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Legal Resources Centre



WOMEN'S LEGAL CENTRE

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***SUBMISSIONS TO THE UNITED NATIONS SPECIAL RAPPOREUR ON VIOLENCE AGAINST  
WOMEN:***

***Mistreatment and violence against women during reproductive health care with a focus on  
childbirth***

**Submitted by**

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## I. INTRODUCTION

1. We refer to the call for written submissions by the United Nations Special Rapporteur on Violence against Women (SRVAW) relating to the **Mistreatment and violence against women during reproductive health care with a focus on childbirth**. We hereby respond to this call and accordingly provide this submission for consideration in the development of the next thematic report to be presented at the 74th session of the General Assembly in September 2019.
2. We welcome and appreciate this opportunity to make these submissions and to engage with issues related to violence experienced by women in accessing reproductive health care.
3. We note that this Special Rapporteur's report to the General Assembly will be the first human rights report by a special procedure focused solely on the issue of mistreatment and violence experienced by women in reproductive health care and facility-based childbirth and placing it in the broader context of a continuum of sexual and reproductive rights violations. We wish to commend the SRVAW for this achievement and we very much look forward to reading the report on this critical issue for women.
4. The organisations making these submissions align themselves with the a statement of the World Health Organisation published in 2014, highlighted by the call for submissions which reported that disrespectful and abusive treatment occurs during childbirth in facilities and includes *“outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.”*<sup>1</sup>
5. Our submission will seek to highlight the following from the experiences of women in South Africa including the gendered nature of this harm.
  - 5.1. We will focus on the plight of women in South Africa who experience serious human rights violations, in their various forms, when accessing public hospitals in order to give birth, or access prenatal healthcare services.
  - 5.2. We centre our submissions on the disproportionate effect that poor public health care services have on women in South Africa, and note the absence of concrete positive steps taken currently to address the root problem causing many women to suffer such injustices and resorting to courts for relief.

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<sup>1</sup> World Health Organization, [statement on “prevention and elimination of disrespect and abuse during childbirth](#).

5.3. We emphasise that holding the state liable therefore remains the main source of recourse available to women in this position to vindicate their rights and allow them to live in equality and dignity as envisaged by the Constitution of the Republic of South Africa, 1996 ('the Constitution'). We also highlight some negative steps that have been taken thus far to possibly frustrate this option for women.

6. Our submission is divided into three parts:

6.1. In **Part II** we introduce the organisations making this submission;

6.2. In **Part III** provides a brief overview of the right to healthcare services in South Africa;

6.3. In **Part IV** specifically addresses the four questions posed by the SRVAW in the call for submissions relating to the mistreatment and violence against women in accessing reproductive health for childbirth.

## II. INTRODUCTION TO THE AUTHORS

7. The **Legal Resources Centre ('LRC')** is a public interest, non-profit law clinic in South Africa that was founded in 1979. The LRC uses the law as an instrument of justice to facilitate the ability of vulnerable and marginalised persons and communities to assert and develop their rights; promote gender and racial equality and oppose all forms of unfair discrimination; as well as contribute to the development of human rights jurisprudence and to the social and economic transformation of society. The LRC operates throughout South Africa with offices situated in Johannesburg, Cape Town, Durban and Grahamstown. Through strategic litigation, advocacy, education and training, the LRC has played a pivotal role in developing a robust jurisprudence in the promotion and protection of equality and non-discrimination, and other constitutional rights. A significant proportion of the LRC's work has been in the sphere of gender equality, non-discrimination and addressing the disproportionate burden faced by women in poor service delivery. Within the arena of equality and non-discrimination, the LRC has viewed the rights of vulnerable and marginalised persons including refugees, children and women, among others, as being integral to the advancement of society and achieving equality in justice for all.

Website: [www.lrc.org.za](http://www.lrc.org.za)

8. The **Women's Legal Centre** ("The Centre") is an African feminist legal centre that advances women's rights and equality through strategic litigation, advocacy, education and training. We aim to develop feminist jurisprudence that recognises and advances women's rights. The Centre drives a feminist agenda that appreciates the impact that discrimination has on women within their different classes, race, ethnicity, sexual orientation, gender identity and disability. The Centre does its work across five programmatic areas including the right to be free from violence, women's rights in relationships, and women's rights to land,

housing property and tenure security, women's sexual and reproductive health rights and women's rights to work and at conditions of work.

Website: [www.wlce.co.za](http://www.wlce.co.za)

### III. PREVAILING CONTEXT OF ACCESS TO HEALTH CARE IN SOUTH AFRICA: THE UNENDING STRUGGLE FOR WOMEN

#### a. Gendered Burden of Poverty

9. Women in South Africa are more impoverished than men, with a poverty headcount of 58,6% as compared to 54,9% for men according to Statistics South Africa.<sup>2</sup> Approximately 83% of the population in South Africa rely on public facilities for healthcare; therefore more than 46 million people rely on public healthcare.<sup>3</sup>

#### b. Racial divide in accessing healthcare services in South Africa

10. As was noted by the Health Department, prior to the 1994 democratic breakthrough, South Africa had a fragmented healthcare system designed along racial lines. One system was highly resourced and benefited the white minority while the other was systematically under-resourced and was for the black majority.<sup>4</sup> It was further noted that, *"post-1994 attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted. This has entrenched a two-tiered health system, public and private, based on socioeconomic status and this system continues to perpetuate inequalities in the current health system."*<sup>5</sup>
11. While there has been some progress in trying to bridge the poverty and racial gap in accessing health care services, *"the health system's effectiveness and efficiency still remains a huge challenge. These challenges are more pronounced in relation to the inequitable financing of the health care system whereby the poor are still largely marginalised and many other South Africans are at risk of catastrophic health expenditure."*<sup>6</sup> Catastrophic health care expenditure: health care expenditure resulting from severe illness/injury that usually requires prolonged hospitalisation and involves high costs for hospitals, doctors and medicines, leads to impoverishment or total financial collapse of the household.<sup>7</sup> In simple

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<sup>2</sup> Statistics South Africa "Poverty in South Africa". Available at: [http://www.statssa.gov.za/?page\\_id=739&id=1](http://www.statssa.gov.za/?page_id=739&id=1).

<sup>3</sup> The Council for Medical Schemes. Annual report 2014/15. Council for Medical Schemes; 2015 Available at: [https://www.medicalschemes.com/files/Annual%20Reports/AR2014\\_2015.pdf](https://www.medicalschemes.com/files/Annual%20Reports/AR2014_2015.pdf).

<sup>4</sup> Republic of South Africa Department of Health. National health insurance for South Africa: towards universal health coverage. Republic of South Africa Department of Health; 2015 Available at: <https://www.health-e.org.za/wpcontent/uploads/2015/12/National-Health-Insurance-for-South-AfricaWhite-Paper.pdf>.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

terms, those injured or harmed through negligence potentially could be pushed deeper into poverty because of the medical needs required as a result of the injury.

### **c. Poor Public Health Facilities**

12. The current dire state of health care in South Africa necessitates the need to reform health service delivery. The state has an obligation to provide women who approach a public healthcare facility with positive experiences.
13. According to the Office of Health Standards Compliance only five out of 649 health facilities across South Africa are found to be compliant with the Department of Health's norms and standards.<sup>8</sup> It is our contention that all available resources and time should first be spent on fixing the hospitals to improve the experiences of those accessing such services before legislative amendments are considered that prescribes the way in which redress can be sought. We believe that this approach puts women first and sends a clear message about their position and value in society.

### **d. Violations of the Right to Health including Sexual and Reproductive Healthcare**

14. We emphasise that childbirth is a women-specific experience. As a result of the direct link between gender, poverty and racial discrimination from apartheid, indigent women continue to be marginalised in their ability to access basic services, such as healthcare. The Constitutional Court in South Africa is committed to the transformative values of the Constitution and has reiterated the importance of providing adequate services to marginalised, vulnerable persons. An example of the Court's commitment is the case of *The Government of the Republic of South Africa and others v Grootboom and others*<sup>9</sup> in which Mrs Irene Grootboom and other respondents were left homeless after an eviction from their informal homes. The Court confirmed that rights entrenched in the Bill of Rights cannot only be understood in their textual setting, but rights must be understood in their social and historical context.<sup>10</sup>
15. The right to health care is not only guaranteed in the Constitution but is also a well-established right in international law. Section 27 of the Constitution provides for the right to healthcare for *everyone*, which explicitly includes access to reproductive health care. Section 12(2) of the Constitution confirms that everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction and to control over their body.
16. The International Covenant on Economic, Social and Cultural Rights ("ICESCR") provides for the right to health in article 12 by enjoining states to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The

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<sup>8</sup> <https://www.news24.com/SouthAfrica/News/the-dire-state-of-healthcare-20180610-2>

<sup>9</sup>[2000] ZACC 19.

<sup>10</sup> Paragraph 22.

Committee on Economic, Social and Cultural rights (CESCR), in its General Comment No. 14, has elaborated on the normative content of the right to health by recognising the right to health to include equal access for all, on the principle of non-discrimination, to health care facilities, goods and services.

17. Article 12 of the Convention on the Elimination of all forms of Discrimination against Women (“CEDAW”) encourages states to take appropriate measures to eliminate discrimination against women in the field of health care. Additionally, states are compelled to guarantee women-specific services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.
18. On a regional front, Article 14(1) of The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa provides that states parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted.
19. All the above clearly establish that the state has an obligation to act and improve the experiences of women in childbirth including guaranteeing the right to equality, dignity, health care, bodily autonomy among others. Section 7(1) of the Constitution is clear in its statement that the state must respect, protect, promote and fulfil the rights in the Bill of Rights, with the state including the Legislature.

#### IV. QUESTIONS OF THE SRVAW IN THE CALL FOR SUBMISSIONS

##### Question 1:

**Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country’s response and any good practices, including protection of human rights;**

##### **a. Introducing Obstetric Violence**

20. We note that the term obstetric violence “*emerged in the 2000s in Latin America and Spain as an extension of the activist struggle to humanise and demedicalise childbirth and empower women and girls during pregnancy, labour and birth. It emerged as a legal term in Venezuela in 2007 and was adopted by Argentina in 2009 and by Mexico in 2014.*”<sup>11</sup> In these countries perpetrators of acts of obstetric violence are criminally liable.

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<sup>11</sup> Rachele Joy Chadwick, Obstetric violence in South Africa, S Afr Med J 2016;106(5):423-424 available <http://www.scielo.org.za/pdf/samj/v106n5/02.pdf> [Accessed on 30 April 2019].

21. It has been reported that the choice of the word ‘obstetric violence’ over words like ‘mistreatment’ is an intentional step to “confront problematic practices, which have often been hidden, invisible and unacknowledged, as forms of violence.”<sup>12</sup>

**b. Experiences of Women in accessing Women Specific Services in Public Health: The perpetuation of Gender Discrimination**

22. As already mentioned, health care services in South Africa have historically been skewed in terms of race, gender and socio-economic status. The institutional mechanisms established to deliver health care services have historically reflected and continue to reflect a disproportionate bias in favour of dominant groupings in society, with specific services for women continuing to lag behind other services.<sup>13</sup>

22.1. Childbirth in South Africa continues to be divided along racial lines with black and coloured women giving birth primarily in public facilities and white women giving birth with specialist physicians in private hospitals.<sup>14</sup>

22.2. Increasingly women are being encouraged to give birth in a health facility.<sup>15</sup> It has been reported that 90% of women are giving birth in healthcare facilities.

22.3. The public sector is providing care for 83% of the South African population.<sup>16</sup> Therefore it is imperative for the state to inspect the status of obstetric care provided in public health facilities in hopes of putting measures in place to address the burdens and vulnerabilities mentioned above.

23. Some of the specific examples of poor birthing experiences that women have undergone in South Africa that indicates poor, unequal, inefficient medical care which has led to medical negligence claims include (these are examples taken from court cases or judgments):

i. High Perinatal Mortality Rates

24. The perinatal mortality rate is not only an indicator of maternal health but also a vital indicator of quality of obstetric care offered. According to Statistics South Africa, the perinatal mortality rate in South Africa in 2016 was 21 deaths per 1000 live births. The vast majority of perinatal deaths are preventable with proper maternal care.<sup>17</sup> A report compiled for the Perinatal Problem Identification Program found that almost half of the deaths that occur due to asphyxia – a complication that can cause cerebral palsy – were preventable with better foetal monitoring.<sup>18</sup> The report further notes that in a third of

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<sup>12</sup> Ibid.

<sup>13</sup> K Moyo “Realising the right to health in South Africa” (2016) Foundation for Human Rights page 5.

<sup>14</sup> M Hasting-Tolma, A Tolte & A Temane “Birth Stories From South Africa: Voices Unheard” (2018) *Women and Birth* 31 p43.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> <http://www.statssa.gov.za/publications/P03094/P030942014.pdf>

<sup>18</sup> Report available at: <https://www.ppip.co.za/wp-content/uploads/Saving-Babies-2012-2013.pdf>

babies dying with hypertension, the hypertension was detected but the medical staff failed to act on the matter.

25. The World Health Organization (WHO) defines the perinatal mortality rate as the number of stillbirths and deaths in the first week of life per 1000 births. The Birth and Death Registration Act 51 of 1992 defines stillborn as “at least 26 weeks of intra-uterine existence but showed no signs of life after complete birth”.

ii. Worsening Maternal Mortality Rates

26. South Africa’s maternal mortality rate has increased from 85 deaths per 100 000 live births in 2005 to 138 deaths per 100 000 live births in 2015 according to the WHO.<sup>19</sup> We noted that in 1990 WHO reports this to have 108 deaths per 100 000 births. Therefore, South Africa is experiencing an increase in maternal mortality whereas the global trend shows a sharp decrease. This is an indication of regression in the quality of obstetric care offered by public health facilities in South Africa.

iii. High Incidences of Obstetric Medical Negligence

27. Although substandard care has been recognised as a serious problem in South Africa, there is very limited research on the quality of care during childbirth.<sup>20</sup> A study done by Silal et al<sup>21</sup> highlights the low standard of quality of care experienced by women in public health facilities during antenatal care and delivery. The empirical research showed that out of the sample size of 300 women, all but one woman were generally dissatisfied with the quality of care they received in the public health facility. Four of the 300 women experienced stillbirths and explained that after the stillbirth they were placed in maternity wards with mothers and new born babies. Another study done by Chadwick et al<sup>22</sup> highlighted four central themes in women’s narrative of distress in health facilities:

- 27.1. **(1) Negative interpersonal relations with caregivers:** women receive hostile and punitive treatment; humiliation; they are being told to ‘clean up their mess’ after giving birth and screamed at.
- 27.2. **(2) Lack of information:** nurses and midwives withheld information from women even after they request the specific information and birth complications were not explained to women. Consequently, they could not actively participate in their own birth experience and have a say about their own bodies.
- 27.3. **(3) Neglect and abandonment:** women are being left alone for hours and nurses tell patients ‘they forget about them’.

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<sup>19</sup> <http://apps.who.int/gho/data/node.main.15?lang=en>

<sup>20</sup> M Hasting-Tolma, A Tolte & A Temane “Birth Stories From South Africa: Voices Unheard” (2018) *Women and Birth* 31 p43.

<sup>21</sup> S Silal, L Penn-Kekana, B Harris, S Birch & D McIntyre “Exploring inequalities in access to and use of maternal health services in South Africa” (2012) 12 *BMC Health Services Research*.

<sup>22</sup> R Chadwick, D Cooper & J Harris “Narratives of distress about birth in South African public maternity settings: A qualitative study” (2014) 30 *Midwifery*.



27.4. **(4) Absence of labour companion:** women giving birth in public facilities are often denied the presence of labour companions.

28. These studies indicate serious levels of poor service delivery in public health facilities. We highlight a few cases that have been litigated as a result of the poor services:

28.1. **Still birth caused by medical negligence:**

28.1.1. ***Hoffman v Member of the Executive Council Department of Health, Eastern Cape 2011 JDR 1081 (ECP):*** Plaintiff was ignored when she informed the hospital staff that she is a high-risk patient and must give birth by caesarean section. After the hospital staff informed the plaintiff that she must monitor the foetal heart rate with a machine, the plaintiff informed the staff that the heart rate was low. The caesarean section was only performed hours later, and the infant was stillborn. The court held that the defendants acted negligently and is liable to pay damages to the plaintiff.

28.1.2. ***Mbhele v MEC for Health (355/15) [2016] ZASCA 166:*** The foetus was in distress and despite the woman requiring urgent medical treatment, the hospital staff did not attend to her during labour and the child was stillborn. The plaintiff was also placed in a ward with mothers and their new-born babies and compelled to identify the body of her baby at the mortuary. The defendant was held liable and ordered to pay damages for the pain and suffering caused by negligence.

28.2. **Children born with cerebral palsy caused by birth implications:**

28.2.1. ***Makgomarela v Premier of Gauteng and another [2012] ZAGPJHC 217:*** The plaintiff was given Prostin during labour, which is against hospital regulations and placed the baby in distress. The negligence caused hypoxia which resulted in cerebral palsy. The court held that the hospital, and by vicarious liability the two defendants, was negligent and liable to pay the plaintiff damages.

28.2.2. ***Sifumba v Member of the Executive Council for Health Eastern Cape 2015 JDR 1597 (ECM):*** The plaintiff sought and was denied emergency medical treatment, the defendant's employees failed to monitor the foetal heart rate at 30 minute intervals, failed to take precautions against foetal distress, failed to detect foetal distress, failed to transfer the plaintiff to another hospital and failed to perform a caesarean section timeously. The child's brain injury resulted in cerebral palsy and the court held that the defendant was negligent.

28.2.3. ***Tsita v MEC for Health and Social Development Gauteng 2015 JDR 1539 (GJ):*** Plaintiff was in prolonged labour and the hospital should have opted for a caesarean section. Instead they waited for normal birth. The long labour resulted in the baby being born with cerebral palsy.

28.2.4. See also: ***Xolile v MEC for Health and Social Development Gauteng 2016 JDR 2004 (GJ); Smith v MEC for Health Gauteng 2015 JDR 1819 (GJ); Paia v MEC for Health and Social Development 2017 JDR 0735 (GJ).***

### 28.3. Surgical negligence during birth:

28.3.1. ***Nzimande v Member of the Executive Council for Health, Gauteng 2015 (6) SA 192 (GP)***: During the caesarean section the surgeon cut the baby on its arm and the child later required further surgery as the wound became infected. The hospital waited 9 days to clean the wounds of the baby. The court held that the hospital was negligent and ordered the defendant to pay damages for patrimonial and non-patrimonial losses.

29. These systemic problems and the lack of positive steps by the state to address them was raised in the case of *M v Member of the Executive Council for Health, KwaZulu-Natal*<sup>23</sup> in which the court said the following:

*“Although they represent as a bipolar dispute between a plaintiff and a defendant with the remedy being findings on liability, compensation and costs **the problem of malpractice remains institutional.** Malpractice suits are retroactive in the sense that they seek to remedy past wrongs. The litigation resolves the dispute but not the institutional problems. **Remedies that are forward-looking, that seek to resolve problems for the future should be considered for long-term sustainable solutions. The court cannot initiate such remedies without the co-operation of the litigants.**”<sup>24</sup>*

30. Because of the poor services received, by mid-2017, contingent liabilities for alleged medical negligence in the public sector reached R55 billion, excluding legal expenses.<sup>25</sup> As stated in the Issue Paper 33 on Project 141 Medico-Legal Claims by the South African Law Reform Commission (‘the Issue Paper’) not all claims of medical negligence go as far as the court and the majority of claims are settled before proceeding to court.<sup>26</sup> Some claims do not reach the courts at all as they are settled beforehand after the responsible facility admits negligence. This indicates that the magnitude of the problem exceeds far beyond what has been reported or been made accessible through reports. More worryingly, there is a continued violation of women’s bodies, their positions in society marginalised, and women continue to be invisible or blatantly ignored when key steps are taken to budget and plan for their empowerment, equality and affirmation of their place in society.

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<sup>23</sup> Unreported case no 14275/2014.

<sup>24</sup> Para 79.

<sup>25</sup> B Taylor, J van Waart, S Ranchod & A Taylor “Medicolegal storm threatening maternal and child healthcare services” (2018) 108 *South African Medical Journal* 149-150.

<sup>26</sup> Paragraph 2.30

**RECOMMENDATIONS FOR GOOD PRACTICE IN ORDER TO PROTECT WOMEN’S RIGHTS IN CHILD BIRTH:**

31. **The state as the holder of obligations in the Constitution, must take urgent and immediate steps to address the systemic failures and shortfalls in the public health sector facilities providing services to women for child birth in order to guarantee the rights of women.**
32. We emphasise the role of the state to take positive measures to ensure that women’s rights in this regard are protected. The court in South Africa has emphasised that:
- “The state is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The state is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the state’s obligations. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the state’s obligations.”<sup>27</sup>*
33. Further, Chapter 5 of the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 emphasises that the state has a duty and responsibility to promote and achieve equality. More importantly, Section 25 provides that the state must, where necessary, take steps to develop and implement programmes in order to promote equality, develop action plans to address any unfair discrimination and develop appropriate internal mechanisms to deal with complaints of unfair discrimination. Further, section 25(4) specifically states that:
- All Ministers must implement measures within the available resources which are aimed at the achievement of equality in their areas of responsibility by—*
- (a) eliminating any form of unfair discrimination or the perpetuation of inequality in any law, policy or practice for which those Ministers are responsible; and*
- (b) preparing and implementing equality plans in the prescribed manner, the contents of which must include a time frame for implementation of such plans, formulated in consultation with the Minister of Finance.*
34. We also emphasise that preventative measures needs to be taken that are aimed at addressing the root causes of the violence and mistreatment to ensure that this systematic failure of the healthcare system is addressed effectively. These interventions will have to be multi-dimensional and must include state actors as well as the health workers themselves.

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<sup>27</sup> Paragraph 42.

## **Question 2:**

### **Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care**

35. The Constitution of South Africa, in terms of section 12(2), provides that everyone has a right to bodily and psychological integrity. This right includes the right to make decisions concerning reproduction.<sup>28</sup> Fundamental to the exercise and enjoyment of this right is that, in the context of medical treatment during child birth, a patient has the right to make decisions regarding the treatment they receive, which means their consent is required prior to receiving such treatment.
36. The section 12(2)(a) right is read with the right to health care, as provided for in terms of section 27(1)(a) of the Constitution. It specifically provides that everyone has the right to have access to health care services, including reproductive health care.
37. Generally, in the arena of medical treatment, the patient's consent is required before a health care provider may administer medical or surgical treatment to them. Further to this, the consent is dependent upon the patient being provided with the necessary information to make a fully informed decision.
38. The National Health Act, enacted in 2003, provides the framework for '*a structured uniform health system within the Republic [of South Africa]*'. Its objects are to regulate national health and provide uniformity in respect of health services in the South Africa by establishing a national health system. The Act and its provisions therefore apply to the healthcare system in South Africa, and the manner in which it is administered, among others.
39. Section 6 of the National Health Act<sup>29</sup> provides that users of the healthcare system are to have full knowledge, in that every health care provider must inform a user of:
- (a) *the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;*
  - (b) *the range of diagnostic procedures and treatment options generally available to the user;*
  - (c) *the benefits, risks, costs and consequences generally associated with each option;*  
*and*
  - (d) *the user's right to refuse health services and explain the implications, risks, obligations of such refusal.*

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<sup>28</sup> Constitution of the Republic of South Africa, section 12(2)(a).

<sup>29</sup> Act 61 of 2003.

40. The above information is necessary for the user or patient to make an informed decision regarding their health care, and the methods of treatment they would choose to embark on given their personal circumstances. The information is to be relayed in the user's preferred language to ensure they fully understand.<sup>30</sup>
41. Section 7 then provides that a health service may not be provided to a user without the user's informed consent, which is dependent upon the health care provider informing the user of the necessary information stipulated in section 6 of the National Health Act.
42. In order to provide consent, the patient must be capable of doing so, and be fully informed of the extent of the harm they may experience, and the procedure to which they are consenting. All adults in South Africa are capable of providing consent. Circumstances in which an adult cannot provide consent are where they lack the capacity to do so. Incapacity can be as a result of intoxication, substance-related intoxication, or unconsciousness.
43. A health care provider will wait for the incapacity to pass in order to obtain the consent of the patient before embarking on medical or surgical treatment.
44. The consent of the user is always required, however the law recognises that there may be circumstances where obtaining the user's consent is not possible. In these instances, specific persons may provide consent on behalf of the user so that they may receive medical or surgical treatment at the health care facility. These are:
  - 44.1. Where the incapacity does not pass, then the consent may be provided by someone who is mandated by the user to provide consent on their behalf. This can be effected by way of a proxy.
  - 44.2. It may be given by someone authorised to do so in terms of law, or by way of a court order.
  - 44.3. Where express authorisation in the form of a mandate or order of court does not exist, then consent may be given by the user's spouse or partner, parent, grandparent, adult child of the user, or sibling. The National Health Act stipulates that consent is given by the persons in the specific order listed.
  - 44.4. In cases of emergency, where the patient cannot provide consent to the health care treatment, then any one of the listed persons above may provide consent. However, where none of the listed persons are available to provide consent in an emergency, then where an adult has not expressed an unwillingness to undergo treatment, but is temporarily incapable of providing consent then emergency treatment may be administered without consent. In these circumstances, treatment provided without consent will be justified on the grounds of necessity. Strauss<sup>31</sup> provides that there are four requirements to be met for emergency treatment to apply in the circumstances:

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<sup>30</sup> National Health Act, section 6(2).

<sup>31</sup> Strauss, *Doctor, Patient and the Law*, 93.

- 44.4.1. There must be a real state of emergency – the patient must be faced with a real possibility of death, serious bodily injury, or deterioration of their health;
- 44.4.2. The patient is unaware of the envisaged treatment to be administered, or incapable of appreciating the situation;
- 44.4.3. The treatment must not be against the patient’s will – they must not have expressed an unwillingness to undergo the treatment; and
- 44.4.4. The treatment must be intended to be in the patient’s best interests.

In these instances, it is justified for a medical practitioner to administer medical assistance to the patient without their consent.

45. These requirements for obtaining the patient’s consent in the provision of health care services applies to reproductive health care as well, as it is a form of health care, and child birth. Therefore, where a woman requires medical assistance during child birth, before any assistance can be administered, and where the woman is capable of doing so, then she must provide her informed consent. The rules stated above would apply equally to her circumstances during child birth.
46. From a practical perspective, Human Rights Watch conducted an empirical study in 2011 and produced a report titled “Stop Making Excuses”: Accountability for Maternal Health Care in South Africa.<sup>32</sup> In relation to consent, this report found that;
  - 46.1. health workers failed to provide information to women about issues crucial to their obstetric care. This information included failing to obtain informed consent from women before Caesarean surgery;
  - 46.2. ambulance dispatchers provided poor, or lack of, communication which resulted in women not being able to deliver in a health facility;
  - 46.3. Some women were reported as saying that “poor communication by health workers, sometimes due to language barriers, resulted in situations where the women had too little information to know whether to consent to procedures.”<sup>33</sup> This is often linked to challenges in communication and language barriers especially with migrant women.
47. Human Rights Watch report found that “These failures in communication can lead to a delay in diagnosis and treatment and in turn to increased morbidity and mortality. They also may contribute to unnecessary psychological suffering in women, and can drive women away from seeking care.”<sup>34</sup>

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<sup>32</sup> Available at <https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa> [Accessed on 15 May 2019].

<sup>33</sup> Human Rights Watch interview with Aasiya H., Port Elizabeth, November 14, 2010 available at <https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa> [Accessed on 15 May 2019].

<sup>34</sup> Ibid.

### **Question 3:**

**Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations**

48. South Africa provides for redress in three settings for victims of mistreatment and violence: internal remedies (in terms of the laws relating medical care); external, broader remedies that exist beyond the sphere of medical care but operate within these circumstances; and criminal law.
49. In terms of these remedies, women who experience mistreatment and violence during the child birth process may choose to pursue whichever option best suits their experience. This section will begin discussing those internal remedies created by the National Health Act, and which apply specifically to health establishments. It will then discuss broader, external civil remedies before discussing the victim's criminal law options.

#### **a. Internal Procedures**

50. The National Health Act provides for the laying of complaints. Section 18 of the Act explicitly provides that *'[a]ny person may lay a complaint about the manner in which he or she was treated at a health establishment<sup>35</sup> and have the complaint investigated.'* Complaints are to be lodged in terms of procedures established by the Member of the Executive Council for health for the relevant province (of which there are nine), and every municipal council in the area for which they are responsible.
51. The procedures are to be publicly displayed at all health establishments so that users are aware of the applicable procedure should they experience mistreatment or violence at the establishment.<sup>36</sup> The procedure to be followed is dependent on the health establishment at which the wrong occurred, that is the province in which it is in, and whether the procedure was designed by the MEC or the municipality.
52. Each province and their municipalities are tasked with providing a complaints procedure for those health establishments falling under their relevant jurisdictions. Of the nine provinces in South Africa, four provide detail regarding the complaints procedure tailored to the respective provinces, and which are accessible outside of a health establishment where they are to be publicly available. It would be common practice to lodge the complaint with the establishment itself, and where it is not resolved, or resolved unsatisfactorily, then it gets escalated according to the procedure set out.

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<sup>35</sup> In terms of section 1 of the National Health Act, a 'health establishment' is defined as: 'the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services.'

<sup>36</sup> Section 18(3)(a) of the National Health Act.

53. From a practical perspective, we do not have much information from these procedures of what is being complained about, by whom, remedial steps that are taken after such complaints and the impact and effect of these remedial steps to both the complainant and the service providers. These complaints are not publically available and as such this submission simply lists these internal processes without providing an analysis of their efficacy, availability and whether they provide any redress to the complainant.

i. Western Cape Department of Health

53.1. The Western Cape Department of Health has established a complaints hotline, as well as procedures that allow for members of the public to lodge complaints, or start the procedure via text and email. The information required for these modes of complaining is the complainant's name and surname, the facility at which the incident occurred; the nature of the complaint; and the staff member against whom the complaint is being made (if known, or applicable in the circumstances).<sup>37</sup>

53.2. The complaint will usually be handled by an agent handling the hotline or other medium through which the complaint was laid; however, where the complaint requires more attention than can be allotted by the agent, then it is escalated to the official managing the hotline. They will contact the complainant and provide progress on the handling of the complaint.

53.3. Beyond the hotline established by the provincial government, each health establishment in the Western Cape will have a procedure published at the establishment. For example, the procedure at Tygerberg Hospital in Cape Town stipulates that complaints should be made to a team member caring for the patient, or a member of the Patient Advice and Liaison Services. The process to follow will then be an acknowledgement of receipt to be sent to the complainant, followed by an investigation, which then ends with a communication from the Chief Director of the establishment regarding the action to follow.

53.4. The Western Cape has also established the Independent Health Complaints Committee,<sup>38</sup> with members appointed by the MEC for Health. The Committee considers complaints referred to it by the Minister or Head of Department, but is not to consider any complaints referred to it directly by the public.<sup>39</sup> This then means that where a complaint has been escalated to the Minister or Head of Department, or is of such a nature that it has been brought to either's attention, that they may then refer it to the Committee for its consideration.

53.5. After considering the complaint, the Committee produces a report and makes recommendations to the party that referred the matter to it.<sup>40</sup> The

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<sup>37</sup> [https://www.westerncape.gov.za/dept/health/documents/public\\_info/H/32120](https://www.westerncape.gov.za/dept/health/documents/public_info/H/32120) discussing the complaints project, and complaints procedure at a Western Cape health facility, accessed on 09 May 2019.

<sup>38</sup> Western Cape Health Complaints Committee Act 2 of 2014, section 2.

<sup>39</sup> Ibid sections 10(a) and 10(c).

<sup>40</sup> Ibid section 13(1).



recommendation must contain a recommended solution of the complaint, and within a period of 60 days of receiving such report the Minister or Head of Department must furnish the complainant with a written response regarding their complaint.<sup>41</sup>

53.6. Thus, the Western Cape Health Department allows for three complaints procedure mechanisms: the general hotline and its related telecommunications media of submitting complaints; directly lodging complaints at the health establishment at which the incident occurred, and according to the published policy; and have a complaint referred to the Independent Health Complaints Committee by the Minister or Head of Department for the provincial department of health.

ii. KwaZulu Natal Department of Health

53.7. The KwaZulu Natal ('KZN') Health Act 1 of 2009 provides that '*a health care user has a right to lodge a complaint in respect of health care services rendered as provided for in national legislation and in this Act, and have their complaint investigated and addressed.*'<sup>42</sup> The Act goes further, in section 34, to establish the KZN Provincial Operations Centre, which is to provide a '*professional, effective and efficient operations support service to internal and external customers of the Department [of Health] in respect of... customer complaints line service.*'<sup>43</sup>

53.8. The Act therefore allows, much like the Western Cape Department of Health, for users of the health care services to lodge complaints via a complaints line service.

53.9. It also establishes the Inspectorate for Health Establishments, which is tasked with ensuring compliance with the Act, and the National Health Act. The inspectorate also includes an ombudsperson in its office.<sup>44</sup> To draw attention to non-compliance with either Act by way of ill-treatment of patients, a complainant may assert the right discussed above and lodge a complaint directly with the ombudsperson. This may also be an avenue open to a user of the health care system in KZN as it is the duty of the ombudsperson to deal with complaints.<sup>45</sup>

53.10. Section 65 reiterates that the MEC for health on the province is to establish a complaints procedure as provided for in section 18 of the National Health Act, which, as stated before, is to be published in health establishments for the public's knowledge.

53.11. Accordingly, complaints in KZN may then be made in terms of a customer care line (telephonically), purportedly directly to the ombudsperson, or according to the procedure created by the MEC and posted in health establishments.

iii. Free State Department of Health

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<sup>41</sup> Ibid section 14.

<sup>42</sup> KwaZulu Natal Health Act 1 of 2009, section 7(1)(i).

<sup>43</sup> Ibid section 35(1)(f).

<sup>44</sup> Ibid section 63.

<sup>45</sup> Ibid section 66(1)(b).

- 53.12. Section 17 of the Provincial Health Act<sup>46</sup> reads the same as the National Health Act, that a person may lay a complaint about the manner in which they were treated at a health establishment, and have the complaint investigated. The person tasked with resolving these complaints is an ombudsperson established in terms of section 18 of the Provincial Health Act.
- 53.13. The complaint may be lodged directly with the ombudsperson, or it may come before them upon a referral by the health establishment at which the complaint was laid.<sup>47</sup>
- 53.14. Additionally to the office of the ombudsperson, the Free State Department of Health has established a policy and procedure document for the laying of complaints, their investigation, as well as an escalations procedure where the complaint was not resolved, or resolved unsatisfactorily. This policy and procedure document applies to all facilities in the Free State.<sup>48</sup>
- 53.15. In terms of the 'Flow Chart for Managing a Complaint' the following procedure applies to a complaint lodged verbally, telephonically, by email, or in writing<sup>49</sup>:
- 53.15.1. The complaint is registered with the service point head;
  - 53.15.2. The service head acknowledges receipt of the complaint and attempts to resolve it immediately;
  - 53.15.3. If it cannot be resolved immediately then the complaint is reduced to writing and referred to the Customer Care Co-ordinator who will then attempt to resolve the matter within 10 working days;
  - 53.15.4. If the complaint is still unresolved, then it will be referred to the Chief Executive Officer or Facility Manager who will then institute further investigation and provide a final institutional response within 10 days of receiving the complaint.
- 53.16. Where the Chief Executive Officer or Facility Manager is still unable to resolve the complaint then it is referred to the Service Marketing Sub-directorate at a number provided, and where it continues to remain unresolved it is then escalated to the Office of the Ombudsman.<sup>50</sup>
- 53.17. In the event a complainant is dissatisfied with the outcome of their complaint then they may contact the Customer Relation Officer at the toll-free number provided.<sup>51</sup>

#### iv. Eastern Cape Department of Health

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<sup>46</sup> Act 3 of 2009.

<sup>47</sup> Provincial Health Act 3 of 2009, section 18(4).

<sup>48</sup> Free State Department of Health: Complaints Policy and Procedure, MEC Foreword, 3; Scope, 4 at [http://www.fshealth.gov.za/portal/pls/portal/PORAL.wwsbr\\_imt\\_services.GenericView?p\\_docname=3136406.DOC&p\\_type=DOC&p\\_viewservice=VAH&p\\_searchstring=](http://www.fshealth.gov.za/portal/pls/portal/PORAL.wwsbr_imt_services.GenericView?p_docname=3136406.DOC&p_type=DOC&p_viewservice=VAH&p_searchstring=) (accessed on 08 May 2019).

<sup>49</sup> Ibid, 6.

<sup>50</sup> Ibid.

<sup>51</sup> Ibid, 8.

- 53.18. Alongside the procedures to be developed by the MEC of the province, or its municipalities, the Eastern Cape has promulgated the Provincial Health Act 10 of 1999 (before the advent of the National Health Act) to provide for a complaints procedure.
- 53.19. The complaint is submitted in writing to the MEC who must then investigate it within 30 working days of receipt of the complaint. Within 60 days of receipt of the complaint, the MEC must rule on the matter.<sup>52</sup>
- 53.20. The Act also provides for an ombudsperson who may assist the complainant during their process with the MEC, but it does not speak to the ombudsperson investigating and handling complaints separately to the MEC.<sup>53</sup>
54. The remaining five provinces<sup>54</sup> do not have their policies accessible by way of desktop research, but will have policies and procedures formulated for their jurisdictional health establishments as is required in terms of the National Health Act. This will be available and should be published at the health establishments.
55. Over and above the province-specific procedures established by the respective health departments, the National Health Act has also established the Office of Health Standards Compliance ('OHSC').<sup>55</sup> The objects of the OHSC are to promote and protect the health and safety of users of health services in South Africa, which is done via ensuring compliance with, and investigating non-compliance of, the norms and standards set for different health establishments by the Minister of Health in South Africa.
56. The OHSC also deals with complaints relating to the non-compliance or breaches of norms and standards applicable to health establishments nationally, and as provided for by the Minister of Health in terms of Regulations.<sup>56</sup> Section 81 of the National Health Act establishes the Office of the Ombud within the OHSC, who is tasked with handling and investigating the complaints received.
57. The Ombud, who is available to complainants beyond the procedures provided for at provincial level, is appointed by the Minister of Health after consultation with the OHSC Board, and serves for a period of 7 years.<sup>57</sup> The Ombud receives complaints, or investigates such on its own initiative, and the complaint may involve and act or omission by an official at a health establishment.<sup>58</sup>

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<sup>52</sup> Provincial Health Act, section 19.

<sup>53</sup> Ibid section 19(3).

<sup>54</sup> Northern Cape; Mpumalanga; Limpopo; Gauteng; and North West provincial departments of health.

<sup>55</sup> National Health Act, Chapter 10.

<sup>56</sup> Norms and Standards Regulations Applicable to Different Categories of Health Establishments, GN 67 of Government Gazette 41419, 02 February 2018.

<sup>57</sup> National Health Act, section 81(3).

<sup>58</sup> Ibid sections 81A(1) and 81A(2).

58. After the investigation has been completed, the Ombud drafts and submits a report to the CEO of the OHSC Board with its recommendations as to the resolution of the complaint.<sup>59</sup> It is then for the OHSC to act on the recommendations or not.
59. According to the 'What Complaints We Investigate' section on the website of the Office of the Ombud, the Ombud investigates complaints relating to:
- 59.1. Inappropriate treatment or care;
  - 59.2. Inappropriate behaviour by a healthcare facility;
  - 59.3. Poor quality healthcare service provided by a healthcare establishment; and
  - 59.4. Unsatisfactory management of a complaint by a healthcare establishment.<sup>60</sup>
60. Therefore, the Office of the Health Ombud is available to investigate a complaint submitted directly to it by a member of the public, or it will investigate a complaint that was first, but poorly handled by a health establishment. So, where a woman experiences mistreatment or violence during her pregnancy or the child birthing process, then she has an option to approach the Office of the Health Ombud who sits at a national level, and does not necessarily have to use the mechanisms established within the health establishment at which she experienced the mistreatment, or the additional processes (if any) established by the provincial department of health in whose jurisdiction the health establishment falls.
61. Even more, a complaint may also be lodged with the Health Professional Council of South Africa ('HPCSA'), with which health practitioners are to register. Registration with the Council is necessary for practising as a health practitioner.<sup>61</sup> The HPCSA determines standards of professional education and training, and setting standards of ethical and professional practice.
62. The HPCSA has the power to institute disciplinary proceedings regarding any complaint against a person registered with the Council. Therefore, depending on who perpetrated the obstetric violence and whether they are registered with the HPCSA, a woman may lodge a complaint with the HPCSA and have it resolved by this body through disciplinary proceedings for transgressing the rules laid down by the Professional Board.
63. Nurses may be reported to the South African Nursing Council ('SANC') who will then investigate the complaint relating to a specific nurse. The avenues of the HPCSA and SANC depend on the victim of the obstetric violence knowing the position of the person and their names.

**b. External avenues of recourse**

64. Due to the nature of the wrong committed against women when they experience mistreatment or violence during their pregnancy or child birthing process, and that these

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<sup>59</sup> Ibid section 81A(11).

<sup>60</sup> Office of the Health Ombud, 'What Complaints We Investigate', <http://healthombud.org.za/submit-complaint/> (accessed on 08 May 2019).

<sup>61</sup> Health Professions Act 56 of 1974.

acts occur at the hands of state employees, women have access to redress that sit outside of the health establishment, or the health care system and its laws. This section explores the other possible avenues of accountability that women may take in these circumstances. These avenues include civil procedures, approaching a Chapter 9 institution, or laying a criminal charge against the official who committed the wrong.

i. **Civil law remedies**

65. The applicable remedies available to women in this respect, which we will discuss, are redress in terms of the Equality protections; redress in terms of the law of delict; and bringing an application in the High Court.

a) Redress in the Equality protections

66. It is our submission that when the state allows poor services to continue to be rendered to women for women specific health care services like child birth, the state discriminates against women on the basis of race, pregnancy, sex, gender among others. Section 9 of the Constitution prohibits unfair discrimination. Accordingly this is an avenue that is available for women in such instances; to pursue holding the state accountable for the failures of services in childbirth.

67. The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 ('**PEPUDA**') gives effect to section 9 of the Constitution and also prohibits discrimination on the basis of sex, gender, and pregnancy. Section 8 of PEPUDA specifically prohibits unfair discrimination on the ground of gender including gender-based violence; any practice which impairs the dignity of women and undermines equality between women and men; discrimination based on the ground of pregnancy and systematic inequality of access to opportunities by women as a result of the sexual division of labour. This is the case with childbirth.

68. In determining whether discrimination is fair or unfair, section 14 of PEPUDA states that some of the factors taken into account include whether the discrimination impairs or is likely to impair the dignity of a person; the impact of the discrimination; position of a person in society and whether they have suffered patterns of disadvantage; extent of the discrimination; and whether it is systematic, among others.

69. In further assessing the fairness or unfairness of the discrimination, one of the factors that are considered is whether and to what extent reasonable steps have been taken to address the disadvantage which arises from or is related to one or more of the prohibited grounds. We do not believe that reasonable or any steps have been taken to systematically overhaul the structural failures and abuses faced by women when approaching public facilities to improve the experiences of women during childbirth.

70. The redress sought in medical malpractice cases therefore is a way for these women to restore their dignity and vindicate their marginalisation in health care. Accordingly, the judiciary in South Africa plays an important role to ensure that a person harmed or whose rights were violated has access to justice as envisaged by the Constitution of South Africa.

71. This option has its limitations specifically that women do not always know that they can hold the actors liable for the poor services rendered. For those who know, the expense of litigation becomes a hindrance in seeking redress.

b) Redress in terms of the Law of Delict

72. The Law of Delict in South Africa governs those situations in which one experiences a loss, be it monetary or psychological, caused by the intentional or negligent act of another. It is a general rule that loss lies where it falls, in that everyone is responsible for the loss they experience. Delict is the exception to this rule, providing that the responsibility for the loss experienced to lay with another who was responsible therefor. Thus, if one can prove that all the elements of delict exist, then one can receive compensation from the defendant who caused the loss.

73. A delictual claim is usually brought in the High Court by way of action proceedings.. This means that the plaintiff must prove that a delict occurred, and then prove the amount to which they have to be compensated by the defendant. Action proceedings involve a trial wherein the plaintiff (and others) will be called to give oral evidence about her(or their) experience(s). The compensation can be for monetary loss (also known as patrimonial loss), or psychological harm (non-patrimonial loss). One may also be compensated for past loss or future loss (where one has to claim for future loss of earnings, for example).

74. Delictual claims brought in the High Court require legal assistance in the form of an attorney, and an advocate where applicable. Thus before a woman decides to embark on High Court proceedings to claim for the loss she experienced, she needs to be informed of the cost of such proceedings, the merits of her matter, what the process would entail, and the time it would take for the matter to be finalised.

75. In the scenario where a woman experiences obstetric violence, depending on the type of harm she experienced and the effects thereof, she may bring a delictual claim at the High Court in whose jurisdiction the facility is to be compensated for the loss she experienced. The claim would be brought against the state by way of citing the MEC for Health in the relevant province, and it would be claiming for a sum of money quantifying the loss, whether past or future, or both.

76. Claims in terms of the Law of Delict are subject to the Prescription Act 68 of 1969, which provides that one has to bring a claim for a debt within three years of knowledge of the debt. In these circumstances the debt will be the amount to be claimed in terms of the loss experienced.<sup>62</sup>

77. It is often common practice that the claims are settled between the parties before the matter is finalised by the Court.

c) Redress in terms of a High Court application

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<sup>62</sup> Prescription Act 68 of 1969, section 11(d).

78. An additional avenue that may be explored by women who experience obstetric violence is to bring a High Court application seeking a declaration of infringement of rights and a structural interdict. Application proceedings differ from action proceedings in that they do not entail a trial and the presentation of oral evidence. The process entails the exchange of pleadings, which includes evidence necessary to prove one's version, and a hearing. Thus, application proceedings are decided on the papers.
79. This form of redress would often pursue a remedy at a systemic level, and would benefit from multiple applicants coming forward individually, as well as through an institutional client. It would not necessarily be for compensation, however where one can prove that the applicants' constitutional rights were infringed, then there may be an opportunity to claim for constitutional damages. This will allow the women to be compensated for the infringement of their constitutional rights as a result of the experience of obstetric violence.
80. Ultimately, the application would then ask for a declaration of rights applicable within the factual matrix; a declaration of an infringement of these rights; and to produce systemic relief by way of a structural interdict. The structural interdict, depending on the change the applicants would want to see implemented in their province, would involve the state developing a plan that the court would oversee, and which often involve meaningful engagement with the applicants and other relevant stakeholders.

## ii. Chapter 9 institutions

81. The Constitution of South Africa established specific institutions envisioned to support constitutional democracy in South Africa. These institutions are provided for in terms of Chapter 9 of the Constitution. They are *'independent, and subject only to the Constitution and the law, and they must be impartial and must exercise their powers and perform their functions without fear, favour or prejudice.'*<sup>63</sup>
82. These institutions may be available to women for lodging and investigation of complaints related to obstetric violence experienced at a health establishment.

### a) Public Protector

83. Governed by sections 181 to 183 of the Constitution, and the Public Protector Act 23 of 1994, the office of the Public Protector has the power *'to investigate any conduct in state affairs, or in the public administration in any sphere of government, that is alleged or suspected to be improper or to have resulted in any impropriety or prejudice'*.<sup>64</sup> It would be an avenue, through the lodging of a complaint, of the measures in place at a health establishment to train, sensitise, and discipline members of staff for obstetric violence at that establishment or more broadly within that province. It may be used to tease out systemic issues that require an in-depth investigation.

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<sup>63</sup> Constitution of the Republic of South Africa, section 181(2).

<sup>64</sup> Public Protector Act 23 of 1994, Preamble.

84. Section 6(4) of the Public Protector Act provides for those matters the Public Protector is competent to investigate on their own initiative, or on receipt of a complaint from a member of the public. Of the matters listed, it is our submission that those applicable to a matter involving obstetric violence would be:
- 84.1. Abuse or unjustifiable exercise of power, or unfair, capricious, discourteous or other improper conduct or undue delay by a person performing a public function;<sup>65</sup> and
- 84.2. An act or omission by a person in the employ of government at any level, or a person performing a public function, which results in unlawful or improper prejudice to any other person.<sup>66</sup>
85. After an investigation has been conducted, the Public Protector would produce a report that makes a finding on the complaint, and make an order as to remedial action. The findings and recommendations as to remedial action are binding until set aside on review by a court of law.<sup>67</sup>
86. It is a powerful mechanism for holding health establishments accountable for the actions of their staff, especially as they infringe on the rights of women through obstetric violence. The Public Protector has wide powers to direct any person to appear before it, or submit an affidavit or declaration regarding the incident or incidents. Due to the position of the office, it has the necessary investigative powers to do an in-depth, thorough investigation to produce a remedy that best resolves the complaint. Even more, the Public Protector reports on its work to the National Assembly, which means that the issue will be brought to the attention of Parliament. This may lead to further, high-level consideration of the issues raised in the complaint, and possible action being taken by the Legislature to prevent the recurrence of this problem.
87. Complaints should be reported to the office of the Public Protector within two years from the occurrence of the incident or matter concerned.<sup>68</sup>

b) South African Human Rights Commission

88. The South African Human Rights Commission ('SAHRC') derives its mandate from section 184 of the Constitution, which provides that the SAHRC is mandated to promote, protect and monitor human rights in South Africa, and matters related thereto, which includes investigative powers.<sup>69</sup>
89. Like the Public Protector, and other Chapter 9 institutions, the SAHRC is an institution independent of any government department, and is accountable to the Parliament of South Africa.

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<sup>65</sup> Ibid, section 4(a)(ii).

<sup>66</sup> Public Protector Act, section 6(4)(a)(v).

<sup>67</sup> *Minister of Home Affairs and another v Public Protector of the Republic of South Africa* 2018 (3) SA 380 (SCA) para 5.

<sup>68</sup> Ibid section 6(9).

<sup>69</sup> Constitution of the Republic of South Africa, section 184(1)(a), (b) and (c).



90. The SAHRC consists of 8 Commissioners who are each allocated a specific human rights focus area of which health care is its own focus area (coupled with migration). The Commissioners are mandated to ensure that policies, programmes and allocated resources are consistent with the vision of the SAHRC.
91. The SAHRC is also mandated to receive complaints from the public into an alleged violation of a fundamental right. In the case of obstetric violence experienced at a health establishment, a woman may come forward to complain about the violation of their constitutional rights to dignity, privacy, bodily and psychological integrity, and equality, among others. The SAHRC will then investigate the violation, but will only do so if the complaint is not currently the subject of court proceedings, before a tribunal, or any statutory body with internal dispute resolution mechanisms. It will also not investigate a complaint that has already been settled between the parties, or there is a finding by a court of law, tribunal, statutory body, or other body.
92. Where a woman wants to bring their complaint before the SAHRC, then she must do so within three years from the date on which the violation occurred. It will be lodged at the provincial office of the SAHRC in whose jurisdiction the rights violation occurred. It may be lodged in person, telephonically, in writing, or by completing the complaints form online.

c) Commission for Gender Equality

93. Established in terms of section 187 of the Constitution, the Commission for Gender Equality ('CGE' or 'Commission') is mandated to '*promote respect for gender equality and the protection, development and attainment of gender equality.*'<sup>70</sup> The powers incidental to the realisation of this mandate is to monitor, research, educate, lobby, advise, report on, and investigate issues concerning gender equality. Due to the fact that obstetric violence affects the rights of women, the matter is inherently impacting a woman's right to equality on the basis of gender, sex, and pregnancy. The CGE would be suited to handling a complaint of this nature.
94. The Commission of Gender Equality Act 39 of 1996 fleshes out the Constitutional imperative established in terms of section 187 of the Constitution. Section 11(1)(e) provides that the Commission shall '*investigate any gender-related issues... on receipt of a complaint, and shall endeavour to– (i) resolve any dispute; or (ii) rectify any act or omission, by mediation, conciliation or negotiation*'. Therefore, a woman who has experienced obstetric violence may approach the CGE to handle its complaint, and one of its focal areas for the realisation of its mandate is Gender and Health.
95. A complaint may be submitted via the established hotline, at a provincial office, or via the online complaints form. After a complaint is lodged, a legal officer is allocated to the matter and an investigation is started. The legal officer is responsible for communicating with and updating the complainant on the process going forward and its outcome.

iii. **Criminal charges**

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<sup>70</sup> Constitution of the Republic of South Africa, section 187(1).

96. Where the obstetric violence is of such a nature that it amounts to a criminal charge then the victim may lodge a complaint with the South African Police Services in whose jurisdiction the act occurred. In order for the Police Service to properly investigate the matter, and for the National Prosecuting Authority to prosecute the complaint, it will be necessary for the victim to be as detailed as possible in their complaint, which includes having the name of the person or persons who committed the act.

97. Obstetric violence may amount to:

97.1. Assault – the unlawful and intentional application of force to the person of another, or inspiring a belief that force will immediately be applied to their person;

97.2. Assault with intent to cause grievous bodily harm – it has the same elements as discussed above committed with the intention to cause serious bodily harm.

97.3. Crimen injuria – unlawfully and intentionally impairing the dignity or privacy of another person; and

97.4. Culpable homicide – the unlawful negligent killing of another human being, among others.

Where a victim has experienced an act that amounts to any of the above, then it would be in their best interests, should they have the emotional and mental wherewithal to follow through with the criminal process, to lodge a complaint with the police.

98. The National Health Act also creates specific statutory offences for which the penalty is a fine or imprisonment for a term not exceeding 10 years. In this respect, the section 89(1)(h) offence of interfering with, hindering or obstructing the Ombud or any other person rendering support or assistance to the Ombud when they are performing or exercising a function or power under the National Health Act will be relevant. During the investigation of the complaint, should anyone commit this statutory offence, then the matter may be referred to the Police.

99. The criminal process will run parallel to whichever other process a victim of obstetric violence may be embarking on, be it a complaints procedure with the specific health establishment; in terms of additional provincial complaints procedures; following a process with the Office of the Health Ombud; reporting the health practitioner or nurse to their respective Councils; approaching a Chapter 9 institution; or embarking on a process in terms of civil law.

100. These are the various means of seeking redress for an experience of obstetric violence that women may embark upon in terms of South African law. We note however that they are not always utilised for a number of reasons including lack of knowledge about holding the health system accountable, lack of knowledge about individual rights, lack of responsiveness from duty bearers and/or those receiving the complaints, culture of impunity and fear of reporting a health facility that you will use for more than one birth. Consequently, while there is no shortage of mechanisms, their efficacy remains to be seen.

101. While there is no shortage of mechanisms, their efficacy remains to be seen. A report by the Human Rights Watch<sup>71</sup> on accountability for maternal Health Care in South Africa shows that in the Eastern Cape province of South Africa the complaint procedures fail in the following ways:

- 101.1. Few mechanisms exist for informing health care users that procedures and processes exist for lodging complaints;
- 101.2. The “suggestion boxes” in the health facilities are no longer existing or are not functional;
- 101.3. Individuals are not aware of the province’s call-centre system and facilities do not display information about the call centres;
- 101.4. Patients are too afraid to submit complaints directly to officers in charge of facilities due to fear of retaliation.
- 101.5. Patients do not submit their complaints due to lack of trust that their complaints will be investigated and responded to;
- 101.6. Facilities often fail to respond and to provide redress when patients complain;
- 101.7. Health authorities fail to address problems that give rise to complaints – the main focus is on individual abuse by health staff. As a result, the complaints procedure fails to ensure non-recurrence of systemic failure and gaps;
- 101.8. As the complaints procedure does not address the larger issue, health workers consider the complaints procedure as a mechanism to discipline them and identify performance problems.

102.

#### **Question 4:**

**Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue, see: 1 | 2<sup>72</sup>**

103. The World Health Organisation (WHO) has stated that, to prevent and eliminate disrespect and abuse during facility-based childbirth 5 key steps must be taken including:

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<sup>71</sup> “Stop Making Excuses” Accountability for Maternal Health Care in South Africa by the Human Rights Watch. Available at <https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa> [accessed 17 May 2019].

<sup>72</sup> 1. Bohren MA et al., [The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review](#)

2. World Health Organization, [statement on “prevention and elimination of disrespect and abuse during childbirth](#).

- 103.1. Greater support from governments and development partners for research and action on disrespect and abuse. This is critical in researching the context and measuring the abuse of women in childbirth globally and to understand the impact this has on women's health and rights generally.
  - 103.2. Initiate, support and sustain programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care
  - 103.3. Emphasizing the rights of women to dignified, respectful health care throughout pregnancy and childbirth
  - 103.4. Generating data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support are required
  - 103.5. Involve all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices.
104. While there are laws and policies in place that specifically deal with violence against women in South Africa, we are not aware of any policy that has been developed and implemented specifically to address mistreatment and violence against women seeking to access reproductive health care including childbirth services.
105. We therefore recommend that governments like South Africa take steps to develop and implement laws and policies that are aimed at addressing violence against women in the context of sexual and reproductive health.
106. We further recommend that steps are taken to make this law and/or policy widely available and accessible for women who utilise public health facilities to have a guideline to which they can measure the treatment received at the facility.
107. Women in such facilities must be encouraged to report any shortcomings in the services they have received to the management of the applicable facilities. The state must request such complaints and reviews in order to evaluate the services given.

## **V CONCLUSION AND RECOMMENDATIONS**

108. We trust that you will find this submission made by the LRC and WLC in this document useful. Should you have any comments or questions please do not hesitate to contact Ms Mudarikwa at [mandy@lrc.org.za](mailto:mandy@lrc.org.za) and Ms Solomons at [nasreen@wlce.co.za](mailto:nasreen@wlce.co.za)

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**\*\*\*ENDS\*\*\***