'can do to us, cannot do to us and should do for us.'[174] International human rights law can be used as the legal framework and foundation for accountability when obstetric violence is committed. Importantly, whilst landmark cases like the *Alyne* case, which found against Brazil for violating the mother's right to health and non-discriminatory health services, create hope for the future of women's rights, the effect of such judgments are limited.[175] The international treaty bodies that deliver the verdicts do not have the enforcement mechanisms necessary to ensure states comply with its recommendations.[176] Consequently, these judgments often go unheeded for years.[177] Therefore, whilst human rights litigation can bring about systemic change through human rights lawyers, it cannot do so in isolation. All relevant stakeholders need to lend a hand to implementing the necessary changes.

The right to redress is important for victims of obstetric violence. This right is dependent on the right to information, as without knowledge of the complaints process, a

[172] Ibid 294.
[173] Children's TG at [64].
[174] Gruskin et al. (note 19 above) 8.
[175] C Gianella & AE Yamin 'Struggle and Resistance: Using International Bodies to Advance Sexual and Reproductive Rights in Peru' (2018) 33 *BerkeleyJ. GenderL. & Just.* 42, 46.
[176] Ibid.
[177] Ibid.

victim cannot seek the available remedy in cases of rights violations.[178] Lack of accountability at facilities also contributes to the denial of this right.[179]

The existing accountability measures that are in place include the courts, quasi- and non-judicial mechanisms (such as those institutions advocating for human rights), the Health Ombudsman, and hospital complaints procedures. These are important in bringing the accountability aspect of an HRBA to light.

Thus, redress may be sought in South Africa at domestic courts. Also, international human rights law provides avenues of seeking remedies such as through approaching treaty monitoring bodies; reliance on the UN treaty optional protocols which have been adopted by South Africa; referring complaints to the relevant Special Rapporteur such as those dealing with Health, Violence against Women, Discrimination Against Women, Torture and Cruel, Inhuman or Degrading Treatment.[180]

The right to complain about treatment at health facilities is protected by section 18 of the NHA. The OHSC, provided for in Chapter 10 of the NHA, can be used to investigate facility compliance rather than individual obstetricians. The latter can be complained about through the HPCSA. Since obstetric violence is a human rights issue, complaints may also be directed to the Public Protector, the South African Human Rights Commission and due to its recognition of obstetric violence as a form of gender-based violence, possibly the CGE as well.[181] Complaints may also be lodged on an internet-based system since April 2018.[182]

Traditionally, human rights advocacy consisted of a linear process of identifying 'a violation, a violator and a remedy.'[183] However, this approach is not ideal for encouraging maternal health accountability due to its overly punitive nature toward the consequences faced by alleged defaulting health care workers; such as being summarily dismissed without

[178] Bowser & Hill (note 28 above) 19.
[179] Ibid.
[180] White Ribbon Alliance 'Respectful Maternity Care: Tackling Disrespect & Abuse During Facility-Based Childbirth' (2018) available at: *https://www.whiteribbonalliance.org/wp-content/uploads/2018/12/Respectful-Maternity-CareRSFDT.pptx*, accessed on 22 May 2019.
[181] The Constitution establishes the Public Protector (section 182) and the South African Human Rights Commission (section 181). Stevenson (note 116 above) 11.
[182] 'Presidential Health Summit 2018 Report' (2018), *South African Government* available at: *https://www.gov.za/sites/default/files/gcis_document/201902/presidential-health-summit-report.pdf*, accessed on 13 September 2019.
[183] Yamin (note 26 above) 97.

an investigation.[184] To adopt this stance to the maternal health problem is counteractive, 'frequently makes little headway and gives a human rights approach a bad name.'[185]

Individual practitioners need to be aware that maternal health care standards will be enforced and that deviance will result in accountability.[186] However, the sanction imposed on one individual should not be used to 'scapegoat a doctor, pacify the public, and cover up wider, deeper problems.'[187] Thus, the question of finding an acceptable sanction becomes important.

The law should not only provide remedies to individual victims but accountability mechanisms should ensure that there is constructive redress throughout responsible health systems as well as making certain that continued violations are prevented. The diagram below, drawn up by the researcher, indicates the available remedies upon the occurrence of obstetric violence which have been identified in this project.

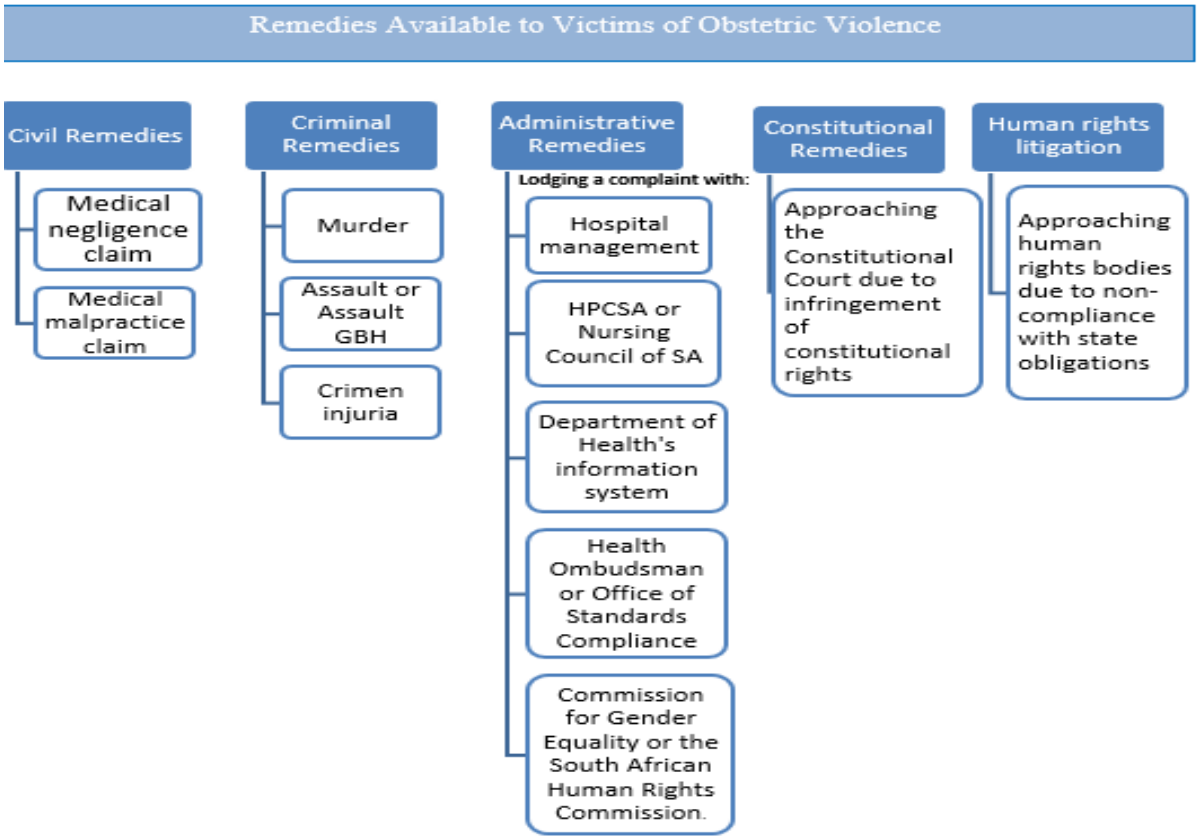

Diagram 6 above: *Remedies Available to Victims of Obstetric Violence*

[184] Ibid.
[185] Ibid 98.
[186] A Yamin (note 26 above) 97. As Freedman notes, 'Of course, individual punishment (and knowledge that professional standards will be enforced) has an appropriate place in a constructive accountability system.' cf: LP Freedman 'Human rights, constructive accountability and maternal mortality in the Dominican Republic: A Commentary' (2003) 82 *International Journal of Gynecology and Obstetrics* 111, 112.
[187] Yamin (note 26 above) 97.

5.4. LEGAL REMEDIES

When obstetric violence occurs, the remedies afforded to the victim need to be transformative.[188] Thus, it should not only address the structural inequalities that led to the violation of women's rights but also address the affected women's needs in order to provide for a remedy that prevents reoccurrence. Importantly, section 38 of the Constitution gives a person whose constitutional rights have been unjustifiably infringed the right to approach an appropriate court for redress, which may include a declaration of rights.

Human rights litigation is one way in which focus is drawn to the existing discrimination and women's unfulfilled rights and values resulting from poor health care services.[189] Through this litigious route, uneven structures which enable the perpetuation of such violence can be demolished. It also highlights campaigns regarding maternal health. This type of litigation is a catalyst for transformation of societal norms and structures and can improve access to health care through legal advocacy. The uneven power relations when obstetric violence occurs can also be addressed. Law has the ability to either disempower women by restricting their rights or it can be used as a tool to empower women.[190] The purpose of human rights laws is to achieve the latter through guaranteeing 'equal power to each person, including persons who would otherwise be powerless.'[191]

Litigation based on human rights has been described as an 'empowering strategy' as it brings to the fore the underlying discrimination that women are subjected to as well as spurs on the social, legal, political and cultural momentum for change.[192] Hence, it is the platform for systemic change with a wider reach.

An important aspect of reliance on rights is their legally binding nature.[193] Four areas are targeted by judicial and quasi-judicial remedies in the context of birthing women's sexual and reproductive health rights.[194] First, bringing about the implementation of existing laws and policies.[195] Secondly, budgets and policies that do not sufficiently protect and promote

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[188] Ibid 198.
[189] JT Dunn, K Lesyna & A Zaret 'The Role of Human Rights Litigation in Improving Access to Reproductive Health Care and Achieving Reductions in Maternal Mortality' (2017) 17(Suppl 2) *BMC Pregnancy and Childbirth* 71, 72.
[190] Amnesty International (note 6 above) 20.
[191] Dunn, Lesyna & Zaret (note 189 above) 72.
[192] Ibid.
[193] Yamin (note 26 above) 106.
[194] Ibid.
[195] Ibid.

health rights should be ameliorated.[196] Thirdly, laws that restrict women's health care provision need to be abolished.[197] The remedy provided for in the judgement of the Constitutional Court in the case of *Minister of Health v Treatment Action Campaign*[198], 2002 provides an example of how preventing the availability of Nevirapine treatment was unreasonable. The court not only declared such behaviour as being contrary to the right to health but also ordered that a national plan of action be devised, placing itself as the guardian for ensuring the implementation of that plan.[199] Lastly, these remedies must address and eliminate the continual systemic violation of women's maternal and reproductive health rights.[200]

Judicial and quasi-judicial remedies are, therefore, significant in expanding the platforms for accountability.[201] These remedies assist with eliminating practices and health systems that discriminate against birthing women and their well-being.[202]

The overall purpose of strengthening the health system is embodied in the sentiment voiced by Hunt and Gunilla Backman who write:

> '*In any society, an effective health system is a core institution, no less than a fair justice system or democratic political system. … It is only through building and strengthening health systems that it will be possible to secure sustainable development, poverty reduction, economic prosperity, improved health for individuals and populations, as well as the right to the highest attainable standard of health.*'[203]

5.5. DISCUSSION: WHY IS AN INTEGRATED SOLUTION SUGGESTED?

The topic of obstetric violence is interdisciplinary and requires the collaboration of various stakeholders. For it to be adequately addressed, it needs to be accepted that every sector on its own cannot be the mastermind behind preventing the occurrence of obstetric violence. This means that whilst the legal sector may be familiar with utilising the law to prevent rights violations and its experts are trained in legal advocacy, they will not be familiar with the

[196] Ibid.
[197] Ibid.
[198] 2002 (5) SA 703 (CC).
[199] Yamin (note 26 above) 107.
[200] Ibid 106.
[201] Ibid 108.
[202] Ibid.
[203] Ibid 113.

medical sector's knowledge about clinical practice, budgeting and feasible programming, and vice versa. Thus, the ideas pooled together have a better chance of resolving the issue.

Utilising the legal system alone to tackle obstetric violence will not be sufficient. The same applies to the clinical approaches that have already been taken in the medical sector. Rather, a socio-legal problem such as obstetric violence necessitates the development of intersectoral initiatives that can address the problem holistically. To address one part, such as the violations of rights, whilst another part is flailing, such as structural inadequacies, will not assist with resolving the matter. By the working together of the decisionmakers at the medical, legal and political level, it is submitted that progress can be made.

The UN Technical Guidance is alive to the fact that international assistance is imperative when dealing with global problems such as maternal and sexual and reproductive health rights.[204] It states:

> *'All development partners should contribute to the creation of a social and international order in which human rights, including women's sexual and reproductive health rights, may be reali[s]ed. Human rights obligations with regard to advancing global health, including sexual and reproductive health, call for shared approaches and systems of collective responsibility together with a global development agenda that centrally reflects issues of social and environmental sustainability, equality and respect, and the fulfilment of human rights.'*[205]

International organisations such as FIGO and WHO assist in implementing HRBAs since the members of these organisations can provide expertise on the requisite medical and public health knowledge necessary to ensure feasible action and strategies. The input from these organisations would likely make governments more receptive to suggested changes.

Since the issue is multi-disciplinary, linking many different sectors, the following actors should play a role in the HRBA process; namely, the government and the relevant departments such as the Department of Health; health professionals involved in women's care, health facilities, development partners, as well as input from civil society and the impacted population. The KZN Department of Health supports an intersectoral human rights-based approach and has committed itself to promoting SRHR through community engagement and education, not only at the different governmental levels but also at schools,

[204] UNTG at section VI [81-90].
[205] UNTG at [81].

places of employment, health clinics and community centres.[206] To facilitate this intended outreach, the Department has anticipated utilising mass media, campaigns, dialogue and workshops to achieve its objectives.[207]

The political will to address obstetric violence is important. The pull and sway of political leaders in joining the obstetric violence cause will not only put the issue in the public limelight but also call for international attention and solutions. As the problem currently stands, the health sector is addressing obstetric violence from their viewpoint and the legal sector is gaining momentum by addressing the issue from a legal perspective. These different views result in different goals and no communication. A viable solution gets lost in the lack of collaboration and translation due to the of crossing wires. Rather, by working together, a single, strong stance and vision can be formed that sends out a clear message to stop obstetric violence.

The lack of implementation of guidelines to improve maternal health care is an indication that the health system is dysfunctional.[208] It needs to be realised that the quality of health services is not dependent on 'islands of independent services' but on 'coherent, co-operative' approaches.[209] As was mentioned in Chapter Two, without a proper understanding of the epidemiology of obstetric violence adequate interventions cannot be made. Without understanding the link between obstetric violence and the resultant effects on the rights of birthing women, it cannot be broken through implementation of programmes.

It is submitted that multisectoral collaboration contributes to the availability and access of maternal health facilities to women. By working together, the quality of maternal health care can be improved and resources will not be duplicated.

When the researcher refers to the law as a tool and mechanism for redress, it is not only being used to promote quality health care but also used as a deterrent for endangering birthing women's health.[210] This can either be achieved through fines, revoking licences, or incarceration.[211]

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[206] Department of Health (note 90 above) 13.
[207] Ibid 13.
[208] K Moyo 'Realising the right to health in South Africa' in J Dugard et al. *Socio-economic rights–progressive realisation?* (2018) at 426, available at: *https://www.fhr.org.za/files/8015/1247/0285/Socio_Economic_Rights.pdf*, accessed on 27 May 2019.
[209] Ibid.
[210] D Uberoi & M de Bruyn 'Human rights versus legal control over women's reproductive self-determination' (2013) 15 *Health and Human Rights* 161.
[211] Ibid.

However, involving the law does not mean the judiciary should overstep their bounds. For example, in 2006, a woman in New Jersey who had refused to undergo a c-section in the event that such procedure would become necessary, gave birth naturally.[212] She was charged for endangering the life of her infant, who was then taken out of her custody after birth.[213] However, in Illinois, a court of appeal refused to compel a pregnant woman to undergo a c-section and blood transfusion, finding that '[t]he potential impact upon the fetus is not legally relevant; to the contrary, the … court explicitly rejected the view that the woman's rights can be subordinated to fetal rights.'[214]

Furthermore, when imposing sanctions for obstetric violence occurrence it should not be so harsh so as to detract future professionals from branching into obstetrics for fear of being imprisoned, nor should it be so lenient that the legal remedy is a mere slap on the wrist. A middle ground needs to be found. It is the researcher's submission that restorative justice mechanisms may offer such a compromise. Such remedies aim to place the victim in the position she would have been in before the incident. It has been defined as follows:

> '*Restorative justice is an approach to justice that focuses on repairing the harm caused by crime while holding the offender responsible for his or her actions, by providing an opportunity for the parties directly affected by the crime – victim(s), offender and community – to identify and address their needs in the aftermath of the crime, and seek a resolution that affords healing, reparation and reintegration, and prevents further harm*.'[215]

However, in instances where the crime is too serious or there is no remorse on behalf of the offending health practitioner restorative justice cannot be an option.

Also, South Africa already has a comprehensive Act which embodies progressive remedies in terms section 21 of the Promotion of Equality and Prevention of Unfair Discrimination Act.[216] The legislature may be wise to consider the approach taken in this Act if obstetric violence legislation is tabled before it. However, to explore these suggestions in further detail is beyond the scope of this project.

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[212] Ibid 164.
[213] Ibid.
[214] Ibid.
[215] 'What is restorative justice?' available at *http://orjn.org/what-is-rj/*, accessed on 19 January 2020.
[216] Act 4 of 2000.

5.6. CONCLUSION

The purpose of this dissertation is not to lay blame at the door of health professionals. Rather, it points out the deficiencies in the health system, highlighting the gaps in approaching a multifactorial problem with blinders on, ignoring the other levels at which interventions need to occur.

By adopting an integrated HRBA to obstetric violence, the quality of maternal health care will take centre stage in the process for change. This will entail identifying the shortcomings of the current system and redesigning it to overcome them. Thereafter, through continual monitoring, and evaluation, the health care system can keep up with change whilst having positive patient quality outcomes.

Thus, adopting an HRBA in the obstetric violence context assists with the identification of the potential barriers to overcoming disrespectful maternal health care. Also, using the legal framework to assess this type of behaviour strengthens the efforts in the public health sector aimed at improving maternal health. Through such an approach, women who are more vulnerable to obstetric violence can be identified and provided with protection. Any law, policy or strategy that is implemented to combat obstetric violence occurrence should be couched in human rights terminology and grounded in human rights principles.[217]

Also, the capacity gaps in translating the principles on which an HRBA is based, such as accountability, participation and equality, into practice can be addressed in quality improvement strategies and long-term comprehensive solutions. This process ultimately ensures the protection of the dignity of women who have been exposed to obstetric violence and those susceptible to being a victim of this conduct.

It is hoped that this research project has sparked further discourse regarding the public policy regarding violence experienced by birthing women at the hands of health personnel. Change will be possible and quality care can be achieved once the mindset regarding the birth as a medical event changes to viewing it as a human experience.[218]

There is no single solution that can resolve the obstetric violence issue, nor is there a 'magic bullet' to annihilate it.[219] An available, accessible, quality health care system is

[217] Children's TG at [20].
[218] Oliveira & de Mattos Penna (note 77 above) 8.
[219] Van den Broek (note 2 above) 353.

necessary to enable birthing women to survive and bring new life into the world in a congenial environment.

CHAPTER 6

CONCLUSION

6.1. INTRODUCTION

This Chapter aims to synthesise the conclusions that have been drawn in the preceding chapters, providing a summary of the key findings that this project has reached regarding South Africa's stance on obstetric violence. The occurrence of obstetric violence is indubitably a human rights violation. Hence, hinging off this identification, this dissertation explored the topic from a human rights perspective. Although this project aims to be a contribution to the legal field, the researcher did not turn a blind eye to the other facets and levels at which the problem presents itself.

It has been suggested by scholars that the disrespect and mistreatment that flows from the incidence of obstetric violence be dealt with through a human rights-based approach,[1] however, these studies have not provided further detail as to how such a strategy will operate. To address this gap in research and the legal field, this dissertation explored how an HRBA works in practice. Ensuing from the conclusions set out hereunder, recommendations regarding the way forward for tackling obstetric violence in South Africa are provided.

6.2. KEY FINDINGS

The main findings that have been made throughout this project are set out below.

Finding: Obstetric violence violates numerous human rights of birthing people

The maternal health and human rights of women and girls worldwide 'are being gravely undermined in health care facilities.'[2] The potential rights affected by obstetric violence occurrence can range from the right to equality; dignity; life; freedom from cruel, inhuman or degrading punishment; bodily and psychological integrity; privacy; and access to health care.[3] These rights were broken down and explained individually under Chapter Two. The recognition of obstetric violence as a rights violation is a turning point for framing it within the existent body of rights and addressing it within the legal sphere.

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[1] S Fawcus 'Respectful Maternity Care' (2016) 4 *Obstetrics & Gynaecology Forum* 32.
[2] Human Rights in Childbirth *Written Response to: Call for Submissions issued on UNHCHR website: Mistreatment and violence against women during reproductive health care, with a focus on childbirth* (2019) 10.
[3] Sections 9; 10; 11; 12; 14; 27 of the Constitution, 1996.

Finding: The absence of a globally accepted definition of obstetric violence prevents the term from being operationalised uniformly across the board

Studies have shown that birthing women are being abused and disrespected during facility-based care.[4] Although the occurrence of obstetric violence is undisputed, the various forms in which it occurs has made it difficult to define. Those countries, such as Venezuela, which have attempted to define such violence have been criticised for the broad range of provider behaviour covered by such catchments.[5] Thus, it is necessary to find a uniform working definition that allows the term to be operationalised both within the legal framework and without.

Finding: South Africa does not have any specific law regulating obstetric violence occurrence

Certain countries have taken a strong stance against obstetric violence by introducing legislation to govern its manifestation and prevention,[6] South Africa not being amongst such movement. Notably, whilst there is no specific law against obstetric violence in South Africa, the country does have an existing comprehensive civil, criminal and administrative legal system in place, together with relevant rights-advocating documents such as its world-renowned Bill of Rights and the National Patient's Charter.

Finding: Obstetric violence has become normalised, with repercussions not ensuing upon the proliferation of the phenomena

Normalisation of obstetric violence is perpetuated by certain forms of the violence being more recognisable and visible as an injustice than others. For example, forced sterilisations and non-consensual caesarean-sections are more likely to be reported than slaps or insults which are deemed as a normal part of the birthing process by patients and nursing staff alike.[7] This leads to lack of accountability as well as patient ignorance regarding their rights.[8]

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[4] R Jewkes; N Abrahams & Z Mvo 'Why do nurses abuse patients? Reflections from South African obstetric services' (1998) 47(11) *Soc Sci Med* 1781.
[5] R Jewkes & L Penn-Kekana 'Mistreatment of women in childbirth: time for action on this important dimension of violence against women' (2015) 12(6) *PLoS Med.* 1, 2.
[6] Presentation by Organisation of American States 'Sexual and Reproductive Rights in Latin America and the Caribbean' (2016) available at: *https://www.thedialogue.org/wp-content/uploads/2016/04/Presentacio%CC%81n-InterAmerican-Dialoghe-ENG.ppt*, accessed on 22 May 2019.
[7] Amnesty International *The State as a Catalyst for Violence Against Women: Violence Against Women and Torture or Other Ill-Treatment in The Context Of Sexual and Reproductive Health in Latin America and The Caribbean* (2016) 63.
[8] Human Rights in Childbirth *Written Response to: Call for Submissions issued on UNHCHR website: Mistreatment and violence against women during reproductive health care, with a focus on childbirth* (2019) 8.

Finding: The negative consequences of obstetric violence are not linear but systemic; thus, not being confined to one victimised patient alone

Research that has been conducted has indicated the domino-effect of obstetric violence on affected patients.[9] It has been found that 35% of women display some symptoms of post-traumatic stress disorder after childbirth.[10] This has been attributed to the occurrence of obstetric violence. Negative attitudes to facility-based maternity care is, thus, a hindrance to health care access.

Finding: There are a broad range of contributory factors which constitute barriers to overcoming obstetric violence

Obstetric violence is not only a medical health problem, it is also a legal human rights problem. Various factors have been identified by exposés investigating the drivers of disrespect and abuse at medical facilities. Some reasons for disrespectful treatment are professional burnout, lack of knowledge regarding how to deal with birthing women emotionally; and the sexual dimensions of childbirth.[11] The provision of dehumanising paternalistic maternal treatment results in birthing women being treated as sub-human.[12] Legislative measures are necessary to address the legal barriers to quality maternity services.[13] Legal interventions, however, should be accompanied by interventions at the different levels at which obstetric violence occurs.

Finding: Existing health guidelines and policies to promote respectful maternity care fall short at the implementation stage

Although programmatic efforts have been made to address obstetric violence, without effective implementation and redress, they are rendered futile. Rucell criticises the policy developed to tackle obstetric violence as being 'poorly developed and implemented.'[14] This highlights the need for the reconstruction of the approach toward tackling obstetric violence, with stronger policies being necessary.

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[9] E Kukura 'Obstetric Violence' (2018) 106(721) *Georgetown Law Journal* 721, 754 – 756.
[10] IO Fernández 'Estrés postraumático secundario en profesionales de la atención al parto. Aproximación al concepto de violencia obstétrica' (2014) 111 *C. Med. Psicosom* 79.
[11] Ibid.
[12] Human Rights in Childbirth *Written Response to: Call for Submissions issued on UNHCHR website: Mistreatment and violence against women during reproductive health care, with a focus on childbirth* (2019) 8.
[13] M Sadler 'Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence' (2016) 24(47) *Reproductive Health Matters* 47, 52.
[14] J Rucell 'Ethics Review and the Social Powerlessness of Data: Reflecting on a Study of Violence in South Africa's Health System' in CI Macleod et al. *The Palgrave Handbook of Ethics in Critical Research* (2018) 291, 294.

Finding: South Africa has a comprehensive criminal law system within which obstetric violence could be accommodated

Obstetric violence, depending on its severity and the facts of each case, can constitute a common law crime ranging from murder; assault; assault with intent to commit grievous bodily harm; or crimen injuria. Thus, when the elements of these crimes are met, obstetric violence already amounts to a crime. However, lack of awareness by victims and reports of incidents not being filed result in questioning the need for a specific law being enacted to demarcate the penalties for this specific crime.

Notably, defensive medicine is a disincentive against criminalising obstetric violence. The effect of criminalisation on the already short-staffed maternity wards and cash-strapped government makes one pause before deciding to place health care personnel behind bars for their disrespectful patient attendance. With medical malpractice claims on the rise, the doctors leaving practice are a concern.[15] This necessitates perhaps looking at other avenues for remedies, such as retributive justice mechanisms rather than a purely punitive sanction.

Finding: HRBAs are increasingly being applied to health development[16]

An HRBA has been suggested by the UN to improve maternal health as was seen in the UNTG.[17] Furthermore, an HRBA has specifically been suggested by academics to address the disrespect and abuse at maternal health facilities.[18] An HRBA can address underlying social determinants of obstetric violence, the power dynamics, and gender discrimination. Also, accountability is an important aspect that can be incorporated through an HRBA.

Finding: Obstetric violence is a socio-legal problem accompanied by aspects of gender-based violence

The failure to achieve MDG 5 has been attributed by the CEDAW Committee to the underlying discrimination faced by women, which governments need to remedy in terms of

[15] WT Oosthuizen & PA Carstens 'Medical malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 269, 278.
[16] A Smith-Estelle; L Ferguson & S Gruskin 'Applying Human Rights-Based Approaches to Public Health: Lessons Learned from Maternal, Newborn and Child Health Programs' (2015) *African Population Studies Special Edition* 1713.
[17] UNTG.
[18] Fawcus (note 1 above) 32, C Pickles 'Reflections on obstetric violence and the law: What remains to be done for women's rights in childbirth?' (08 March 2017), *Oxford Faculty of Law* available at *https://www.law.ox.ac.uk/research-and-subject-groups/international-womens-day/blog/2017/03/reflections-obstetric-violence-and*, accessed on 20 February 2019.

their obligations.[19] The turning point in the importance given to maternal health rights was the decision of the CEDAW Committee in the *Alyne da Silva Pimentel Teixeira*[20] case. However, the cases coming before international tribunals emphasise that states need to ensure, as duty-bearers, that women are not hindered in their access to timeous, appropriate and non-discriminatory maternal health care and services.[21] Thus, gender, race and income should not be an obstacle to adequate health care in an ideal health system.[22] These underlying social determinants are factors that an HRBA aims to equalise. Ultimately, obstetric violence should be recognised as a form of gender-based violence.[23]

6.3. CONCLUSIONS

The following conclusions are derived from the above findings:

Obstetric violence is a term that should be framed within a common understanding

The three building blocks for a definition of obstetric violence suggested by Freedman et al. should be the starting point for arriving at a globally accepted definition. This consists of, namely, (i) behaviour that is locally agreed upon as being abusive and disrespectful; (ii) subjective experiences of individual birthing women and (iii) intentionality.[24]

Respectful maternity care is dependent on quality health care services

Although states are striving to increase facility-based births, patient experience is unlikely to be positive if the quality of care is not improved.[25] Women are unlikely to utilise a health facility for consequent births after being subjected to obstetric violence.[26]

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[19] D Shaw & RJ Cook 'Applying Human Rights to Improve Access to Reproductive Health Services' 119 (2012) *International Journal of Gynecology & Obstetrics* S55.
[20] *Alyne da Silva Pimentel Teixeira ('Alyne') v. Brazil*, CEDAW/C/49/D/17/2008.
[21] Shaw & Cook (note 19 above) S56.
[22] Ibid.
[23] Human Rights in Childbirth *Written Response to: Call for Submissions issued on UNHCHR website: Mistreatment and violence against women during reproductive health care, with a focus on childbirth* (2019) 83.
[24] Freedman *et al.* 'Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda' (2014) 92(12) *Bulletin of the World Health Organisation* 915.
[25] N van den Broek 'Happy Mother's Day? Maternal and Neonatal Mortality and Morbidity in Low- and Middle-Income Countries' *International Health* (2019) 11(5) 353, 354.
[26] M Hastings-Tolsma; AGW Nolte & A Temane 'Birth stories from South Africa: Voices Unheard' (2018) 31 *Women and Birth* 42; 45.

Human rights litigation is an important remedy in addressing maternal health rights

The international human rights decisions made regarding Brazil and India are landmark cases as these were the first time that governments were called to account utilising constitutional and human rights law.[27] The willingness by these forums to adjudicate over such matters, although their recommendations are not binding,[28] indicates the seriousness with which maternal health rights are being dealt with at an international level.

Legal reform is necessary to address the obstetric violence lacuna

Sanctions need to be put in place for the violation of birthing women's reproductive health rights.[29] Both civil law and criminal law may come to the aid of the victim of obstetric violence currently, depending on the severity of abuse.

It is the researcher's suggestion that an HRBA to obstetric violence can be adopted and incorporated into national laws, policies, programmes and strategies aimed at improving the quality of maternal health care in South Africa. Thus, by assessing the existing measures that have been taken, the extent to which they are in line with human rights standards and the principles relating to monitoring, evaluation and budgeting can be determined and measured. If they fall short, and gaps are revealed, these measures must be adapted and be brought in line with the standards and principles that the HRBA deems to be optimal. The HRBA can, therefore, address the shortcomings of a purely health systems approach.

A criminalisation strategy alone is not the best solution

The European and Latin American countries discussed in Chapter Three lean toward the criminalisation of obstetric violence. However, the African and Asian countries prefer to compensate victims. Unfortunately, compensation does not remedy a defective system. Most of the compensation in a successful case is used to pay legal costs instead of being utilised to remedy the medical error.[30] Moreover, harsh criminal penalties may do more harm to the flailing health system than good. Thus, restorative justice may propose a solution between retribution and compensation. An HRBA is able to address the problem through a combination of criminal law, human rights law, constitutional law and programmatic efforts.

[27] Shaw & Cook (note 19 above) S56.
[28] C Gianella & AE Yamin 'Struggle and Resistance: Using International Bodies to Advance Sexual and Reproductive Rights in Peru' (2018) 33 *BerkeleyJ. GenderL. & Just.* 41, 46.
[29] E Shakibazadeh et al. 'Respectful Care during Childbirth in Health Facilities Globally: A Qualitative Evidence Synthesis' (2018) 125(8) *BJOG: An International Journal of Obstetrics & Gynaecology* 932, 938.
[30] WT Oosthuizen & PA Carstens 'Medical malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 269, 275.

6.4. RECOMMENDATIONS

Interventions should take place at various levels

An integrated solution is necessary to address socio-legal problem posed by obstetric violence. In order to drive for systemic change, stakeholders need to have an accurate representation of the current failings of maternal health care provided to them. The quality change process needs to be open, accessible and transparent so that all those who have an interest in the outcome can contribute.[31]

Building on South Africa's participatory democracy and community engagement, 'the public must see itself not merely as a patient, but also as an agent of change.'[32]

Anti-obstetric violence programmes are required

Solutions to tackling obstetric violence include training health care workers. Further, better supervision needs to be enforced and a model for quality maternal health care needs to be established. Further, mechanisms need to be put in place at health facilities to address gender inequality.

The different needs of the different users of health services need to be met. Changes need to be worked into the course material at medical schools.[33] As was seen in Chapter One, the normalisation of violence against birthing women is a concern. To counter the normalisation of disrespectful patient attendance, it is suggested that health care providers and medical students during their training attend courses that inculcate ethical behavioural standards in learners. The essence of providing respectful maternity care ensures that patients seeking reproductive health care are treated with the respect and dignity they deserve. Thus, even if training incorporates basic ethical values, follow-up procedures need to be put in place to ensure humane patient care is being provided.

The complex points of contact between patients and facility staff are difficult to manage.[34] The relationship between caregivers and the patients in their interactions within the health system need to be strengthened. Reshaping management strategies at health facilities is a top priority in overcoming the lack of response to obstetric violence. Caring for the

[31] National Department of Health *Policy on Quality in Health Care for South Africa* (2007) 11.
[32] S Gruskin & D Tarantola 'Health and Human Rights' in S Gruskin et al. (eds) *Perspectives on Health and Human Rights* (2005) 1.
[33] CSG Diniz et al. 'Disrespect and Abuse in Childbirth in Brazil: Social Activism, Public Policies and Providers' Training' (2018) 26(53) *Reproductive Health Matters* 19, 30.
[34] National Department of Health *Policy on Quality in Health Care for South Africa* (2007) 14.

caregivers is also an important method of mollifying the tenuous health worker-patient relationship.

Research

In the South African context, the research around obstetric violence is still in need of fleshing out. To answer the call of WHO and to contribute to the future of the country's handling of obstetric violence, further research will be necessary.

Legal reform

Propounding for law reform is founded on four arguments: (i) The recognition of the rights to equality; dignity; life; freedom from cruel, inhuman or degrading punishment; bodily and psychological integrity; privacy; and access to health care[35] are jeopardised when obstetric violence occurs. (ii) Obstetric violence violates numerous human rights. (iii) Allowing obstetric violence to continue unabated not only violates patient rights but also subverts the rule of law. (iv) If the state is to address its section 7 constitutional obligation, it needs to 'respect, protect, promote and fulfil' the rights of women victimised by obstetric violence.

Legal literacy

Educating women about their SRHR in the context of obstetric violence is important, especially about the legal recourse they may have in such cases. It empowers women to claim their rights. At the micro level obstetric violence needs to be understood together with its consequences. Women should be given platforms to voice their birthing experiences. Research and counselling for victims must be carried out. On a larger scale, the 'social, political and structural roots of the problem' need to be addressed. Women need to be educated about their birthing rights to respectful maternity care.

6.5. CONCLUSION

Obstetric violence should be recognised as a crime in South Africa. However, whether it falls within the existing body of law or is dealt with under a newly enacted piece of legislation remains to be seen. Ultimately, the legal sector should make known the way in which obstetric violence will be dealt with under South African law.

[35] Sections 9; 10; 11; 12; 14; 27 of the Constitution of the Republic of South Africa, Act 108 of 1996 respectively.

It is hoped that this project be the steppingstone for other authors to take the plunge into this research topic that straddles various sectors. Although obstetric violence is a legal problem, it is also a social, political and medical issue. Hence, instead of shying away from the programmatic solutions and having a one-track legal approach to obstetric violence, this dissertation embraced the various contributors to its occurrence and the possible range of solutions that could provide available, accessible, appropriate and quality maternal health care services through the adoption of an HRBA.

It is submitted that medical interventions to address the rights that are being blatantly disregarded are commendable, but do not suffice. Since medical policies are not being taken seriously, it is necessary for the law to step in. Despite countries adopting different methods to combat the occurrence of obstetric violence, an underlying theme emerges: obstetric violence in health facilities is occurring and has become commonplace. Whilst medical researchers bemoan the lack of measurement tools to quantify the prevalence of obstetric violence, from a legal view, the breach of one person's rights is still a breach of the Constitution protecting those rights.

Thus, the South African human rights agenda should be borne in mind when reflecting upon the following concluding quote:

> '*The way a society views a pregnant and birthing woman, reflects how that society views women as a whole. If women are considered weak in their most powerful moments, what does that mean?*'[36]

[36] Marcie Macari *She Births: A Modern Woman's Guidebook for an Ancient Rite of Passage* (2006).

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